

FEMALES of AFRICAN DESCENT and ISSUES of RACISM and SUICIDE

By

Nichola Watson

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Dr. Susan Breiddal

Division of Arts and Sciences

ABSTRACT

The purpose of this study was to investigate the question: What does the current literature say concerning the connection between racism and suicide among females of African descent, (herein referred to as African women, black women, or black females) according to the theories of intersectionality, black feminist thought, and Afrocentricity (African culture). Thematic analysis was used. Although there was rare connection in the literature between racism and suicide among black women and white supremacist violence, its impact was traced from the time of Cleopatra through the transatlantic slave trade era, to the current day. Four key themes were highlighted: the stereotype of “strong” black women and the impact on their health and well-being; cases of suicide among black women; and the need for professional consideration regarding these issues. A model for working with black women focusing on suicide prevention and intervention is discussed along with suggestions to assist non-black professionals in offering health services to these women and other marginalized populations. Methodological limitations and possible directions for future research are then discussed.

Keywords: Females of African descent, African women, black women, black females, racism, suicide, wellbeing, white-supremacy, strong black woman, cultural competency, and thematic analysis.

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Dedication

I would like to dedicate this work to black women past and present who have confronted and continue to struggle through issues of racism and suicide. I would also like to dedicate this research to the specific population who attend to their own health and wellbeing, to those who do not know how to ask for help and to those who do not have access to health care resources. Finally, this work is dedicated to these women as a source of encouragement, particularly to those who may become discouraged by racism to the point where they may engage in suicidal ideology.

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Chapter 1

I SING

*I sing
for my Ancestors
Those whose voices were
silenced
I sing
for Afro-women
who were told they are not
human
I sing
for Girls who were told
they cannot receive an
education
because of their sable skin
I sing
for every Sistah
who was forced
to barter sacred flesh
with a man
she never loved*

*I sing
for Those
who are unable to
lift their voices
I sing
because it identifies
the best parts
of Me
I sing, shout, and feel
My Story
all around
Me
A cherished gift
born in my
heart
that **MUST** be
shared
and so...
I sing*

(Watson, 2013)

I saw the movie “Amistad” and it had a profound and immeasurable impact on me. It brought to life fictional characters from a turbulent time in history, capturing historical events such as the revolt of African captives aboard ships such as La Amistad (Meissner, 2009). The film also addressed discourses between justice and law and the economic enterprise of chattel slavery (Greenspan, 2014; Meissner, 2009). La Amistad was a historical ship which transported 54 Africans from Cuba to the United States of America (Meissner, 2009). Ironically, Amistad is a Spanish noun meaning friendship. The African captives in the film represented real people who were originally captured in West Africa and subsequently transported from Cuba to America (Meissner, 2009).

Before launching into my impressions of the movie, I want to provide contextual information and define some terms. The middle passage refers to the routes slave ships travelled carrying African captives for the transatlantic slave-trade (DeGruy, 2005) from 1525 to 1866 (Gates, 2014; Royal Museums Greenwich, 2017). The transatlantic slave-trade saw over 12.5 million people of African descent transported from the continent of Africa (Gates, 2014; Royal Museums Greenwich, 2017). These people became the property of Portuguese, British, French, Spanish and Dutch slave-traders through purchases and captivity, and they were then transported to the New World for enslavement (Gates, 2014; Royal Museum, Greenwich, 2017).

This slave-trade would not have happened without the cooperation of the African elite who worked in harmony with European slave-traders (Gates, as cited in Greenspan, 2014). Within the context of domination, there were political, economic, and racial discourses that intersected and fueled the engines of the transatlantic slave-trade (Sivanandan, as cited in Skanthakumar, 2018). Throughout this document, the use of the terms slave-traders and slave-

holders refer to those people who exercised violence over African people during the time of slavery (DeGruy, 2005; Kendi, 2016).

One of the promotional previews of the movie alarmed me and captivated my soul. It stated that the movie re-enacted events that occurred during the transatlantic slave-trade, such as brown bodies shackled with chains around their necks, feet, and hands (DeGruy, 2005; Gates, 2014; Greenspan, 2014; Kendi, 2016). Historically, slaves were kidnapped, stripped naked, raped, shackled, packaged as human chattel onto ships like *La Amistad*, and forced, still naked, into confined spaces with other enslaved Africans (DeGruy, 2005; Greenspan, 2014).

The images of the chained brown bodies were horrifying and dehumanizing. There was a clip that had shown a woman shackled as she lay on her back on the wet wooden floor of the ship while giving birth. She died that night, and the next morning the film showed another woman leaping overboard with the new born in her arms, choosing to die.

These clips caused me to reflect for some time on several issues and to note how starkly different the reality on the ship was compared to my own community life. In the black community in which I was raised, births were celebratory and full of ritual. For example, christening is the name of the traditional rite of the birth ceremony that takes place in Christian churches, where the parents and chosen family members and friends gather publicly to acknowledge and bless the arrival of the new baby (Davis, 2017). At this ceremony, religious or spiritual leaders pray for the new baby. The godparents are special individuals selected by the parents to be part of the baby's life, and they receive honourable mention at the christening ceremony. A critical role of godparents is to assume parental responsibility for the children if their parents are deceased before the children reach adulthood. Following the religious ceremony, there are celebrations in the family home or in the community, where serving food is

a widespread practice. There was no such celebration or ritual on the night the baby entered the world on La Amistad.

Instead, it was shocking to see the white supremacist violence as the baby arrived. I have deep empathy for enslaved parents, specifically mothers – who raised their children to endure the same kind of violence that they had experienced from childhood into adulthood and parenthood. The deep despair, hopelessness, and helplessness the parents would have experienced when they considered their children and their children's future are unimaginable. I wondered if there was a specific way in which parents prepared their children to be raped by slave-masters. At what age or stage in life were parents informing their daughters that they would bear children and become parents themselves? What were the conversations between parents and their sons concerning the possibility of them forcibly raping or beating family members? How did parents communicate to their children the distinct possibility of displacement, in which case they might never see each other again?

I have considered the enslaved blacks within the framework of generations of traumatized parents, children, and communities (DeGruy, 2005). Enslavement was and is traumatic (DeGruy, 2005); and in my mind, the intense distress that enslaved parents endured on an ongoing basis is inconceivable. When I imagine pregnant women, whom the slave-holders raped, I see fetuses in distress from the time of their conception to their delivery and beyond, and in distress throughout the developmental stages of their lives. I do not know the number of enslaved babies who survived white supremacist violence and made it to adulthood; but I do know that I will never be able to suppress my disdain for the recurrent captivity and enslavement of African people historically and presently by white supremacist violence.

I was unable to find data to verify that anyone from the ship *La Amistad* threw themselves overboard. The scene with the female leaping overboard with the baby depicts real events aboard other slave ships where the captured jumped to their deaths or slave-holders or slave-traders threw captives overboard (Kneeland, 2006). That event captured my soul and brought history to life. It inspired me to learn specifically about the woman and the child who died, and in general to know more about African women who ended their lives because of their vulnerabilities and the brutalities of slavery. It also motivated me to examine the relationship between the ending of African women's lives due to self-determination or to enslavement, and other forms of oppression (Kendi, 2016; Kneeland, 2006).

Having seen the movie and the inhumane depiction of the treatment by white slave-holders of the enslaved Africans for the sake of economic wealth, I empathize with mothers and caregivers who in real life had to make the complex decision of whether or not to leap overboard with or without their children. I can understand that women who decided to end their lives and the lives of their children were unable to imagine futures for their children beyond what they had already endured during captivity and enslavement. While this decision was morally complex, it may have been liberating within the context of being free from enslavement and the brutality and inhumanity they would have to endure (Kneeland, 2006).

Beyond this, the movie disturbed me on multiple levels. Specific scenes revealed horrific race-based violence and the total lack of humanity on the part of the slave-traders (DeGruy, 2005; Kendi, 2016; Kneeland, 2006). For example, it was difficult to comprehend the slave-traders' decision to leave dead bodies among the living captives, only removing them at their own convenience, as is historically documented (Greenspan, 2014). Also, the images where white slave-traders were applying lashes to the brown bodies shattered my heart. The

whippings created open bleeding wounds. It is impossible to comprehend what threat the enslaved posed to the slave-traders while shackled in the bottom of a ship.

The movie is in agreement with the historical reports documenting real-life events of the transatlantic slave-trade. For example, the enslaved consistently showed tremendous determination and perseverance in the face of intentional and vicious violence that they endured from the slave-traders and other forces of white domination (DeGruy, 2005; Kendi, 2016; Kneeland, 2006). The movie portrays other versions of real-life events, such as the discourse around racism, morality, criminality, and dignity (Carten, n.d; DeGruy, 2005; Kendi, 2016; Poussaint & Alexander, 2001). It highlights the issue of what is known as acts of suicide through acts of resistance (Carten, n.d; DeGruy, 2005; Poussaint & Alexander, 2001). It is possible that through suicidal acts of resistance, enslaved Africans were trying to gain what Professor Allan Wade (2007) refers to as a sense of agency and power; and they were reclaiming control from slave-holders/traders/masters and other sources of domination (Kneeland, 2006). Wade, in speaking about oppression writes that people who are oppressed will take actions of resistance to reclaim control. While the transatlantic slave-trade highlights the capitalistic nature of racism that resulted in death; contemporary issues of racial discrimination have also evolved into hate that kills (Reynolds, 2011, as cited in White, Marsh, Kral, and Morris, 2016; Sivanandan, as cited in Skanthakumar, 2018).

Stories of Racism

I was born in Jamaica and lived there until the age of twelve. During my childhood, I cannot recall any discussion of suicide in my family, in the community, or in politics. However, it is possible that in Jamaica it may have occurred. At the age of twelve, my family emigrated to Canada, where I began to learn about suicide by listening to adult conversations. Specifically, I recall comments made by people within the black community such as “weak people kill themselves.” Other comments included: “Black people have too much to live for,” or “Suicide is for White people.” “We are a people of strength,” or “The Bible says you should not kill; therefore, it is sinful to kill yourself.” My awareness of suicide also increased through the television news media, which primarily reported suicide and its complexities as a mental health issue within the general population. Before my post-secondary studies, I considered the act of committing suicide as a health issue that was not present in the black community. While suicide was absent from my cultural vocabulary as a young person, racism was evident both socio-culturally and politically.

From an early age, in Jamaica, I understood the complexities of racism through comments concerning appearance. Racist commentaries were directed at others and never toward me. It was common to hear other people’s parents, school teachers, religious leaders, and family members make racist comments or give racist directives to my peers. Examples of this I remember include; “Get out of the sun before your skin darkens,” or “You are such a pretty girl despite your dark skin,” or “That person is so dark and ugly.” Racist commentary remains in Jamaica as evidenced through the social and political discourse.

Interculturally, not only were people assessed by the colour of their skin; it was clear that better opportunities and superior treatment were available to people of mixed heritage than those

of non-mixed heritage and those with a lighter complexion compared to darker skinned people. This behaviour is referred to as “colourism,” where preferences for lighter complexion exist within a racial or ethnic group (Bodenhorn, 2006; Hochschild & Weaver, 2007; Keith & Thompson, 2003, as cited in Perry, Stevens-Watkins; Oscar, 2013, p. 6). Educator, Dr. Joy DeGruy (2005) states that colourism “is racist socialization, where many [Black people] have adopted white standards of beauty” (pp. 135 & 137).

While the people around me made disparaging comments to others concerning their skin complexion, I knew “I was a female child with beautiful dark skin,” (Watson, 2016, p. 4), because family, friends, and other people in my community were positive in their comments about me. Whereas, “in Canada, in addition to being female, I learned that I was a black nigger...” (Watson, 2016, p. 4). “I encountered verbal and psychological violence from a few cruel white children and adults,” which has continued both socially and professionally into my adulthood (Watson, 2016, p. 4). Historically, and more recently, the white supremacist violence that I have experienced has occurred in places designated for professional learning, places of employment, medical facilities, religious institutions, and in public.

Here is one woman’s story. While workplace performance has never been an issue for her, white supremacist management teams have. In institutions where racist violence was directed at her, she has responded by highlighting the individual’s patterns of violence and insisted on addressing the issues. Even though she had competently performed her duties and responsibilities, the offenders had the power to terminate her employment. She said that a resolution was not a simple matter of power differences between employer and employee, but an issue of white domination exercised through actions of racial oppression – which professor Hill-Collins (2017) would say, that white supremacy relegated this woman and her blackness to being

disposable. She is aware from these experiences of white supremacist violence and practiced domination that these are methods intended to “keep her [a black woman] in her place” (James, Este, Bernard, Benjamin, Lloyd, & Turner, 2010, p. 21).

For a concrete example of how this plays out in the workplace, she described a personal incident. A white man was giving a presentation that she attended. She asked him, in what she thought was a non-challenging and respectful way, if it was possible that some of his practice might be oppressive to the people he served. He later reported her to her administrators, stating that her question had made him uncomfortable. The administrators said that they listened to his complaint against her, and discussed it in her absence. Upon being made aware of the issue, she asked to have a meeting with the person. She requested the meeting because she had genuinely asked the question in the hope of having an intellectual discussion. In response to her request for the meeting, she learned that because of the nature of her administrator’s relationship with this man, her request was being denied. The administrators’ response was difficult for her brain and heart to comprehend. She would not be able to address the complaint and, the people who were supervising her were not interested in discussing her concerns. She was shocked that the man had reported her and she did not understand what he was hoping to accomplish. It was only later that she thought that the man reported the incident because she was a black woman who had challenged his position of white supremacy.

That evening, she recalls arriving home and crying in the arms of her partner. She cried because she thought that she was in an environment with professionals who had good moral character and ethical standards. Furthermore, she did not think that these professionals would work to conceal this man’s violence and therefore she had expected a process of resolution that adhered to common professional standards.

In the days following the conversation with her administrators where she was denied the opportunity to address her concerns, their behaviours communicated that she was not worthy of learning in that environment. For example, there were insults directed at her academic and clinical work. According to one administrator, she was operating below institutional expectations and standards, and this person thus undermined her confidence in a way that was psychologically manipulative. With the profound humiliation that she experienced due to those words, she found herself internalizing the negative messaging and began questioning her intelligence and mental capability.

Through conversations with her husband, and upon reflection, she came to believe this manipulation was an example of what is known as “gaslighting.” This administrator was abusing his position of power by manipulating the student’s psychological health, and as a result, the student began thinking that she was both incompetent and unwell. She thought this because she had experienced trauma from the racist violence directed at her, which began to impact her body and her brain. Also, the student mentioned, from the moment she learned of the complaint against her, and because the complainant conjured up a story where the man was the injured one, her brain began shutting down. From then on, she said she felt unsafe and mistrustful of those administrators, leading to an inability and an aversion to learning from them.

According to this woman, she not only suffered psychologically from this situation; for the next two months she experienced a myriad of physical pains. She reported that migraines moved to different places in her head, sometimes lasting two to seven days, and the intensity made it impossible to read her computer screen. Her gums bled when she flossed them, and her teeth ached. An appointment with her dentist identified the problem –she was grinding her teeth, which was entirely unconscious. For the first time, she said she chewed a section of her mouth

guard. Her shoulder blade was in constant pain, and there were unexplained rashes on her skin. Her sleep pattern changed dramatically – from seven to eight hours each night to three to four hours of sleep completely absent of deep sleep. Her stomach was unsettled for two weeks. Even though she knew that her asking the question was not the primary issue, she had internalized her administrators' responses as shameful because they seemed to have claimed the man's version of the event as valid. Within this context, Wade (2014), states that this woman likely felt humiliated because she was violated.

This woman reported that she gained a new perspective when she consulted with her academic advisor at the institution she was attending, and they reassured her that the administrator's comments were contrary to her academic performance, and reaffirmed that she should continue with her academics and clinical work. Following her communication with her academic advisor, she asked for feedback on her communication from a peer who was present at the time that she had asked the question. In response, this person pointed out that after she had asked the question, other peers asked related questions that examined the ethics of the man's work. This peer declared that by asking the question, she, the student, positively shifted the dialogue. She reflected on the feedback from her peer and wondered if perhaps the man had initially felt exposed and reacted defensively. Nevertheless, by attacking her character to the administrators, he was using his privilege in the act of violence aimed directly at her.

This woman said her partner and friends encouraged her and loved her throughout this difficult time; and under the guidance of her academic advisor, she was able to plan an exit from the agency. Following the development of this plan, she began to have a positive outlook. Even though she had to remain temporarily in the toxic environment, she had hope because there was

a future end date. Her characterization of the overall experience is that she went into this environment healthy and enthusiastic, and she left feeling physically and psychologically sick.

Today, because of the healing that has taken place, she said she can share this experience without re-experiencing physical or psychological pain. Rather than engaging in a discourse about white fragility and micro-aggressions, she has chosen to frame the experience as a white supremacist or racist violence. Taking the feedback that she received, and reflecting on her actions retrospectively, she feels good about having asked the question, and she has decided that it was the correct course of action, despite the repercussions.

Among the black women I know personally, many share their stories of innumerable racist incidents, however the issue of suicide is rarely acknowledged. I have often wondered why it seems so much easier for these women to discuss incidents of racism than it is to discuss suicide. It seems, from the numerous females that I have spoken with on this topic, that they have not felt safe, or for some other reason not felt able, to share the details of their suicidal thoughts, or attempts. Under specific circumstances, during individual conversations, women have spoken to me of suicidal thoughts, behaviours or attempts.

Definitions

This study asks the following: What does the current literature say concerning the connection between racism and suicide among females of African descent? Before continuing, it may be helpful if I define specific terms. For this thesis, racism is defined as “the beliefs, attitudes, and actions resulting from categorizing individuals and groups based on phenotype, heritage, or culture” (Pachter & Coll, 2009). While racism may be directed towards blacks from other groups, for this paper, racism is referring to that which occurs from white people. A racist idea is defined as “any concept that regards one racial group as inferior or superior to another racial group in any way” (Kendi, 2016, p. 5). White supremacy refers to “an historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and people of colour by white people and nations of the European continent, for establishing, maintaining and defending a system of wealth, power and privilege” (Ellinger & Martinas n.d., as cited in Martinas, 1994, p. 3). Also, throughout this document, the words suicidality or suicidal behaviours will refer to terms such as suicide, suicide ideation, suicide attempts (Prempeh, 2013). Females of African descent refers “to a phenotypic group of black women” (J. W. Elias, personal communication, May 31, 2018) whose native homeland and ancestral home is the continent of Africa, but who may be living in various parts of the world (European Network Against Racism, 2012).

Significance of Research

This research is important because it links two well-documented phenomena – racism and suicidality – and at the same time directs the focus specifically towards females of African descent. Extensive research on these topics has been conducted for the general population of people of African descent (Anglin, Gabriel, & Kaslow, 2005; Crosby & Molock, 2006; Grant, 2013; Prempeh, 2013; Willis, Coombs, Drentea, & Cockerham, 2003). However, despite evidence that black women do engage in suicidality (Perry et al., 2013; Wright, 2012) they have not been the main or exclusive focus of the studies (Molock, Puri, Matlin & Barksdale, 2006; Prempeh, 2013). It is imperative to acknowledge the experiences of suicidal behaviours among black women in the research because the topics among this group contextualize their lived realities, and it further encourages data collection that is culturally specific to them (Fullagar & O'Brien, as cited in White et al., 2016).

The social construct of race has resulted in conscious and unconscious actions of racism (DeGruy, 2005; Kivel, 2002; Okeke, 2013; Welsing, 1991), and while “the notion of race is illusionary, racism is not” (DeGruy, 2005, p. 22). Scholars have been discussing the impact of racism socially and politically for some time (DeGruy, 2005; Hall, 1997; Kivel, 2002; Poussaint & Alexander, 2001; Welsing, 1991), and it is recognized by academic scholars as a determinant of the health of black people (James et al., 2010; Poussaint & Alexander, 2001; Wright, 2012), as well as non-academic writers (Baldeh, 2017; Bell, 2017; Chatterjee, 2017; Washington, 2014; Wortham 2015). For this thesis, race is defined as a “concept of society that insists there is a genetic significance behind human variations in skin colour that transcends outward appearance” (King, as cited in DeGruy, 2005, p. 22).

Research also shows that racism is a determinant of health for black male youth – resulting in despair, hopelessness, powerlessness, and alienation, arising from a sense of

devaluation by mainstream systems within society (James et al., 2010, p. 129). These feelings, as well as depression and anxiety are characteristic of the risk factors associated with suicide (Prempeh, 2013; Wright, 2012). “Risk factors are characteristics of a person or [that person’s] environment that increase the likelihood [for that person] to die by suicide” (Suicide Prevention Resource Center, 2013). For black women, the identified risk factors of suicidality include the cultural stigmatization of medical diagnoses, suffering in silence (Bell, 2017; Dookie, 2017; Monroe, 2014; Okeke, 2013; Sealy, 2015; Washington, 2014; Wright, 2012), race-based stressors, gender-based stressors, class-based stressors, and social contexts (Perry et al., 2013). Dr. Monica Williams who is a psychologist, professor, and the director of the University of Louisville’s Center for Mental Health Disparities (as cited in Wortham, 2015), states that experiences of racism, including racial harassment and hostility among people of colour, leads to race-based traumatic stress injury. The research on racism among black women is prolific (DeGruy, 2005; Hill-Collins, 2000; James et al., 2010; Kivel, 2002; Michael, 2015). In contrast, and as discussed above, the research on suicides among this group is rare (Perry et al., 2013; Poussaint & Alexander, 2001). Nevertheless, the research that exists is clear that racism and suicidality have adverse effects on the health and wellbeing of the sufferers (James et al., 2010; Michael 2015; Perry et al., 2013; Poussaint & Alexander, 2001). By asking the question: ‘What does the literature say concerning the connection between racism and suicidality among females of African descent?’ this research links two complex topics – racism and suicide – that are extensively but separately studied psychological and sociological processes (Clarke, 2011).

First, this research will provide personal and academic empowerment by producing authentic knowledge (Wright, 2012) on connections between racism and suicide among black women. It will provide culturally relevant content to black people, and hopefully affirm,

validate, dignify, and inspire black women to continue to engage in conversations concerning interpersonal or intrapersonal experiences with issues of suicide, racism, health and wellbeing. It may also provide opportunities to raise awareness and consciousness with respect to the complexity and impact of suicidality and racism among black people, by increasing the knowledge-base of clinical practitioners and other professionals. In identifying the relationship between these two problems, this work may help anyone who encounters black females including teachers, frontline workers, social workers, medical practitioners, and counsellors. It will assist them in framing an understanding and awareness that may help them to avoid exacerbating problems and instead provide their clients with the support they so need.

In this chapter, I have shown how my interest in investigating this thesis question developed by linking the historical white supremacist violence of racism to current practices. I have also shown that in these contexts there are severe consequences to racial oppression, including suicidality. Furthermore, I have shared experiences of the ways racist practices have occurred in aspects of my life. These informed the development of my research question: What does the current literature say concerning the connection between racism and suicidality among females of African descent? I have provided reasons why this research question is important and who will be interested. In the next chapter, I will review the existing literature on this topic.

Chapter 2

This literature review consists of four sections. In the first section, I will review theories of intersectionality, black feminist thought, and Afrocentricity, that examine the literature on racism, suicide, and other forms of oppression among black women. Interspersed throughout, I will draw on the connections between racism and suicide among black women prior to and during the transatlantic slave-trade, and in contemporary society. In addition to discussions about enslaved women and their strategies for coping with pain and suffering, I will offer three ideologies that slave-masters used to justify their violence. Discussions on enslaved women and forced breeding for capitalism, colourism and the enslaved, and enslaved women and vaginal fistula disorder will conclude this section.

The second section will examine the creation of the “strong” black woman stereotype and the impact of this stigma on the health and wellbeing of black women. Black women and their responses to the stigmatization of being strong, and coping with the stereotype are a part of this section.

The third section will investigate the multiple operations of racism as a determinant of both physical and emotional health among black women. I will also include a brief discussion of the reason for the scarcity of research on racism as a determinant of health among the studied population. Furthermore, I will discuss issues that impede the publication of empirical data in peer-review journals that should recognize race-based traumatic injury. A discussion of race-based traumatic stress injuries is interwoven throughout. To end this section, I will examine the topic of post traumatic stress disorder, symptomatically as chronic stress due to racial discrimination, and theoretically as explanations for racist violence.

The fourth section will examine suicide among black women, including the rates of suicidality and explanations for the rates of suicide among black women in the United States of America (USA). I will discuss the factors that increase the risk of suicide and examine suicidal behaviours among black women, and I will include an examination of suicidality among all people of African descent.

The fifth and final section will address black women, racism and suicide for professional consideration. I will include a discussion about black women as they relate to racism and issues of stigmatization towards mental illness. I will also discuss the issue of black patients and white helping professionals. In particular, I will examine theoretical frameworks for helping these professionals. In addition, I include discussions on white privilege, white dominance and capitalism as well as commentary on white helping professionals when they are discussing issues of race and racism as they relate to cultural competency. I will highlight the work of Lisa M. Wexier and Joseph P. Gone (2012), which address four assumptions about suicide prevention and intervention that incorporate cultural practices congruent with Indigenous beliefs and practices. Finally, I will offer a brief overview of the issues of suicide among the studied group and among the general diasporic African community for the benefit of cultivating professional awareness.

Theories

Intersectionality.

Oppression is defined as situations of injustice where “one group organizes systematically to withhold or deny another group access to the resources of society” (Hill-Collins, 2000, p. 4). Oppression by force refers to “the use of coercion or duress in an act which imposes on another or others an object, label, role, experience, or set of living conditions that is unwanted, needlessly painful, and detracts from physical or psychological wellbeing” (Hanna et al., 2000, p. 431, as cited in Gregory, 2013, p. 165). Oppression by deprivation is an “act that deprives another or others of an object, role, experience or set of living conditions that are desirable and conducive to physical or psychological wellbeing” (Hanna et al., as cited in Gregory, 2013, p. 156).

The American abolitionist Maria W. Stewart (1803-1879) challenged black women to address oppressive practices such as issues of racism, sexism, and classism (African American Registry, n.d.; Hill-Collins, 2000; Soogrun, 2015). She viewed these injustices as barriers against black women’s upward mobility, encouraging black women to confront such systems of oppression by seeking education and professional careers outside of domestic servitude (Soogrim, 2015).

Kimberle Williams Crenshaw is a legal scholar and professor in the USA who developed intersectional theory. In her 1989 essay “*Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*,” Crenshaw conceptualized the experiences of black women within the contexts of race, gender, sex, and social class. Crenshaw’s theory of intersectionality builds on Stewart’s work by examining both feminist theory and anti-racist policy where black women’s experiences and

concerns are often absent from these theoretical discourses. That is, feminist theory prioritizes the experiences of white women, and anti-racism policies address black men and other people of colour and their issues of discrimination (Crenshaw, 1989). Crenshaw's theory combines feminist theory and anti-racism policies, attending to the particular realities of concurrent gender and racial discrimination that black women experience, making visible the multiple social, structural, and systemic political policies that were created and are in place to keep them oppressed (Charleswell, 2014; Crenshaw, 1989; Hill-Collins, 2000).

Black feminist thought.

In the USA, black feminist thought was a standpoint taken by black women towards emancipation from oppressive practices within the Black Liberation Movement, the Civil Rights Movements, and various white feminist movements (Charleswell, 2014). Black women's experiences of racism and sexism were made invisible within the latter movements (Charleswell, 2014). The core components of black feminist thought are "clarifying black women's experiences and ideas," and focusing on their self-determination (Hill-Collins, 2000, p. 16). By placing black women at the center, it "empowers them to recognize social injustice through multiple and intersecting oppressions" (Hill-Collins, 2000, p. 22). Black women reclaiming, reconceptualising, and reinterpreting dimensions of oppression through intellectual discourse is equally significant to black feminist thought (Hill-Collins, 2000). Black women intellectually contribute to black feminist thought through critical social theory in academia, in the art world, in activism, in caretaking roles, in professional fields, and as students of all ages, just to name a few (Hill-Collins, 2000). Intellectual work recognizes black feminists who are engaged in what Hill-Collins (2000), a professor and author in the USA, known for her work on black feminist thought, calls "a process of self-conscious struggle on behalf of other black women, regardless

of the actual social location where that work occurs” (p. 15). The intellectual discourses of black women reflect a sense of purpose (Walker, 1983, as cited in Hill-Collins, 2000) along with reclaiming the historically preserved work and ideas of black women who are no longer living (Hill-Collins, 2000).

Afrocentricity.

Conceptually, Afrocentrism is a term that has been used for some time but is accredited to Professor Molefi Kete Asante (Asante, 2009). During the 1970s, Asante spoke about the need for Afrocentric data, and he cemented this ideology as a philosophical concept in his 1980 book *Afrocentricity: The Theory of Social Change* (Asante, 2009; James et al., 2010). African people are at the center of this paradigm (Asante 2009; James et al., 2010). Primarily, the black perspective guides African people’s agency and thoughts (Asante; 2009). Subsequently, this paradigm rejects the Eurocentric framework as central to African people’s reality; Eurocentric framework is viewed by African people as the source of human and social problems (Asante, 2009; Schiele, 1997, as cited in James et al., 2010). While Eurocentricity focuses on an individualistic approach, Afrocentrism embraces a collective cultural identity (Este & Bernard, 2003, as cited in James et al., 2010).

The perspective of Afrocentrism raises consciousness among Africans and African culture (Asante, 2009); and it examines the personal, cultural, psychological, cognitive, and structural locations of Africans (Asante, 2009). Through their lived experiences, Africans can locate their voices, forming a template for seeking self-knowledge (Dei, 1996, as cited in James et al., 2010). Afrocentrists acknowledge feelings and intuition as aspects of this self-knowledge or knowing (Asante, 2009; Este & Bernard, 2003, as cited in James et al., 2010) as well as spirituality, viewed as legitimate ways of being (Schiele, 1997, as cited in James et al., 2010).

The first key assumption of Afrocentrism is that black people are the central agents actively participating in advancing within the political and economic arenas (Asante, 2009). Another assumption states that Afrocentric scholars or practitioners engage in what Asante calls “marking” (Asante, 2009). Asante does not provide a prescription for this process of marking but says that it entails doing what is in the best interest of all oppressed black people. Marking is the process of acknowledging the work of those who are no longer with us (Asante, 2009). This recognition is central to African people’s history and contributors of today (Asante, 2009).

Since intersectional theory, black feminist thought, and Afrocentrism have contributed to black theorizing (Hill-Collins, 2000), they are important for this thesis question. They prioritize the standpoints of black women when investigating connections between racism and suicidality.

Racism and Suicidality Among Females of African Descent Before and During the Transatlantic Slave-trade

There is no clear written history of the first incident of suicidality among females of African descent. Incidents of suicide among African women were rare throughout the three-millennia-long history of ancient Egypt (“Ancient Egypt: Suicide,” n.d.). The three millennia began in 3100 Before Common Era (B.C.E.) with King Pharaoh establishing Egyptian dynasties (History World, n.d.). However, I begin the written history of suicide by acknowledging the suicide death of Queen Cleopatra VII in 30 B.C.E., an African and a warrior. She was the last of the Hellenist Ptolemies, and is said to have committed suicide in 30 B.C.E. following the loss of her bid to keep Egypt independent (Ancient Egypt: Suicide, n.d.). While my investigation did not produce much data on suicidal behaviours among black women during the three millennia, the literature concerning the transatlantic slave-trade showed evidence connecting racism and suicidality among this group.

Producing accurate data on the number of suicide deaths throughout the time of slavery in the USA and from different parts of the world is challenging (Lester, as cited in National Humanities Center Resource Toolbox, n.d.). As stated above, the transatlantic slave-trade (1525-1866) involved over 12.5 million people of African descent from the continent of Africa who were purchased or captured by European elites and brought on ships to the New World for enslavement as human cattle (Gates, 2014; Royal Museums Greenwich, 2017). The enslaved Africans were brought to the New World to benefit European economic enterprise (Greenspan, 2014). In Canada, the French colonists enslaved over 1,400 African peoples (Historica Canada, n.d.) beginning in New France in the late 1600s and is said to have ended in 1834 at the time of the establishment of British North America (Historica Canada, n.d.).

Henry Louis Gates Junior (2014), professor and historian, states that "...of the 12.5 million Africans that were placed on ships, only 10.7 million survived the dreaded middle passage, disembarking in North America, the Caribbean and South America" (para. 6).

However, the estimation is that 20 to 30 million people were captured and transported by slave-traders during the 430 years of slavery (DeGruy, 2005; Gates, 2014). Events that accounted for the reduced numbers included rebellions between African captives and slave-holders or ship captains, illnesses due to the poor conditions on the ships, and issues of jumping from or being thrown over the ship decks to their deaths (Gates, 2014; Royal Museums Greenwich, 2017). The transactions by the operators of the transatlantic slave-trade meant that captured and enslaved Africans endured pain and suffering (Kendi, 2016; Kneeland, 2006).

Females of African descent and issues of pain and suffering because of enslavement.

Pain is defined as "an unpleasant sensation and emotional experience associated with actual or potential tissue damage" (Felman, 2017, para. 1). The bio-psychosocial model of pain theorizes that pain involves the neurophysiological, the social, and the psychological (Physiopedia, n.d.). The influence of environmental factors on "pain perception [that] affects a person's emotions, behaviours, and cognition" are also considered (Physiopedia, n.d., para. 13). Taking one's life was a method used among the enslaved, to eliminate pain, in addition to faking illnesses, burning crops, destroying properties, rebellions, revenge, escaping, cooperation, accepting of the pain, and distraction, (Kneeland, 2006; National Humanities Center Resource Toolbox, n.d.). There is evidence that enslaved women developed strategies to reduce or to end their pain and suffering, and these strategies were similar to those used by enslaved men (Kneeland, 2006).

Trauma is an injury that results from extraordinary stressful events (DeGruy, 2005). Within the context of slavery, physical, emotional and psychological trauma occurred because there were stressful events that were ongoing and relentless, and therefore threatened the lives of the captured and enslaved, as well as their sense of security, safety, and stability (DeGruy, 2005; Robinson, Smith, & Segal, 2017). Enslaved women who were captured and held against their will, were traumatized by the planned and terrorist-strategic actions of slave-traders (DeGruy, 2005; Gates, 2014). They were forced to travel (DeGruy, 2005), and upon arrival at unknown destinations, they were forced into free labour production (DeGruy, 2005; Kendi, 2016). As well, predatory slave-masters raped enslaved women to reproduce offspring for the sole purpose of adding to the labour force (DeGruy, 2005; Kneeland, 2006). Throughout their time of captivity, enslaved women were traumatized on multiple levels (DeGruy, 2005).

David Lester, a psychologist, and suicidologist highlighted slave narratives from census and plantation records that included enslaved girls and women who ended their lives (as cited in National Humanities Center Resource Toolbox, n.d.). They did this as an act of resistance against being sold, re-sold, recaptured, and whipped; enslaved women ended their lives by drowning, hanging, or by jumping off cliffs (Kneeland, 2006; National Humanities Center Resource Toolbox, n.d.). Lester (National Humanities Centre Resource Toolbox, n.d.) documented specific enslaved girls and women who ended their lives. The incidents included Lucy, who swallowed a coin before drowning herself; Adeline, who tied a rope around her neck and then tied the same rope to a tree before jumping from the tree to her death; and Nellie, who rolled down a hill to her death. Also included was an unnamed enslaved woman who jumped from a steamship to her death, while in transition to another plantation, after having watched the sale of her family to a different plantation (n.d.). The savagery and the brutality of violence

showed by slave-masters meant that before their acts of suicide the above enslaved women endured inhumane conditions that were overwhelming, threatening their sanity, dignity, and integrity (Kneeland, 2006).

Pain was delivered by the slave-masters through various methods and the enslaved responded by engaging in acts of suicide (Kneeland, 2006). While the practice of suicide was rare among enslaved Africans in the USA, the taking of one's life by death became an option, especially when the circumstances of life were severe, increasing following rebellions (Kneeland, 2006).

Christianity and Slavery.

The ideology where slaves placed their trust in God derived from their interpretations of suffering and their understanding of God (Kneeland, 2006). The religious conversion of black people was a topic of contention because as Christians, the souls of enslaved would be freed. (Kendi, 2016). Kneeland (2006) states that, "Since the enslaved believed that God was at work in their lives, their valuation of suffering had those redeeming properties... Suffering was temporary, and like pain, it was a small part of their existence" (p. 12).

According to some white supremacist Christian slave-masters, God the Supreme Being directed them to plan and engage in the enslavement of a specific group of people, Africans, as human cattle for economic profit (DeGruy, 2005; Kendi, 2016; Kneeland, 2006). These ideologies were racist constructions through the manipulation of Biblical content by slave-masters who justified their decisions and acts of violence against the enslaved (Kendi, 2016). As an illustration, slave-masters referred to the story of Noah (Genesis 9:18-29), who had cursed his son Ham; resulting in Ham and his children being given dark skin and giving justification of enslavement of Africans as inflicted by God (Kendi, 2016). Also, slave-masters commonly

referred to several books in the Bible that speak to the enslaved, commanding obedience to their heavenly and earthly masters (Kendi, 2016; White, 2010). The enslaved persevered because of their traditional African spiritual beliefs and their reliance on their own gods as well as on the Christian God's promise of deliverance from pain and suffering (Bristol & Transatlantic Slavery, n.d.; Kneeland, 2006; Paris, 1995). While scholars believed it was a matter of the strategic use of biblical content by slave-masters to justify their classification of dark-skinned human beings as animals (DeGruy, 2005; Kneeland, 2006), others believed that the deceptive and intentional use of biblical content by slave-masters enabled them to manufacture and spread racist ideologies concerning black people, which then justified their violent behaviours toward the slaves (Kendi, 2016).

Cognitive dissonance.

The slave-masters engaged in the deceptive use of biblical content to justify their behaviours through cognitive dissonance (DeGruy, 2005). The theory of cognitive dissonance states that as perpetrators of terrorist violence, slave-masters "had to demonize the enslaved as sub-human to justify their actions" (DeGruy, 2005, p. 52). White slave-masters can be understood as having cognitive dissonance by their justification of their violent actions against other human beings. They did this through the creation of climate theory, curse theory, beast theory, evangelical theory, biracial theory, and other such racist and oppressive ideas (DeGruy, 2005; Kendi, 2016). Research shows that the culture of white supremacy seeks to exploit, destroy, and oppress nations (Martinas, 1994). White supremacy includes people with power, constructing theories and policies concerning the behaviours of people without power (Wade, 2014). Within the auspices of dominant white culture, African Americans and other people of colour continue to experience different forms of oppression, suppression, and appropriation

(Martinas, 1994). The “deadly brew” of white dominant culture reinforces “capitalism, [white] supremacist male fear, hatred of the power of women, and historical Christianity’s hatred and fear of sexuality and its ideology to divide humanity into the “saved” and the “damned,” among other ideas that persist” (Martinas, 1994, p. 4).

The interactional and discursive view of violence and resistance framework.

Another scholarly perspective that examines the use of biblical scriptures by slave-masters that perpetuated and justified their violence is from the Interactional and Discursive View of Violence and Resistance framework (Coates & Wade, 2007). Linda Coates and Allan Wade are Canadian response-based therapists (Reynolds, 2011, as cited in White et al., 2016). Response-based theory offers an understanding of people’s responses when their dignity and safety are attacked exposing such attacks and making the implications for working with people who have suffered violence visible (Reynolds, 2011, as cited in White et al., 2016). This paper explores the four operations of language that are grounded in the social discourse of this theory (Coates & Wade, 2007; Reynolds, 2011, as cited in White et al., 2016. Coates and Wade (2007) state that with these “four discursive operations, language can be used to conceal violence, to obscure and mitigate the responsibility of perpetrators, to conceal the resistance of victims, and to blame or pathologize the victims” (p. 513).

First, slave-masters used biblical language that concealed their violence toward the enslaved (Coates & Wade, 2007). For example, to justify predatory behaviours such as rape and other forms of physical violence, slave-masters preached biblical scriptures of obedience and submission to the slaves (Kendi, 2016). Secondly, they described the slaves as “African beasts and Barbarians needing nurturing” (Kendi, 2016, pp. 17 & 31). As per the human hierarchy, this was stated to be pre-ordained by God, whereby “God is at the top, they – the slave-masters are in

the middle, and the enslaved are at the bottom” (Kendi, 2016, p. 17). Third, the masters blamed and pathologized the enslaved as “morally inferior people who were ugly and who therefore lacked the capacity for freedom and self-government” (Kendi, 2016, p. 17). Fourth, slave-masters willfully neglected the use of language that addressed the resistance of the enslaved (Coates & Wade, 2007). “Whenever individuals are subjected to violence, they resist” (Coates & Wade, 2007, p. 512). For enslaved African women, the taking of one’s life was often contemplated, attempted, or completed (Kneeland, 2006). The choice of ending one’s life was one of their acts of resistance (Carten, n.d.; DeGruy, 2005; Poussaint & Alexander, 2001).

Enslaved women and forced breeding for capitalism.

In addition to being economically productive as field labourers, another primary role of enslaved women was “breeding” in order to increase the slave labour force for capitalism (Bristol and Transatlantic Slavery, n.d.; Kneeland, 2006). The average number of children an enslaved woman produced in the USA was nine to ten, and this number doubled in the West Indies (Gilder Institute of American History, as cited in Gates, 2014). “The rape of slave women by their masters was primarily a weapon of terror that reinforced whites’ domination over their human property” (Roberts, 1999, as cited in DeGruy, 2005, p. 77). Often, enslaved married females and those in cohabiting relationships produced children because slave-masters raped them (Bristol and Transatlantic Slavery, n.d.; Kneeland, 2006). Furthermore, there were forced marriages between enslaved women and men for the sole purpose of breeding for capitalism (Bristol and Transatlantic Slavery, n.d.).

However, in the Caribbean and specifically in Jamaica, slave marriages did not occur until the late 18th century (Bristol and Transatlantic Slavery, n.d.). Throughout the transatlantic slave-trade, white rapists included slave-masters, politicians, doctors, fathers, theologians,

academics, priests, preachers, lawyers, and judges, to name just a few (DeGruy, 2005; Historica Canada, n.d.). These people were the benefactors of slavery (Kendi, 2016).

In reading accounts of the life of the enslaved it is painful to imagine the life experience and the vulnerability of the enslaved women who were raped in front of their husbands and children by slave-masters, supervisors, and employers (Kneeland, 2006). It is difficult to envisage the enslaved women who watched their children and husband sold at slave auctions, and who watched while their children and husbands and other relatives were placed in chains and taken away to unknown places. It is distressing to conceive of what the enslaved male partners or lovers felt as they were forced by slave-masters to publicly beat their wives for a supposed offense (Bristol and Transatlantic Slavery, n.d.).

Colourism and capitalism.

Colourism divided family members on the plantation labour force and further complicated the dynamics (Bristol and Transatlantic Slavery, n.d.). Females who had lighter skin complexions (due to rape by slave-masters) were assigned less labour-intensive jobs in comparison to those who had darker complexions (Bristol and Transatlantic Slavery, n.d.; Kneeland, 2006). How can modern-day readers fathom the rage, anger, pain, suffering, despair, and hopelessness that the enslaved women endured? And what was it like when the option of suicide was not within their reach, and they somehow had to rely on their trust in God (Kneeland, 2006). For the enslaved, temporary relief from suffering and pain was achieved through spiritual or religious practices and belief and trust in their God to eventually end their suffering and pain (Kneeland, 2006).

Enslaved women and vaginal fistula disorder.

Within the context of slavery and bondage, enslaved women who were unable to conceive children were at risk of enduring more violence (DeGruy, 2005; Dudley, 2012; Okeke, 2013). Vaginal fistula disorder was the result of long and complex birthing labour combined with the physically intensive work that pregnant enslaved women underwent (DeGruy, 2005; Dudley, 2012). This disorder meant that enslaved women were incontinent in both their vagina and their rectum (DeGruy, 2005; Dudley, 2012). In 1845, in response to the complaints of slave-masters concerning enslaved females and their inability to breed or to have children, gynecologist Dr. James Marion Sims, developed violent and unethical medical procedures (DeGruy, 2005; Dudley, 2012; Okeke, 2013). While conducting vaginal fistula procedures and by using his invention the vaginal speculum, the doctor inflicted physical pain on enslaved black women (DeGruy, 2005; Okeke, 2013). Yet, in the medical field, he is heralded as “the founder of the Women’s hospital in New York and the father of modern gynecology” (Dudley, 2012, para. 6). Sims was also one of many racist medical professionals who engaged in medical experimentations that led to committing atrocities on African bodies (DeGruy, 2005; Kendi, 2016). Although not a physician, Margaret Sanger operated birth control clinics in impoverished neighbourhoods in Lower West Side Manhattan from 1927 to 1937, where black women were sterilized without their knowledge (Reed, n.d.).

Racism and Suicidality in Contemporary Society

The current literature provided limited data connecting racism and suicide. Historically, both black and white researchers claimed that suicide was absent within the African-American population (Prudhomme, 1938; Prange & Vitols, 1962; Bevis, 1921; Early & Akers, 1993, as cited in Crosby & Molock, 2006). However, presently, evidence shows that this is not so (Perry

et al., 2013; Poussaint & Alexander, 2001). When racism, suicidal ideation and sexism are operating together, a difficult life becomes even more difficult (Bell, 2017). When sexism operates with racism among a class of black women (Bell, 2017; Perry et al., 2013), it becomes a devaluing of personhood referred to as double jeopardy (Perry et al., 2013). Double jeopardy results in the second-class citizenship of African-American women of low socioeconomic status who encounter sexual objectification, and are therefore socialized as inferior across multiple settings outside of their communities (Sue, 2010, as cited in Perry et al., 2013).

It is important to address the impact of white domination violence on the sense of identity of black women, which creates the desperation of deep physical and emotional pain associated with suicidal issues (Bell, 2017). Those who are witnesses, or in relationships with people suffering from suicide ideology, need to be cautious and attentive to the narratives of those who are suffering; listen to what sufferers are communicating, and offer kindness, as this can play a role in “the sufferers decision” to not end their lives (2017, para. 16). The pain of suicidal ideation is real and terrifying, and it can help to speak to a friend, a family member, a stranger, or a professional (2017).

The “Strong” Black Woman Stereotype and the Impact of this Stigma on Their Health and Wellbeing

“The details and symbols of your life have been deliberately constructed to make you believe what white people say about you. Please try to remember that what they believe, as well as what they do and cause you to endure, does not testify to your inferiority but to their inhumanity and fear.” – James Baldwin

Another area of socialization that stigmatizes black women is the evolution of the strong black woman stereotype. It is understood that black women practiced this stereotype as a defensive mechanism to counter suffering and trauma; to give them the appearance of being strong (Okeke, 2013). Fundamental to this stereotype is an unrealistic and racialized expectation concerning black women’s abilities (Kendi, 2016; Okeke, 2013; West et al., 2016). For example, black women are stereotyped as having the ability to withstand severe pain and to handle multiple stressors simultaneously (DeGruy, 2005; Kendi, 2016; Okeke, 2013; West et al., 2016). Besides, white elites constructed the strong black woman phrase with the negative connotation that referred to black women’s capacity to persevere through “hardship without breaking down, physically and mentally” (hooks, 1993, as cited in Okeke, 2013, p. 6). The phrase evolved beyond its racist use from the time of slavery, with the generalization of black women as strong, to black women in contemporary society having ideas that are held and practiced because of this stereotype (Bos, Pryor, Reeder, & Stutterheim., 2013; Kendi, 2016).

The impact of stigma.

Any signs of weakness are often stigmatized (Okeke, 2013). Stigma is defined as recognizing differences and devaluation for social disapproval (Dovidio, Major, & Crocker, 2000, as cited in Bos et al., 2013). Within the context of black women, stigma referred to gender racism by white supremacy during the time of slavery (Bos et al.), and to black womanhood as being marked by inferiority and tainted by their dark skin (Kendi, 2016). Placing deficits on a black woman could result in an emotional response that impacts her self-esteem (DeGruy, 2005; Thomas, Witherspoon, & Speight, 2004). Socially, self-esteem refers to “our beliefs [concerning] our value, our value to our families, our friends, community and the world at large” (DeGruy, 2005, p. 123).

Sociologically, stigma is noted as the erasing of the whole person’s identity, both interpersonally and relationally (Bos et al., 2013; Yang, Kleinman, Link, Phelan, Lee, & Good, 2007). Within this interplay of the interpersonal and the relational is the social construction of stigma (Bos et al., 2013; Goffman, 1963, as cited in Yang et al., 2007), wherein there are contentions between “virtual social identity,” (the characterization of a person by society) and “actual social identity” (the attributes actually possessed by a person) (Goffman, 1963, p. 2, as cited in Yang et al., 2007).

The moral dimension of stigma refocuses it from the individual to the interpersonal, or transactional (Yang et al., 2007). Stigma can be thought of as being beyond its individual and social constructs and instead viewed as a moral issue causing suffering (Yang et al., 2007). From this perspective, critical components of what is threatened and what is at stake in relationships between the one stigmatizing and the one stigmatized are revealed (Yang et al., 2007).

As a discourse on what is at stake for black women in the USA, an example would include experimentations by medical professionals and medical systems that revealed systems of oppression on black bodies (Okeke, 2013). For example, the sterilization of black women in the post-World War II era, resulted in negative views of the medical system and medical professionals among black people in the USA (Okeke, 2013).

Responses to being stigmatized as strong.

When confronted with distressful situations, the inner courage of strength is revealed; this revelation conflicts with an outsider status within any given society (Poussaint & Alexander, 2001). African Americans reveal this conflict by operating between these two worlds in a process known as “double consciousness” (Poussaint & Alexander 2001, p. 131) by acting as though they are strong (Bell, 2017; Poussaint & Alexander, 2001; Thomas et al., 2004). For example, silence and the tendency to take ownership of problems remain common features among black people struggling with health issues (Bell, 2017; Okeke, 2013; Thomas et al., 2004), which, when faced with problems may prevent blacks from seeking professional care (Poussaint & Alexander, 2001). However, when blacks have sought help, they report “unfriendliness and/or insensitivity of the clinical professional community” (Poussaint & Alexander, 2001, p. 61). These attitudes only add to the problem (Tso & Samuelson, 2014). Professional services that are culturally competent and non-racist are critical for healing (Bell, 2014).

Pedagogically, when examining the functions of the strong black woman stereotype, the social psychological theories center around a socially constructed identity created by an internalized process by stigmatized individuals known as “impression engulfment” (Jones et al., 1984, p. 9, as cited in Yang et al., 2007, p. 1525). This type of response to stigma refers to the

internalization process of individuals, and to social identity, wherein “contexts define an attribute as devaluing” (Yang et al., p. 1525). This approach is troublesome, because it excludes the stigmatized person’s perspective and looks at the internalizing individual, instead “of the myriad of societal forces that shape exclusion from social life” (Parker & Aggleton, 2003, as cited in Yang et al., p. 1525). Components that make up the construction of stigma are “labeling, stereotyping, cognitive separation, emotional reactions, and social processes” (Link, Yang, Phelan, and Collins, 2004, as cited in Yang et al., 2007, p. 1525). This construction takes place “within the sociocultural environment where it is possible to observe the effects within the individual” (Link et al., 2004, as cited in Yang et al., 2007, p. 1525).

The strong black woman stereotype and coping.

Hamin’s (2008) discourse on women of African descent and their strategies around coping illustrates the effect of negative stereotypes that results in “shifting.” Shifting refers to the “common behaviours that women of African descent use to cope with the stereotypes and the bias/mistreatment they experience [because of] the application of generalizations” (Jones & Shorter-Gooden, 2003, as cited in Hamin, 2008, p. 14). Shifting can be perplexing because it can be self-sustaining, or it can be self-destructive (Hamin, 2008; Thomas, 2004). For example, black women may alter their speech and mannerisms in ways that are reflective of the people and their present environment (Hamin, 2008). Also, black women may change their physical appearance (their style of clothing or their hairstyles) based on their environment. Black women who wear hair pieces such as wigs at their places of employment may remove their wigs and expose their natural hairstyles among close friends and family. Because social context shapes identity, and how individuals cognitively maintain the integrity of the self and actively construct social identity (Crocker et al., 1998, as cited in Yang et al., 2007), black women have learned to

adapt and fit within their environment (Hamin, 2008). This might be a positive act and yet, in doing so they betray their real identities so that either choice can seem negative.

The strong black woman stereotype as it relates to coping strategies when examined within cultural and social lenses shows that for black women, stress occurs on multiple levels (Hamin, 2008). For black women, self-reliance concerns learned expectation (Hamin, 2008; Poussaint & Alexander, 2001). When discussing the individual, culturally the strong black woman stereotype can influence them if they struggle with mental wellbeing (Hamin, 2008; Okeke, 2013). In contrast, the stereotype can be an obstruction wherein black women place the health and wellbeing of others ahead of their own (Okeke, 2013; Thomas et al., 2004). Stereotyping, prejudice, and discrimination can contribute to mental illness (Ottati, Bodenhausen, & Newman, 2005, as cited in Yang et al., 2007; Thomas et al., 2004), and black women may hesitate to pursue mental health care and avoid addressing their personal experiences of mental illness (Okeke, 2013; Thomas et al., 2004; Washington, 2014). Black women's perception and response to the stereotype of the strong black woman is influenced by their identification within black communities and the wider society and their lived experiences of group identification (Hamin, 2008).

The reality of slavery through socialization resulted in the strong black woman behaviour (Hamin, 2008; Okeke, 2013; Poussaint & Alexander, 2001). The guaranteed separation of black families resulted in reinforced submissiveness through suppression of their feelings (hooks, 2005; Painter, 2007, as cited in Hamin, 2008). The systematic separation of black families resulted in female-headed households, where black women had to prioritize the needs of others ahead of their own (Poussaint & Alexander, 2001). The method black single mothers chose to resist systems of oppression was resiliency, which fueled their commitment towards their

children and for their homes (Poussaint & Alexander, 2001). While black women revolutionized the strong black woman stereotype as resistance and empowerment, white elites created it to control black women's image (Hill-Collins, 2000).

Racism as a Determinant of Health Among Females of African Descent

The absence of narratives of African Canadians as they relate to the impact of racism on their health and wellbeing from the Canadian research agenda is due to limited knowledge and understanding of African Canadians and structural issues, such as lack of representation in research and policy (James et al., 2010; Nnorom, as cited in Baldeh, 2017). Within the discussion of treatment services, Dr. Monica Williams, a psychologist, professor, and director of the University of Louisville's Center for Mental Health Disparities investigates the impact of race-based traumatic stress injury on people of colour (Wortham, 2015). Whereas treatments of trauma are supported empirically, race-based traumatic injury has yet to be recognized (Williams, as cited in Wortham, 2015). Canada has however, recently made a movement to pass legislation to collect racial and ethnic based data (James et al., 2010; Nnorom, as cited in Baldeh, 2017).

The inclusion of race-based traumatic stress injury in the Diagnostic and Statistical Manual is premised on publications in reputable peer-reviewed journals (Williams, as cited in Wortham, 2015). Specifically, "the system of approved worthiness towards publication in peer-reviewed journals and their selection process of topic applicability impacts establishing empiricism" (Williams, as cited in Wortham, 2015, para. 16). Minority researchers must "fuel the engine of empirical data by addressing the racial piece of trauma" (Williams, as cited in Wortham, 2015, para. 16).

To establish race and ethnicity-based research that identifies the specific challenges faced by minority groups, Canadian public health officials began collecting such data (Nnorom, as cited in Baldeh, 2017). However, challenges in discourses of diversity result in universalizing of group experiences (Crosby & Molock, 2006; Fullagar & O'Brien, as cited in White et al., 2016). An example of this is information collected about “immigrants” as a group, and “visible minorities” as a group rather than focusing, as is necessary, on specific challenges for each immigrant population or minority group (Nnorom, as cited in Baldeh, 2017).

Race-based traumatic stress-injury and its impact.

There is a link between racism and post-traumatic stress disorder, which is known as race-based traumatic stress injury or emotional distress (Williams, as cited in Wortham, 2015). Race-based traumatic stress injuries are “experiences of racial harassments or hostility that minorities have to deal with on a regular basis” (Wortham, 2015, para. 4). While this injury is treatable, many do not recognize the symptoms (Williams, as cited in Wortham, 2015). Williams (as cited in Wortham, 2015) states, “the symptoms of race-based traumatic injury include depression that is intrusive, vigilance that is isonomic and fueled by fear, anger, loss of appetite, apathy or lack of interest, avoidance, and emotional numbing” (para. 7). There are symptomatic similarities between race-based traumatic stress injury and post-traumatic stress disorder (Browne, as cited in Baldeh, 2017; DeGruy, 2005; Williams, as cited in Wortham, 2015). For example, Toronto psychologist Dr. Natasha Browne (as cited in Baldeh, 2017) states that “experiences of racial discrimination can trigger post-traumatic stress disorder...through nightmares and flashbacks...where there is a constant sense of feeling unsafe in the environment you are in” (para. 33).

Additionally, Michael (2015) details the physical, psychological, and mental impacts of Afrophobic racism through an investigation of racism against people of African descent in Ireland. Racism and racist incidents dehumanize (James et al., 2010; DeGruy, 2005; Kendi, 2016), wherein the experiences of victims' manifests in shock, fear, disgust, humiliation, anger, and living in isolation (James et al., 2010; Michael, 2015). While the impact is different for witnesses of the racist assaults, they also report feeling ashamed, embarrassed, disgusted, anxious, and physically ill (Michael, 2015). Vicarious racism includes "events that exert their influence on individuals through the observations and reports of others" (James et al., 2010, p. 124).

Narratives of Racist Assaults as Described by Females of African Descent

There are diverse ways in which racism impacts the individual and people with whom they are in a relationship (James et al., 2010; Wortham, 2015). The following are examples of racist assaults. Williams (as cited in Wortham, 2015) relates a story from Louisville, Kentucky, where she treated a highly-educated woman of African-American descent who was harassed by a director of the company for which she worked. Williams (as cited in Wortham, 2015) described the woman as a "high-functioning patient, with two master's degrees" (para. 3). However, the experience of the workplace racial violence impacted the patient's health and wellbeing, where isolation and "extreme" anxiety was evident (Williams, as cited in Wortham, 2015, para. 3).

Similarly, from the City of Vancouver, in the province of British Columbia, Canada, Doaa Magdy tells a story of a customer who said to Magdy "Fuck you, black bitch." She reported being frozen, and then retreating to the staff bathroom to cry. She stated that the racist incident "was hurtful [and] ... felt like someone just stabbed ...her" (Baldeh, 2017, para. 6).

While the incidents of racial discrimination impacted Madgy's mental health and wellbeing, it also brought up issues of cultural belonging, homesickness, racial identity, and Islamophobia (Baldeh, 2017).

In the research of James et al. (2010), the participants include youth and adults from the three Canadian cities of Halifax, Calgary, and Toronto. The participants represent the Caribbean, immigrant African, and Canadian Black communities, who shared experiences of racism and the impact of racism when combined with stressors on their health and wellbeing. Here is the narrative of a female participant:

“From personal experience, it is very harmful to the person's sense of self. It's like a perfectly shaped ice sculpture. Racism can literally chip away a whole arm. It is that hurtful – that painful. It doesn't kill; it doesn't totally demolish the statue, although in some instances it might if the person goes towards suicide and self-harm. But in my personal experience, the racism directed against me was equivalent to cutting [off] an arm. Not just a hand-a whole arm. And that was in junior high. That has taken years and years and years and years to re-grow.” (James et al., 2010, p. 132)

And a second example from an African-Canadian born female:

You cannot afford to relax no matter how good you are. You can never stop measuring yourself against others. You cannot afford to make a mistake. You cannot come to the point of relaxation and simply take your own competence for granted. The constant questioning erodes your confidence and increases an existing sense of isolation. (James et al., 2010, p. 133).

These four women's responses to racist violence may have been due to internalizing of racist violence (James et al., 2010; Michael, 2015; Williams & Williams, 2000). Internalized

racism as it relates to the annihilation of the individual is descriptive of “rage focused inwards” (James et al., 2010, p. 127). This rage is multi-layered, permeating the individual’s overall wellbeing, which can lead to subsequently transferred within the family and “may lead to depression, anxiety, fear, stress, traumatic stress, hyper-vigilance, and explosive anger, among other health issues” (James et al., 2010, pp. 127-130).

My story.

I hate racism, and since I have experienced racist violence, I echo the sentiments in the above stories. In the introduction, I spoke about experiences of racism that I met when I first arrived in Canada and as well as more recent occurrences. The following is an excerpt of my experience described elsewhere (Watson, 2016):

In the social spheres of life, I encountered verbal and psychological racist violence from white children and [white] adults. In Canada’s mainstream white-dominant school system, I was unable to locate myself. Theories of colourism, discursive language, and white supremacy were operating as social discourses in my life. As a teenager, I fell victim to racially oppressive paradigms. Consequently, my demeanor and deportment embodied that which was storied by racial discrimination. Having witnessed my transformation from being an energetic and engaging child to being unresponsive, my mother enrolled me in a specialized weekend program. She was certain that I would benefit from this program’s psycho-educational approach that implemented a curriculum of Afrocentricity. That curriculum was instrumental in strengthening my identity as a young black girl and has nurtured the person that I am today.... The knowledge that I gained from the program was empowering, and my goal was to counter racial discrimination by learning all that I could [concerning] the beauty of racial diversity.

Primarily, I learned to love and appreciate my beautiful brown skin. Furthermore, I was given the tools to live and operate in my [brown] skin within this society of white privilege and dominance. (pp. 4-5)

Upon my arrival in Canada from Jamaica, racism negatively impacted my health. As earlier stated, my energy decreased significantly, and I began to disengage socially. I am grateful that my mother was attentive to my health and wellbeing. Throughout the program that she had enrolled me in, I learned black history and black pride. For me, receiving the label of a “nigger” on multiple occasions, and not knowing the meaning of the word, resulted in internalized rage (James et al., 2010), mostly due to the tone that racists used. Eventually, someone told me that it was a derogatory and racist word when referring to black people. I also learned that the word ‘nigger’ was used by whites from the time of slavery to refer to black women and then subsequently to the entire collective of black people that they had enslaved. Armed with that knowledge, when white people referred to me as a nigger, I responded with the question: “When was I your black slave?” Often, the facial expressions on the faces of those white people who had used the word nigger indicated shock and bewilderment. I realized that many of the racist white people who had used that word did not expect a response from me and there were surprising reactions when they learned that that I knew the meaning of that word. My guess is that white people who have used and continue to use that word may not know the origin or the meaning of it.

Racial discrimination and the symptomology of post-traumatic stress disorder.

Research into post-traumatic stress disorder and its presenting symptomatology of chronic stress due to racial discrimination shows that it is manifested in three ways: “Firstly, through flashbacks; secondly, through the avoidance of situations that are a reminder of

traumatic events and the avoidance of close emotional ties; and thirdly, through hyper-arousal and the feeling of being constantly threatened” (Butts, 2002; White et al., n.d., as cited in James et al., 2010, p. 122).

The effects of racism have an impact on black people’s psychological and physiological wellbeing (Krieger et al., 1993, as cited in James et al., 2010). For example, the effects include increased blood pressure (Armstead et al., 1989, as cited in James et al., 2010), and having long-term stress that has strong negative effects on the cardiovascular system (Guyll et al., 2001; Wyatt et al., 2001, as cited in James et al., 2010). Also, the likelihood of cancer increases (Byrd & Clayton, 1993, as cited in James et al., 2010). Through the expression and suppression of anger, racism affects the physical health of victims (Armstead et al., 1989). Impacts of racial discrimination on one’s health can include a fear-based sensitivity from persistent exposure, which intensifies the level of the stress hormone cortisol, and can lead to health problems (Brown, as cited in Baldeh, 2017).

Racism-related stress has measurable effects on people of colour (James et al., 2010), and specific to African-American women experiencing racism, there is the increased likelihood of developing breast cancer (Taylor et al., 2007, as cited in James et al., 2010). Also, there is an increase in low birth-weight among African-American women with socio-economic status used as a control (Collins et al., 2004, as cited in James et al., 2010). Unlike Hispanic and White American women, the attainment of post-secondary education does not decrease the high rate of infant mortality for African-American mothers (Collins et al., 2004, as cited in James et al., 2010). The psychological toll of racism on the health of black women in America is affecting the health of their unborn children (Collins et al., 2004, as cited in James et al., 2010).

Michael's (2015) research in Ireland includes 22 reported incidents of Afrophobic racism and aggravated assaults that resulted in physical and emotional injuries. These Irish racist perpetrators of violence have been compared to the Klansmen (Henry, 2017). However, these narratives explicitly outlined perpetrators such as children and adults who engaged in incidents of harassment and assaults against other children, and other black people (Michael, 2015). People were beaten or injured with the use of dogs, fists, and feet as well as other weapons (Michael, 2015). Other incidents included criminal damage to property, verbal threats to life, and public shaming (Michael, 2015). Perpetrators used racial slurs such as "nigger," "monkey," and "black apes" (Michael, 2015). The perpetrators of racist violence showed attitudes empowered by white racial superiority (Kendi, 2016; Michael, 2015). In contrast, the responses of victims and witnesses included helplessness, hopelessness, a lack of physical and emotional safety (Michael, 2015).

Like the racism and racist violence in Ireland, Canada also has racist problems (James et al., 2010). While most of the racism "[is still] hidden beneath a veneer of normality" (Gillborn, as cited in Henry, 2017), racist violence is occurring (Henry, 2017; James et al., 2010; Michael, 2015). The perpetrators of racist violence are not Klansmen wearing white sheets over their heads; rather, they are likely in every institution and often within families (Henry, 2017).

Theoretical Explanations and Racist Violence

In Michael's (2015) research, acts of racist violence by perpetrators were intentional, and the victims experienced harm. The police showed a lack of support towards the victims and police did not intervene to stop the violence (Michael, 2015). The police force's response was "intentional as well as unintentional and includes acts of omission as well as acts of commission" (Jones, 2000, as cited in James et al., 2010, p. 115). A common occurrence

throughout Michael's (2015) report was the police inaction that was complicit and sympathetic with the perpetrators. However, another explanation for police inaction is secondary oppression (Gregory, 2013), which refers to "situations where someone may not themselves actively oppress but who do not object to others carrying it out and/or someone who may benefit in some way from the oppression of others" (Hann, Tally & Guindon, 2000, as cited in Gregory, 2013, p. 156). In Ireland, while the Irish were the perpetrators of racist violence, the police practiced secondary oppression because it is implied that they knew about the racist incidents and emboldened the perpetrators (Michael, 2015). Michael's (2015) research shows that law enforcement agencies reinforced perpetrators racist violence, and not only highlights a national problem but one that is also pervasive globally (Barrett, 2017; Levin, 2016; Quammie, 2016).

The government does not hold the public and public servants (such as the police and other government officials) accountable for their roles and participation in incidents of racist violence (Michael, 2015). The Afrophobic racist assaults and aggravated assaults that affected the overall health and wellbeing of witnesses and victims revealed the inequities within the police force (Michael, 2015). In the USA and in Canada, law enforcement and government agencies have a long history of directing racists actions towards black people, whether intentional or unintentional (Barrett, 2017; Levin, 2016; Quammie, 2016). In response to recent police brutality, Janaya Khan and Yusra Ali created the organization Black Lives Matter (Clarke, 2015).

Structural racism involves occurrences of racist incidents where systemic violence is maintained in institutions such as police forces, public government organizations, and private organizations (McKenzie, 2017). And while an incident of racism may be unintentional, "it is often caused by hidden institutional biases in policies, practices, and processes that privilege or

disadvantage people based on race” (McKenzie, 2017, p. 6). In Canada and the USA, personally mediated racism, structural racism, and institutional racism are entrenched in law enforcement agencies, government agencies, and academic institutions, to name just a few (Barrett, 2017; Foster, 1996; Henry, as cited in Hyslop, 2017; Levin, 2016). University of British Columbia professor and researcher of race and education Annette Henry (2017) stated that “institutions of higher education are especially prone to reproducing inequalities beneath a façade of meritocracy and colour blindness” (para. 8). Skillings and Dobbins (1991, as cited in James et al., 2010), further state that “institutional racism serves to maintain social control and uphold the status quo in favour of the dominant group” (p. 89). “Institutional racism is seeing racial disparities and doing nothing effective about them” (McKenzie, 2017, p. 7).

Everyday racism, which is often ignored, involves micro-aggression namely small or [subtle] acts of rejection which have “damaging effects over time” (Michael, 2015, p. 7). An example of a subtle act of micro-aggression is being overlooked when waiting in public places” (James et al., 2010, p. 124). Amani Nuru-Jeter (as cited in Corely, 2015), a public health professor and epidemiologist at the University of California at Berkeley, said that these subtle incidents of racist micro-aggression can be traumatic, and in many cases, result in fatalities. There are acts of micro-aggression that include racist incidents where there are assumptions that Black people are rapists and killers (Bell, as cited in Corely, 2015), or perceived as robbers (Nuru-Jeter, as cited in Corely, 2015). The individuals experiencing these micro-aggressions feel “demoralized, dehumanized, disrespected or objectified” (Harell, 2000, as cited in James et al., 2010, p. 125). Social exclusion occurs when groups of people feel excluded from others.

Suicidality Among Females of African Descent

"Trouble In Mind"

*Trouble in mind, I'm blue
But I won't be blue always,
'cause the sun's gonna shine
In my backdoor some day.*

*I'm all alone at midnight
And my lamp is burnin' low
Ain't never had so much
Trouble in my life before.*

*Trouble in mind, that's true
I have almost lost my mind,
Life ain't worth livin',
Sometimes I feel like dyin'.*

Goin' down to the river

*Gonna take my ol' rockin' chair
And if the blues don't leave me
I'll rock away from there.*

*You been a hard-hearted mama
Great god! you been unkind
Gonna be a cold, cold papa
Cause you to lose your mind.*

*I'm gonna lay my head down
On some lonesome railroad line
And let the two nineteen
Pacify my mind.*

*Well it's trouble, oh trouble
Trouble on my worried mind,
When you see me laughin'
I'm laughin' just to keep from cryin'.*

(Simone, 1963, track 1 as cited in Discography, n.d.)

The focus of this section is suicidality among females of African descent. Every 4.5 hours in the USA, one African-American will die by suicide (Crosby & Molock, 2006; Monroe, 2014). According to the American Association of Suicidology 2016 and 2013 fact sheets, the rate of suicide among African American female in the USA are:

- In 2016, 564
- In 2015, 481
- In 2014, 475
- In 2013, 462
- In 2012, 449

While black women end their lives at a significantly lower rate in comparison to black men (Monroe, 2014; Poussaint & Alexander, 2001; Tso & Samuelson, 2014), in the USA, black women are more likely than black men to *attempt* suicide (Bell, 2017). In the USA, “When comparing suicide rates between genders within the African American community, females of all ages are more likely to attempt suicide and experience suicide ideation, while males are four to six times more likely to complete the act” (American Association of Suicidology, 2012a; Bingham et al., 1994; Garrison et al., 1993; Gibbs & Hines, 1989; Moscicki, 1994; U.S. Public Service, 2001, as cited in Wright, 2012, p. 25). In the USA, the national rate of suicide among African-American women is 1.7 percent-lower in comparison to white women who have a rate of 5.18 percent (Tso & Samuelson, 2014).

Researchers offer several theories that account for the low rate of completed suicide among females of African descent (Barnes, as cited in Tso & Samuelson, 2014; Okeke, 2013; Poussaint & Alexander, 2001; Wright, 2012). For instance, the strength and resilience among females of African descent (Barnes, as cited in Tso & Samuelson, 2014; Poussaint & Alexander,

2001; Wright, 2012) as related to the leadership role that black women play in their communities, where family and other community members often rely on them (Tso & Samuelson, 2014).

Another reason given is that protective factors, such as connectedness and a sense of purpose are key for, primarily for African-American single mothers ,(Gray, as cited in Tso & Samuelson, 2014; Poussaint & Alexander, 2001) which can develop through the efforts of black women to build families, engage in religious practices, and maintain social relations (Poussaint & Alexander, 2001). An example of this strength is found in black women having sustained and maintained family connections and social networks in the post-World War II era, who have rates of depression twice that of black men (Poussaint & Alexander, 2001). The above comparison between black women and black men is made while recognizing the multitude of racist violence and forms of oppression that black men encountered historically and continue to face today (James et al., 2010; Kendi, 2016; Poussaint & Alexander, 2001; Welsing, 1991). Therefore, it is unclear whether the form of racist violence directed at black men has made it more difficult for them to connect in the way that black women have been able to.

In addition to family support and religion, mental health counselling is a preventative effort against suicide amongst African Americans (Wright, 2012). Debra Mackey (as cited in Tso & Samuelson, 2014), is one of many women of African descent who have spoken about her issues of suicidality and the services received at a transitional living facility for women of colour in Los Angeles. Mackey (as cited in Tso & Samuelson, 2014) said that even though she struggled with suicidal thoughts due to clinical depression, she did not end her life because of her “son, friends, and family” (para. 22).

The role of religion and prayer, and the Christian faith, could be an explanation for the lower African-American suicide rate (Gray, as cited in Tso & Samuelson, 2014; Whittington, as cited in Tso & Samuelson, 2014). According to a 2012 Washington Post-Kaiser Family Foundation survey, religious life is of critical importance to African-American women (Monroe, 2014). Since religion and spirituality are large constructs, it is important to define them (Koenig, 2012). Koenig, King, and Carson (2012, as cited in Koenig, 2012) state that “Religion is an organized system of beliefs, practices, and symbols designed (a) to facilitate closeness to a transcendent being (such as God, Allah, HaShem, Braham, Buddha, and Dao); and (b) to foster an understanding of one’s relationship and responsibility to others in living together in a community” (p. 3). “Spirituality focuses on a subconscious sense of self and an examination of the soul” (Barrett, 2009, as cited in Watson, 2015). Spirituality further addresses innate human attributes such as hope, forgiveness, courage, confidence, and faith” (Barrett, 2009; Ehrlich, 2011, as cited in Watson, 2015, p. 4). To illustrate, Bell (2014) notes the importance of spiritual practices such as prayer, but also states that “one simply cannot pray the pain away” (para. 15). For Michelle Taylor Greene (as cited in Tso & Samuelson, 2014), who struggled with depression and suicidal thoughts, claims that “the prospect of going to hell” was a powerful deterrent (para. 11).

The African-American church is a significant preventative factor regarding the suicide rate among black people (Molock et al., 2006; Poussaint & Alexander, 2001; Wright, 2012). Black religious institutions provide support that ensure a sense of belonging, which in turn, protects against suicidality (Green & Stoppelbein, 2002, as cited in Phemph, 2013; Taylor, Chatters, & Joe, 2011) and participating in religious activities strengthens fellowship and relationships, which can be a protective factor against suicide (Martin, 1984; Pescosolido &

Georginna, 1989; Stack, 1983, as cited in Willis, Coombs, Drentea, & Cockerham, 2003). While religion decreases the likelihood of suicide (Wright, 2012), the African-American church can be controversial because of its tendency to be judgmental when addressing suicide, as it is fraught with discomfort when addressing suicide that has occurred among family members or friends (Crosby & Molock, 2006).

Next, the black community and the concept of unity around suffering provides another explanation for the lower suicide rate (Tso & Samuelson, 2014). Segregated community support systems emphasize the commonality of suicidal suffering that is premised on connections, relationships, responsibility, and accountability to each other within the group context (Poussaint & Alexander, 2001; 2014). The Sistah friend network concept offers access to resources for women who may not otherwise use counselling services due to economic hardship (Tso & Samuelson, 2014). It is significant to note that while health care services may be available, they may not be accessible due to high financial costs (Okeke, 2013).

Also, Wright (2012) states that among the students surveyed in her research study, there is a belief that the primary risk factors for suicide among African Americans included “depression, drug use, lack of family and support, and economic hardship” (p. 100). Among black women today, the correlation between isolation and economic hardship shows an increase in the suicide rate (Barnes, as cited in Tso & Samuelson, 2014). Gray (as cited in Tso & Samuelson, 2014) notes that “while isolation is a huge risk factor for black men, the social and cultural responsibilities of black women as the sole family provider places a higher expectation upon them” (para. 19).

Suicide Among People of African Descent

Five contributing factors to suicide in communities of African descent in the USA are homophobic bullying, religion, police-assisted suicide, the strong black woman stereotype, and untreated mental illness (Monroe, 2014). Homophobic bullying relates to the “assaults and hateful treatments experienced by Lesbians, Gays, Bisexuals, Trans-folk, and Queer-folks (LGBTQ) of African-American descent” (Monroe, 2014, para. 7). There is a high suicide rate among African-American LGBTQ youth due to sexual abuse and rape (Bell, 2017). An examination of the experiences of sexual and gender diverse youth and suicide reveal the importance of framing those experiences as motivated by the intensity of the hatred directed at them (Reynolds, 2011, as cited in White et al., 2016), so that homophobic bullying is like any hate that kills (Reynolds, 2011, as cited in White et al., 2016) rather than an individual flaw in the victim’s character.

Next, and as mentioned above, religion plays a role in suicidal behaviours in America’s Black community (Monroe, 2014; Poussaint & Alexander, 2001; Prempeh, 2013), for example, “conservative Christianity [can be harmful] to the LGBTQ community and to others” (Monroe, 2014, para. 12). Since I am writing about the harm of homophobic-bullying within the black community, I feel compelled to speak out concerning my Jamaican-Canadian experiences of homophobia and the Christian church:

In Canada, some Judeo-Christian churches deliver messages of condemnation and homophobia towards individuals exclusive to the heteronormative construct. It is a religious discourse of control, classism, patriarchy, and white supremacy that has spread to dominate other racially diverse societies. Christianity with regards to gender and sexuality imposes specific identities, attitudes, and actions into the lives of Jamaicans.

Thoughts and practices that are contrary to the Christian faith are deemed sinful and therefore punishable. And while Christianity remains the faith that I practice, the combination of a rich Jamaican heritage and the diverse appreciation evident in Canadian society enables me to be explicitly critical of Christianity's discourse of dominance as it relates to the individual and others. (Watson, 2016, p. 8)

While the black church is an essential resource for the black community, "it...is a place that has furthered discrimination and homophobic and heterosexist rhetoric and actively blocked social justice for queer people" (Clarke, 2011, p. 23). The influence of the African church is global (Paris, 1995), so it also feels important for me to discuss my Jamaica-Canadian experience:

Contemporary Jamaica is explicitly homophobic, and often both Christian and Rastafarian congregations are the leading force behind this attitude (Quinn, 2013).

According to Jennifer Quinn (2013), a reporter for an online magazine, "religious groups regularly protest gay rights, saying that homosexuality is an affront to God and Jamaican values" (Quinn, 2013, para. 7). Perpetuated are overt acts of social, psychological, and spiritual violence and bias-related injustice. Also, and even though Jamaica is a vacation destination for many, "those who are assumed to be outside of the dominant discourse of the heteronormative union of male and female are punished and in some cases killed." (Quinn, 2013, pp. 5-6)

Homophobia and other forms of oppressive practices against sexually and gender diverse citizens of Jamaica are what Reynolds (2011, as cited in White et al., 2016) calls acts of violence and therefore acts of hatred, as are police-assisted suicides. These are where black people provoke police officer shootings with the intention of the police officer killing them (Monroe,

2014). Police-assisted suicide, seems to go against the perception that police officer's primary role is to serve and protect the public, thereby making it difficult to believe that an unwell suicidal person caused a police officer to pull the trigger of a gun. The phrase "police-assisted suicide" seems to blame the unwell victim instead of examining each police officer's ethics, training, and competency. Further research is needed to determine the factors that require each police officer to pull the trigger of a gun aimed at a person.

As discussed in an earlier section, the strong black women concept was created by the white supremacist hatred of black women (Hamin, 2008; Kendi, 2016; Okeke, 2013). This is "hate that kills" (Richardson & Reynolds, 2012, as cited in White et al., 2016, p. 171) through social contexts such as stigma (Goffman, 1963, as cited in White et al., 2016, p. 171) which categorizes and organizes power (Crenshaw, 1995).

There are factors that prevent black people from accessing professional treatments for mental health (Monroe, 2014; Morgan, 2015). Barriers for accessing professional care include the cultural stigma concerning mental illness, economic hardship, and the dearth of practitioners who closely match the racial or ethnic background of the group for whom care is being provided (Monroe, 2014; Okeke, 2013; Sealy, 2015), and the "perceived unfriendliness" of the service provider (Poussaint & Alexander, 2001, p. 61).

Females of African Descent and Issues of Racism and Suicidality for Professional Consideration

Even though I recognize the role of mental illness such as depression and its relationship to suicidal behaviours, I have avoided discussions where suicidality as mental illness places the problem on the individual. Instead I prefer discourses exclusive to events that occur within the social, cultural, and political contexts (Reynolds, 2011, as cited in White et al., 2016; Wexier & Gone, 2012; White et al., 2016) that place the responsibility on social injustice and not mental illness within the individual (Reynolds, 2011, as cited in White, et al 2016). Refraining from pathologizing the individual is critical to understanding the dimensions and functions of hate (Reynolds, 2011, as cited in White et al., 2016). Rather, it is important to make the issues of suicidal behaviours among black women visible, and their experiences a priority in all domains and especially in professional practices (Fullagar & O'Brien, as cited in White et al., 2016).

Racism and the stigma of mental illness.

Further to the psychological toll of racism, both black females and males experience stigma associated with discussing mental illness and seeking mental health treatments (James et al., 2010; Okeke, 2013; Tso & Samuelson, 2014; Wortham, 2015). For example, there are black women who label people with depression as “having a weak mind, poor health, a troubled spirit, and a lack of self-love” (Ward & Hendrich, as cited in Tso & Samuelson, 2014, para. 24), believing clinical treatment is not for them, which results in their unwillingness to discuss mental health in the African-American community (Tso & Samuelson 2014).

Black patients and white helping professionals.

When providing professional care, it is preferable for practitioners to closely match the racial or ethnic background of the group requiring care (Okeke, 2013). However, in Toronto, Canada, patients who prefer to seek therapists of colour may find this challenging because of the scarcity of black professionals (Browne, as cited in Patel, 2015) in that only 4 percent of the nation's psychiatrists, 3 percent of the psychologists, and 7 percent of social workers are black" (Monroe, 2014, para. 6). It is possible that when charting elements of a Western ontology grounded in colonial history and social problems and strategies for the helping professions, there are expectations of elements that are in the Eurocentric Western ontology of hierarchies, dominance, and assimilation (Saraceno, 2012).

Theoretical frameworks for helping professionals.

The following is an examination of the theoretical frameworks for helping white professionals when discussing issues of race and racism as they relate to cultural competency. Cultural competency includes "the ability to understand another culture well enough to be able to communicate and work with people from that culture" (Kivel, 2002, p. 226). Teaching is one forum to examine the application of white privilege and colour-blind racial attitudes to counselling psychology training (Neville, Worthington, & Spanierman, as cited in Ponterotto, Casas, Suzuki, & Alexander, 2001). "White privilege results from an identifiable racial hierarchy that creates a system of social advantages or special rights for whites based primarily on race rather than merit" (Neville et al., p. 261, as cited in Ponterotto et al., 2001). White privilege equates to the collective sense of entitlement and unearned advantages acquired because of race and not because of competence (Kivel, 2002).

Using four main tenets, and with a focus on micro-level expression, Neville et al. (as cited in Ponterotto et al., 2001) define colour-blind racial attitudes as, “the denial that racism exists on either the ideological or structural level” (p. 272). The first tenet deals with new forms of racial attitude expressions that are separate from but related to racial prejudice. The second tenet provides a cognitive schema, reflecting a conceptual framework and a corresponding effect. When individuals think that race is unimportant, they combine that way of thinking with feelings of anxiety about race (Gregory, 2013; Neville et al., as cited in Ponterotto et al., 2001), and this perspective “may lead individuals to deny the influence of race or racism in each situation” (Neville et al., p. 272, as cited in Ponterotto et al., 2001). Instead of a colour-blind racial approach, a colour-consciousness framework focuses on behaviours and actions outlined in policies “to promote justice and fairness” (Neville et al., p. 272, as cited in Ponterotto et al., 2001). The third tenet sees colour-blind racial attitudes as multidimensional, whereby colour evasion manifests through assumptions about homogeneity and evasion of power differences. The fourth tenet suggests that the expression of colour-blind racial attitudes is different in the white population compared to people of colour: the racial ideology among whites is social dominance, while for people of colour it is false consciousness; in both cases, the racial hierarchy is accepted as the status quo (Neville et al., as cited in Ponterotto et al., 2001).

At the institutional level and when thinking of the structural dimension of racism, there are contentions of multicultural practice and their interpretation as integration and tokenism (Kivel, 2002). If integration requires people of colour to adapt to the mainstream, or to white dominant standards and values, then integration cannot be the solution to anti-racism (Kivel, 2002). Integration creates “the illusion of participation, but there is still no sharing of power” (Kivel, 2002, p. 236), known as tokenism. Tokenism is discriminatory since white people are

selective as to which people of colour are gaining access to power (Kivel, 2002). When white people are willing to relinquish power and control, this results in the creation of a democratic, anti-racist and multicultural process in every aspect of society (Kivil, 2002). Social justice frameworks require theories that move beyond multiculturalism and empowerment (Saraceno, 2012), the creation of a democratic, anti-racist, multicultural process in every aspect of society will make a difference in the struggle for racial justice (Kivil, 2002). What then, are the next steps?

White privilege.

An examination of white privilege may provide answers. Neville et al. (as cited in Ponterotto et al., 2001) identifies seven interrelated core components and processes of white privilege:

1. There are differential benefits to whites, where the intersection of class and gender meet.
2. White privilege embodies both macro and micro-expressions. Macro-level privileges are structural systems of institutionalization that seek to benefit and give advantages to whites as a group. Micro-level privileges are those characterized by individualization and expressions that convey a sense of entitlement.
3. White privilege consists of unearned advantages; therefore, racial hierarchy determines access to resources and services.
4. White privilege offers immunity to selected social ills. An example of this is the criminal justice system that is comparatively lenient towards white criminality.

5. White privilege that embodies an expression of power. The maintenance of this expression of power occurs through its operation at the macro and micro-level and is practiced consciously and unconsciously.

6. White privilege is invisible and unacknowledged, wherein society is conceptualized, organized, and communicated through the lens of whiteness. Whiteness occurs through the normalizing and maintaining of racial hierarchy. Individually and psychologically, whiteness addresses personal entitlement. The racist pedagogy at the individual and psychological level implies that only white people can achieve success and that marginalized groups are undeserving of achievements. “There is the lack of accountability that does not question human dignity because of the power structures and benefactors from racial privilege due to group membership” (Neville et al., p. 266, as cited in Ponterotto et al., 2001). Furthermore, the dehumanizing of people of colour by white people occurs through micro-aggression experiences (James et al., 2010; Neville et al., as cited in Ponterotto et al., 2001). “Dignity and self-worth for people of colour means establishing connectedness, community relations, and [is] driven by culturally relevant symbols that affirm one’s basic humanity” (Neville et al., p. 266, as cited in Ponterotto et al., 2001).

7. There is a cost to white people. In discussing cost manifestation on a psychological level and at the micro-level, an individual either “(a) denies the existence of white privilege and how he or she wittingly or unwittingly benefits or, (b) acknowledges white privilege and acts on or ignores this awareness” (Neville et al., p. 267, as cited in Ponterotto et al., 2001).

“Dysconscious denial is the inability by whites to acknowledge race-based privileges through socialization” (Neville et al., p. 267, as cited in Ponterotto et al., 2001). “Conscious denial is the choice to ignore” (Neville et al., p. 267, as cited in Ponterotto et al., 2001). Dysconsciousness is

“an uncritical habit of mind and an impaired consciousness or distorted way of thinking” (King’s, 1999, as cited in Neville et al., p. 267, as cited in Ponterotto et al., 2001), with psychological costs and cognitive costs, which are “distortions of self, other, and reality” (Neville et al., p. 267, as cited in Ponterotto et al., 2001).

White dominance and capitalism.

Within the Canadian context, discourses of whiteness and white privilege are explored historically as the internalized superiority of European settler races over indigenous and African people (Saraceno, 2012). The evolution of whiteness and white male privilege were maintained throughout North American society with governmental implementation of legislative policies that favoured white patriarchy and further disadvantaged minority groups by class, gender, and location (Kendi, 2016; Martinas, 1994; Saraceno, 2012). The Indian Act is a Canadian example of this because it affords privilege to white people, whiteness, and white dominance, causing indigenous populations to face marginalization and disenfranchisement (Saraceno, 2012). Consequently, under Western ontology, the bodies of Indigenous and racialized women and girls are subjugated to violence (Saraceno, 2012; White et al., 2016).

Coloniality is an integral part of global capitalism; in that dominant Western ideologies become entrenched with the themes of “universality” and “equality of all men” (Saraceno, 2012, p. 250). Coloniality and capitalism intersect conceptually and practically whereby the subjugated are groups of people placed into “manageable units of individual disease or disorder” (de Finney & Dean et al., 2011; Jakobsen, 198; Kivel, 2002; McKnight, 1995; Szasz, 2002, as cited in Saraceno, 2012, p. 252). For white helping professionals who are working with black people, this could mean being advocates and not experts who speak for them (Kivel, 2002;

Saraceno, 2012) so that helping professionals will be able to value African people, their experiences, and their process (Kivel, 2002).

White Helping Professionals Raising Issues of Race and Racism

When discussing the decision of psychotherapists about raising or not raising the issue of race, particularly when race is at the forefront of their minds, there is the dilemma of the psychotherapist adding to the oppression of patients/clients (Gregory, 2013). Psychotherapists may face challenges concerning presenting the issue of race with patients, because of the power imbalance of the patient-therapist relationship (Gregory, 2013). This investigation of race “brings together thoughts on race difference, oppression, and identity, and it raises tough questions encountered when working as psychotherapists and with keeping ethics in practice, and the challenge that race brings to the dimension of the ethical as practice” (Gregory, 2013, p. 153).

Since there is a relationship between racism and oppression (Kendi, 2016; DeGruy, 2005; Gregory, 2013), one theory is that there are benefits to orienting white helping professionals and specifically those working in the mental health field among racially diverse people on issues of oppression (Gregory, 2013). When working with racially diverse people, white helping professionals must exercise a willingness to evolve with their patients (Cormier, Nurius, & Osborn, 2012), this willingness does not mean that helping professionals know everything about each patient that they are working with (Cormier et al., 2012). Instead, helping professionals need to work towards becoming multiculturally and culturally competent (Cormier et al., 2012).

Since the focus is on white helping professionals and cultural competence, the following discussion will address their advantaged position. Instead of discussing the possibility of oppressing the “disadvantaged,” Neville et al. (as cited in Ponterotto et al., 2001) shift the racial

discourse in psychology through an examination of the “advantaged” position of white superiority and privilege (p. 260). This shift refers to conversations that conceptualize the discussion about the implications of race and power in the field of counselling psychology’ (Neville et al., as cited in Ponterotto et al., 2001). Neville et al. (as cited in Ponterotto et al., 2001) point to the invisibility and the lack of acknowledgment and a system of power that supports and reinforces such cultural pedagogy from the advantaged benefactors.

For white helping professionals where the balancing of race and power exist, how do anti-racist practices change their way of being? “Anti-racism is the process of actively and consistently confronting racism...wherever [it] occurs” (Kivel, 2002, p. 230), and this confrontation needs anti-racist analyses and actions that examine the commitment to being attentive to power structures that practice exclusion (Kivel, 2002; Saraceno, 2012). The ending of racial injustice calls for a social justice approach, where anti-racist practice attends to those who are absent from the discussion (Kivel, 2002). Since the function of white cultural dominance appears to be an attempt to transform lives according to white standards (Kivel, 2002) and to define other people’s realities (Martinas, 1994; Saraceno, 2012), an intentionally analytical approach concerning issues of race and power is achievable for helping professionals (Gregory, 2013; Neville et al., as cited in Ponterotto et al., 2001). One area to begin the examination of race and power is by considering multicultural competence, which starts with cultural competence (Kivel, 2002). Multicultural competence “is fluency in more than one culture, in whichever cultures are part of your surroundings” (Kivel, 2002, p. 226). And cultural competence requires understanding another culture in order to communicate and work within that cultural group (Kivel, 2002). Since multicultural competence and cultural competence are not short-term goals, white helping professionals seeking to become culturally competent must

be intentional when practicing “respect for the ways that others live-in and organize the world and [have] an openness to learn from the people and cultural groups that they are serving” (Kivel, 2002, p. 227). Multicultural competence and cultural competence help professionals to “speak the language of cultural empathy” (Cormier et al., 2012, p. 59).

Since the identity of professional helpers is adoptive to spaces and with relationships (Cormier et al., 2012), one argument is that there may be a connection between the ego of white helping professionals’ understanding of their own racial identity that affects their ability to think critically about issues of race and power (Helms, 1995, as cited in Neville et al., in Ponterotto et al., 2001). Therefore, white helping professionals must become critically aware of their white privilege to deeply understand and shift their own ethical practices (Neville et al., as cited in Ponterotto et al., 2001; Saraceno, 2012). However, the internalized and overinflated superiority of (white people) could be a barrier to becoming multi-culturally competent (Kivel, 2002). Nevertheless, helping professionals and their way of being with clients is contingent upon who they are (Cormier et al., 2012). Who we are in person is who we are as professionals (Cormier et al, 2012).

While multicultural counselling competence through training and activity development is not yet fully actualized in the field of psychology, there have been shifts towards this in terms of theoretical scholarship in this area (Neville et al. as cited in Ponterotto et al., 2001).

Multicultural counselling competency models consist of three main domains that include: “a) awareness of one’s values, beliefs, and prejudice; b) knowledge relating to the cultural realities of various ethnic groups; and c) the possession of culturally relevant intervention skills and techniques that require an understanding of power systems by counselling professionals” (Arredondo, 1999; Constantine & Ladany, as cited in Neville et al., p. 258, as cited in Ponterotto

et al., 2001). Competency further requires or necessitates counselling professionals obtaining knowledge regarding white privilege and colour-blind racial attitudes, and awareness of their reactions to the racial system and how they are impacted (Neville et al., cited in Ponterotto et al., 2001). While the disruption of white privilege in clinical environments and within the profession requires critical consciousness, this awareness of their reactions to the racial system shows that counselling professionals' emotional responses are about "content re-exposure" and their processing of that information (Neville et al., p. 278, as cited in Ponterotto et al., 2001).

Because of uncertainties around the use and interpretations of race, psychotherapists and other helping professionals may become nervous about "what to do" (Gregory, 2013, p. 154). A consideration when thinking about the possibility of discussing race in psychotherapy is understanding the client's understanding of race (Gregory, 2013). While Gregory (2013) notes the significance of race and identity in the practitioner's life, thought must be given to the dimensions of the practitioner's identity. The moral dimension of identity prioritizes human dignity, and the patient's agency (Gregory, 2013). "The moral responsibility of psychotherapists is to ensure the basic human dignity of self-conception free from restriction or undermining actions from others" (Gregory, 2013, p. 157).

Helping professionals who do not want to practice racial oppression or other forms of discriminatory practices must look at a belief system rather than actions of inferiority versus superiority (Neville et al., as cited in Ponterotto et al., 2001). To illustrate, clinical training and practice as they relate to white privilege and colour-blind racial attitudes focus on the levels of racial identity ego statuses of white counsellors (Neville et al., as cited in Ponterotto et al., 2001). Because white counsellors may or may not have processed the impact of white privilege or colour-blind racial attitudes in the counselling process, racial identity attitudes such as white

privilege should be given attention while counsellors are in training (Neville et al., as cited in Ponterotto et al., 2001). Counsellors with lower colour-blind racial attitudes, who are aware that racism exist are likely to share content relating to race and racism with their clients, which improves the outcome and process of counselling (Neville et al., 2001, as cited in Ponterotto et al., 2001). Counsellors must consider racial and cultural factors that are imperative for working with clients from diverse ethnic groups (Neville et al., as cited in Ponterotto et al., 2001).

Because white privilege and colour-blind racial attitudes include the ideological and structural dimensions of racism, they must be a part of the discussion when considering Western ontological values and powers, and issue of racism (Neville et al, as cited in Ponterotto et al, 2001). Although, the institutional maintenance of white superiority in society is evident in academic scholarship, in government agencies, and through the religion of Christianity (DeGruy, 2005; Kendi, 2016; Kivel, 2002; Martinas, 1994). Likewise, within the Canadian framework, the contextualizing of structural dimensions of racism is evident, whereby, economic value takes priority over human value (James et al., 2010; Saraceno, 2012).

There are structural benefits of professionalism such as assumptions of better service delivery to patients, problem-solving by experts, deficit production that calls for specialized certification, education, and training from professional helpers (Saraceno, 2012). However, the resiliency of patients, and the role of community networks that include “the knowledge and action of friends, neighbours, citizens, and associations” (McKnight, 1995, p. 106, as cited in Saraceno, 2012) have been neglected. This neglect is because within neo-liberal ideology, there is a manufactured colonial dominance of professionalizing human services that produce categories and labels, and it creates deficits that disadvantage marginalized and minoritized populations (Saraceno, 2012). This system of neo-liberal global capitalism conceals their

operations, and avoids their role and responsibility as a contributor and producer of social problems (2012). This concealment is accomplished by keeping the attention on marginalized individuals instead of making changes “outside of [these] individuals” (Saraceno, 2012, p. 257).

Within the purview of neo-liberal ideology and dominance, empowerment and liberation concepts view the self-consciousness of the individual “as [someone] who is capable of social change” (Jackson, 2007, as cited in Saraceno, 2012, p. 257). A shift from this to a social justice approach through the process of decolonization, and by interrogating power dynamics in relationships, and confronting existing structural inequities (Saraceno, 2012) is required in order to help black women. Professional care within the context of justice and social change requires that practitioners address the root causes of the problems that are based on exploitation and violence (Reynolds, 2011, as cited in White et al., 2016; Saraceno, 2012). This shifting and transformation requires a collective, collaborative and politicized response that moves away from the individualistic culture of self-interest that can be found in human services (de Finney, 2007; Lang, 2005; Reyes Cruz & Sonn, 2011; Reynolds, 2010; Skott-Mhyre, 2005; Wade, 1995; White, 2007, as cited in Saraceno, 2012; de Finney, Dean et al., 2011, as cited in Saraceno, 2012).

An Approach to Suicide Prevention and Intervention when Working with Females of African Descent

When I originally tried to envision a framework for working with suicide among the African community, I found that the work of Lisa M. Wexier and Joseph P. Gone (2012) on suicide prevention and intervention efforts among Indigenous communities looked promising. Given more time, I am optimistic that there will be specific models for suicide prevention and intervention for working with suicidality among females of African descent and the general black community. Until such a discovery, the work of Wexier and Gone (2012) should serve as an example.

While the behaviour of suicidality among Indigenous communities (Kral, 2012; White, 2016) and African communities varies (Perry et al., 2013; Poussaint & Alexander, 2001; Wright, 2013), there is much to learn from Wexier and Gone's (2012) four assumptions on cultural congruency around suicide prevention and intervention. For their investigation, they drew on over 30 years of research from different domains on American Indian/Alaska Native (AI/AN) people. Guided by their work experience in Indigenous communities, Wexier and Gone (2012) examined four prevalent assumptions that underpin professional suicide prevention approaches that may conflict with the Indigenous understandings of suicide. These assumptions looked at prevention and intervention that incorporate cultural practices that are in concert with Indigenous beliefs and practices. They are: psychological versus social framing; personal choice versus social obligation; clinical expertise versus social relations; and health services versus community projects (Wexier & Gone, 2012). These ideas grew organically and embodies the strength of Indigenous communities (Wexier & Gone, 2012, as cited in White et al, 2016). Wexier and Gone (2012) were able to develop suicide approaches by challenging the universality of the four

assumptions, by having discussions within health services, and by helping to construct interventions that are cross-culturally relevant (Wexier & Gone's, 2012, as cited in White et al, 2016, p. 56).

The consideration of Western societies towards non-western communities for health and services is critical to prevention and intervention as a cultural practice (Okeke, 2012; Wexier & Gone, 2012). Also, the service development and service delivery would better serve these communities by shifting away from individualistic approaches and toward services that are reflective of cultural models within the local context (Neville et al., as cited in Ponterotto et al., 2001; Saraceno, 2012; Wexier & Gone, 2012). Westernized health and service practices pathologize suicide as an individualized problem of the mind and continue to determine how to respond to suicide and decides who delivers these clinical services to Indigenous communities in North America (Reynolds, 2011, as cited in White et al., 2016; Wexier & Gone, 2012; White et al., 2016).

Suicide among Indigenous people is social; therefore, going beyond an individualistic and internalized psychological framework would be beneficial (Kral, 2012; Wexier & Gone, 2012). Historical, social, and political factors contribute to the suffering of suicide in indigenous communities (Kral, 2012; Wexier & Gone, 2012). Parallel to the experiences of black people, the historical and traumatic aspects of suicide as social suffering speak to the cultural genocide and racism that they endured (Poussaint & Alexander, 2001; Wexier & Gone, 2012). While trauma is ongoing through systems of oppression, "Indigenous people [often]...mistakenly attribute their present struggles to both personal and collective failings" (Wexier & Gone, 2012, p. 801). This mistaken attribution is accomplished "through kin, orientation within communities and established through social and cultural processes" (Wexier & Gone, 2012, p. 801). The

primary features of these processes include interpersonal relationships, the meaning, and interpretation of language, and shared roles that imbue responsibility (2012). There are arguments against clinical intervention as the only solution among Indigenous communities (Reynolds, 2011, as cited in White et al., 2016; Saraceno, 2012; Wexier & Gone, 2012). African people do not see clinical intervention as the only solution (Okeke, 2013; Phempeh, 2013; Poussaint & Alexander, 2001; Wright, 2012).

With personal choice versus social obligation, when deaths occur by suicide, there is collective suffering and a loss of culture (Wexier & Gone, 2012, p. 802). During the grief and loss processes of funerals the collective burden is shared, where “funerals, their public spaces, and ritualized activities invite the community to support the affected family through the collective grieving of culture loss” (Wexier & Gone, 2012, p. 802). Healing is embedded in this shared grief (Wexier & Gone, 2012). Conversely, there are higher suicide rates due to a lack of cultural continuity (Wexier & Gone, 2012). Wexier and Gone (2012) attribute the lower suicide rates to the “renewing or revitalizing of Indigenous cultures and having political control over local tribal institutions” (Wexier & Gone, 2012, p. 802).

Clinical expertise versus social relations addresses conflicts between Westernized psychopathology and the individualistic model of suicide versus the emphasis of Indigenous communities on their culture (Wexier & Gone, 2012). Suicide intervention services from short-term clinicians and counsellors who lack understanding and knowledge concerning the cultural significance of relationship miss opportunities to “appropriately influence the social context of an individual” (Wexier & Gone, 2012, p. 803). Relational suicide intervention offers a response to the community members as established through kinship; thereby, exposing the significance of trust and competence (Wexier & Gone, 2012). Relational suicide intervention is a response in

solidarity with the individual, and it builds connectedness in relationships (Wexier & Gone, 2012).

With health services versus community projects, these concerns focus on the suicide prevention initiatives offered to Indigenous communities by clinically based mental health professionals. These initiatives are based on the “belief that suicide is a clinical outcome in the face of mental illness” (Wexier & Gone, 2012, p. 803). This approach fails to consider the myriad of “undesirable social outcomes” (Wexier & Gone, 2012, p. 803). For example, crisis suicide interventions in health services relate to safety concerns that include incarceration, the removal of children from their homes, and their placements in distant inpatient facilities, the enforcement of programs, and hospitalization without consent from family (Wexier & Gone, 2012). Without disputing the immediate safety of such crisis responses, the larger issue is about practices that are the “extension of cultural subjugation and colonial intrusion” (Wexier & Gone, 2012, p. 804). Indigenous communities emphasize aiding members by keeping them in the community, which prevents social and cultural dislocation (Wexier & Gone, 2012). Therefore, during counselling or therapy, it is necessary to place emphasis on developing intervention approaches that are culturally-based and have cultural meanings (Wexier & Gone, 2012). Wexier and Gone offer a culturally responsive suicide prevention model that focuses on results from their work and research in Indigenous communities. Primarily their approach is a social response to a social problem (Bell, 2017; Reynolds, 2011, as cited in White et al., 2016).

Issues of Suicide when Females of African Descent are Working with Helping Professionals

When working with black women who are struggling with suicidality, helping professionals must be aware of the social, cultural, intercultural, psychological, religious, spiritual, and interpersonal operations of strength and silence (Hamin, 2008; Okeke, 2013; Tso & Samuelson, 2014; Wright, 2012). In culturally based practices, the white-centrism of some mental health approaches need to be changed, and efforts made to avoid using these practices to define and treat black people and other racialized groups (Chatterjee, 2017). Helping professionals must recognize that unity around suicidal suffering has origin in connections, relationships, responsibility, and accountability, which are characteristics of the approaches of black women to the suffering of suicidality (Whittington, as cited in Tso & Samuelson, 2014).

For black people, the protective factors against suicidality are connectedness, family support, built-in networks, a sense of purpose, a sense of identity, access to mental health counselling, religion, spirituality that includes prayer, some aspects of the black church, and segregated black communities (Bell, 2017; Monroe, 2017; Poussaint & Alexander, 2001; Wright, 2014). Risk factors include isolation, homophobic bullying, religion, some aspects of the black church, police-assisted suicide, the strong black woman stereotype, stigma about mental illness, and untreated mental illness (Monroe, 2014; Clarke, 2011; Gibbs, 2015; Poussaint & Alexander, 2001; Prempeh, 2013; Wright, 2014). While the rate of suicidality among black women in the USA is low, it does occur within this group (Poussaint & Alexander, 2001; Wright, 2012).

It is essential that helping professionals understand that the primary barrier to black women seeking professional help is the fact that there is a stigma associated with mental illness. I have offered insights into the scarcity of black helping professionals and the challenge this may

present for black people seeking professional help. Due to the paucity of black professional helpers, there were theoretical explanations for helping professionals and specifically for white professionals when discussing issues of race and racism as they relate to cultural competence. Wexier and Gone's (2012) model closely matches the framework that I envisioned when working with females of African descent and the general African community. Lastly, I attended to the issues of suicidality among these women and the general African community for the benefit of cultivating professional awareness.

Chapter 3

In this chapter, I outline the methodological framework for the approach taken and the thematic analysis method that I used to investigate the thesis question. Also, I give explanations of the philosophy of the research, the transformative approach, and the thematic analysis method. I also include the procedures and processes for completing the thematic analysis. Specifically, I discuss searching for and collecting data, the selection criteria, and the data corpus examination processes. Finally, I offer explanations for searching for themes and sub themes.

This study asks the following: What does the current literature say concerning the connection between racism and suicidality among females of African descent? In thinking about theories and methodologies, my focus centered on epistemologies that would capture the literature concerning the lives of females of African descent, as stated in my thesis question (Hill-Collins, 2000). Since scholars and non-scholars contributed to the data for interpretation (Creswell, 2014), it seemed appropriate to have used a qualitative research approach that grounded the research in theory (Clarke & Braun, 2006). Accordingly, I selected thematic analysis, because its research design helped me to capture and organize data specifically in answering the thesis question (Clarke & Braun, 2006; Creswell, 2014; Javadi & Zarea, 2016). Furthermore, the flexibility of this approach helped me to research, locate, retrieve, organize, and analyze the data from multiple sources into themes and sub themes (Clarke & Braun, 2006).

Philosophy of Research and Key Epistemological Assumptions

The interpretive paradigms of the research method should validate the research data found during the thematic analysis (Clarke & Braun, 2006; Creswell, 2014). I estimated that standpoints from social epistemologies such as black feminist thought, Afrocentrism, intersectionality, and psychological theories on suicidality would emerge from the literature. I was curious to see if these theorizing epistemologies within the thematic analysis would work to reflect the findings and standpoints drawn from the research literature connecting racism and suicidality among females of African descent.

A transformative approach.

The reason for reviewing the literature is to provide evidence-based knowledge and contexts that support a transformative approach, developed during the 1980s and 1990s in reaction to the post-positivist worldview at the time (Creswell, 2014). The transformative approach takes issue with imposed structural laws and theories that ignore issues such as marginalized people, power and social justice, discrimination, and other forms of oppression (2014). Karl Marx's (1818-1883) critical theory of capitalism and structural oppression had laid the foundation for the transformative philosophical worldviews (Joll, 2010). However, the individuals credited with developing transformative approaches were: Max Horkheimer (1895-1973), Herbert Marcuse (1898-1979), Theodor Adorno (1903-1969), Paulo Freire (1921-1997), and Jurgen Habermas (1929-present) (Neuman, 2009; Fay, 1989, as cited in Creswell, 2014). Furthermore, based on its origin in the 1970s (Merton, 1975, as cited in Braun & Clarke, 2013) and founder Gerald Horton (Joffe, 2012), thematic analysis assisted with "identifying and analyzing the patterns in the qualitative data" (Clarke & Braun, 2013, p. 3).

The transformative worldview embraces inquiry that investigates social and psychological issues such as racism and suicidality, which are oriented in power and justice (Creswell, 2014). The transformative worldview seemed appropriate because the thesis question that I have posed challenges social oppression using a political change agenda (2014). This approach also allowed me to offer an analysis of discourses to help society work together towards the elimination of oppressive behaviours and practices that result in racism and suicidality among females of African descent. I identify with this group, as I have experienced and still experience racist violence, and I work professionally with issues of suicidality. As such, I am a benefactor of this approach (Creswell, 2014).

Ontological and epistemological philosophical views bring context and evidence-based knowledge forward that are critical to this approach (Lofgren, 2013). “Epistemology accounts for standards used to assess knowledge or [examine] why we believe what we believe to be true” (Hill-Collins, 2000, p. 252).

Thematic analysis.

First, I chose thematic analysis because it is evidence-based, allowing me to capture the data from the review of the literature, and offering processes and procedures that focused on answering the challenging intersections (Crenshaw, 1991) of race, suicidality, and gender. Thematic analysis is a qualitative analytical methodology, and with its interpretive theoretical, and epistemological orientation, it allowed me to closely analyze and search for patterns within and across the data corpus (Clarke & Braun, 2006). Patterns are defined as the meanings found within the data set (Clarke & Braun, 2006), which can be defined as the data corpus, or all the literature that I drew from during the review of the literature, for analysis (Clark & Braun, 2006; Javadi & Zarea, 2016). For example, the patterns found in the peer articles, magazine articles,

and books made up the data corpus, and the data content selected from the data corpus provided the data set.

Thematic analysis allowed me to capture and report on the themes for the thesis question (Clarke & Braun, 2006). “Themes are patterns across the data set that captures something important on the data and ideas on the thesis question” (Clarke & Braun, 2006, p. 82). The themes explain the meaning of the data for interpretation (Clarke & Braun, 2006). Clusters of themes are “formed by grouping units of meaning together (Creswell, 2007, as cited in Davis & Maldonado, 2015, p. 57). Thematic analysis engages researchers in making active choices, both epistemologically and methodologically (Clarke & Braun, 2006). For instance, the formation of the thesis question was helpful in creating the basis of search strings for the search of themes or patterns.

The Search for Data and the Collection of Data

Second, I engaged in an exhaustive search for potential articles. Because this investigation was theory-driven (Clarke & Braun 2006), I began by breaking the research question into individual concepts that created search terms or search strings. The scholarly and non-scholarly data were located using an inductive approach from general to specific words and phrases related to the thesis question (Creswell, 2014). Where general search terms from the thesis question provided unmanageable results – for example, data in the millions – I selected search terms with a specific focus on parts of the thesis question. To illustrate search terms and search strings, I began with terms that built on words and phrases from the thesis question (see Table 1 below).

Table 1. Data Results from Websites and Databases

Website or Database	Words or Phrases Inputted	Number of Documents
City University of Seattle library	Racism	Over a million
City University of Seattle library	Racism among females of African descent”	10,371
City University of Seattle library	Racism and suicidality among females of African descent	149
Google Scholar	Racism	Over a million
Google Scholar	Racism among females of African descent	24,600
Google Scholar	Racism and suicidality among females of African descent	9,330
PubMed Database	Racism	3623
PubMed Database	Racism among females of African descent	6
PubMed Database	Racism and suicidality among females of African descent”	0

While in databases where I was not successful in obtaining manageable results from the search terms (such as the results from the term “racism”), I applied the following search strings that focused on the thesis question in other computerized databases. I selected articles that answered the thesis question by scrolling through each search term result.

Examples of the search terms.

- Racism and suicidality among people of colour
- Racism and suicide among Black people
- Racism and suicide and black women
- Racism and suicide and girls of African descent
- Racial discrimination among females of African descent
- Racial discrimination and suicidality among females of African descent
- Racial discrimination and suicidality among people of colour
- Racial discrimination and suicidality among Black people
- Racial discrimination and suicidality among black women
- Racial discrimination and suicidality among girls of African descent
- Racial discrimination and suicidality among adolescents of African descent
- Racism and females of African descent
- Suicide and females of African descent
- Suicidality and females of African descent
- Black people and suicidality
- Black people and suicide
- Black people who commit suicide
- Black people who attempt suicide
- Completed suicide and Black people
- Do Black people commit suicide?
- Why do black women commit suicide?
- Racism and the impact on the health of females of African descent
- Racism and the impact on people of colour
- Racism and the impact on Black people
- Racism and the impact on black women
- Racism and the impact on girls of African descent
- Black women and mental health issues
- Racism as a determinant of health

Phase one of thematic analysis accounts for the collection of data. I searched database sources that included Google open website, Google Scholar website, and City University Library. Additional websites visited were PubMed, Cochrane Library, National Institute

Guidelines Clearinghouse, and PsycInfo. I also visited the Black Health Alliance and the Canadian Centre for Suicide Prevention web sights. The Cochrane Library, the National Institute Guidelines Clearinghouse, and the Canadian Centre for Suicide Prevention did not produce any results relevant to my thesis question. However, Google open website and Google Scholar website, City University Library and PsycInfo database provided publications from sources such as the West Indian Medical Journal, the Journal of Black Psychology, Psychotherapy and Politics International, the British Medical Journal, the American Journal of Orthopsychiatry, Race and Social Problem Journal, the Annual Review of Psychology, the Journal of Ethnicity and Health, and The Handbook of Transcultural Counselling and Psychotherapy, and the American Journal of Public Health. The search also provided content from culturally relevant online magazines and editorials.

The Selection Criteria

Third, a decision-making process regarding article inclusion for the literature review ensued. To determine the acceptability of studies, articles, and texts, I read numerous articles, abstract summaries, and their conclusions (Clarke & Braun, 2006). Common inclusion and exclusion criteria included data related to the thesis question, the terms and concepts within the thesis question, theoretical and empirical considerations, research designs, and studies with female participants of African descent. For the selection of the non-scholarly articles, the data had to include discussions of racism and, or suicidality among the studied population and the content had to include information from expert practitioners or professionals. Non-scholarly articles were included from culturally relevant online magazine articles and editorials. Articles with data that discussed females of African descent, but also included data non-specific to other aspects of the thesis question, were excluded, as well as articles that generalized the experiences

of black women and where this population were invisible within the data. The primary focus of the “inclusion and exclusion process was to determine the value of what the literature had to offer” (Creswell, 2014, p. 32).

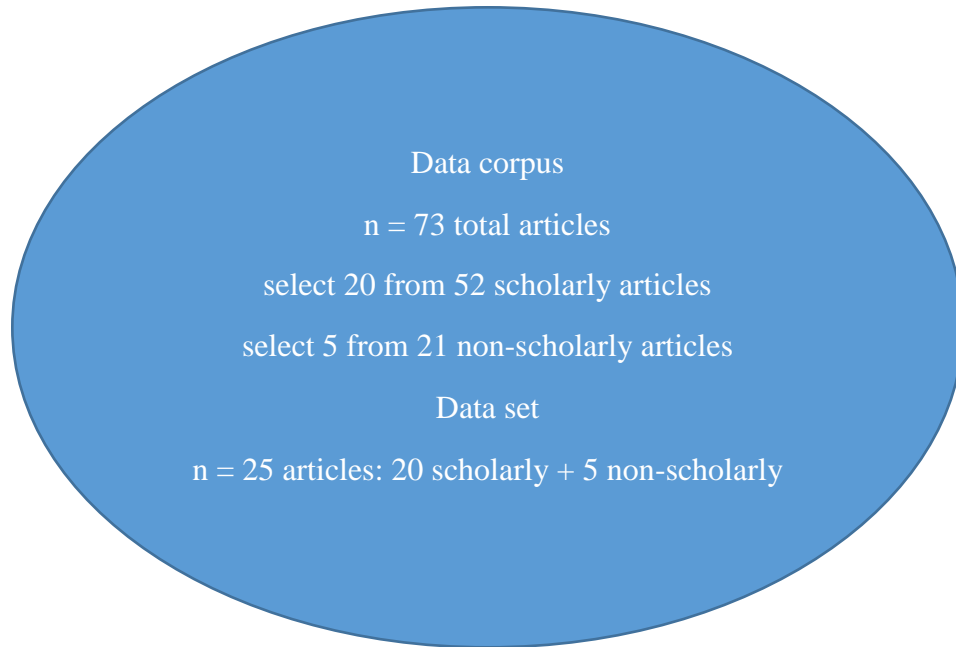
Data Corpus Examination

Fourth, I examined the data corpus. The search engines produced 106 documents, and these are the data corpus. From the data corpus, I selected 73 documents, wherein, 52 were scholarly articles, and 21 were non-scholarly. Of the scholarly articles, seven were peer-reviewed, and three books included the other articles. With the 73 articles selected, I created a comprehensive reference list. Also, I saved 106 documents on an external drive, and I printed 70 documents. Initially, because I conducted the search based on the thesis question, which was a preconceived notion of what I would find, I also searched with an open-mind regarding what might emerge. In total I found 73 documents for further analysis, all of which answered some aspect of the thesis question (see Table 2 below).

Table 2. Data Collection Between June 2016 and August 2017

Dates	Number of Documents
June 2017 to August 2017	n = 106
August 2017	n = 73 70 documents printed & 3 books purchased
	52 scholarly articles
	21 non-scholarly articles

Fifth, for a thorough analysis of the data, I became familiar with the 73 documents (Clarke & Braun, 2006). To illustrate, I read the documents and watched and listened to the audio-visual materials. For the articles and books, I printed hard copies and grouped information in binders. In the binders, I used colourful sticky notes for organizing and accessing the data. For instance, I wrote the words “yes,” “no,” and, “maybe” on the sticky notes. At this second phase of the thematic analysis, I collated articles that made a connection between racism and suicide among females of African descent and grouped those that described racism or suicide among the studied population. I used Microsoft Word for documenting the data from the audio-visual material; and I saved the website links and notes from the hard copy data and audio-visual material to an external drive.

Flow Chart 1: Inductive Logic Selection of Articles

Following the collating process, I used inductive logic to select 20 scholarly peer articles and texts from the 52 scholarly documents and five from the 21 non-scholarly documents considering the thesis question and the inclusion and exclusion criteria (Creswell, 2014) (see Flow Chart 1 above for the inductive logic selection process of articles). The data analysis process helped me to categorize the data into a perspective, created from the content of the thesis question – that summarizes the themes (Clarke & Braun, 2006).

A Perspective that Summarizes the Themes: Racism and Suicide Among Females of African Descent Historically and in Contemporary Society

To search for themes, which is the third phase of thematic analysis methodology (Clarke & Braun, 2006), I immersed myself in reading the three scholarly articles, one from Perry et al. (2013): chapters 2 and 7 of Poussiant and Alexander (2001), and one non-scholarly article by Bell (2017). These four documents made the connections between racism and suicidality among females of African descent. The content analysis process from reviewing these four documents helped with confirming and creating the thesis question and produced four themes within the data set. To further identify themes, I utilized a semantic approach to draw explicit meaning from the latter four documents (Clarke & Braun, 2006). While the perspective and the themes are interrelated when answering the thesis question, they are also independent of each other (Clarke & Braun, 2006). The themes that originated from the four documents that provided insight to the thesis question are in the Flow chart 2 below.

Flow Chart 2: Themes from the Four Documents that made Connections Between Racism and Suicidality Among Females of African Descent

Themes

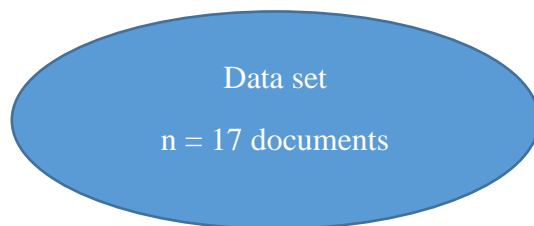
Theme one: The “strong” black woman stereotype and the impact of this stigma on the health and wellbeing of females of African descent

Theme two: Racism as a determinant of health among females of African descent

Theme three: Suicidality among females of African descent

Theme four: Females of African descent and issues of racism and suicidality for professional consideration

At this point, I had located, revised, and confirmed the four candidate themes, which is the fourth phase of thematic analysis (Clarke & Braun, 2006). “Candidate themes are the themes that form coherent patterns from the collated data extracts” (Clarke & Braun, 2006, p. 20). Confirming the four candidate themes enabled further in-depth analysis at the latent theorizing level of the data from the 25 documents. The latent level exceeds the semantic level, “and starts to identify or examine the underlying ideas, assumptions, and conceptualizations and ideologies that are theorized as shaping or informing the semantic content of the data” (Clarke & Braun, 2006, p. 13). Therefore, after further revising the 25 documents as located in the one perspective and four themes, I eliminated eight documents because they did not add anything substantial to answering the thesis question (Clarke & Braun, 2006). The one perspective drawn from the thesis question and the four candidate themes included 17 documents for the data set (see Flow Chart 3 below).

Flow Chart 3: Data Set for Analysis

Sixth, I read and re-read, summarized, analyzed, and interpreted the data. These processes helped me in the organizing of the data set that the perspective and four themes captured (Clarke & Braun, 2006). After additional review of the data, there were eight emerging sub-themes for discussion in the findings and results section (see the List below).

List 1: Sub themes

Sub themes

- Criminalizing suicide
- Contemporary society and pathologizing language
- The oppressed must fix the problems caused by the oppressors
- The socio-economics of colourism
- Mental illness and stigmatizing, and eliminating the myths of “strength” and “perfection”
- White children as perpetrators of racist violence
- Suicidality intersects with religion
- Spirituality and suicide and family networks

Next, I completed the fifth phase which was organizing the information for the thesis proposal and the literature review. For the sixth and final phase, I produced the literature review that is an analytic narrative answering the thesis question. In the following section, I present the interpretation of the findings, which determines the strength of the evidence from the selected reviewed literature (Creswell, 2014).

Chapter 4

Before providing the analysis of the data set, there are several issues for discussion. First, I thought the data would have produced more information connecting racism and suicide. However, after initial searches, I found very little data that made the connection. Since confirmation is a primary concern when doing a literature review I conducted further extensive searches as I wanted to ensure that I had been thorough. Second, I reflected on the barriers to searching data sources for the literature with comprehensive concepts such as racism, suicidality, and females of African descent (See Chapter Three Methodology and page 88 to 89 for other concepts searched). The search for data investigating the thesis question showed that racism and suicide are huge concepts. Third, when I used the search phrase “racism and suicidality among females of African descent” at the same time, I had very limited results (See Chapter Three Methodology and page 88 for databases searched). The paucity of literature discovered in the search suggests that the connection between racism and suicidality among black women is rare. However, when searched separately, the results were substantive. Again, the comprehensive concepts may account for the overwhelming results. Alternatively, it is possible that black women are rare study participants when investigating racism and suicidality together. However, the information found regarding diverse groups of people was invaluable. Fullagar and O’Brien (as cited in White et al., 2016), acknowledge the importance of suicide research, data collection, and policy responses for diverse groups. An issue of concern is epidemiological data that frames all women’s and men’s experiences together (Fullagar & O’Brien, as cited in White et al., 2016).

Fourth and finally, black women may typically not wish to participate in academic research studies, which could be, at least in part, due to mistrust. If mistrust is a factor, researchers may have to investigate processes and procedures that will be appropriate for these

females. A consideration for researchers is that while black women may be participating in research and public discourses on racism (Bell, 2017; James et al., 2010; Michael, 2015; Okeke, 2013), the stigma associated with mental health issues such as suicidality (Hamin, 2008; Perry et al., 2013; Tso & Samuelson, 2014; Washington, 2014) may impact their participation.

With the results produced from the search, which included a perspective that I created, namely four themes and nine sub themes, I will examine the data set and provide an analytic narrative by discussing the research question (Braun & Clarke, 2006). The four themes evolved from the four sources that made connections between racism and suicidality among females of African descent: Perry et al. (2013); Poussiant and Alexander (2001) Chapter two and seven; and Bell's (2017) article. The sub themes emerged throughout the writing process. In the discussion chapter (see page 123 to page 130), I will discuss theme number four, which looks at issues for helping professionals when working with females of African descent concerning racism and suicide.

A Perspective that Summarizes the Themes: Racism and Suicidality Among Females of African Descent Historically and in Contemporary Society

Historically, there is a connection between racism and suicidality among people of African descent living in the United States of America (Gates, 2014; Perry et al., 2013; Poussaint & Alexander, 2001). The connections of racism and suicidality highlight historical oppressive practices against black Americans (Poussaint & Alexander, 2001). The events of the transatlantic slave-trade reveal intersections of racism and suicidality among black Americans (Gates, 2014) such as European slave-traders' construction of economic agendas and racist ideas whereby they were the benefactors of enslaved African people's free labour (Gates, 2014; Kendi, 2016). Enslavement reveal slave-masters' dehumanization and brutalization of captured

African people and specifically forced rapes of black women for economic profit (DeGruy, 2006; Gates, 2014; Kneeland, 2006).

During the transporting of African people on ships from the continent of Africa to various parts of the world, suicide was one way in which the deaths of African captives occurred (Gates, 2014; Royal Museums Greenwich, 2017). Upon their arrival to places in the USA, the ending of their lives by suicide was a method by which enslaved Africans, specifically black females coped with pain and suffering (Lester, as cited in The National Humanities Center Resource Toolbox, n.d.; Kneeland, 2006).

Criminalizing suicide.

Historically, martyrdom was self-sacrifice committed by people because of their religious convictions and affiliations. In contrast, historically, the Christian theological perspective contextualizes suicide as sinful (Poussaint & Alexander, 2001), others criminalize suicide and treat it as a mental illness (Reynolds, 2011, as cited in White et al., 2016). In fact, criminalizing people for ending their lives by suicide was a widespread practice in England and the USA (Poussaint & Alexander, 2001).

Refusing to allow the bodies of people who had died by suicide to be buried on sacred ground was also a widespread practice (Poussaint & Alexander, 2001). This practice was justified by Christians, who believe that God has the sole power to end human lives (Poussaint & Alexander, 2001). A common phrase that I have heard in the Black Church is: “It is God who gives life and it is God who should end life.” Although suicide and sacred burial on the basis of biblical theory is beyond the scope of this research study, I remain curious about how a loving and forgiving deity can object to suicide even when pain and suffering exist (Kneeland, 2006; Poussaint & Alexander, 2001). I personally find it hard to reconcile a merciful and

compassionate God with one who watches while people suffer. It seems to me that the Biblical framework does not attend to the social contexts in what Reynolds (2011, as cited in White et al., 2016) calls the evolution of suicide.

Contemporary society and pathologizing language.

In the United States of America research shows that the combination of racism and suicidality, while rare, is operating among black women and the general African population today (Perry et al., 2013; Poussaint & Alexander, 2001). This is a key insight into suicide and self-destructive behaviour among this population (see Poussaint & Alexander, 2001, pp. 50-51). When discussing suicide among black men and women, it is unclear if the language is pathologizing and criminalizing the behaviours of the victims, or if the language is examining the behaviours of society towards the victims (Poussaint & Alexander, 2001). When describing suicide and the protective and risk factors, Taylor Gibbs (1988, as cited in Poussaint & Alexander, 2001) states:

Although this is not a simple question to answer, some clues can be found in an analysis of several social indicators which suggest that young black males are at significantly higher risk than black females for a number of deviant and self-destructive behaviours. (p. 131)

Specifically, it appears that researchers such as Poussaint and Alexander (2001) tend to pathologize behaviours among African Americans. To illustrate, when describing the similarities between homicides and suicides among African American males, Poussaint and Alexander (2001) ask the question, “Couldn’t these killings have been precipitated by individuals suffering from a lack of self-worth and other emotional dynamics that are similar to suicidal behaviours?” (p. 48). This statement suggests that the act of suicide is an

individualized and internalized action. Such a criminalizing and pathologizing narrative obscures the complexities of the context in which these people lived (Bell, 2017; Washington, 2014; White et al., 2016).

The act of suicide can be a violent act (Gibbs, as cited in Poussaint & Alexander, 2001); understanding suicide and suicidal acts must be based, not solely on individual characteristics but rather on people in the context of the culture in which they have lived their lives (Reynolds, 2011, as cited in White et al., 2016; Washington, 2014). There is power in the language of suicide (Reynolds, 2011, as cited in White et al., 2016). Language that pathologizes or individualizes suicide fails to consider the humanity and deep pain of people's daily struggles (Reynolds, 2011 as cited in White et al., 2016).

The oppressed must fix the problems caused by the oppressors.

Researchers state that racism impacts the health and wellbeing of victims (James et al., 2010; Perry et al., 2013; Poussaint & Alexander, 2001). However, "When African-American women of low-socioeconomic status can utilize their senses of ethnic identity and access ethnically or culturally-specific resources, this creates a sense of pride, a sense of belonging, and a protective role against racism related stressors" (Perry et al., 2013, p. 5). This perspective suggests that while African-American women are not responsible for their lived reality of poverty, this empowerment may improve their situation (Perry et al., 2013). Empowerment strategies can be achievable solutions (Perry et al., 2013), suggesting that the responses of African-American women of low socioeconomic status to social pressure, such as racism and discrimination, depend on the development of interpersonal, emotional, and psychological skills among individuals (Poussaint & Alexander, 2001). While finding strength is commendable for black women in the United States of America (Perry et al., 2013; Poussaint & Alexander, 2001),

it is not helpful to perpetuate the notion that victims who have experienced racism and other forms of discrimination are responsible for fixing problems that they did not want or create. While studies show that connectedness and strong cultural practices contribute to ethnic affirmation (Perry et al., 2013), people experiencing social exclusion due to racism and poverty are still less likely to access health care and to attend to wellbeing issues (Reading et al., 2007, as cited in James et al., 2010).

The socio-economics of colourism.

Skin colour is a discourse of cultural racism among African-American women where through racist social conditioning, lighter skin complexion is the preference over darker complexions (DeGruy, 2005; hooks, 2003). Historically, the division of labour by white dominance among enslaved black women meant lighter skin females were assigned lighter work duties (Bristol and Transatlantic Slavery, n.d.; Kneeland, 2006). hooks (2003) writes:

We will never know when enslaved black folks began to understand fully that the more they imitated their white colonizers, the better they might be treated. We will never recall that exact moment in time when a significant number of dark-skinned enslaved Africans began to see lighter skin as better. A colour caste system existed in the minds of white colonizers long before the systematic rape of black women produced children with mixed skin colour. It may have been as simple a transition as slaves observing that white folks treated lighter-skinned people better, and ultimately this began to establish a new standard of aesthetics based primarily on the longing to be treated with less brutality. (p. 38)

Racism was and is a systemic problem of oppression (Chatterjee, 2017; James et al., 2010; Poussaint & Alexander, 2001). Perry et al.'s (2013) investigation of African American

women of low-socioeconomic status, state that for ethnic affirmation, women with darker skin experience more discrimination than lighter skinned women, and women with medium to dark skin identify with their culture more. Women with medium to dark skin receive more support and affirmation from their black culture than women with lighter skin who do not suffer as much from racism; thereby, darker skin colour becomes a protective factor (Perry et al., 2013).

hooks (2003) writes:

All black people have witnessed someone being victimized by politics of colour, whether it's hearing slogans like "a black nigger is a no-good nigger" or watching an adult degrade a child by suggesting he is evil because he is so black, or by hearing a child speak contemptuously to another child about her appearance. Every day somewhere in our culture a child is telling another child: "I can't play with you because you are too dark." Or, "You can't come to my party' cause your hair is too nappy." My maternal grandmother, who was able to pass for white, always degraded our darker-skinned sister, calling her "Blackie." As children we witnessed my sister's wounds, the ways in which they affected her self-worth, and we felt fearful for our own. (p. 42)

As someone with medium to darker skin who lived in the low-income neighbourhood of Toronto, Ontario's Jane and Finch, I was surrounded by dark and light skinned black people who were committed to advancing and affirming Black Power and Black Pride. The incidents of aesthetic racism that I experienced occurred in white neighbourhoods and the perpetrators were white people living outside of my community. Meanwhile, I received love and comfort from people and resources within my community. This meant that I was conscious of my dark skin complexion because of white supremacist racist messaging that broadcast a preference for lighter skin complexions as evident interpersonally, on magazine covers, in commercial beauty

displays, on television shows, in movies, and in music videos (hooks, 2003). Over time, I learned to appreciate and love my beautiful brown skin. The black church that I attended as a young person and into my adulthood played a significant role in positively affirming the group's and my ethnic identity and ethnic pride.

Skin colour and protective factors and risk factors.

Protective factors for African American women of low-socioeconomic-status are lighter skin and more European features because these can mean fewer encounters with racism (Perry et al., 2013). These two factors “have an especially strong effect on the psychological wellbeing and life chances of these women” (Perry et al., 2013, p. 13). Having darker skin, being female, and being poor are the “triple disadvantages” of women of African descent (Perry et al., 2013, p. 13). For example, there are connections between African-American women of low-socioeconomic-status who are experiencing racism, where being black, female, and poor contribute to suicidal thoughts and behaviours among this group (Perry et al., 2013). Having a history of mental illness further increases suicidal thoughts and behaviours among African-American women of low-socioeconomic-status in comparison to those without such mental health histories (Perry et al.). Black women endure racism (Bell, 2017; James et al., 2010; Kendi, 2016; Kneeland, 2006; Poussaint & Alexander, 2001), and experience suicidal behaviours irrespective of socio-economic background (Perry et al., 2013; Wortham, 2015).

Theme One: The “Strong” Black Woman Stereotype and the Impact of this Stigma on the Health and Wellbeing of Females of African Descent

Over many decades, African Americans developed an internalized belief of strength or being strong (Poussaint & Alexander, 2001, p. 131). Even though the strong black woman stereotype is a myth, the belief in it continues (Bell, 2017; Hamin, 2008; Okeke, 2013). The strong black woman stereotype is a socially constructed stigmatizing idea put forth by white supremacists for their economic wealth during the time of slavery (Hamin, 2008; Kendi, 2016; Okeke, 2013; Washington, 2014). It places unrealistic expectations on black women’s abilities (Bos et al., 2013; Hamin, 2008; Kendi, 2016; Okeke, 2013; Washington, 2014; West et al., 2016), promotes submissiveness (hooks, 1993, as cited in Okeke, 2013) and the tendency to ignore their own wellbeing while attending to the health of others (Hamin, 2008; Okeke, 2013).

In a discussion about the strong black woman stereotype with researcher Okeke (2013), one participant states, “another common perception in black communities is that mental illness is not something that affects black people” (p. 9). A key stressor for black women is having their mental capacity questioned (Okeke, 2013). Another participant said that “some black women living with mental illness have expressed donning the ‘strong’ black woman façade so much that they came to believe it was real” (Okeke, 2013, p. 9). According to Jarune Uwujaren (2014)

The phrase “strong black woman” conjures up images of single mothers doing it all, putting up with all manner of social ills from sexist black men to racist white society without flinching. The strong black woman of these images, who seems more superhuman than real, cares for everyone else’s needs before her own and does it all without crying on anyone’s shoulders or relying on anyone’s help.... The myth of the strong black woman, who is distinct from the strong black women that really walk this

earth, reminds me of the myth that black wet nurses enjoyed breast feeding their masters' children. This was a myth designed to make slave owners feel less guilty about the socioeconomic circumstances that forced black women to be mammies and nannies and housekeepers and maids back in "those" days. This was a myth that survived in black communities when mammies and nannies and housekeepers and maids still tended to their own families when they came home. (paras. 1, 2, 5, 6, & 7)

Within American society, as well as in other societies where individualism and working hard are core values, socialization, and labelling of the "strong" black woman stereotyping of females of African descent results in negative characterizations (Okeke, 2013). Living with the diagnosis of mental illness could impact their way of life for black females who are enduring experiences of stigmatization (Okeke, 2013). The threat of being stigmatized means concealing diagnoses of mental illness and this approach of concealing mental diagnoses protects family networks and family status (Yang et al., 2007). For example, the revelation of mental diagnoses means those people with mental illness may not be able to marry and have children, which suggest a devaluation of individuals with mental illness because their dignity and humanity within the community are at risk (Yang et al., 2007).

Stigmatization and eliminating the myths of strength and perfection.

"All Black folks risk being victimized by the perpetuation of the notion that we can triumph with ease over degradation and dehumanization." (hooks, 2003, p. 54)

When African Americans are working through distressful situations, there are conflicts with the internalization of "strength" (Poussaint & Alexander, 2001, p. 131). Among African Americans and especially black women, the idea of strength is appealing (Hamin, 2008; Poussaint & Alexander, 2001). African Americans reveal this conflict by operating between

these two worlds, known as “double consciousness” (Poussaint & Alexander, 2001, p. 131). On one hand, black women want to appear strong; on the other hand, experiences of racism may lead to the erosion of their identities (Bos et al., 2013; Hamin, 2008). While historically the racist construction of the strength and perfection of black womanhood added to the erasing of black women’s identities (Bos et al., 2013; DeGruy, 2005; Hamin, 2008; Kendi, 2016), today the manifestation of the strong black woman stereotype sees black women struggling with health issues, enduring through silence, and tending to take ownership of problems (Bell, 2017; Hamin, 2008; Okeke, 2013).

Washington (2014) attempts to eliminate the expectation of strength and perfection among black women that associate discussing mental wellbeing issues and seeking help with shame. There is an expectation that black women should endure pain and should suffer in silence (Washington, 2014). When they raise concerns relating to their pain and suffering, they can be seen as lacking in strength and perfection (Washington, 2014). Washington (2014) writes:

Linda and I shared times when we hid our depression out of fear [of] being judged as weak or a burden to friends and family. We were careful to guard our pain—only sharing it in whispered phone calls, in snatches of time away from broader society. Black women who go to therapy or admit they are struggling are often regarded as “weak,” “crazy,” or “self-pitying” for not stoically shouldering the burden of their families and communities. In order to better address the problem of mental health, we must stop shaming black women for not being strong or perfect. Black women can experience depression because human beings experience depression. There is nothing coded in our DNA that makes us invulnerable to trauma, generations of pain, and

unequal treatment in our families, [and] communities. In order to create an open space for the discussion of mental health, we must allow ourselves to be human, and part of this is to acknowledge [that] parts of ourselves are not always defined by strength. (para. 5)

The idea of “being strong” when faced with problems prevents blacks from seeking professional care (Poussaint & Alexander, 2001, p. 61) due to stigma (Okeke, 2013; Washington, 2014). Washington (2014) advocates developing a more realistic view of women so they are free to seek professional help when needed, and reframing vulnerability as strength, where individuals who are struggling with their mental wellbeing (such as depression and suicidal behaviours) should, without shame or fear, connect with friends and family and/or seek professional help. However, it should be noted that when blacks have sought help, they often experience “unfriendliness and/or insensitivity of the clinical professional community” (Poussaint & Alexander, 2001, p. 61). More work needs to be done with professionals to increase their cultural competency in order to validate black people’s health and wellbeing issues (Chatterjee, 2017).

Theme Two: Racism as a Determinant of Health Among Females of African Descent

Racism negatively affects the health of black women and the health of Black people in general (Baldeh, 2019; James et al., 2010; Perry et al., 2013; Poussaint & Alexander, 2001), physically, emotionally, and interpersonally (James et al., 2010). The effects of racism are traumatizing and multigenerational (Baldeh, 2017; DeGruy, 2005). Upon examining racism among Black people, beginning from the time of the transatlantic slave-trade to the present day, it is clear that unresolved trauma is transferred from one generation to the next (DeGruy, 2005). Acts of racist violence by slave-masters against enslaved Africans were common occurrences

(Kendi, 2016; Kneeland, 2006; DeGruy, 2005) that often led to post traumatic stress disorder (DeGruy, 2005; Williams, as cited in Wortham, 2015).

DeGruy (2005), states:

Post-Traumatic Slave Syndrome is a condition that exists when a population has experienced multigenerational trauma resulting from centuries of slavery and continues to experience oppression and institutionalized racism today. Added to this condition is a belief, real or imagined, that the benefits of the society in which they live are not accessible to them (p. 121). Enslaved Africans' post-traumatic slave syndrome explains untreated, unresolved, and accumulated multigenerational injuries and stresses from the time of slavery to the present day. (DeGruy, 2005)

White children as perpetrators of racist violence.

Black children have the right to grow-up in this society without experiences of fear and racial violence (James et al., 2010). Racial taunting and harassment by white children towards black children highlight the painful reality of racialized violence (James et al., 2010: Michael, 2015). In their discussion on internalized racism, Canadian researchers James et al. (2010) state:

For those raised in Canada, the uncertainty about what's going to happen "because of my race" can begin in early childhood. In reflecting on her childhood, one woman said she has now come to understand the rage she experienced as a child. For her, it was a protective mechanism against racist slurs directed at her. Recalling how she felt the many times she was taunted by White children yelling "your skin is the same colour as shit," she appreciates how painful racism is for many young black children and how difficult it is for them to "hold onto dignity." Young people, especially, "search for ways

in which they can bolster self-respect in a society that constantly denies their humanity,” she says. (p. 128)

In North Dublin, Ireland [one mother speaks out against her neighbour:

This Irish woman (about 35 years old) would not let my children play outside even in my own backyard; she said they are black and have no business being here. Calls my 12 years old daughter fat black bitch. She lives seven houses away from me, but she would send her children to come and be playing and throwing their ball into my garden just to provoke us and start a fight. She has threatened to bring her family to come trash my house and set it on fire. So, I am doing everything humanly possible to avoid them. We sleep with one eye open not knowing if the house will be set on fire while we are asleep, as she threatens. I understand she does the same to the other Africans in the neighbourhood. (Michael, 2015, p. 13)

Racist hostility leads to race-based traumatic stress injuries (Wortham, 2015) and post traumatic stress disorder (Brown, as cited in Baldeh, 2017), and a constant feeling of being unsafe (Baldeh, 2017). Afrophobia is the term that refers to the Irish perpetuation of racist violence against people of African descent living in Ireland (Michael, 2015). One woman shares her experience of constant fear due to Afrophobic racism:

I felt worth less than a human. The day the guy threw the rock at me, the only thing I could do, after entering the bus, was cry. I have never felt so lonely, so afraid and so humiliated. I was called nigger [on] several occasions, including by the people who work at the building I live [in]. People who ignore me, people who look down on me in all places, just because I’m different. I can’t even go to the supermarket, because the area nearby where I live has a lot of young people who love to throw things at people,

like tomatoes, eggs, onions, potatoes, even a Haribo was threw at me once, and an iron bar was thrown at a friend of mine. I feel constantly threatened in this country, which has the [reputation] of being so warm and open with foreigners, but it is just “the land of hate.” I know I should not generalize, and that there are people who might not like me, but they at least let me be; nevertheless, especially where I live, Dublin, things couldn’t be worse. I even started to see a psychologist, because, on top of all the problems I had, I was feeling so scared that I didn’t want to leave my apartment. I am constantly afraid living in this neighbourhood, but, unfortunately, it is what I can pay. I wish I was getting everything people think I get from the Irish government. Then my life would be so much easier and I would be able to live wherever I wanted. I am sorry for the outburst, it is just that I was holding these things for so long, that everything came out at once. (EU National, North Dublin, as cited in Michael, 2015, p. 36)

The diminishing of people’s self-worth is dehumanizing (DeGruy, 2005; James et al., 2010; Michael, 2015). Racism, mental health issues, and physical health issues are interrelated (James et al., 2010; Msosa, as cited in Baldeh, 2017) and the cost of racist violence is multidimensional (James et al., 2010). Racism is not limited to Ireland. It is also present in Canada (Baldeh, 2017; James et al., 2010) and thus reveals the contradictions in countries that are known as “warm and welcoming to foreigners” (Michael, 2015, p. 36). For some people, these are also places of hate (Michael, 2015).

Theme Three: Suicidality Among Females of African descent

Suicide is occurring among black women in the United States of America, and suicide among this group is the lowest in comparison to black men, white women, and among women of all ethnicities (American Association of Suicidology, 2016). Compared to all women black females in the United States of America are at the highest rate of engaging in physically harmful self-injuries from suicide attempts often requiring medical care (Perry et al., 2013).

Suicidality intersects with religion and spirituality.

There is a relationship between the impact and role of religion and spirituality and the taking of lives (Tso & Samuelson, 2014; Monroe, 2014). Tso and Samuelson offer narratives from African-American women who attempted to commit suicide or contemplated suicide.

Donna Guidry (as cited in Tso & Samuelson, 2014) said:

I was like ‘I don’t know who I’m praying to. But whoever you are, I need you to send me an angel, so I can get my life together.’ [This was] on the night one year ago when she tried to kill herself while high on methamphetamines. She had stood in the middle of a busy road for perhaps a full minute and was astonished when none of the cars speeding by hit her. “At that moment of clarity,” she said, “I just looked up.” Guidry credits that act of God with not only saving her life but motivating her to get on a bus to Los Angeles to seek help. (para. 7, 8, 9)

While a sense of belonging is present in many Christian-based religious institutions, the black church is inconsistent when it comes to providing support for people experiencing suicidality (Crosby & Molock, 2006; Green & Stoppelbein, 2002, as cited in Phempeh, 2003; Taylor et al., 2011). In the African-American community, suicide is “forbidden,” the church

does not discuss it, and the silence around suicide contributes to further issues in the community (Wright, 2012, p. 100).

Suicidal Behaviours and the family network.

When discussing the role of the family network and the presence of suicidal thought, Tso and Samuelson (2014) offer the following narrative from Debra Mackey who struggles with thoughts of suicide and who said that she did not end her life because of her role in her family and community. “If my nieces and nephews who already told me they look up to me [as] an aunt who chose not to continue with this, what does that say [regarding] their existence?” (Mackey, as cited in Tso & Samuelson, 2014, para. 20).

When discussing the struggles of herself and her friend with moments of despair that included thoughts of suicide, Washington (2014) stated:

My worries about the future were compounded by the fact that I knew it could get much worse, and that I was not the only one struggling with mental health. My friend Linda, a black woman and [a] beautiful spirit, tried to end her life just a few weeks ago. “If anything happens, just know I love you,” she texted that Sunday afternoon. I knew [that] the effects of multiple traumas, shame, and the incredible pressure of donning a mask for survival had taken its toll, and [that] she had decided she just couldn’t bear it anymore. I could not imagine life without my friend, but I could not blame her for being unable to see a way out. Thankfully, Linda sent the text to multiple people, and we all scrambled to contact family members to ensure her safety. (para. 3)

In summary, the thematic analysis that I applied for this thesis investigation conceptualized a perspective that draws on the content of the thesis subject: Racism and suicidality among females of African descent historically and in contemporary society. The five

subthemes identified in this perspective were criminalizing suicide; contemporary society and pathologizing language; the oppressed must fix the problems caused by the oppressors; the socio-economics of skin colour and protective and risk factors.

I identified four themes for analysis within the data set. The first of three themes discussed in the findings and result section is the “strong” black woman stereotype and the impact of this stigma on the health and wellbeing of females of African descent. The two subthemes under this theme are the “strong” black woman stereotype and mental illness, and stigmatizing and eliminating the myths of strength and perfection. The second theme identified is racism as a determinant of health among females in general, and the subtheme is white children as perpetrators of racist violence. The third and last theme examined is suicidality among females in general. The two subthemes from the latter are how suicidality intersects with religion and spirituality and the theme of suicide and the family networks.

The thematic analysis of the data set revealed the interrelationship between the constructed perspective, themes, and subthemes, thereby providing insight to the thesis question with rare connections between racism and suicide among females of African descent. The perspective, themes, and subthemes considered the thesis question and embraced the meanings of females of African descent and their experiences of racism and suicide.

Chapter 5

My original study question asked: What does the current literature say concerning the connection between racism and suicide among females of African descent? The results from the data show that the link between racism and suicidality among this population is largely unexplored. While there is a relationship between racism and suicidality among females of African descent, the data were rare and therefore insufficient to make a definitive conclusion (Bell, 2013; Perry et al., 2013; Poussaint & Alexander, 2001). It is clear from the literature that black women are experiencing both racism (Baldeh, 2017; Okeke, 2013; Perry et al., 2013; Wortham, 2015) and suicidality (Bell, 2017; Perry et al., 2013; Poussaint & Alexander, 2001). While black women in the United States of American rarely end their lives by suicide (American Association of Suicidology, 2016; Monroe, 2014; Poussaint & Alexander, 2001) there is a high rate at which they are having thoughts of suicide and attempting to commit suicide (American Association of Suicidology, 2016; Perry et al., 2013). Even though it was difficult to locate data on suicide deaths, black women did engage in suicidality due to racist brutality during the time of slavery (Kneeland, 2006; Lester, as cited in National Humanities Center Resource Toolbox, n.d.; Poussaint & Alexander, 2001).

Resiliency and Strength Among Females of African Descent

Females of African descent continue to experience health and wellbeing issues resulting from racism (Baldeh, 2017; James et al., 2010; Michael, 2015; Okeke, 2013). However, although this thesis has focused on racism and suicidality, these issues do not define us or capture the wholeness, diversity, and authenticity of black women. Historically, and presently, when black females experience racism and other health and wellbeing issues such as thoughts and attempts of suicide, they are showing resourcefulness and resiliency (Okeke, 2013;

Poussaint & Alexander, 2001; Tso & Samuelson, 2014) by trying to address the racism that affects them so deeply.

However, when discussing suicide among the Black community in the USA, with a specific focus on suicide ideation and attempting suicide, witnesses should be aware of "...the polite narratives of sufferers" (Bell, 2017, para. 16), in that they may be suffering in silence, embracing and or reinventing the meaning of strength and perfection (Hamin, 2008) and in many cases, while their health deteriorates, they continue to persevere (James et al., 2010; Poussaint & Alexander, 2001; Tso & Samuelson, 2014). While black women are resilient when confronted with struggles such as health and wellbeing issues (Hamin, 2008; Tso & Samuelson, 2014), it is unclear whether this is cause to celebrate (Bell, 2017; Poussaint & Alexander, 2001; Washington, 2014). Resiliency is beneficial if these females can attend to their struggles (Carten, n.d.; Hamin, 2008). On the other hand, pushing through their problems and ignoring health and wellbeing issues can be harmful (Chatterjee, 2017; Okeke, 2013; Poussaint & Alexander, 2001). Additional concerns are their propensity to take care of others, usually at the expense of their health (Hamin, 2008; Okeke, 2013; Poussaint & Alexander, 2001), and to endure pain as a sign of strength (Hamin, 2008; Washington, 2014; West et al., 2016). Engaging in these practices of pain endurance and strength relates to the role and impact of the strong black woman stereotype (DeGruy, 2005; Hamin, 2008; Kendi, 2016; Okeke, 2013).

Despite signs of resiliency, suicide is occurring among black women even though the rate of suicide is lower for them in comparison to white women and is the lowest among all ethnicities in the USA (American Association of Suicidology, 2016; Perry et al., 2013; Tso & Samuelson, 2014).

Suicidality among black people is likely to occur when they are in isolation, when they are experiencing homophobic bullying, when due to police-assisted suicide (Clarke, 2011; Gibbs, 2015; Monroe, 2014; Tso & Samuelson, 2014) and where negative aspects of religion are present (Clarke, 2011; Monroe, 2014; Prempeh, 2013; Wright, 2014), such as the expectation that they can pray illnesses away (Bell, 2014; Washington, 2014). A complicating issue is that within the Black Church there could be discomfort, silence, and judgment when discussing suicidality (Crosby & Molock, 2006), as it is a common belief that if suicide is involved, the person will go to hell after death (Tso & Samuelson, 2014).

Among black women, there are protective factors for suicidality that include connectedness and maintaining social networks (Bell, 2017; Poussaint & Alexander, 2001; Tso & Samuelson, 2014), and having strong family ties, that provide a sense of purpose and identity (Bell, 2017; Monroe, 2017; Perry et al., 2013; Tso & Samuelson, 2014). Other protective factors include having access to mental health counselling, participation in and practice of religion, and engaging in spirituality that includes prayer (Bell, 2017; Monroe, 2017; Poussaint & Alexander, 2001). Strengthening relationships through participation in church activities and fellowship decrease the likelihood of suicidality (Martin, 1984; Pescosolido & Georginna, 1989; Stack, 1989, as cited in Willis et al., 2003; Wright, 2014). Similarly, a non-judgmental approach and an openness to discussing issues of suicidality within the Black Church could decrease suicidality (Crosby & Molock, 2006). The Black Church views suicide as unforgivable and sinful; and this approach decreases suicide (Anglin, Gabriel, & Kaslow, 2005; Willis et al., 2003). Black Churches that create safe spaces for sexually diverse and gender non-conforming people could decrease suicidality among those members (Clarke, 2011; Gibbs, 2015; Monroe,

2014; Quinn, 2013). Finally, suicidality is less likely to occur when black women are in safe and healthy black spaces (Bell, 2017; Chatterjee, 2017; Monroe, 2017; Tso & Samuelson, 2014).

Issues of Racism and Suicidal Behaviours for Professional Consideration

When examining issues of racism and suicidality, five subthemes emerge:

- raising the issue of race and racism in psychotherapy;
- raising professionals' awareness about suicidal behaviours among females of African descent;
- education regarding racism and anti-racist issues;
- multicultural counselling competency in psychology and professional practice; and
- counsellors' awareness of white privilege and its impact on females of African descent.

Raising the issue of race and racism in psychotherapy.

Raising the issue of race in psychotherapy can be challenging for helping professionals (Gregory, 2013) if they do not have a cultural lens on issues of race or racism within the broader social context (Neville et al., as cited in Ponterotto et al., 2001; Sanchez-Hucles, n.d.). In addition to considerations regarding the historical and contemporary issues of race and racism against black women, helping professionals should consider their cultural identities, the power dynamics within the client-therapist relationship, and the views of black women concerning accessing professional help (Gregory, 2013; Neville et al., as cited in Ponterotto et al., 2001). Specifically, the stigma of mental illness may impede their access and receptiveness to mental health services (James et al., 2010; Patel, 2015; Tso & Samuelson, 2014; Sanchez-Hucles, n.d.; Wortham, 2015). If raising the issue of race in psychotherapy is part of cultural competency for helping professionals, then they must be willing to learn by accessing knowledge and having the resources to become competent (Neville et al., as cited in Ponterotto et al., 2001). Black women

are more likely to seek professional help than their male counterparts (Poussaint& Alexander, 2001), and the dearth of practitioners who closely match their racial or ethnic background creates a barrier (Monroe, 2014; Okeke, 2013; Patel; 2015; Sealy, 2015).

Helping professionals who feel that raising the issue of race is unimportant will also combine that way of thinking with feelings of anxiety concerning race (Gregory, 2013; Neville et al., as cited in Ponterotto et al., 2001). Discussion regarding raising the issue of race is important because while researchers believe that helping professionals should closely match the ethnic groups that they are servicing (Browne, as cited in Patel, 2015; Okeke, 2013), most helping professionals are white (Browne, as cited in Patel, 2015; Monroe, 2014; Saraceno, 2012). However, helping professionals should be able to provide service to racially diverse clientele even if they do not match the racial or cultural groups of their clients (Sanchez-Hucles, n.d.). Racially diverse clients may sometimes have concerns working with helping professionals of the same or similar ethnic backgrounds due to differences in levels of education, social class, and life experiences, to name a few (Sanchez-Hucles, n.d.).

If raising the issue of race is uncomfortable for helping professionals, then issues of racism may present greater challenges (Sanchez-Hucles, n.d.; Williams, as cited in Wortham, 2015). Avoiding raising the issue of racism because they view it as unnecessary or unimportant may contribute to high or early dropout rates of clients (Sanchez-Hucles, n.d.; Williams, as cited in Wortham, 2015). For example, in the first session where therapists are unable to understand “issues that are unique” (Sanchez-Hucles, n.d) to black people, the contributing factors to those issues may result in over forty percent of black people dropping out of psychotherapy services in the USA (p. 14). The interpretation of subtle racist views or insults by helping professionals impact the decision of clients as to whether they return to therapy (Chartterjee, 2017; Sanchez-

Hucles, n.d.; Wortham, 2015). An avoidance approach to raising the issue does not reduce suffering and may add to it (Wortham, 2015). If helping professionals avoid speaking to their clients about race or racism, these issues will remain (Wortham, 2015).

Raising professionals' awareness about suicidal behaviours among females of African descent

When working with females of African descent on issues of suicidality, helping professionals may have to examine the origin and purpose of prevention and intervention strategies (Saraceno, 2012; Wexier & Gone, 2012). The cultural framework of their clients and the social contexts of suicidality should be considerations when seeking approaches for prevention and interventions (Fullagar & O'Brien, as cited in White et al., 2016). Black women are the experts on their experiences and their lives (Okeke, 2013; Washington, 2014), and it is up to competent professional helpers to create safe spaces for meaningful conversations (Richardson, 2013; Saraceno, 2012). In addition to generating and enhancing approaches to service provision, it is important for professionals to recognize that these clients have ways of coping and caring for themselves (Fullagar & O'Brien, as cited in White et al., 2016). Within the social contexts of black women, Saraceno (2012) would say that helping professionals who strategize on suicide prevention and intervention without considering the cultural meanings, practices, among this group obscure their Western ontology with policies and practices that are contrary to the health and wellbeing this population.). Reynolds (2011, as cited in White et al., 2016), Saraceno (2012), and White et al. (2016) would agree that care as justice and as social change requires helping professionals to work with black women making a point of examining the causes of the problems, such as exploitation through colonial violence, heteronormativity, social exclusion, and other injustices.

Education regarding racism and anti-racist issues

“Minoritized and racialized groups remain frequent targets of professionalized and specialized human service interventions” (de Finney, Loisel, and Dean, 2011, as cited in Saraceno, 2012, p. 257). Depending on the field of practice, it is likely that black females will be working with diverse groups of helping professionals. However, since psychologists serve racially diverse populations and in the context of hegemonic Western norms of power and control (Saraceno, 2012), it is critical to focus on service delivery to this group of women by white helping professionals. All helping professionals must begin with an understanding of the dynamics of race and racism, and this is especially necessary for white helping professionals who want to make a difference in the struggle for racial justice (Kivel, 2002). Furthermore, white helping professionals must be aware that anti-racism is a component of the multicultural process, where society “actively and consistently confront[s] racism... through a commitment to use anti-racist analysis and action” (Kivel, 2002, p. 230).

Since the values of whiteness and colonial power are present in professional practices, whenever possible, helping professionals must be willing to disrupt the intersections of patriarchy, masculinity, hierarchy, and heteronormative perspective, and thereby transform lives (Saraceno, 2012). White helping professionals’ willingness and ability to let go of power and control indicates that they are creating a democratic, anti-racist, multicultural process in their professional practice (Kivel, 2002).

Multicultural counselling competency in psychology and professional practice.

While the field of psychology has diverse counsellors and diverse clientele (Arthur & Januszkowski, 2001), depending on social location, racial diversity may be more representative of the clientele versus the counsellors (Browne, as cited in Patel, 2015; Monroe, 2014; Saraceno,

2012). The increased racially diverse clientele signals a responsibility to counsellors to deliver optimal services to clients (Ahmed, Wilson, Henriksen, & Jones, 2011; Arthur & Januszkowski, 2001). Multicultural counselling competency is one approach that addresses service delivery by professionals and meets the needs of racially diverse clients (Arthur & Januszkowski, 2001).

The actualization and evolution of multicultural counselling competency through training and activity development is visible in the field of psychology through theoretical scholarship (Neville et al., as cited in Ponterotto et al., 2001). The three constructs of multicultural counselling competency are awareness, knowledge, and skills (Arthur & Januszkowski, 2001; Neville et al., as cited in Ponterotto et al., 2001). First, self-awareness addresses counsellors' understanding of how their cultural framework conditions them to see their worlds within specific previews (Ahmed et al., 2011; Arthur & Januszkowski, 2001). Culturally conditioned counsellors are unconscious of the worldviews of their clients, and as Ahmed et al. (2011) state, these counsellors "assume that everyone shares the nature of reality and truth regardless of race, culture, ethnicity, or gender" (p. 21). Multiculturally competent counsellors who are working with females of African descent are likely to imagine and appreciate the worldview of black women differently from their own (Daniels & D'Andrea, 1996, & Pedersen, 1995, as cited in Arthur & Januszkowski, 2001; Sanchez-Hucles, n.d.). To be able to imagine the worldviews of their clients, responsible counsellors will seek opportunities to enhance their skills in becoming multiculturally competent, by becoming cognizant of their own beliefs and attitudes, orientation towards social justice, and willingness to share knowledge with peers (Ahmed et al., 2011). In this way, counsellors can assist black females and other racially diverse clientele in overcoming mistrust and bias towards accessing professional care (Daniels & D'Andrea, 1996; Pedersen, 1995, as cited in Arthur & Januszkowski, 2001; Sanchez-Hucles, n.d.).

Counsellors' awareness of their white privilege.

Since a number of white counsellors are serving some racially diverse clientele populations (Monroe, 2014; Patel, 2015), discussions about white privilege and colour-blind racial attitudes are representations of counsellors evolving their self-awareness by viewing the culturally diverse worlds of their clients (Arthur & Januszkowski, 2001; Browne, as cited in Patel, 2015; Monroe, 2014; Neville et al., as cited in Ponterotto et al., 2001; Saraceno, 2012). First, with white privilege and colour-blind racial attitudes in multicultural counselling competency, the broader social context of racism addresses race relations within the client-counsellor relationship (Neville et al., as cited in Ponterotto et al., 2001). Second, counsellors can seek information that creates awareness and increases their knowledge concerning beliefs and values of diverse cultural groups (Arthur & Januszkowski, 2001). Counsellors need an awareness of how culture shapes their values and beliefs (Arthur & Januszkowski, 2001). Third, counsellors, need to gain and nurture their ability to become culturally flexible (Arthur & Januszkowski, 2001; Neville et al., as cited in Ponterotto et al., 2001).

Formal training and education can be an opportunity to learn about and practice the principles behind white privilege and colour-blind racial attitudes (Neville et al., as cited in Ponterotto et al., 2001). For example, Neville et al. (as cited in Ponterotto et al., 2001) state that introductory counselling courses should focus on critical content analyses that expose students to the complex dimensions of racism, which could further develop their multicultural counselling competency. Through the development of power literacy skills, pre-service counsellors can learn to analyze the impact of racism (Neville et al., as cited in Ponterotto et al., 2001). Power literacy skills offer abilities to students that help them “(a) to recognize social conflict and imbalances of power between social groups; (b) to think and act systemically; and (c) to be

accountable for their actions, that is, to use power truthfully” (Welch, 2000, pp. 1-2, as cited in Neville et al., pp. 279-280, as cited in Ponterotto et al., 2001).

Another consideration in teaching white privilege and colour-blind racial attitudes to students in counselling psychology is the reception of students (Neville et al., as cited in Ponterotto et al., 2001). It is common for students to be defensive in these discussions, and thus they require sensitive delivery, explanations, and opportunities to process (Neville et al., as cited in Ponterotto et al., 2001). In addition to the class reading and the discussing of white privilege and colour-blind racial attitudes, students should be exposed to learning processes that include conversations about their frustrations or “defensiveness around the topic of power and power relationships within a stratified society” (Neville et al. p. 280, as cited in Ponterotto et al., 2001). During the training process, students learning among culturally diverse groups of people can increase their knowledge and skills in multicultural counselling competency (Arthur & Januszkowski, 2001). This type of learning will give counsellors the opportunity to acknowledge the value in appreciating and recognizing clients’ cultural differences, beliefs, and practices (Arthur & Januszkowski, 2001; Sanchez-Hucles, n.d.). Counsellors who are knowledgeable concerning the cultural diversity of their clients, and who can consult and access community resources can use these strategies to enhance multicultural counselling interactions (Arthur & Januszkowski, 2001).

Dilemmas and conflicts can arise through the multicultural counselling competency process (Ahmed et al., 2011; Arthur & Januszkowski, 2001). Counsellors who lack the resources to meet the needs of clients from diverse cultural backgrounds may experience culture shock and may feel a sense of inadequacy (Ahmed et al., 2011). “Counsellors should not become culturally encapsulated, where they are at risk of using stereotypes, becoming

judgmental, and imposing their values on their clients” (Ahmed et al., 2011, p. 20). The above stance is likely to negatively affect the collaborative client-counsellor relationship, whereas becoming aware decreases overt discrimination, and validates the active processes of learning (Ahmed et al., 2011).

Limitations

The results of this study require cautious interpretation, given the limitations of the thematic analysis method. As stated above, the articles within the data set analysis in the findings and results section may be the result of a selection issue. Although the search strings provided data on adolescents, the voices of girls of African descent were absent. It is important to note that the voices of sexually diverse and gender non-conforming people of African descent are rare as well. This is due to the limitations of the focused thesis topic. Furthermore, time and care are necessary for a credible and thorough investigation into their lives.

Finally, the data set consists of over eighty percent of data from the USA that investigated the thesis question; this suggests that in the United States of America, researchers are studying racism and suicidality separately and concurrently. More research into this subject is needed in Canada.

Future Research

The strong black woman stereotype is a reoccurring theme in the data (Hamin, 2008; Okeke, 2013). Due to the historical, social, cultural, intercultural, and interpersonal factors associated with this stereotype, this might be an area for future investigation (Hamin, 2008; Okeke, 2013). It may be valuable to know if females of African descent are conscious of its use and its impact. For professional care, an investigation into how the strong black woman stereotype impacts service delivery to females of African descent could be beneficial. Primarily,

future research could investigate whether the strong black woman stereotype affects the results of suicide assessment tools, processes, and procedures. Equally important is research that investigates suicidality among black children with specific attention to sexually diverse and gender variant children.

The topic of racism and suicidality among females of African descent is significant. In the literature, there is an absence regarding black women taking their lives due to concurrent issues of racism and suicidality. This absence makes it even more important to continue searching for knowledge of the social contexts in which black women are ending their lives, attempting to end their lives, and having thoughts of suicide. Empirical research investigating the high rate at which black women are having suicidal ideations and attempting to commit suicide is critical to understanding the causes (Bell, 2017; Perry et al., 2013; Tso & Samuelson, 2014). It is equally important to continue to explore the social contexts that support black women to be resilient. Without individualizing suicidal behaviours, further investigation into the social causes of suicidality among people of African descent and an examination of the social justice issues that promote the preventative and protective factors of suicidality may also be beneficial (Reynolds, 2011, as cited in White et al., 2016; Saraceno, 2012).

Conclusion

In conclusion, females of African descent have agency as evident through their methods of survival that include perseverance, resistance, and resiliency concerning issues of racism and suicidality (Kneeland, 2006; Okeke, 2013; Poussaint & Alexander, 2001). The strength of black women is a consequence of their determination to be functional (Bell, 2017; Hamin, 2008; Kneeland, 2006; Tso & Samuelson, 2014). Black women continue to recognize the benefits of attending to their health and wellbeing issues (Bell, 2017; Tso & Samuelson, 2014) and should

be encouraged to persists in working through pain and denial and the dismantling of the culture that promotes suffering in silence (Hamin, 2008; Michael, 2015). Invisible wounds and visible scars are the imprints of pain, suffering, and humiliation for many black women (hooks, 2003). Coping with issues of racism and suicidality requires a collective response wherein black woman continue practicing valuing themselves by attending to these and other health and wellbeing issues. And second, as a collective, black female and the general black population must continue to respond by practicing consciousness and conscientiousness concerning the geopolitical and social contexts of racism and suicidality that are operating.

Racism has been and will continue to be a determinant of my own health. While I do not have any specific insight into the reasons that I have not considered suicide in response to racism, and though I cannot guarantee that it will never occur, I can offer my process of healing. This process has involved: connecting with acquaintances, friends and family; continuing my engagement in social networks; tending to my faith and spirituality; accessing professional care; singing and listening to a variety of music artists; writing poetry, articles, and books. My creative endeavours have played a critical role in my healing and I can say that in my experience, engaging in music and writing have been supportive and transforming. They reveal my strengths and my essence as well as my imperfections and vulnerabilities. Researching and writing this thesis has further increased my knowledge, and have been helpful with processing my thoughts. Therefore, it makes sense that I would explore the connection between racism and suicide among black women. As Dr. Maya Angelou says, “If you are always trying to be normal, you will never know how amazing you can be” (Goodreads, n.d.).

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