# The Impact of Systemic Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA)

A thesis submitted to the Committee on Graduate Studies in partial fulfillment of the requirements for the degree of Master of Science in Nursing in the Faculty of Arts and Science

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# ABSTRACT

The Impact of Systemic Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA)

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The prevalence of hypertension and mental illness among Black Canadians is a growing public health concern. There is a paucity of Canadian research exploring the lived experiences of Black individuals with both hypertension and anxiety, particularly in relation to how racism shapes access to healthcare. This study aimed to advance awareness and cultural understanding of systemic and institutional racism, with a focus on its impact on access to care. A qualitative design employing descriptive and interpretive phenomenology was used. Ten participants were recruited through purposive sampling. Data were collected via semi-structured interviews with Black individuals residing in the Greater Toronto Area (GTA). Key findings suggest that racial inequities and disparities continue to directly affect the quality of care received, with racism emerging as a persistent barrier. These findings underscore the need for culturally responsive, equitable care approaches to address the structural barriers faced by Black communities in Canada.

**Keywords**: Black health disparities, institutionalized racism, hypertension, anxiety, healthcare access, systemic racism, racial inequities in healthcare, gatekeeping in healthcare, self-determination

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## Table of Contents

# List of Figures

## List of Tables

## List of Abbreviations and Symbols

**α** – Alpha

**AABH-CoE** – African American Behavioral Health Center of Excellence

**AHA** – American Heart Association

**APA** – American Psychiatric Association

**AICD** – Automatic Implantable Cardioverter Defibrillator

**BPG** – Best Practice Guideline

**BMI** – Body Mass Index

**CVD** – Cardiovascular Diseases

**CAMH** – Centre for Addictions and Mental Health

**CDC** – Centers for Disease Control

**CNO** – College of Nurses of Ontario

**CRT** – Critical Race Theory

**ED** – Emergency Department

**FCC** – Family-Centered Care

**GAD-7** – Generalized Anxiety Disorder

**GSR** – Generalized Stress Response

**GTA** – Greater Toronto Area

**H-SCALE** – Hypertension Self-Care Activity Level Effects

**IR** – Internalized Racism

**IROS** – Internalized Racial Oppression Scale

**PMR** – Personally Mediated Racism

**RNAO** – Registered Nurses Association of Ontario

**REB** – Research Ethics Board

**RQ** – Research Questions

**SPIDER** – Sample, Phenomenon of Interest, Design, Evaluation, Research type

**SDOH** – Social Determinant of Health

**SIISR** – Stigma-Induced Identity Stress Response

**US** – United States

**WHO** – World Health Organization

# Chapter 1: Introduction

The prevalence of hypertension and mental illness amongst Black Canadians is a growing crisis that needs to be addressed. In 2017, Hypertension Canada reported that persons who self-identified as Black were three times more likely to develop hypertension. Between 2008 and 2017, the rates of anxiety almost doubled among Blacks from 3.2% to 8.9% (Sreenivasan et al., 2021, as cited in Josiah et al., 2021). It has been reported that Black Canadians experience more everyday discrimination (30.8%) when compared to other minority groups (Raphael et al., 2020). Canadian cardiologist Banerjee et al., in 2021, stated that “the effects of racism impair mental and physical health and are the driver of poor cardiovascular health in minority individuals” (p. S170). Anxiety symptoms have been found to be a link between racism and chronic health problems such as hypertension (Carter et al., 2016), which are elevated among Black people in Canada (Veenstra & Patterson, 2016).

The Black experience in Canada has been deeply rooted in systemic racism that negatively impacts the well-being of Black people due to Anti-Black policies and procedures that are embedded in the systems that have been designed to protect and care for its citizens (Javed et al., 2022; Josiah et al., 2020). In this paper, systemic racism will be referred to as a “broad range of White-racist dimensions: the racist ideology, attitudes, emotions, habits, actions, and institutions of Whites in this society” (Feagin, 2006, p.2). It includes material, social, and ideological reality well-embedded in major institutions that give advantage to another (Banerjee et al., 2021; Feagin, 2006). Developing research continues to suggest that racism and stress have both been linked to the Black experience, resulting in the prevalence of hypertension and anxiety within the Black community.

At the intersection of hypertension and anxiety is the fact that being Black is a non-modifiable risk factor for developing both of these chronic conditions. Hypertension is one of the leading causes of premature death worldwide, and anxiety, as a mental illness, also increases the risk of premature death (Centre for Addictions and Mental Health [CAMH], 2025a; World Health Organization [WHO], 2023).

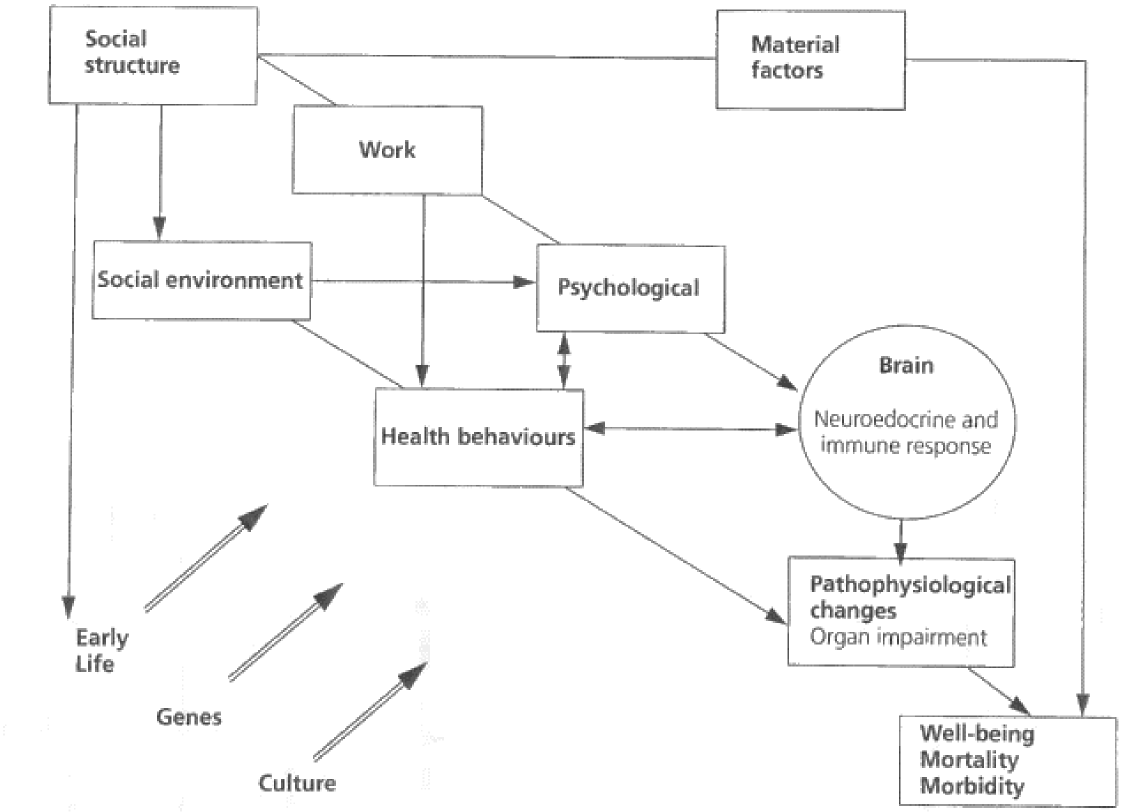
There is a paucity of research in Canada that explores the experiences of Black people living with both hypertension and anxiety and how racism has contributed to this experience when utilizing and accessing healthcare resources. To the best of the researcher's knowledge, no study in Canada has explored the effects of systemic barriers and racism / institutionalized racism on the accessibility and utilization of community health resources for Black people living with hypertension and anxiety.

## Background

Race is a social determinant of health (SDOH) that directly impacts the lives of Black Canadians (Raphael et al., 2020). The SDOH model illustrates the various pathways in which social structure is linked to health and disease (Figure 1). The pathways include material, psychosocial, and behavioural, with some influence from genetic, early life, and cultural factors (Brunner & Marmot, 2006). The literature indicates that exposure to repeated incidents of racial discrimination increases the risk for developing anxiety disorders (Kogan et al., 2022). Likewise, Banerjee et al. (2021) reported that even the perception of racism similarly increases stress response and increases the risk of developing hypertension and depression. The consequences of racism on an individual's health and wellbeing include a harmful biological, psychological, and behavioural response within the lives of Black people (Javed et al.,2022; Raphael et al., 2020; Toronto Public Health, 2013 as cited in the City of Toronto, 2017). In 2019, Public Health Ontario reported that "modifiable risk factors accounted for approximately 65 to 90 percent of cardiovascular disease incidence; in fact, stress is a modifiable risk factor in preventing both hypertension and anxiety. Stress has been reported to have a deleterious effect on an individual's health and health outcomes (Raphael et al., 2020).

**Figure 1.**

***The Social Determinant of Health Model (SDOH)***



Source: Source: Brunner E., & Marmot, M. G. (2006). 'Social Organization, Stress, and Health. In M. G. Marmot & R. G. Wilkinson (Eds.), Social Determinants of Health. Oxford: Oxford University Press, Figure 2.2, p. 9.

## Chapter 2: Literature Review

In an attempt to understand the correlation between racism, hypertension, and anxiety, the researcher conducted a literature review between September 2022 and January 2025. The search engine Trent+ Omni library was used from Trent University's library because it allowed the search of multiple databases through its platform. Active filters were applied, such as peer-reviewed journals, online availability, and publications in English with a publication date of less than 10 years. The search terms "hypertension and anxiety", "Black Canadians and hypertension", "Caribbean Canadians and hypertension", "African Canadians and hypertension", "internalized racism Black hypertension", "internalized racism Black high blood pressure", "internalized racism African anxiety", "systemic racism, hypertension and anxiety", "prevalence of hypertension in Canada", "prevalence of anxiety in Canada", "access and utilization for Black people OR African", "access for health services for Black people OR African",

"utilization for health services Black people OR African" in multiple searches with Boolean operators for best results. The terms African or Caribbean Canadian and hypertension did not provide useful results with limited and increased filters, and as a result, the term was changed to "Black Canadians." "Systemic racism, hypertension, and anxiety" provided zero results. It was changed to "racism, high blood, and anxiety" with no useful results. Additionally, manual searches were done through Google and Google Scholar to obtain relevant materials and in text citations.

### Hypertension and Racism in Black Canadians

Hypertension is one of the leading causes of death and disability worldwide and a key risk factor for developing cardiovascular diseases (CVD) (Heart and Stroke, 2025). In fact, CVDs are the leading cause of death in Canada and globally (Public Health Ontario, 2019; Statistics Canada, 2023; WHO, 2023). In Canada, hypertension was estimated to have cost more than 20 billion dollars in 2020 (DeGuire et al., 2019). Hypertension Canada reported that persons who self-identified as Black had a much higher prevalence of hypertension (Hypertension Canada, p.44, 2017). Similarly, the Centers for Disease Control (CDC) and American Heart Association (AHA) reported that Black people in the United States (US), in comparison to other races, are more likely to develop hypertension earlier in life (AHA, 2024); CDC, 2025. For instance, Veenstra & Patterson (2016) completed a cross-sectional survey that found hypertension to be more prevalent and lethal amongst Black Canadians than White due to racism. Mensah (2018) has reported a higher prevalence of cardiovascular diseases in African Americans with fewer survival rates; in fact, African Americans had a rate of 20% higher for heart disease and 40% higher for stroke in comparison to rates in White people.

Banerjee et al. (2021) found racial biases and disparities played a role in the care of cardiovascular diseases in Black people. They reported that (1) Heart failure specialists were more likely to consider a Black man at risk for non-adherence to treatment, (2) Black patients have increased wait times in the emergency departments and delay in treatments for a coronary angiogram with a reduction in the use of drug eluding stents, (3) Black males and females were less likely to receive an automatic implantable cardioverter defibrillator (AICD) implantation although it is considered a class 1 treatment following a cardiac arrest. These findings appear to provide some explanation regarding the higher mortality rates of CVDs in Blacks. The national emergency department (ED) wait times across the US from 2013 to 2017, reported that minority groups had a longer wait time of 139 minutes if not seen promptly on arrival (Lu et a., 2021). In parallel, a retrospective cross-sectional study of the national ED wait time average from 2003 to 2017, found a 3.8-minute decrease and stabilization in wait times for Blacks 2008-2017 (Abdulai et al., 2022).

Racial inequities, lack of culturally competent care, and barriers to treatment services are all contributing factors to the high prevalence and mortality rates of Black people living with chronic diseases. In society, Black people are perceived to be a threat, less educated, and are treated with less respect (Bambra et al., 2020). In a 2016 study, the authors reported key themes such as provider mistrust due to racial biases and poor communication due to perceived discrimination, which resulted in underutilization of healthcare resources. Due to the unpleasant interactions, participants would refrain from disclosing information and were no longer actively engaging with treatment services (Cuevas et al., 2016). Many authors have recommended that addressing some of the biases and discrimination within healthcare requires education, culturally competent care providers, collaboration, diversity in cardiology, anti-Black racism policy's and a shift towards viewing SDOH as a major contributor to adverse health outcomes (Banerjee et al., 2021; Javed et al., 2022; Raphael et al., 2020).

Several studies have investigated the effects of perceived racism or discrimination and hypertension. Dolezsar et al. (2014), reported that there is a significant link between perceived racism and hypertension. Black people with lower education were found to have the strongest association, possibly due to chronic exposure to racial discrimination. A longitudinal study found that medium to high levels of lifetime racial discrimination were associated with a 49% and a 34% increased risk of developing hypertension (Forde et al., 2020). Similarly, Forde et al. (2021), found that Black people reporting any lifetime discrimination had a 35% higher risk of developing hypertension. The participants in this study were followed for seven years with no baseline history of hypertension. No significant associations of discrimination were observed between hypertension and other racial groups.

## The Association between Anxiety and Hypertension

Anxiety increases blood pressure and damages the endothelial cells, which increases the risk of CVDs.  Adults with hypertension were more likely to have anxiety and those with anxiety were more likely to have hypertension (Levent et al., 2022; Pan et al., 2015). In a meta-analysis of 13 cross-sectional studies, the authors have recognized that anxiety is an independent risk factor for incident hypertension due to several mechanisms and pathways in the human body. It has also been suggested that anxiety is a barrier to the treatment or lifestyle modification of hypertension (Pan et al., 2015). In a later cross-sectional study, researchers found that anxiety, depression, and a high body mass index (BMI) were strongly associated with hypertension in patients under 45 years of age (Levent et al., 2022). Therefore, the evidence continues to suggest that there is a complex relationship between hypertension and anxiety despite the lack of consensus within the literature.  Several authors have found no significant correlation between hypertension and anxiety. For example, a prospective longitudinal study found no significance for hypertension and anxiety when adjusting for other variables such as depression and BMI (Jackson et al., 2016). Similarly, Pan et al (2015) found that factors such as BMI, medication use, and lifestyle choices are key variables in discussing the association.

Johnson (2019) conducted a literature review and found that there is a significant under-recognition and under-treatment of anxiety disorders and hypertension in the general population. In this literature review, she found numerous gaps in understanding the relationship between anxiety and hypertension.

A stressful and traumatic life event can precipitate anxiety disorders in individuals. Cénat et al. (2023), found 95.1% of Black people in Canada may experience at least one traumatic experience in their lifetime. Correspondingly, in a 2020 survey by Statistics Canada, 32% of Black individuals reported symptoms of anxiety in comparison to 24% of their White counterparts (CAMH, 2025b). Supporting research from Raphael et al. (2020) reported that in Canada, people at risk for developing mental illnesses are Black. Moreover, at the intersection of stress and trauma is a Black person experiencing chronic exposure to stress and discrimination as a result of anti-Black racism that has been proven to have a lethal effect on their health. Due to the elevated rates of stress, racism, risk for trauma and hypertension experienced by Black people, they are at an increased risk of developing an anxiety disorder. Stress is a risk factor for developing both anxiety and hypertension, and as a result, generalized anxiety disorder will be referenced in this study.

## Racism: Systemic and Internalized

True health equity cannot be achieved without acting on the systemic racism embedded in policymaking and practices (Javed et al., 2022). Black people in Canada experience racism and microaggressions almost daily and in almost every area of their lives, and this leads to substantial health inequities (Kogan et al., 2022; Raphael et al., 2020). In a recent study by Kogan et al. (2022), results were consistent with previous reports that racism and microaggression had a positive association with a high prevalence of anxiety. Like other research published in the US, Kogan et al. (2022) found that having faith-based community support acted as a buffer when dealing with overt racism and having a social support system in the community buffered the effects of microaggression. Healthcare has a lengthy history of systemic racism, from the “Negro Project” to the “Tuskegee Experiments” to modern-day policy’s that predicts who receives services, the kind and quality (Feagin & Bennefield, 2014). In the current state, the White framing of systemic racism in healthcare is manifested as unconscious bias from healthcare practitioners that misdiagnose or underdiagnose Black people, inappropriate treatment interventions, ignore their concerns, and make assumptions (Feagin & Bennefield, 2014).

A recent study in Canada found that 65.33% of participants between the ages of 25-40 experienced low self-esteem when compared to those aged 15-24 years old in the presence of racial discrimination and that Black Canadian-born participants had a higher prevalence of low self-esteem when compared to other Black migrants (Cénat et al., 2024). Similarly, Cénat et al.’s (2023), earlier work found that Black people born in Canada had a higher risk of being exposed to trauma. The literature suggests that there is some level of protection for Black mental health that is linked to racial identity (Cénat et al., 2024; Willis et al., 2021). This could be a dangerous assumption given the existing racial biases that Blacks are stronger, more tolerant of pain, or to be blamed for their poor mental health (Access Alliance, 2005; Feagin & Bennefield, 2014). Racial discrimination has been linked to a poor coping mechanism that results in unhealthy lifestyle choices such as alcohol or tobacco use, non-adherence to treatment plans, or limited interaction with the healthcare system due to access barriers or fear of ill-treatment which can all result in deleterious health effects (Bambra et al., 2020; Javed et al., 2022; Raphael et al., 2020).

Several studies have examined racism and its impact on health. Graham et al. (2016) found that participants reporting elevated levels of racism experienced poorer mental health and more anxiety symptoms. The authors suggest that IR is the pathway that links racial discrimination and bias to elevated anxiety levels. Mouzon & McLean (2017) found that racism is associated with poor mental health. The authors found a weaker significance of depressive symptoms and severe psychological distress in foreign-born Caribbean Blacks compared to their US-born counterparts and African Americans. These findings are similar to Cénat et al (2024) regarding Canadian-born Black mental health.

## Black Peoples Utilization and Accessbility of Healthcare Resources

Accessibility in healthcare is defined as access to health services without financial or other barriers, such as location or service provider while utilization addresses the frequency of use for healthcare services (Health Canada, 2025). The literature has reported that Black people experience significant disparities when seeking care for mental health and hypertension. Park et al. (2023) found that primary care services were underutilized by black people in comparison to Whites due to several systemic barriers such as transportation difficulties, appointment scheduling conflicts or perceived and actual discrimination, but had a more significant use of the emergency department (ED) services. Similarly, Sripipatana et al., (2019) found that systemic barriers such as hypertension management education and outcomes influenced Black people’s access to primary care services, resulting in more emergency department utilization. Black people tend to utilize the ED when they are sicker, where they are often diagnosed and treated for their hypertension (Goldberg et al., 2018).

Black people often delay accessing treatment services for mental illnesses due to the cultural or societal stigma that exists around mental illness. In addition to the stigma, there are barriers such as provider mistrust, lack of representation, financial constraints, and lack of culturally competent care that create health disparities in the lives of Black people experiencing mental health challenges (Suggs et al., 2022). Similarly, in a white paper published by African American Behavioral Health Center of Excellence (AABH-CoE), they found several barriers such as Black people experience a lower quality of care, limited availability of services in certain communities, transportation issues, provider mistrust, stigma and lack of culturally competent care to impact the access and utilization of services for mental health in Black people (National Council for Mental Wellbeing, 2022). In parallel, CAMH (2020) reported that Black children and emerging adults experienced similar barriers such as longer wait times, referral delays, personally mediated racism, financial constraints, geographical challenges, cultural stigma, and lack of culturally responsive care. The American Psychiatric Association (APA) reports an underutilization of outpatient mental health services in Black people when compared to non-Hispanic Whites but a higher utilization of inpatient services (2017).

## Problem Statement

The researchers seek to explore the experiences of Black people and measure the impact of systemic racism on the accessibility and utilization of community health resources for Black people living with hypertension and anxiety in the Greater Toronto Area (GTA). This research study aims to bring increased awareness and cultural knowledge about systemic and internalized racism and how Black people perceive the association between them and hypertension and anxiety. The current study will add to the body of knowledge findings about how Black people perceive the impact of systemic and internalized racism on their accessibility to healthcare services.

This qualitative study has been conducted using descriptive and interpretive phenomenology. Additionally, the thematic findings about barriers and recommendations will help nurses and healthcare providers understand the experiences of Black people when choosing to access care/ resources for hypertension and anxiety. The findings will also help policymakers develop strategies for better resource accessibility among the target population. A purposive sampling method was utilized to recruit participants, and a semi-structured interview method was employed to collect data about the experiences of Black people living in the GTA.

The decision to explore the impact of systemic and IR on the experiences of Black people living with hypertension and anxiety in the GTA stems from the paucity of existing data. The experiences of Black Canadians when accessing and utilizing health resources and services have not been well studied, demanding the need to explore the essence of this phenomenon. The next several chapters will delve deeper into the past and present findings of the association between racism, hypertension, and anxiety. Several bodies of literature will be discussed, with the key findings summarized.

## Theoretical Framework

### *Critical Race Theory and Intersectionality*

The critical social paradigm seeks to change the way of thinking that will address and transform the injustices suffered by marginalized groups (Sun, 2021). Within the critical social paradigm is the Critical Race Theory. The Critical Race Theory (CRT), founded back in the 1970s, emphasizes "studying and transforming the relationship between race, racism and power" (Delgado & Stefanic, 2017, p.3). Critical race theorists emphasize racial equity to remove systemic barriers instead of equality. The World Health Organization (2025) defines equity as the "absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality. CRT was employed as a framework to design and guide this study because it focused on racial equity to remove systemic barriers for Black people. Individuals within the Black community experience racial inequities daily due to racism and power. Therefore, the lens of CRT was utilized to guide the interviews and analyze the data.

The tenets of CRT provide the tools and language needed to describe, analyze, and discuss the shared lived experiences of Black people in a society dominated by racism and power. They guide the researcher in identifying oppressive systems and structures and provide concepts needed to create change. It has been documented that, unlike other academic disciplines, CRT wants to change how society organizes itself regarding racial lines and hierarchies for the better (Delgado & Stefanic, 2017).

Critical race theorists such as Derrick Bell, Alan Freeman, Kimberlé Crenshaw and Angela Harris agree on several central tenets: ordinariness, interest conversion, social construction, differential racialization, intersectionality, antiessentialism, and the unique voice of colour ((Delgado & Stefanic, 2017). This study uses the intersectionality lens as outline by Delegado and Stefianc (2017), and further supported by the works of Hill-Collins (2019), which further explored and examined intersectional characteristics of deemed to be relevant to members of the Black community in the GTA living with hypertension and anxiety. Ordinariness refers to the lack of acknowledgement of racism within society, and as a result, it is challenging to address or cure (Delgado & Stefanic, 2017). The ideology of colour-blindness shifts the attention away from race to focus on one's humanity, resulting in the concept of equality that causes disengagement of race and racism (Delgado & Stefanic, 2017; Holoien & Shelton, 2012). Equality is when all individuals are given the same resources or opportunities to achieve the same outcome without recognizing that there are differences, such as race, gender, or disability (Alvarez, 2020). The danger of equality is that it results in policies that do not address the gaps that are created by racism. It only recognizes overt discrimination (Delgado & Stefanic, 2017, p.8). With a colour-blind approach, "The unjust, deeply institutionalized, ongoing intergenerational reproduction of Whites' wealth, power, and privilege is never the center of in-depth mainstream analyses and is rarely seriously discussed" (Feagin, 2006, p. 4). In the case of State v. Buggs 581 N.W. 2d 329, 344 (Minn. 1998), it was said that race is viewed as a problem for just members of a minority group, but it should be treated as a problem for all of us (As reported in Delgado & Stefanic, 2017).

Dereck Bell's Interest Convergence theory addresses the fact that "racism advances the interest of both White elites (materially) and working-class Whites (physically)" therefore, there is little incentive to rid society it if there are no benefits to the White elites (Delgado & Stefanic, 2017, p.9). In liberal welfare states such as Canada, it is known that "political and social welfare history is dominated by corporate and business interest (Bryant & Raphael, 2020, p. 6). It has been reported that the "business and corporate sector has power and influence through its control of the economic system" and as a result it has a direct impact on how public policies are developed and implemented (Raphael, 2015 as reported in Bryant & Raphael, 2020, p. 8). "White-maintained oppression is far more than a matter of individual bigotry, for it has been from the beginning a material, social, and ideological reality" (Feagin, 2006, p. xiii). Racialized Canadians often have higher unemployment rates as well as lower incomes in comparison to Canadians of European descent. So most often, they are not at the decision-making table (Raphael et al., 2020). Interest convergence argues that the White dominant group must see a direct benefit to support any racial policy change, such as in the case of "Brown v. Board of Education" (Delgado & Stefanic, 2017, p.9).

Another central tenet of CRT is that race is a "social construction" (Delgado & Stefanic, 2017, p.9). The "social construct" thesis states that "race and races are a product of social thought and relation. Not objective, inherent or fixed, they correspond to no biological or genetic reality" (Delgado & Stefanic, 2017, p.9). Feagin (2006) states, "the category of race symbolizes social conflicts by referring to human physical characteristics, yet it is not fixed, but rather variable over time" (p.27). Similarly, Delgado & Stefanic (2017) report that when it comes to race, "society invents, manipulates or retires when convenient" (P. 9). For example, in differential racialization, society racializes different minority groups at different times for varying reasons. Intersectionality and antiessentialism refer to the fact that no individual within a group will be unique because a Black female may be conservative, from the Caribbean, or a single mother. Intersectionality addresses the different forms of inequality that can overlap and build on to each other (Delgado & Stefanic, 2017). It addresses the complex challenges that are often overlooked by society. In the Black community, several intersections such as race, ethnicity, abilities, socio-economic status, and age directly impact the well-being of Black men and women. Finally, the voice of colour thesis believes that people of colour share similar experiences with oppression and are qualified to communicate with White people regarding unknown details (Delgado & Stefanic, 2017). This theory is now evidenced by the Black, Indigenous and People of Colour (BIPOC) initiatives funded to represent and advocate for the various communities.

There are three main goals of CRT as summarized by Creswell & Poth (2018) are first, it focuses on stories about discrimination from the perspective of people of colour, the eradication of racial subjugation while recognizing race as a social construct and lastly, other areas of inequities these individuals may face relating to age, gender, class or ability. Various groups have used the art of storytelling for many different reasons. However, CRT is used to validate the voices of minorities by sharing their daily living experiences and bringing insight into how others view race. Doing so generates empathy; others are now invited into a new and unfamiliar world that can help to bridge the gap between realities (Delgado & Stefanic, 2017). Additionally, when individuals from racialized groups share their stories, it highlights who is experiencing what kind of discrimination, such as microaggression, disproportionality, and disparity, and how it can be addressed through affirmative action (Delgado & Stefanic, 2017). Participants in this study were invited to share their stories about health, access to care, and the varying levels of racism.

### *Levels of Racism: Theoretical Framework*

Jones (2000) presented the Levels of Racism Theoretical Framework and a Gardener's Tale, which identified three levels of racism. Institutional racism, personally mediated racism, and internalized racism. "Personally mediated racism (PMR) is defined as prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race" (Jones, 2000, pp. 1212-1213). Institutionalized racism is rooted in power. The government holds the power to decide, act, or control resources (Jones, 2000). In Canada, policies, structures, and practices are influenced by businesses and corporate sectors, affecting how social and economic resources are distributed (Bryant & Raphael, 2020). In the interest convergence theory, the business and corporate sectors profit. In contrast, the health of racialized people continues to decline because there is minimal benefit to the White elites to decrease the socioeconomic gap of inequities amongst Black and White people. Due to the ordinariness of racism embedded in policies, practices, and structures, Black people continue to experience inequities leading to adverse health outcomes and premature deaths. Jones (2000) reports that institutionalized racism is the most fundamental and must be addressed for important changes to occur; because of these changes, internalized racism (IR) and PMR "may eventually cure themselves over time" (p. 121

## Chapter 3: Research Methods

This chapter outlines the methodology employed in this study. It begins with the

research questions, design, and rationale for this study. It will discuss the study’s methodology, including participant inclusion and exclusion criteria, recruitment process and procedures, instrumentation, data collection, and data analysis plans. The chapter will conclude with a discussion of the study’s validity and trustworthiness, confirming the rigor and credibility of the research findings.

### Research Questions

The purpose of this study is to explore the impact of systemic and internalized racism on Black people's accessibility and utilization of health resources for hypertension and anxiety in the GTA. This research employed the Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) tool to structure and refine the key elements of the research because it is suitable for use in qualitative research methods (Cooke et al., 2012). Please see Appendix A for a demonstration of how the SPIDER tool is used for the research question. To understand this phenomenon, this study asks the following research questions (RQ) about the experiences of Black people in the GTA.

*RQ1*: How do Black people with hypertension and anxiety access and utilize community health resources in the GTA?

*RQ2*: What are the barriers experienced by Black people with hypertension and anxiety when accessing and utilizing community healthcare services in the GTA?

*RQ3*: What is the relationship between anxiety and hypertension in the Black community?

*RQ4*: What is the impact of systemic and internalized racism on community health resources/ accessibility to community health resources for hypertension and anxiety for Black people?

*Assumption 1*: Systemic racism will have a direct impact on Black people's access and utilization of healthcare resources in the GTA.

*Assumption 2*: Internalized racism or Institutionalized racism will have a direct impact on Black people's access and utilization of healthcare resources in the GTA.

## Research Design

This qualitative study was developed using interpretive descriptive phenomenology. A qualitative approach was taken based on the exploratory nature of the research. Qualitative researchers transform the world by engaging in research and bringing meaning to it by studying things in their natural settings and interpreting the phenomena regarding the meaning people bring to them (Creswell & Poth, 2018; Denzin & Lincoln, 2011). The study aims to explore the shared lived experiences of Black people and the impact of systemic and internalized racism when accessing and utilizing healthcare resources for hypertension and anxiety in the GTA. The focus of this study is to understand the essence of the experiences of Black people, rather than an in-depth analysis of a particular case, therefore, phenomenology is more appropriate than a case study. Phenomenology allows for in-depth insights into the shared meaning and understanding of the participants' experiences, which would be limited in context-bound case study analysis (Creswell & Poth, 2018). Due to the sensitive nature of the research questions, the experiences of Black people living in the GTA were explored using one-to-one interviews. This study embodies the Three Levels of Racism, and CRT in the research design.

## Role of the Researcher

The primary researcher identifies as a Black Canadian and understands that their axiological assumption may influence the way questions were asked and meaning interpreted (Creswell & Poth, 2018). The concept of reflexivity states that researchers are conscious of their biases, values, and experiences brought to the research study (Alvesson et al., 2022; Creswell & Poth, 2018). Reflexive practices such as reflective journaling and self-dialogue were used to minimize biases throughout the research design process. The researcher's previous knowledge and familiarity with the stories of race, racism, and power that emerge from the Black community could potentially influence analysis and reporting. The primary researcher has no lived experience with the phenomenon being studied but has lived experience with the healthcare system both as an end user and a healthcare provider. The primary researcher has lived experiences with other institutions of power and PMR. As a result, this provided a unique lens through which the data was analyzed and presented.

Bracketing or epoche is a technique used by researchers in which they set aside their own experiences to take on a fresh perspective on the phenomenon being studied as if hearing it for the first time (Moustakas, 1994). The stories became familiar throughout the study after each interview; however, the primary researcher practiced bracketing to be present and actively listen to each participant's stories. The researcher was careful to engage in bracketing during the study's data collection and analysis phase to create space for each participant's unique experience. To prevent interpreting the experiences shared by the participant with a theoretical lens, bracketing was used. Additionally, the researcher engaged in bracketing to prevent writing her own biases when interpreting the findings.

## Sampling and Setting

Qualitative research methodologies recommend the collection of data from a small number of participants. The recommended sample size for individual interviews is between seven and twelve

(Ravitch & Carl, 2016). In this study, data saturation was achieved for a total of ten participants. Participants were recruited through a purposive sampling and snowballing method. Purposive sampling methods allow the researcher to intentionally select a group of people who comply with the inclusion criteria and have experienced the phenomenon in question (Creswell & Poth, 2018). Snowballing recruitment occurred during the study because several participants shared the researcher's contact information with others within their network who met the inclusion criteria. Inclusion and exclusion criteria were developed to simplify the recruitment process. The Inclusion criteria established were persons who self-identify as Black, adults 18 and older, the ability to provide consent, a hypertension diagnosis greater than (140/90), and a self-reporting diagnosis of anxiety. Exclusion criteria were participants who did not speak English, did not meet one of the inclusion criteria, and agreed to participate.

## Recruitment

Initially, posters were shared at Trethewey Medical at Central Weston with permission from the primary care provider (Appendix B), but this yielded no participants. The study method was amended with permission from the REB committee to recruit participants through social media platforms. Additionally, the recruitment poster was amended to match the recruitment method. The new poster included more high-contrast colours to bring attention to the study (Appendix C). The posters were shared in private WhatsApp and Facebook groups geared towards Black people in the GTA. Before sharing the study recruitment poster in these groups, the researcher received permission from the group's moderators. Participants contacted the researcher by telephone to express their interest.

## Data Collection

### *Compilation and Transcription*

The study was introduced and discussed during the initial contact, and informed consent was obtained. The researcher provided a detailed overview of the study's scope, time commitment, data collection, privacy, storage, and use. A date and time were discussed and agreed upon to complete the interview and data collection process. Personal information collected was the minimal required to obtain consent and schedule the interview. The participants provided their email addresses to which the interview invitation and research tools were sent. Qualtrics XM, provided and secured by Trent University, was used to collect and store electronic data provided by participants. Consents were signed and stored using Qualtrics XM. All scales and tools were created and converted electronically using Qualtrics XM pre-existing templates to allow participants to enter their data electronically. The interview audio was recorded and electronically transcribed using artificial intelligence. The transcription record was reviewed against the audio recording for accuracy and corrected manually. The transcription and audio records are stored on Microsoft OneDrive, which is provided and secured by Trent University.

### *Study Tools*

Participants were asked predetermined, precise questions about how they experienced the process of accessing and utilizing healthcare services in their communities and the barriers they experienced in accessing and utilizing these health services. The questions were designed to be focused, open-ended, and general, which allowed participants to share relevant and meaningful experiences. Clarifying questions were asked when required to collect additional details. The social interaction of the interview allowed for knowledge construction between the interviewer and the interviewee regarding the phenomena in question (Brinkmann & Kvale, 2015 as reported in Creswell & Poth, 2018; Rubin & Rubin, 2012; Warren & Karner, 2015;). The interviews lasted between one and two hours, depending on the amount of details each participant chose to share. Following the first three interviews, the interview guide and demographic questionnaire were refined and further developed to yield the best results for validity and reliability. The interview guide can be found in Appendix D. Participants were interviewed with their cameras on so that the researcher could observe their body language, but only audio details of the interview were recorded.

The qualitative questions asked during the interview were essential to understanding the experiences of Black people in the context of racism and access to healthcare. The questions explored the perception of the participants living with hypertension and anxiety, and the impact of racism on their access and utilization of healthcare resources. The questions were developed using CRT and the Three Levels of Racism framework to understand the barriers and perceptions of the barriers experienced by Black people living in the GTA with hypertension and anxiety.

Several tools, such as scales and questionnaires, were used in the data collection process. The researchers developed the demographic survey to collect background information such as the participants' age, income, education level, and medical history (see Appendix E). The demographic data collected allowed the researcher to understand and describe the participants, contextualize their experience, and foster transparency of the population studied (Steward et al., 2007).

### Generalized Anxiety Disorder (GAD-7)

To assess anxiety, the Generalized Anxiety Disorder 7-item scale (GAD-7) (Appendix F) developed by Spitzer et al. (2006). was used (see Appendix F). The tool reported to be reliable and valid reporting a Cronbach's $\alpha$ of 0.92 (Spitzer et al., 2006). The GAD-7 has been utilized in previous research involving the Black population and is reliable and valid with a Cronbach's $\alpha$ rating of 0.89-0.91 (Kirakosian, 2018; Shrestha et al., 2020). Participants in this study self-reported their GAD score to determine their level of anxiety.

### Hypertension Self-Care Activity Level Effects (H-SCALE)

The Hypertension Self-Care Activity Level Effects (H-SCALE) was used to assess their self-care activities relating to hypertension (see Appendix G). Dr. Jan Warren-Findlow developed the H-SCALE. The researcher received permission to use this tool for this study (Appendix H). Two studies have been conducted and published examining the validity and reliability of the H-SCALE 6 subscales and their development (Warren-Findlow and Seymour 2011). Additionally, the correlations between the subscale scores and systolic and diastolic blood pressure are reported in the Journal of Clinical Hypertension. Dr. Warren-Findlow provided the scoring system and required documents on how to use the scale, and they have been used. This instrument was chosen due to its ability to assess participants' adherence to their hypertension treatment plan, and it has a Cronbach's $\alpha$ 0.67-0.86 across subscales (Warren-Findlow, et al., 2013). The H-SCALE was developed and validated for use in the African American population by Dr. Warren-Findlow and has been used in subsequent studies with reliable and valid results in Black people (Abel et al., 2022; Brewer et al., 2023; Warren-Findlow et al., 2021; Warren-Findlow & Seymour, 2011).

### Internalized Racial Oppression Scale (IROS)

To measure racism, the Internalized Racial Oppression Scale (IROS) tool examines internalized racism among Black people (Appendix I) tool was used. Internalized racism (IR) is defined as a conscious and unconscious process, and when conceptualized and measured as self-hatred, it is strongly associated with poorer mental health, physical health, and self-evaluations in Black American adults (James, 2022; James, 2021). The IROS measures the five dimensions: the internalization of negative stereotypes, self-destructive behaviors, devaluation of the African worldview and motifs, belief in the biased representation of history, and alteration of physical appearance. This tool was validated and published in 2011 in the Journal of Counseling Psychology. It was used in this study to assess the levels of racism experienced among Black people living in the GTA, and it has a Cronbach's $\alpha$ of 0.89 as reported by Bailey et al (2011). Brown et al. (2017) and Willis et al., (2021) have used the IROS and have found it to be reliable and valid in the Black population with a reported Cronbach's $\alpha$ rating of 0.61-0.86.

## Data Analysis

### *Inductive Thematic Analysis*

An inductive thematic analysis was employed to derive patterns and themes directly from the raw data transcripts and audio recording rather than applying predefined categories. Inductive analysis allowed the researcher to explore the data openly without incorporating theoretical frameworks and to begin coding openly (Thomas, 2006). Following Braun and Clarke's (2006) framework, the six stages of thematic analysis begin with familiarizing yourself with the data. During this initial stage, the researcher listened to the audio interviews, read the transcripts, and reviewed the survey responses. The researcher was mindful of the purpose of this stage and frequently reminded herself to be present with the data and not to begin generating codes. In the second stage, the researcher reviewed each transcript individually and began to generate and label initial codes using Microsoft Word text colour, highlight, and comment features. Initial codes were generated based on recurring words, ideas and concepts shared by the participants. During the iterative process of manually developing codes, clear labelling and organization of the participants' data occurred using the participants' ID codes. To keep track of thoughts and ideas presented on each engagement with the data the researcher engaged in writing memoirs. Coding includes aggregating the data collected through text or visuals into small categories of information to make sense (Creswell & Poth, 2018).

Following the review and generation of codes, initial themes were generated and documented in a separate Word document. The codes helped to identify the commonality amongst what was frequently being expressed by the participants. As a result, the more significant theme concepts were generated to encompass these codes. The themes generated include the commonalities and patterns presented in the stories shared. Stages four and five included reviewing and defining the themes. In this stage, investigator triangulation was used to review and define initial themes. The researcher and supervisor discussed and shared ideas that led to the final themes and development of sub-themes that will be presented in the findings chapter. During all the above stages, the researcher continued to engage in reflexive journaling to document her thoughts, biases, feelings, and emotions. The researcher frequently revisited the research question throughout the data analysis to ensure the generated themes aligned with the established research goal.

### *Interpretive Description*

An interpretative descriptive approach is used in nursing research to understand the core of the lived experiences. It is best for exploring personal and contextual experiences, as in the case of Black people's experience when accessing care for their hypertension and anxiety. The hermeneutical principles of phenomenology allow researchers to describe the stories, interpret them, and find meaning in them (Van Manen, 1990). In this study, participants often shared stories that the researcher could understand and interpret the more profound meaning beyond the words vocalized. Interpretive phenomenology was used to find and give meaning to the experiences of Black people in this study. Participants were asked to share their perceptions of what their experiences meant to them, allowing the researcher to interpret these experiences on a participant and conceptual level.

Descriptive phenomenology focuses on the detailed description of one’s lived experience with a particular phenomenon, while interpretive phenomenology seeks to find the meaning attributed to one’s lived experiences (Creswell & Poth, 2018). During the interviews, the researcher listened, observed, and made memos of tone changes and body language to describe the participant's intent in that moment or what emotions were experienced during their lived event.

With the powerful use of narrative storytelling, Black people in the GTA have been able to share their lived experiences, which will facilitate the researcher’s knowledge and understanding of the correlation between racism and the utilization and access to resources and services for Black people living with anxiety and hypertension. The qualitative methods employed in this study provided structure, yet a flexible analytical approach to ensure that the research produced findings that enhance the understanding of the research question and are directly applicable to nursing practice.

### Trustworthiness

In qualitative research, trustworthiness refers to the rigor, accuracy, dependability, confirmability, and credibility of the study's findings (Lincoln & Guba, 1985; Ravitch & Carl, 2016). The researcher spent a prolonged period engaging with the data to ensure understanding and using multiple sources to cross-check the findings. A systemic approach to coding was undertaken using a new Word document each time a new version was required. Additionally, the researcher engaged in reflexive practices throughout the research design process to ensure minimal biases and that the findings authentically captured the participants' experiences.

### Triangulation

Triangulation includes verifying evidence using multiple data sources, such as methods, investigators, and theories, to highlight a theme (Creswell & Poth, 2018). Investigator and theoretical triangulation were employed in this study to corroborate the data. Following the generation of the study themes, these themes were reviewed and discussed with the research committee to analyse and offer additional perspectives. Additionally, the participant's data was interpreted using the CRT and the Levels of Racism Theoretical Framework. The next chapter will provide a detailed overview of the data analysis process and findings.

### Ethical Considerations

This study obtained Research approval from the Research Ethics Board (REB) at Trent University (Appendix J). All instruments used were submitted and approved. Multiple methods were employed for data collection in this study. In qualitative research, interviews allow for a rich and complex data collection process; therefore, an individual, semi-structured, virtual interview using Zoom was completed. Trent University provided and secured the password-protected Zoom platform. Due to the sensitive nature of the research, where individuals shared their lived experiences, the interviews were conducted using a one-on-one approach that allowed participants to be vulnerable and honest. Interviews allow the researcher to uncover and understand the world from the subject's point of view based on their lived experiences (Brinkman & Kvale, 2015, as reported in Creswell & Poth, 2018). Participants were assigned a unique code that was randomly generated when the electronic tools were initiated to protect their privacy and adhere to the ethical standards outlined by the REB. The unique code was collected prior to commencing the interview and was later matched to the audio recording during data analysis. The informed consent process time commitment and purpose of the study were reviewed again before the interview, and the contact information for Trent University's REB advocate was emphasized if the participant had future ethical concerns (Appendix K). Participants were made aware of any potential risks and benefits. The primary researcher clearly emphasised the voluntary nature of the study, ensuring that participants could withdraw at any time before data analysis without consequences. Participants were thanked for their time and provided with a $25 electronic gift card for participation (Creswell & Poth, 2018).

## Chapter 4: Findings

The literature suggests that racism and stress have both been linked to the prevalence of hypertension and anxiety within the Black community. The WHO (2023) reports that hypertension is one of the leading causes of premature death worldwide, and anxiety, being a mental illness, increases the risk of premature death (CAMH, 2025a). There is an insufficient body of research in Canada that explores the experiences of Black people living with both hypertension and anxiety and how racism has contributed to this phenomenon. This study aims to explore the impact of systemic and internalized racism on the access and utilization of healthcare resources for Black people within the GTA. These findings will actively highlight the lived experiences of some of the individuals in the Black community living with hypertension and anxiety.

### Demographic Data

#### *Participant's Characteristic*

The demographic data collected allowed the researcher to understand and describe the participants, contextualize their experience, and foster transparency of the population studied (Steward et al., 2007). The participants' demographic data were analyzed using several key variables, including gender, age, employment status, income status, marital status, level of education, living status, grocery shopping, meal preparation, and frequency of use of community health resources (Table 1).

**Table 1.**

*Participants' Characteristics*

| Participant | Treatment Plan | Gender | Age | Employment Status | Marital Status | Education Level | Income in $ | Living Status | Grocery Shopping | Frequency of use for Healthcare Resources |
|---|---|---|---|---|---|---|---|---|---|---|
| ID96007 | Medication | F | 50-59 | FT | M | University /College | 50197-100392 | Rent | Other: Self & daughter | Several Times per year |
| ID75332 | Exercise | F | 40-49 | FT | M | University /College | 50197-100392 | Rent | Self | Several Times per year |
| ID97466 | Medication | M | 40-49 | FT | S | University /College | 50197-100392 | Own | Other | Several Times per year |
| ID78865 | Medication | F | 40-49 | FT | M | University /College | 50197-100392 | Rent | Self | Several Times per year |
| ID61336 | Exercise | F | 30-39 | FT | S | University /College | Less than 5 0 197 | Rent | Self | 1-2 times/ month |
| ID71307 | Medication | M | 30-39 | FT | S | University /College | 50197-100392 | Own | Self | Weekly |
| ID97484 | Medication | F | 40-49 | FT | M | University /College | 50197-100392 | Rent | Self | Several Times per year |
| ID99901 | Medication | F | 40-49 | FT | M | Other: Masters | 100 392-155 625 | Rent | Other: Spouse | I don't access resources for my health |
| ID73505 | Medication | F | 60+ | U | M | University /College | 50197-100392 | Own | Self | Several Times per year |
| ID28556 | Medication | F | 60+ | PT | S | Highschool | Less than 5 0 197 | Rent | Self | 1-2 times/ month |

A total of ten (N=10) participants were interviewed for this study, and the data obtained from all participants were included in the analysis. The participants' ages ranged from 30 to 60 plus (N=10), with 80% (n=8) female and 20% (n=2) male. The gender ratio in this study is consistent with previous research, which reveals that Black men are generally underrepresented in research compared to Black women. When analyzing for disparities that are consistently present in the Black community around socioeconomic status, in this sample, 80% (n=8) of the participants were employed full time, 90%(n=9) of the participants had an education level of college/university or higher, 70% (n=7)of the participants had an income higher than $50 197, 60% (n=6)  were married, but 70% (n=7) of the participants were renting for their living status.

Several participants talked about the impact of their finances on their living situation, refilling medications, and making healthier food choices. Although the demographic data did not account for stress as a disparity, 50% (n=5) of the participant shared their perception of stress being a clear link to developing hypertension. Participant ID97484 stated “I know in my case it's stress induced”. Additionally, participant ID75332 stated “Ever since the diagnosis at first I wasn't as anxious or have major concerns because I pretty much correlate that diagnosis with the fact I went through a lot last year in terms of losing my dad and other personal issues as well…I have a very stressful job and it's very hard to control that part on a daily basis”. The analysis of dietary patterns revealed that 70% (n=7) of the participants perform the task of grocery shopping and in-home meal preparation; compared to the other three participants reporting that this activity is being shared with a spouse or child. This finding is significant because zero percent of participants reported diet as part of their treatment plan, which is inconsistent with some of their reports of conversations with their primary care provider about diet and sodium intake. Therefore, this suggests a lack of understanding of how diet impacts hypertension health outcomes and what a treatment plan is. The demographic data introduces the participants and some of the complexities that are shared as a group but are unique to the individual. For example, participant ID97484 and participant ID99901 are both married, Black females between the ages of 40-49 years of age but they have both have distinct experiences when it comes to racism and classism.

### *Anxiety - GAD-7*

The GAD-7, a well-validated tool commonly used in various healthcare settings, was used in this study to assess and verify the diagnosis of anxiety.

**Table 2.**

*GAD-7*

| Participant | Total Score | Anxiety Severity |
|---|---|---|
| ID97466 | 6 | Mild Anxiety |
| ID78865 | 0 | Minimal Anxiety |
| ID61336 | 10 | Moderate Anxiety |
| ID71307 | 9 | Mild Anxiety |
| ID97484 | 2 | Minimal Anxiety |
| ID99901 | 14 | Moderate anxiety |
| ID73505 | 5 | Mild Anxiety |
| ID75332 | 4 | Minimal Anxiety |
| ID96007 | 10 | Moderate Anxiety |
| ID28556 | 0 | Minimal Anxiety |

The participants were asked to complete the GAD-7, scoring themselves using the scoring systems provided within the tool. A score of 0-4 = minimal anxiety, 5-9 = mild anxiety, 10-14 = moderate anxiety and 15-21 = severe anxiety. The participants in this study all reported some levels of anxiety, with 30% (n=3) living with moderate anxiety and 30% (n=3) living with mild anxiety. However, only 40% (n=4) reported a clinical diagnosis of anxiety, which is consistent with the underdiagnosis and reporting of mental illness in Black people (Kogan et al., 2022). When participants were asked how they knew they had anxiety, they often talked about worrying, feeling nervous, or restless. The reported symptoms are considered cognitive and behavioural symptoms of anxiety (CAMH, 2025c). Participants were not asked if these recurring signs or symptoms were reported to their primary care provider. When asked about the association between anxiety and hypertension, 90% (n=9) of the participant were able to vocalize how experiencing anxiety causes an increase in their blood pressure and the symptoms they experience. For many of the participants' there were structural barriers in place that lead to acts of omission by health providers. Participant ID 36007 reported "I just know that I'm feeling this pain from my neck into my chest, under my arm, and it's affecting my teeth. And he basically blew it off. And I knew that he wasn't really interested in what I had to say. I had mentioned it to him. He goes, well, what do you want me to do? Do you want me to sit down and have coffee with you?". Many participants experienced a lack of respect and devaluation which possibly made it challenging to express their anxiety symptoms. These unpleasant experiences can often activate the stigma-induced identity stress response (SIISR) leading to a generalized stress response (GSR) that can result in further worsening of Black people's mental health outcomes.

*The H-SCALE*

The H-SCALE was used to assess the participants' self-care activities related to hypertension. It assesses medication usage, diet, physical activity, smoking, and weight management within the last seven days.

**Table 3.**

***The H-SCALE***

| Sub-Scale | Participant Score | Available range | N (10) | % |
|---|---|---|---|---|
| Medication Usage | ID97466 = 9<br>ID78865 = 19<br>ID61336 = 2<br>ID71307 = 14<br>ID97484 = 12<br>ID99901 = 21<br>ID73505 = 21<br>ID96007 = 6<br>ID75332 = 0<br>ID28556= 21 | 0-21<br>Score of 21 or 80% = adherent | Adherent = 4<br>Non-adherent = 5<br>Not prescribed = 1 | Adherent = 40<br>Non-adherent = 50<br>Not prescribed = 10 |

| | | | | |
|---|---|---|---|---|
| Diet | ID97466 = 14<br>ID78865 = 19<br>ID61336 = 32<br>ID71307 = 38<br>ID97484 = 52<br>ID99901 = 47<br>ID73505= 48<br>ID96007 = 32<br>ID75332 = 45<br>ID28556 = 31 | Scores < 32 are considered low diet quality<br>Scores between 33 and 51 are medium diet quality<br>Scores > 52 is considered adherent | Low diet quality = 5<br>Medium diet quality = 4<br>Adherent = 1 | Low diet quality = 50<br>Medium diet quality = 40<br>Adherent = 1 |
| Physical Activity | ID97466 = 7<br>ID78865 = 0<br>ID61336 – 6<br>ID71307 = 14<br>ID97484 = 14<br>ID99901 = 8<br>ID73505 = 11<br>ID96007 = 5<br>ID75332 = 7<br>ID28556 = 0 | 0-14<br>score of ≥ 8 are considered adherent to physical activity recommendations<br>Less than < 8 are non-adherent | Adherent = 4<br>Non-adherent = 6 | Adherent = 40<br>Non-adherent = 60 |
| Smoking | ID97466 = 0<br>ID78865 = 0<br>ID61336 = 0<br>ID71307 = 0<br>ID97484 = 0<br>ID99901 = 0<br>ID73505 = 0<br>ID96007 = 0<br>ID75332 = 0<br>ID28556 = 0 | 0-14<br>Score of zero is considered adherent | Adherent = 10<br>Non-adherent = 0 | Adherent = 100<br>Non-adherent = 0 |
| Weight Management | ID97466 = 28<br>ID78865 = 44<br>ID61336 = 35<br>ID71307 = 37<br>ID97484 = 41<br>ID99901 = 36<br>ID73505 = 35<br>ID96007 = 37<br>ID75332 = 35<br>ID28556 = 45 | 10-50<br>Score ≥ 40 are considered adherent to good weight management practices. | Adherent = 3<br>Non-adherent = 7 | Adherent = 30<br>Non-adherent = 70 |
| Alcohol Consumption | ID97466 = 3/ week<br>ID78865 = 0/ week<br>ID61336 = 0/ week<br>ID71307 = 6/ week | Zero alcohol consumption in the last seven days or at all are considered adherent | Adherent = 4<br>Non-adherent = 6 | Adherent = 40<br>Non-adherent = 60 |

| | | | | |
|---|---|---|---|---|
| | ID97484 = 1/ week<br>ID99901 = 0/ week<br>ID73505 = 0/week<br>ID96007 2/week<br>ID75332 = 1/ week<br>ID28556 = 2/week | | | |

In this study, 40% (n=4) of participants reported taking their medication as prescribed, while 50% of participants reported either self-dosing based on symptoms, stigma, or simply when they remembered. Participants often talked about not wanting to be on medication forever because of the adverse effects it has on the body, or the lack or no of patient education received about their diagnosis or medication. The issue of mistrusting the primary care provider was consistently heard, although not verbalized, as participants frequently shared stories of the power imbalance in the patient-provider relationships.

When analyzing participants' adherence to diet and weight management approaches, 50% (n=5) of participants currently consume a low-quality diet, while 70% (n=7) were non-adherent to good weight management practices. The dietary management subscale assesses participants' ability to reduce portions, make appropriate food substitutions, and exercise to lose weight. During the interview, participants shared some barriers that affect the decision to consume a high-quality meal. The most common was expense, and what is understood to be a cultural influence. One participant, ID97484, stated, “Taste is priority for Black Caribbean people, our number one thing is taste, because if it not taste good, we don't want it”. These findings correlate with the demographic data reported, as some participants do not understand how diet affects their health. When looking at the big picture from a cultural perspective, Black people frequently do not have access to the right resources to help them make healthier choices. The Canadian food guide, frequently referred to by many care practitioners, does not consider alternatives specifically for Black people.

Utilizing the outdoors for exercise could have several meanings. However, it was already suggested that finances were a barrier when shopping for groceries and medications, so the assumption is that it impacts the chosen exercise method. Gym memberships are expensive, so walking outdoors is free and easily accessible, depending on the neighbourhood one lives in.

*The IROS*

Bailey et al. (2011) created the IROS to measure the levels of internalized racial oppression in Black individuals. The 36 items, IROS includes five subscales: the internalization of negative stereotypes, self-destructive behaviors, devaluation of the African worldview and motifs, belief in the biased representation of history, and alteration of physical appearance. The IROS uses a 5-point Likert scale: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, to 5 = strongly agree. A higher score indicates higher levels of internalized racial oppression. This tool was used to measure racism experienced by the participants.

**Table 4.**

***The IROS***

| Participant Score | Available range |
|---|---|
| ID97466 = 1.63<br>ID78865 = 1.30<br>ID61336 = 2.06<br>ID71307 = 1.47<br>ID97484 = 1.47<br>ID99901 = 1.25<br>ID73505 = 1.61<br>ID96007 = 2.50<br>ID75332 = 1.75<br>ID28556= 2.19 | 1.00-1.99 = Very low internalized racism<br>2.00-2.99 = Low internalized racism<br>3.00-3.99 = Moderate internalized racism<br>4.00-4.99 = High internalized racism<br>5 = Very high internalized racism |

All the participants exhibit very low to low internalized racism on the IROS. Many participants denied being affected by IR but was able to share stories about how they have been influenced by the dominant White voice of society. One participant ID61336, stated, “if you may not have the money or may not have certain thing to get through certain things, it causes anxiety. And then you start thinking that, oh, in this White world, these people are better than me… then you know what, let me try to change my skin colour so that I can match with these people and be accepted into this White supremacy world”. Another participant ID97466 stated “I know with my culture, sometimes we talk crap about each other, where it's like, oh, you could never trust a Black person with work and stuff because they never get it done”. Similarly, participant ID97484, shared “I would internalise different classes of Black or different races of Black…sometimes I'll say, but we're not like them and we're not nasty like them, or we're not thief like them”. These are several of the stories shared with the researcher. Participants appear to more aware of the dominant ways in which IR racism presents such as skin lightening or hair changes but miss the subtle and damaging impact it can have when accessing and utilizing healthcare resources. Participant ID 73503, 60+ with a college/ university education stated “we were almost taught that White people were better than us and we were supposed to bow to them and they're supposed to rule over us, etcetera. So, we accepted that back then and thinking it was okay. But as we get older, we are realising that that's really not what it is”. These are words of maturity and growth, recognizing that Black people have been miseducated in the past.

## Themes

The study examined the unique and diverse experiences of Black people living with hypertension and anxiety in the GTA when accessing and utilizing healthcare resources. The researcher used a descriptive interpretative phenomenological approach to generate meaningful insights into the explored phenomena. An inductive analysis method was used to generate themes and sub-themes that represent the unique ideas, perspectives, and concepts that emerged in the study. Table 5 provides an overview of the themes and sub-themes identified in this study. A Thematic Analysis approach was employed to analyze the interview data and generate themes. “Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p.79). The six steps of Thematic Analysis by Braun & Clarke (2006) were employed throughout the data analysis process.

**Table 5.**

*Organization of Themes and Sub-Themes*

| Theme 1 | Theme 2 | Theme 3 | Theme 4 |
|---|---|---|---|
| Self-Determination | Racism as a Barrier to Care | Dismissiveness of Care Needs | Gatekeeping |
| **Sub-theme** | **Sub-theme** | **Sub-theme** | |
| • Utilizing family/ self as a healthcare resource<br>• Probing for information<br>• Remaining silent | • Systemic barriers<br>• Racism and Internalized Racism | • Dehumanization of Black<br>• Black people as complainers | • Limited access to medical education<br>• Limited awareness of health resources |

**Theme 1: Self-Determination**

The first theme identified is self-determination. It is expressed individually in many of the participants stories by their desires to be an active participant in the decision-making process about their care. Throughout the interviews, participants expressed frustration about always having to self advocate, probe the doctor for information regarding their health, asking for a specialty referral or follow-up testing regarding their diagnosis or symptoms. Some participants displayed feelings of sadness during the interviews, as evidenced by their facial expressions and changes in body language. Participants often expressed feelings of confusion by saying things like “I don’t know” when trying to make sense of their experience. One participant, ID 73503, stated, “I had to request to go see a cardiologist. I've seen quite a few of them…Normally I have to advocate for that for myself…So a lot of times I have to intervene and say, well, maybe I should go to get an ultrasound or maybe I should get an ECG, etcetera…I have to initiate on my own in terms”. Another participant, ID99901, stated “We cannot wait for other people to do our job…We cannot expect the oppressor to just say…we're just going to do this for you guys”. The findings from this study are that Black people collectively want to have the right to control the factors that negatively affect their health outcomes and decolonize the institution of healthcare. The researcher categorized the theme of self-determination into three sub-themes: utilizing family as a healthcare resource, probing for information and remaining silent.

### *Utilizing family/ self as a healthcare Resource*

Three participants brought up the sub-theme of utilizing family as a resource. Participants mentioned seeking medical advice from family members working in the healthcare setting to supplement the information provided to them by their doctors or to gain new knowledge. Two participants also mentioned working in healthcare and drawing on their knowledge to advocate for themselves (Table 6). In the Black Afro-Caribbean culture, the family is often valued and is integral to one’s health. Several of the study participants recognized a gap in the health education they received from their physician and utilized family to enhance their knowledge.

**Table 6.**

*Sub-theme: Utilizing family/ self as a healthcare Resource*

| Participant Code | Quotation |
|---|---|
| ID75332 | “I mentioned to my sister-in-law, she's also a nurse, so we talk briefly about it and what to do.” |
| ID99901 | “I do have a cousin who's a doctor, She has helped a little bit” |
| ID 36007 | “I have family members who are nurses, and so therefore I might go to them and say, oh, what do you do for this? Or what do you do for that?” |
| ID 73503 | “because I'm a nurse, she kind of take it differently when I tell her something” |

| | |
|---|---|
| ID71307 | “He kind of looks at me like I have the answers, which I probably do… he knows I’m a medical professional too, so I don't know if that's where he's coming from” |

*Probing for Information*

Participants frequently stated they had to probe their doctors for further treatment options. One participant mentioned having to change their family physician, participant ID75332 stated, “My previous physician, I kind of get a pushback from her” when trying to advocate for self. These reported experiences, shared below in Table 7, continue to support the theme of self-determination. Participants often stated things like I had to do my research to get the information I needed. Participants often sounded unsatisfied with the care they had received. One participant, ID71307, stated, “I don't even know why I go to him,” indicating that this provider was useless. These interactions with the care providers frequently left participants feeling frustrated. These encounters would further break the provider-patient relationship, resulting in a lack of confidence or mistrust in the care they received. For many of the participants’ there were structural barriers in places such as differential access to information, resources and time. These barriers may or may not have been intentional but the outcome has led to some of the many ways provider mistrust and dissatisfaction have been linked to poorer health outcomes for Black people. Additionally, these barriers demonstrate the unequal access and distribution of resources and opportunities that exist in healthcare for Black people.

**Table 7.**

*Sub-theme: Probing for Information*

| Participant Code | Quotation |
|---|---|
| ID75332 | “If I ask certain questions or would tell her, no, I'm not comfortable, I would like for you to do more testing or before you prescribe me this medicine, can you just do the testing… we don't really have a conversation. It is kind of like whatever I say, I'm the doctor goes.” |

| | |
|---|---|
| ID 73503 | “I always have to see how the medication work and talk on my own initiative to say maybe you could try different medication because this one isn't working. So there's not really an ongoing assessment”<br>“I had to get help from outside my physician” |
| ID99901 | “I feel we have to do so much to find stuff.” |
| ID71307 | “I request blood work. He never says, Hey, let's get you to do some blood work. Let's get you to do this. Let's check your weight. None of that.” |
| ID78865 | “I had to kind of squeeze him and say oh, what do you think is happening here with the numbness” |
| ID97484 | “And sometimes when you go where you're supposed to go, they themselves have you in a merry go round, they're not giving you the right answers. They're not giving you the right recommendations” |

### *Remaining Silent*

The sub-theme of remaining silent was expressed in two different contexts. Participants spoke about remaining silent when accepting the label placed on them by healthcare providers and as a cultural stigma. As a result, participants often spoke about the need to speak up. One participant, ID97484, stated, " People who don't talk or they don't know they have struggles.”

Several participants shared thoughts and experiences about being labeled by society and or healthcare providers (Table 8). ID99901 participant stated, “I'm accepting what's given to me without questioning. Yeah. I'm not putting up a fight, or I am not supposed to put up a fight.” when talking about internalized racism. It appears that some Black people are unsure of how to navigate the boundaries of self determination and choose to be silenced. Participants choosing to remain silent illustrate the voices of oppression that remain in society that label Black people as angry, incompetent, uneducated, combative, or aggressive when they vocalize their concerns, and therefore, they remain silent. The voice of oppression experienced by many of the participants formed the narrative that hypertension is common in the Black community and therefore Black people no longer have the right to self-determination when it comes to being given adequate information and resources to participate in the informed decision-making process about their health. Many Black people’s voices have been silenced and invalidated so they accept both societal and cultural stigma placed upon them.

**Table 8.**

*Sub-theme: Remaining Silent*

| Participant Code | Quotation |
|---|---|
| ID78865 | “They're quick to shove things off on Black people. Black people, high blood pressure, diabetes is common in Black people... So we tend to accept that”<br>“we as Black people, we tend to decide that we accept the diagnosis, and we pop a pill rather than putting the extra work to get healthy or healthier.” |
| ID 73503 | “I feel that because we sometimes don't have the education and we don't know better, we just accept what they give and we don't go further” |
| ID 36007 | “I think that they accept it because…they just figure that…it's a Black people disease” |

### *Cultural Stigma*

The cultural stigma was a recurrent theme throughout the interviews. Several participants talked about the culture's impact on Black people’s decision to seek medical care. Participants talked about how this belief can have a negative impact on one's thoughts and actions (Table 9). Some participants also discussed remaining silent either because of the cultural stigma associated with mental illness or simply because they did not want to disclose their health concerns to others. When sharing her experience with mental illness, one participant ID61336, stated “when you try to come out the box, they start to label you as mental problem”. The impact of culture can define how Black people perceive illness and health outcomes. However, the idea of essentialism that because an individual is Black culture dictates how they disclose information or interact with healthcare services is wrong. Black people are unique in their experiences as evidenced in this study.

**Table 9.**

*Sub-theme: Cultural Stigma*

| Participant Code | Quotation |
|---|---|
| ID61336 | “Some people don't want the help…they don't want to be labelled. They don't want to be labelled and their pride and the traumas affects them… it's a stigma of whatever was taught to us when we're from slavery time until now” |
| ID71307 | “Maybe I thought this subconsciously, that there is no programs especially geared towards Black people in society that are experiencing these things” |
| ID99901 | “I feel it's weird, but I feel like I'm a burden. And even though I'm there to be helped” |
| ID97484 | “I think for us as Black people, we love to eat, but we don't like going to the doctor and doing all that needs to be done.”<br>“We don't talk about mental health… I didn't seek out a counsellor because Black people, oh, we don't want no body in our business” |
| ID 36007 | “I find that within our community, first we don't really talk about what our issues are…We take the diagnosis… There's not much dialogue among ourselves or with the doctor… you just want to take the diagnosis and go with it” |

### Theme 2: Racism as a Barrier to Care

Several participants explicitly stated that racism is a barrier to them receiving adequate care from doctors and other healthcare practitioners (Table 10). This theme was repeated throughout the interviews, either as systemic racism, institutionalized racism, or PMR. Participants expressed feelings of frustration, stress, and confusion when sharing their lived experiences. One participant, ID75332, stated, “It doesn't make sense because we're all paying into the healthcare system, whether you're Black, White, or any other ethnic group, we're all paying into it. So, we should have access to the same resources”. The normative actions of racism have resulted in institutional barriers that continue to disadvantage Black people. Black people in this study have been left feeling devalued and at times helpless. Participants often expressed feelings of confusion by saying things like “I don’t know” when trying to make sense of their experience with racism. This theme has been divided in to the sub-themes’ structural barriers and internalized racism.

### *Systemic Barriers*

In this study participants frequently shared their experiences with differential access to services and opportunities that has manifested as poor service and failure of the care provider to communicate treatment options. One participant, ID61336, during the interview verbalized, “got to breathe now…because I’m stressed” when sharing her experience about the barriers to adherence to her treatment plan. The participant reported consistently reporting to the doctor the side effects of the prescribed medications, and the doctor not listening to her. Another participant, ID99901, after sharing two of what she calls the most demeaning experiences in healthcare, stated, “I've had the worst racist experiences in Canada, Toronto, Montreal…being born and raised in Canada”. This participant's experience is one of many that continues to be dismissed by decision makers, stating that there is no systemic racism in Canada. In 2020, Montreal’s premier, Francois Legault, denied the existence of systemic racism in Quebec. The Premier of Ontario, Doug Ford, also dismissed what he referred to as systemic, deep-rooted racism in Canada and later backtracked on the comments, acknowledging its presence. This kind of dismissive attitude is what continues to keep racism woven into the very policies that exist today. Health equity should be for all and not some when promoting population health. When human connectedness is removed from care, it can result in anxiety and stress. Anxiety and stress are both physiological and emotional experiences that have been linked to Black people experiencing racism. In fact, they are both modifiable risk factors for Black people developing and managing hypertension. The goal should be to eliminate or reduce these modifiable risk factors. Health as a resource should be an achievable goal for all people, not just a select race. The systemic barriers experienced by Black people are a direct consequence ordinariness, interest convergence and the social construction of race all manifesting as health disparities in the Black community.

**Table 10.**

*Sub-theme: Systemic Barriers*

| Participant Code | Quotation |
|---|---|
| ID73503 | “One of the thing is of course my race…I think that race play a big part in how we are treated when we say certain things because it's an assumption that all Black people is going to have hypertension.”<br>“I ended up in the ED a couple of times with high blood pressure and it was…like 159 over 90 something. I thought that's high. And the doctors just basically say, oh, it's okay. Just go home. If anything, follow up with your physician. So in that sense there I would say yes, it has to do with me being a Black person” |
| ID61336 | “Because I'm Black, they're not listening to me. And probably the weight. And I'm not really a fat person…So the barrier is definitely of my skin colour. But if I was White, yeah, I'll be getting all the privileges.”<br>“They don't give you the proper medications…they like to give you the cheap ones or the generic ones than give you the good quality ones because they feel like you cannot afford the good hypertension pills or the right type of pills that is for that specific problem” |
| ID71307 | “I don't even know if he takes me that serious. So he doesn't really, there's no enthusiasm. No, I don’t know what to say.” |
| ID97484 | “I've heard stories from friends who've said that their doctors don't listen.” |
| ID99901 | “I still think that we're not cared for or looked after.”<br>“It was racist. And because, so I'm a Black woman”<br>“I'd be trying my best to find the ways. But how can I put it?...With the systematic racism, I feel we have to do so much to find stuff.” |
| ID97484 | “I know there's some practitioners or some people in healthcare, they might think that Black people don't go through that we don't have anxiety, or we're probably making it up. Some people would say, it's just in your head, it's not true. It's not real.” |
| ID78865 | “I noticed even as a healthcare provider, people wouldn't come to access certain care because of that stigma... I worked in emergency for some time…but you can see the difference when certain healthcare provider dealing with different type of races. You can see a difference with the people of colour, like Black and brown people where it relates to White people” |

### *Racism and Internalized Racism*

Participants were asked to share their experiences and perceptions of IR and their encounters with the healthcare system. IR is present when Black people internalize and accept the labels and limitations placed upon them by the dominant White society. In this study, some participants spoke about accepting their care providers' diagnosis or treatment plan without question removing their right to self-determination. Others discussed some of the more cultural ways Black in which people display IR such as, they are taught not to disclose their personal concerns to each other due to the mistrust of each other. Black people who choose not to self-advocate or ask for help are at a disadvantage that could have a deleterious effect on their health. Additionally, IR is observed when participants believe that there are no programs designed with Black people as the target audience because of the belief that the government does not care. This belief system about their intrinsic worth can directly impacts their accessing and utilizing care because they will not seek it out if they believe the service does not exist. One participant, ID71307, reported, “On one hand, you could be like, yeah, maybe government doesn't care. They're not going to fund these programs, so it doesn't exist. And on the other hand, which is something I'm seeing more of that, no, there's some funding for some of these programs and they do exist”. Although majority of the participants in this study experienced high levels of stress, anxiety, institutionalized racism and PMR they did not exhibit high levels of IR. These stressful exposure to racism was not found to have a correlation to their access and utilization of healthcare resources for their hypertension and anxiety. Some participants talked about the normalization of IR in the black community. Participants referred to the experience as “typical”, “jokes”, “jealousy” or what was “taught to us” (Table 11).

**Table 11.**

*Sub-theme: Racism and Internalized Racism*

| Participant Code | Quotation |
|---|---|
| ID36007 | "I find that we don't want to talk about it. We just want to basically just get the medication and go…because they think that the doctor's just giving you something to shut you up, and then they're basically trying to find other natural solutions to figure it out." |
| ID73503 | "We run these jokes and we think that it's not anything because it's something that we've all experienced ever since we were growing up, ever since we're children. Because we were almost taught that White people were better than us and we were supposed to bow to them and they're supposed to rule over us so we accepted that…". |
| ID61336 | "The White folks has colonized our minds to think that way..."<br>"If you may not have the money or may not have certain things to get through certain things, it causes anxiety. And then you start thinking that, oh, in this White world, these people are better than me"<br>"it's a stigma of whatever was taught to us from slavery time until now" |
| ID97484 | "I would internalize different classes of black or different races of black. Like the Somalians and the Nigerians and the Ghanaians, and sometimes I'll say, but we're not like them and we're not nasty like them, or we're not thief like them…So I think we have our own internal biases too..." |
| ID99901 | "With internalized racism, I may feel that, again, I'm accepting what's given to me without questioning. Yeah. I'm not putting up a fight, or I am not supposed to put up a fight." |
| ID71307 | "I'm not aware of these programs…Maybe I thought this subconsciously, that there is no programs especially geared towards black people in society that are experiencing these thing." |
|  | "Just the typical, well, I shouldn't say typical, but, well, my background's Jamaican, and I know with my culture, sometimes we talk crap about each other…you could never trust a black person with work and stuff because they never get it done...Or even today, we don't trust each other |

| | |
|---|---|
| | with businesses or don't support each other with businesses.” |
| ID78865 | “They're quick to shove things off on black people. Black people, high blood pressure, diabetes is common in black people... So we tend to accept that” |

*Exploring Key Assumptions*

Based on Tables 10 & 11 the following assumptions were explored.

*Assumption 1*: Systemic racism will have a direct impact on Black people’s access and utilization of healthcare resources in the GTA.

*Assumption 2*: Internalized racism will have a direct impact on Black people’s access and utilization of healthcare resources in the GTA.

Assumption 1 was supported in this study. Systemic racism has been found to have a direct impact on Black people’s accessibility and utilization of healthcare resources. Many of the participants in this study reported that racism is a direct barrier to accessing and utilizing healthcare resources for their hypertension and anxiety. Participants believed that systemic racism had a direct impact on receiving optimal or even adequate care. Assumption 2 was not found to be a barrier to accessing and utilizing healthcare resources in this study. The results of these assumptions will be discussed in Chapter 5.

### Theme 3: Dismissiveness of Care Needs

The theme dismissiveness of care needs was generated because of several stories that participants described as they “brush us off”, “blew it off” or “demeaning”. During these interviews, some of the participants laughed while sharing their stories. The laughter was mixed with what appeared to be disbelief and confusion, as evidenced by their facial expressions. Stories were often started or ended with “I don’t know”. As participants recounted their stories, some appeared uncomfortable and sounded hesitant to share in-depth details about their previous encounters. Three sub-themes were created: dehumanization of Black people, Black people as complainers, and racism as a barrier to care.

### *Dehumanization of Black People*

Participants frequently recounted stories about not being seen as a human being. Participants all attributed this dehumanizing experience to being Black. Participants perceived the lack of human connection displayed by the care provider as a barrier to receiving quality care (Table 12). When one is made to feel less than human, it creates an existential crisis within them.

**Table 12.**

*Sub-theme: Dehumanization of Black People*

| Participant Code | Quotation |
|---|---|
| ID 36007 | "Another older doctor told me to man up and get over it when experiencing pain." |
| ID 73503 | "A lot of times I think that they think that we are coming in to get probably drugs or we just are complainers and we don't take care of ourselves and they just kind of brush us off." |
| ID78865 | "There's no rapport. There's no connection. There's no connection at all to the physician." |
| ID71307 | "I think just being viewed as a human in a whole sometimes could be, come on, a White person walks in the clinic or a Black person, chances are the White person's going to get treated better."<br>"You are only human, so there's So much numb feeling or lack of feeling you could have for certain things" |
| ID99901 | "I had gone to see a specialist in Montreal. And let's just say it was the most demeaning session…no, sorry, it's not, it's the second… he basically gave me no options for the way to treat the issue that I had, except a very extreme one…he wanted to sterilise me right then" |
| ID61336 | "Once they say that you…have anxiety they don't look at you as normal anymore…They start to label you. So they stereotype" |

### *Black People as Complainers*

Similarly, to the theme of not being seen as human, several participants shared experiences and thoughts of being labeled as complainers by healthcare practitioners when seeking care. One participant

ID97466 said, “It was just saddening to see actually that happening, where I'm actually reaching out for help, and after not receiving the help or the care that I needed”. When care providers do not effectively listen or assess their patients, misdiagnosis and adverse health outcomes can result. It has been previously documented that Black people are often dismissed and misdiagnosed in comparison to White people. In this study, participants frequently shared their experiences of being dismissed and judged when reporting pain or cardiovascular symptoms. It was also documented in this study that 60% of participants reported ongoing anxiety symptoms, but only 40% had a clinical diagnosis. Half of the participants in this study shared stories of not being believed when reporting certain medical conditions (Table 13). These experiences demonstrate medical gaslighting that further deepens the wounds of dehumanization, resulting in a more significant existential crisis for these individuals.

**Table 13.**

*Sub-theme: Black People as Complainers*

| Participant Code | Quotations |
|---|---|
| ID 36007 | “I almost died where I told him that I was having pain and he told me I'm bending my head and I told him, no…I just know that I'm feeling this pain from my neck into my chest, under my arm, and it's affecting my teeth. And he basically blew it off. And I knew that he wasn't really interested in what I had to say. I had mentioned it to him. He goes, well, what do you want me to do? Do you want me to sit down and have coffee with you? Do you want me to sit down? And I said, no, but something's going on within my body… And then within a couple hours I had lock jaw, and by the next day I had systemic infection where they had to operate on me within 15 minutes when they found out when it could have been prevented when.” |
| ID97466 | “They didn't actually believe me. So it was kind of off putting. It was just more so like, oh, you're just being lazy or whatever you're doing, so I just need to figure it out.” |
| ID78865 | “While working on labour and delivery ward in 2000 and 2021, long hours, no breaks, night shifts, and I didn't cope well… it was realised that when I'm working, my blood pressure was very high 170+/100…. I wanted them to take me off of the night shift, and the cardiologist refused. He said, you know what? You are a nurse and you're expected to work at night shift. So that is when I really gave him up really, because I said, you're not working for me, you're working against me.” |

| | |
|---|---|
| ID97484 | “They might think that Black people don't go through that we don't have anxiety, or we're probably making it up. Some people would say, it's just in your head, it's not true. It's not real. You just need to do this” |
| ID71307 | “The way they look at what we are experiencing, they think it's nothing and they just brush it off.”<br>“I remember one doctor…I had the symptoms that were there and he said, no, there's nothing wrong with you. You can come back to work. And I had to fight, whereas other people had the same issues and they would get the time off”<br>“They look at us as complaining, complainers and not doing the right things to have proper health” |

### Theme 4: Gatekeeping

Gatekeeping in the Black community hinders access to health services and information that can negatively impact health outcomes. Several participants reported not being provided adequate health teaching information and the knowledge required to make an informed decision about their health. Participants were not allowed to collaborate in the healthcare decision-making process. Participants were not educated about their diagnosis and its implications on their health. Participants were provided little guidance on their treatment plan and how to be consistent or succeed. When participants were asked about their experience with the counselling/ education they received from the healthcare provider, many of them said they did not receive any health education or enough information about their hypertension. The ones that reported any education referred to it as “basic” or “nothing elaborate” (Table 14). Participants reported that they had to seek out additional information to self-educate themselves about their diagnosis. One participant, ID78865, shared, “The doctors don't counsel anyone. They give you medication, and they just expect you to follow the regimen.” One hundred percent of the patients interviewed have been prescribed medication on their initial diagnosis. The lack of health teaching provided to these Black patients demonstrates a broader problem that could be related to racial discrimination, lack of competence from the care provider, or possibly burnout from care providers. The intentional or unintentional act of withholding viable health information from Black patients has led to the generation of this theme, gatekeeping. The differential assumptions held by many primary care providers is manifested as differential access to health information and resources that has created an unfair disadvantage for many of the participants in this study.

### *Limited Access to Medical Education*

Hypertension Canada has recommended lifestyle modifications as the first line of treatment for managing hypertension. However, all the patients who participated in this study reported being prescribed medication on initial diagnosis, with limited health education. The limited education has resulted in a 50% medication adherence rate. The use of clinical judgement for prescribing is encouraged by Hypertension Canada with patient education and participation in care, but what is being reported is an overprescribing of antihypertensive medications in the Black community. One participant, ID73505, shared her interaction with the primary care provider, being “quick, quick take this medicine. If you don’t feel well, we give you another one” without understanding the patient’s experience. In addition to the overprescribing, there is limited assessment and ongoing reassessment of Black people in care facilities. The lack of access to medical information is in the Black community is not unintentional, it is the result of system racism, medical neglect and educational marginalization.

**Table 14.**

*Sub-theme: Limited Access to Medical Education*

| Participant Code | Quotation |
|---|---|
| ID97466 | “I was just told about it and he just gave me basic information. Just like watch the salt, drink lots of water, and just give me prescription drug.” |
| ID28556 | “No counselling, only therapist for depression in the past” |
| ID78865 | “Not really, diet, exercise, rest, stress management. Nothing elaborate” |
| ID61336 | “my Black doctor that passed away three years ago, he was always telling me, you got to lose the weight…the White doctors them now will prescribe me” |
| ID71307 | “It was very minimal, very basic…I guess he said it because he has to say it to the patient that just the criteria in this case for hypertension, I don't know.” |
| ID99901 | “No, no, no education in terms of how to manage the hypertension, medication, just loose weight 10-20 pounds” |
| ID73505 | “Not much, I did most of the research myself. I have been given medication to manage it. My doctor to told me to stay away from salt. There is no on-going assessment or education” |

| | |
|---|---|
| ID 36007 | “I was just told, my diet should be regulated. Be careful of the salt intake and stuff like that… they've given me the pills also” |
| ID75332 | “Other than diet…previously I was prescribed medicine… she hasn't really said much to me in terms of educating me on this diagnosis. I pretty much just self-educate myself” |

### *Limited Awareness of Health Resources*

The sub-theme of limited awareness of health resources was evident in several stories shared by the participants. When participants were asked about barriers to accessing and utilizing community health resources for their hypertension and anxiety, many of their responses were that they were not aware of the resources. Several participants expressed a lack of awareness regarding community health resources (Table 15). However, some participants reported that they knew how to access the information they needed. Two participants stated they had to seek help outside of their primary physician. One participant ID75332 stated, “I have spoken with so many different people that's been diagnosed with different issues as well. And it's the same thing. They're saying they have to be jumping from one physician to the next, trying to get answers or trying to get the resources that will assist them with their health condition”. Physician hopping results in a lack of consistency in care and is a barrier to establishing a therapeutic relationship. The limited awareness in the Black community around hypertension and anxiety as a diagnosis and knowledge of health resources can often be misrepresented by the oppressive White voice as a lack of concern or education. This study's findings revealed that systemic racism limits self-determination in the Black community.

**Table 15.**

*Sub-theme: Limited Awareness of Health Resources*

| Participant Code | Quotation |
|---|---|
| ID75332 | “Give access to those resources. I don't know. But I haven't been given the resources. Like I said, I have to self-educate.” |
| ID99901 | “I just don't know, even though it feels like I spent my whole waking hours locked into some kind of device and I still don't know stuff… I hear things here and there, but I don't know. I don't know where things are” |

| | |
|---|---|
| ID71307 | “I still don't really know of the programs out there” |
| ID97484 | “And sometimes when you go where you're supposed to go, they themselves have you in a merry go round, they're not giving you the right answers. They're not giving you the right recommendations” |
| ID 73503 | “I think that there's more out there for us to access.” |
| | “I guess if it is promoted or marketed properly, then even myself will go, oh, okay, cool. Maybe I should try this programme.” |

## Data Saturation

A systematic process of collecting and analyzing data was used to achieve data saturation. A semi-structured interview method was used to collect data from Black individuals in the GTA that is living with hypertension and anxiety. During the data collection process, the researcher explored their lived experiences with systemic and institutionalized racism when accessing healthcare resources. As the interviews progressed, Braun & Clarke's (2006) thematic analysis method was employed to generate codes and themes. Interviews were conducted until no new codes or themes emerged.

There was only a one-time commitment required of the participants, and therefore, during the interview, techniques such as summarizing, reading back, probing, and asking clarifying questions were used to validate the participants' responses. For example, participants were asked to clarify and elaborate on certain parts of their experiences/ stories when the researcher wasn’t quite clear on their intended meaning. A total of ten participants were interviewed who shared similar experiences, characteristics, and patterns of challenges. Achieving data saturation ensured that the findings were thorough and uniquely captured the lived experiences of the Black people living in the GTA when accessing and utilizing healthcare resources for their hypertension and anxiety.

## Chapter 5: Discussion

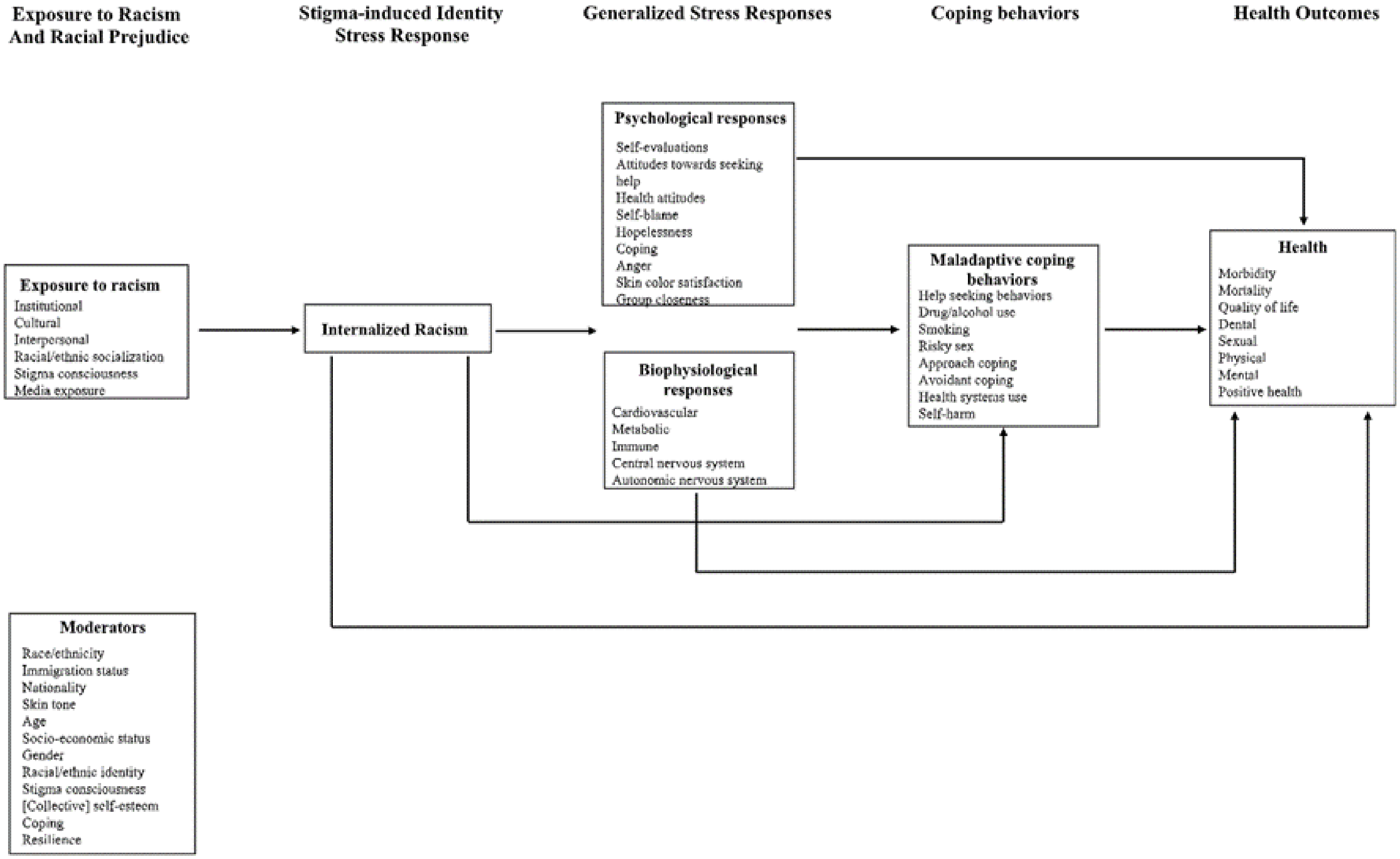
The findings from this study continue to highlight the racial inequities and barriers that exist for Black people in the GTA when accessing and utilizing healthcare resources. These factors contribute to the high prevalence and mortality rates of Black people living with chronic diseases such as hypertension and anxiety. Black people in Canada experience racism and microaggressions almost daily and in almost every area of their lives, and this leads to substantial health inequities (Kogan et al., 2022; Raphael et al., 2020). The IR framework presented by James 2022 (Figure 2) demonstrates how exposure to racism directly impacts an individual’s health outcomes. It has been reported that Black people experience more everyday racism and prejudice when compared to people of any other race. This directly triggers the SIISR that results in IR. The SIISR occurs when an individual assesses the demands of the imposed identity-relevant stressor as harmful to their social identity, and they do not have the resources to cope with the demand (James, 2022; Major & O’Brian, 2005). The SIIRS then causes a GSR that results in either or both psychological and biophysiological responses. These responses directly lead to maladaptive coping behaviours and poor health outcomes such as anxiety and hypertension.

Adults diagnosed with hypertension were more likely to have anxiety, and those diagnosed with anxiety were more likely to have hypertension (Levent et al., 2022; Pan et al., 2015). This study explored the impact of systemic barriers and racism experienced by Black people living with hypertension and anxiety when accessing and utilizing healthcare resources in the GTA. In this chapter, the researcher will delve deeper into these findings that will emphasize and contribute to the greater need for policy and practice changes.

The findings from this study provided rich, valuable data from the lived experiences of Black people living with hypertension and anxiety that allowed the researcher to describe and interpret this phenomenon. This chapter will provide a detailed discussion that will include and contribute to the existing body of literature. Through this discussion, the researcher aims to highlight the health inequities and health disparities that exist for Black people in the GTA. The main themes to be discussed are self-determination, racism as a barrier to care, dismissiveness of care needs, and gatekeeping. Additionally, the researcher will discuss recommendations aimed at empowering Black people living with hypertension and anxiety to improve their access to care, as well as recommendations to decision-makers to improve access to care for Black people.

**Figure 2.**

*A conceptual framework for the study of internalized racism (IR) and health*



Source: James, D. (2022). An initial framework for the study of internalized racism and health: Internalized racism as a racism-induced identity threat response. Social and Personality Psychology Compass. P

### Self-Determination

The participants in this study frequently shared experiences that demonstrated self-determination using various skill set and behaviours. They talked about self-advocacy, self awareness, informed decision making and the right to autonomy. At appointments, they asked pertinent questions regarding their diagnosis, seeking a second opinion, and conducting their own research to find answers. Some participants talked about having to request follow-up assessments or taking the initiative to suggest a change in treatment plan.

Self-determination is a necessary skill and resource for Black people in health care because it can result in better health outcomes for individuals. On the contrary, self-advocacy in healthcare by Black people has been linked to provider biases. Fernandez et al. (2024) found that 48% of healthcare workers surveyed reported that medical providers were more accepting of self-advocacy efforts from White people in comparison to Black people. Gainsburg et al. (2022) found that when patients did not self-advocate, the care providers' implicit racial biases were activated, resulting in poorer treatment for Black people. However, when patients were trained on how to self-advocate, they had better-perceived interactions with the care provider. Systemic racism has positioned Black people to receive unfair treatment regardless of whether they speak up. The findings from this study are consistent with previously reported literature about the health inequities that exist in the Black community. In this study, participants were not directly asked if they believed self-determination was a barrier to receiving care. However, many participants shared their experiences of getting pushback or not being taken seriously when advocating for themselves. Several participants shared their observations regarding the disparity of treatment towards Black people in a healthcare setting based on race, which is a social construct (Delgado & Stefanic, 2017). Black people are often dismissed in healthcare due to all three levels of racism, resulting in emotional distress. This emotional distress may trigger the SIISR, which activates the GSR, to be further discussed in the sections below.

### *Utilizing Family/ Self as a Healthcare Resource*

The findings revealed that several participants consulted with family members who are healthcare providers to seek additional health advice following interactions with their primary care providers. Some participants also reported having to utilize their healthcare knowledge to ensure they received optimal care. The undertone used by some of these participants was doubt and a lack of confidence in their primary care provider, which promoted the need for external confirmation. Similar to these findings, previous research has revealed that patients often seek factual information or recommendations from family members because of shared or similar experiences and trust (Academy of Medical Sciences, 2016). This could possibly be linked to the voice of colour thesis, stating that people of colour share similar experiences of oppression (Delgado & Stefanic, 2017). Additionally, the interactions with family would be a much more pleasant, validating and warmer experience compared to the reports of participants of not being viewed as a human.

Consulting with family as a healthcare resource could be seen as family-centered care (FCC). FCC allows for whoever the patient has determined to be family to be included in the decision-making process. The Registered Nurses Association of Ontario (RNAO) has listed improved health outcomes as a benefit to FCC (2015). Family members who are healthcare providers possess the skills needed to provide guidance that can aid in self-determination, and the decision-making process. Although these family members serve as a tremendous resource, Eastwood (2009) reports that there needs to be boundaries in place to prevent ethical and legal implications. In this study, one participant, ID99901, reported, “I do have a cousin who's a doctor…she's busy and I don't want to burden her asking too many questions all the time”. This participant demonstrated empathy and respect for personal boundaries. The findings in this study are consistent with previous literature, suggesting that patients often trust the information provided to them by their family and friends.

### *Probing for Information*

In this study, participants frequently reported that they had to probe the doctor for additional information or seek information from outside of the primary care provider (Table 7). Some Black people are actively seeking the help that they need, but they are not receiving it. Previous studies have reported that these events lead to a decrease in access and utilization of healthcare services (Cuevas et al., 2016). As previously discussed, many care providers are not invested in the health of Black people because of their PMR. PMR results in implicit biases that have a direct impact on how care is delivered, and as a result, many care providers may intentionally or unintentionally withhold information from Black patients. Withholding of vital information, such as health teaching or referrals, can have a devastating and lasting effect on the health of Black people. The findings from this study are consistent with previous reports that White physicians aren't as involved in the care of Black people when compared to their White counterparts (Thomas, 2023).

Communication has a direct impact on patient care outcomes. Poor communication in patient care can lead to decreased patient satisfaction and serious health inequities and disparities for Black people (Cuevas et al., 2016). When slavery ended, the White elites were no longer able to legally profit from Black people, resulting in what can be described as differential racialization. Due to the lack of direct benefits for White care providers, many of them have zero urgency or concern to address the health inequities and disparities through communication that are present in the Black community. As a result, physicians spending as little time communicating with Black patients continues to be a trend (Gonzalez et al., 2024). In fact, the biases held and discrimination displayed against Black people are severely rooted in systemic racism and are upheld by the anti-Black policies and procedures that exist today (Javed et al., 2022). Jones (2000) stated that the power to decide, act, or control resources is held by the government, and when the White corporate and business sector controls the economic resources that fund the public healthcare system in Canada, this power remains with them (Raphael, 2015 as reported in Bryant & Raphael, 2020). To maintain the status quo, it is easier to take a colour-blind approach and ignore the inequities, such as communication, that exist between Black and White people.

Adults with hypertension are more likely to have anxiety, and those with anxiety are more likely to have hypertension (Levent et al., 2022; Pan et al., 2015). Anxiety is an independent risk factor for incident hypertension, and it has been suggested that anxiety is a barrier to the treatment or lifestyle modification of hypertension (Pan et al., 2015). It has been previously discussed that unpleasant experiences, such as probing for information, time constraints, can increase emotional distress that results in physiological and psychological distress in the body, which is counterintuitive to Black seeking care.

### *Remaining Silent*

The results of this study revealed that Black people choose to remain silent for varying reasons that can be linked to culture or societal stigma. IR is present when Black people choose to internalize and accept the labels, negative views, beliefs, and attitudes placed upon them about themselves, their own racial or ethnic group by the dominant White society, and therefore, remaining silent can be perceived as an outcome to racism, and the direct impact it may have. While the researcher used the IR tool to gain deeper understanding of racism, this concept of internalized racism itself has not been well studied in Black people when accessing and utilizing healthcare for their hypertension and anxiety, and further research is needed to fully understand its implications. As mentioned earlier, Black people choosing to remain silent illustrates the voices of oppression that remain in society that stigmatize and marginalize Black people. This White voice of oppression create the narrative that hypertension is common in the Black community and therefore Black people no longer have the right to self-determination when it comes to being given adequate and credible information and resources to participate in the informed decision-making process about their health.

Many Black people's voices have been silenced and invalidated so they accept both societal and cultural stigma placed upon them. The result of remaining silent can have a psychological and or biophysiological response that manifest as maladaptive coping behaviours that can negatively impact the health outcomes of Black people. These health outcomes may present as increase morbidity and mortality rates, poorer quality of life or chronic diseases (James, 2022).

## Racism as a Barrier to Care

The majority of the patients in this study reported that racism is a direct barrier to receiving equitable treatment. An extensive body of research has reported findings similar to this study. Banerjee et al. (2021) found racial biases and inequities among heart failure specialists, who were more likely to consider a Black man at risk for non-adherence to treatment. Kogan et al. (2022) reported that racism and microaggression had a positive association with a high prevalence of anxiety in Black people. The experiences shared by the participants in this study contribute to a growing body of research that continues to report the detrimental effects of racism on the health of Black people living with hypertension and anxiety.

### *Systemic Barriers*

In this study, participants frequently shared their experiences with differential access to information, services, and opportunities. The differential treatment of Black people because of their race was manifested as acts of omission in providing pertinent health education, control of resources, poor communication, and an attempt to diminish the self-determination of black people. These experiences have been linked to chronic diseases and elevated rates of anxiety and hypertension in the Black community (Banerjee et al., 2021; Kogan et al, 2022; Mensah, 2018; Raphael et al., 2020; Veenstra & Patterson, 2016). Anxiety and stress are both psychological and emotional experiences that have been linked to Black people experiencing racism. They are both modifiable risk factors for Black people developing and managing hypertension. Assumption 1, that systemic racism has a direct impact on Black people's accessibility and utilization of healthcare resources for hypertension and anxiety has been evidenced in this study based on the data in Table 10. While the Canada Health Act aims to protect, promote and restore the physical and mental well-being of all residents, many Black Canadians have not experienced this promise equally because systemic bias and inequities in healthcare have often led to inadequate care and worsened health outcomes. The systemic barriers experienced by Black people are a direct consequence of normative practices that contribute to a colour-blind approach when implementing health policies. Interest convergence and the marginalization of Black people all manifest as health disparities in the Black community. The underlying structure of all the themes generated in this study has been linked to systemic racism, PMR, or IR. This is consistent with previous literature. Jones (2000) believes that to cure PMR and IR, the root of systemic racism must be addressed. Finally, Systemic racism needs to be dismantled at the root while rebuilding the foundation with anti-Black racist policies.

### *Racism and Institutionalized Racism*

The study recognized that IR can be a perceived barrier to access to care for hypertension and anxiety has been explored in this study. Many participants in this study did not experience this as a barrier to care, but shared stories of how it shows up in the lives of others they know. Some demographic data not collected on the demographic survey was shared during the interviews, such as the fact that many of the participants in this study were born in the Caribbean. Their Caribbean-born identity appears to be a protective mechanism against IR compared to some of their Canadian-born counterparts. These findings are similar to those of Mouzon & McLean (2017), who reported less psychological discomfort in Caribbean-born Americans. It appears that some Black people are unaware of the different ways IR shows up in them. IR has been identified in the maladaptive self-care behaviours some participants engaged in, and the choice to remain silent. Previous studies have reported that perceived racism negatively impacts the health outcomes of Black people.

In this study, the IROS did not reveal any significant levels of IR within the participants; however, IR was observed when some participants talked about just passively accepting the information given to them by the care provider. Some participants, on their own after verbalizing these experiences, came to the realization that they do embody some level of IR. Some participants initially denied having any experiences with IR, but as they continued to dialogue and share their past experiences, it was uncovered that they've all had some encounter with IR amongst family or friends. Cénat et al. (2024) found that 65.33% of participants between the ages of 25-40 experienced low self-esteem when compared to those aged 15-24 years old in the presence of racial discrimination. The demographic findings from this study revealed that 70% (n=7) of the participants were between the ages of 30 and 50. As discussed earlier from a previous study, when participants did not actively engage in self-determination, the physician's implicit racial biases were activated, resulting in what can be termed an unpleasant experience. These unpleasant experiences can activate the SIISR, leading to the GSR, which can result in maladaptive behaviours such as consuming too much alcohol or decreasing use of the health system (James, 2022). The findings suggest that many Black people may be engaging in maladaptive behaviours resulting from IR but are unaware of the phenomenon or lack the vocabulary to describe the occurrence. Assumption 2 was not found to have a direct impact on Black people's decision to engage with healthcare resources. Further research is required to continue exploring the impact of IR on Black people's access and utilization of healthcare resources.

This study did not assess the rationale behind the use of alcohol consumption, but 60% (n=6) of participants consumed alcohol at least once within the past seven days of participating in this study, with one participant consuming six drinks within the week. The H-SCALE revealed that 50% (n=5) of participants were non-adherent to taking their antihypertensive medications, 50% (n=5) consumed a low-quality diet, 60% (n=6) were non-adherent to physical activity, and 70% (n=7) were non-adherent to good weight management practices (Table 3). For people living with hypertension and anxiety, these behaviours can be viewed as maladaptive, but before placing blame, it is important to explore and understand the meaning behind these behaviours.

Several participants in this study believed that there are no programs or facilities designed with Black people as the target audience because of their belief that the government does not care. This ideology can directly impact their choice to access and utilize care because if one believes the service does not exist, they will not seek it out. On the contrary, they may access the programs and perceive that there is systemic racism or PMR, but in fact, it could be IR that becomes the barrier to quality care. The findings from this study are similar to previous literature reporting that racial discrimination has been linked to a poor coping mechanism that may results in unhealthy lifestyle choices such as alcohol use, non-adherence to treatment plans, or limited interaction with the healthcare system due to access barriers or fear of ill-treatment (Javed et al., 2022; Raphael et al., 2020; Bambra et al., 2020).

### Dismissiveness of Care Needs

Hypertension is a public health concern and a modifiable risk factor for developing cardiovascular disease. For Black people, they are being diagnosed at a younger age, and it has been reported to be more prevalent and fatal for this group (CDC, 2024; Hypertension Canada, 2017; Veenstra & Patterson, 2016). This is a crisis in the Black community because of the structures of racism that exist today. The anti-Black policies that have been created are present and embedded into the structures of society today as procedures and practices that continue to disadvantage the lives of Black people. In healthcare, some of these ordinary practices show up as dehumanizing and dismissing the care needs of Black people. Systemic racism is fundamental and must be addressed for important downstream changes (Jones, 2000). In this study, participants repeatedly shared experiences of their acute health care needs being ignored by their care provider. This finding is consistent with other reports stating that when barriers such as these exist patients are less likely to follow their treatment plans that could result in adverse health outcomes.

### *Dehumanization of Black People*

In this study, participants recounted many experiences that left them feeling dehumanized. When describing some of their encounters, participants used phrases like “brush us off”, “being viewed as a human”, “there is no connection”, “demeaning” and “you are only human” when referring to how they were made to feel when obtaining care (Table 12). In the matter of interest convergence, there is no direct benefit to some White physicians to acknowledge the care needs of Black people through time or communication, because if they do, it increases their workload and reduces the time available to spend with their patients of the same race. A White-maintained oppressive state keeps Black people uninformed and sicker, with increased mortality rates (Feagin, 2006). This White-maintained oppressive state can activate a harmful psychological and physiological effect that creates a complex cycle of hypertension and anxiety relationship (Levent et al., 2022; Pan et al., 2015; James, 2022). Similarly, to the findings in this study, there are many historical and current healthcare studies that have made Black people feel dehumanized such as the “Negro Project” and “Tuskegee Experiments” (Delgado & Stefanic, 2017). In a recent report published by the Care Quality Commission (2024), there was an overrepresentation of Black people on mental health forms at a rate of 3.5% when compared to White people. These findings are similar to other reports that White people view Black people as dangerous and aggressive in society (Bambra et al., 2020). In 2021, two studies reported that Black people were found to have increased wait times in the ED when compared to their White counterparts (Abdulai et al., 2022; Banerjee et al. 2021;).

### *Black People as Complainers*

Boakye et al. (2024) found medical gaslighting to be present in a recent study completed amongst Black pregnant women in Canada when reporting symptoms such as pain during pregnancy or childbirth. Patients were made to feel devalued and uncertain of their own painful experiences by the care providers because these women did not always have the medical knowledge to describe the acute episode. Similarly, in this study, participants frequently shared experiences of being dismissed and viewed as complainers. One participant, ID36007, shared their experience of what they called near death, and another participant, ID97466, talked about being labeled as lazy when seeking help for mental health services (Table 14). The White framing of systemic racism in healthcare is manifested as implicit bias from healthcare providers that misdiagnose or underdiagnose Black people, inappropriate treatment interventions, ignore their concerns, and make assumptions (Feagin & Bennefield, 2014). Participants in this study talked about care providers making assumptions instead of assessing and analyzing the root cause of the symptoms they are experiencing.

Intersectionality is another theory that can be used to examine some of these experiences reported in this study.  One participant, ID61336, shared her experience, stating, “Because I'm Black, they are not listening to me. And probably the weight. And I'm not really a fat person”. This can be broken down to the fact that this participant is single, Black, a woman with a low-income status, who perceives herself as overweight, and as a result of these intersections, her care needs are being dismissed. Another example is participant ID97466, who, when seeking care for mental health services, was told to “figure it out”. The intersection of this story is a young, Black, male university student struggling to adapt to his new environment, who was called lazy and told to figure it out. This participant continued to advocate for themselves and was later diagnosed with social anxiety.

## Gatekeeping

The final result to be discussed is gatekeeping. The findings of this study reveal that racial biases and discrimination from White healthcare providers is an attempt to maintain power, unearned privilege, structural barriers and control of healthcare resources. Healthcare providers did not readily make recommendations to see a specialist when required, provide health teaching, or share information for community support that could bridge the knowledge gap for some of these participants. Participants often felt confused about why they were not granted the same access to resources as their White counterparts (Tables 14 & 15). One participant ID75332 stated, “Give access to those resources. I don't know. But I haven't been given the resources. Like I said, I have to self-educate”. Gatekeeping access to resources can significantly impact the health outcomes of Black people because it negatively affects their ability to engage in self-management of their chronic diseases. Several participants expressed frustrations of having to request additional assessments or referrals. A study by Banerjee et al. (2021) found that Black people were less likely to receive an AICD implantation, although it is considered a class 1 treatment following a cardiac arrest. Similarly, in a study by Schut (2022), the author found that incidental findings in Black patients were not communicated promptly if the provider believed the patient would not pursue adequate care. Ray (2022) found that implicit racial biases were a key factor in the treatment of pain and symptom management and higher rates of limb amputation in Black people. Gatekeeping impact health literacy and causes harm to Black. Additionally, it can negatively impact the patient-provider relationship, resulting in dissatisfaction, mistrust or limited interactions with the healthcare system.

### *Limited Access to Medical Education*

Health teaching is a necessary resource to achieve optimal health. It fosters trust and empowers individuals with the knowledge to assist with informed decision-making, improved patient engagement, and adherence to treatment recommendations (RNAO, 2012). In this study, the findings reveal that most of the patients did not receive health teachings, and the ones that did considered it to be very basic (Table 14). Only one participant, ID97484, reported being happy with the education they received. The participants identified representation and cultural competence as key factors in the quality of education and the provider-patient relationship. Participants often shared experiences of doing their own research to gain further knowledge. All the participants in this study reported being prescribed medication for their hypertension, but none of these participants were ever given education about the medications. The findings from this study are consistent with previous studies that reported Black people were less likely to receive health teaching due to physicians' implicit racial biases (Gainsburg et al., 2022; Gonzalez et al., 2024). Findings from the demographic data reveal that 90% of patients had higher than a high school education, which possibly contributed to their health literacy in acquiring further knowledge about their hypertension and anxiety diagnosis. Veenstra & Patterson (2016) found that hypertension was more prevalent and lethal amongst Black Canadians than Whites due to racism; additionally, CAMH (2025a) reported that having a diagnosis like anxiety contributes to premature death. These findings emphasize the critical state of the health of some people living in the Black community, and this requires chronic disease health teaching to be provided to Black patients regardless of whether the teacher has anything to gain.

### *Limited Awareness of Heath Resources*

Limited awareness of health resources was evident in several stories shared by the participants. Many participants were not made aware of resources available in their communities to assist with managing their hypertension and anxiety. Differential access to health information, services and resources creates a health disparity in the Black community around hypertension and anxiety as a diagnosis. The limited awareness of health resources can often be misrepresented by White-framing as a lack of concern or education in Black people. Many participants in this study explicitly stated the lack of awareness was a barrier to access. If Black people are unable to access the resources they will not be able to utilize the services to manage or improve their quality of life or chronic diseases. This study findings revealed that systemic racism limits self-determination in the Black community. When Black patients do not have the required information, their right to autonomy and informed decision is restricted. Olukotun et al, (2024) found that regardless of socio-demographic background, Black women experienced similar systemic barriers with navigating the healthcare system leading to reduced awareness of resources. In this study, participant ID99901, married female with a graduate degree stated “I guess I just don't know, even though it feels like I spent my whole waking hours locked into some kind of device and I still don't know stuff." This finding is similar to those of Olukotun et al., in 2024.

### Study Limitations and Strengths

Several limitations were identified in this research study. After receiving the REB approval, the original therapist became unresponsive to the researchers attempt to notify them of the approval. An amendment was made to use Dr. Rasha Wahid as a contact in the event the participants experienced adverse psychological symptoms. Additionally, the study recruitment method had to be amended because of the challenges experienced with recruiting from the family physician's office. The posters were posted for approximately four to six months, and there was no expression of interest from patients visiting the office. Due to the commute distance from the researcher's home to the site, actively recruiting on-site was not feasible. An amendment to the study method could have been requested sooner, or both options could have been incorporated at the start. The demographic data or scales used did not measure the impact of stress or self-care behaviours in the participants' lives. This is a limitation because several participants mentioned stress being a direct link to their hypertension diagnosis, and this data was unmeasured. Exploratory questions regarding self-care behaviours, such as drinking alcohol, were not explored to identify the reasons why participants engaged in these behaviours despite their medical diagnosis.

The IROS was ineffective for measuring IR in how participants choose to access and use healthcare resources. This scale included the five dimensions originally tested by the authors instead of four. Upon validation, Bailey et al., (2011) removed a subscale due to its weakness but the 28-question subscale has not been published. Several participants experienced some life events that they shared were distracting during the interview, such as a neighbourhood shoot, witnessing a subway suicide, and a dead car battery. The researcher offered to reschedule, but the participants wanted to continue the interview. There were some technology challenges with the internet and connecting to ZOOM. The final limitation is the researchers' interview skills. The researcher did not ask as many probing questions for fear that they would become leading questions and affect the data integrity. Some participants' responses could have been probed more when the data, audio, and transcripts were reviewed.

This study explored the experiences of Black people living within the GTA. It may not be generalizable to other minority groups since Black people experience more everyday racism compared to any other minority group. A higher or more diverse sample size would have possibly given more diversity to the experiences of IR.

To the best of the researcher's knowledge, this is the first study in Canada to explore the impact of IR and systemic racism on Black people when accessing care for hypertension and anxiety. The results of this study confirm that racism has an impact on access and utilization of healthcare resources. The framework for IR helped identify the pathways that lead to chronic diseases and maladaptive behaviours, as reported in this study. Further education is needed for Black people on how to not only recognize systemic racism but also IR and how to dismantle it within themselves. This study highlighted a key finding: culture is a precursor and protective mechanism for IR. However, future study recommendations can seek to assess the level of racism present when Black people access and utilize programs or care that have been designed for them. The levels of racism need to be explored to determine if Black people are experiencing IR, PMR, or both. Researchers are encouraged to explore IR in Canadian-born Blacks further when compared to Black Canadians born outside of Canada.

## Implications for Nursing Practice

Nurses are in a unique position that allows them to provide care in various settings. Nurses should consider working in primary care, as this will allow them to address some of the care needs and barriers for Black people. The findings from the study offer detailed insight into how nursing practice can better support Black people when seeking care for hypertension and anxiety. This study identified several gaps, including self-determination, racism as a barrier to care, dismissiveness of care needs, and gatekeeping of health information and resources.

To address self-determination and racism as a barrier to care, it is recommended for nurses to utilize the RNAO ‘s Best Practice Guideline (BPG) on Facilitating Client-Centred Learning. In this BPG, it is recommended that nurses establish a therapeutic relationship with clients and engage in collaborative care when assessing their learning needs and preferences while promoting health literacy (RNAO, 2012). Through health literacy, nurses can assist clients in building their capacity to engage in self-management behaviours to improve health outcomes. Nurses are required to provide clear and timely information (College of Nurses of Ontario, 2024). Additionally, it is recommended that nurses encourage their patients to empower themselves with the knowledge, tools, and resources to engage in self-determination behaviors. Self-determination is a learnable and teachable skill set that can empowers Black people to lead their own life with confidence and dignity.

Additionally, the College of Nurses of Ontario (CNO) recommends that nurses engage in culturally competent care, it is an important part of patient-centered care (2024). This study highlights some of the key cultural norms and values surrounding Black people when engaging with healthcare services to support this community. Nurses can raise awareness and provide education to Black people about the dangers of IR because the findings revealed that there is a knowledge gap in this area. It is recommended that nurses develop culturally focused educational programs that specifically target hypertension and the management of diet, stress, physical activity, weight management, and supporting good mental health. A culturally focused program can help to identify treatment barriers and promote adherence (Meinema et al., 2015). Nurses are also required to be patient advocates and, therefore, should engage in the development of anti-Black racism policies to support the dismantling of systemic racism in practice

## Recommendations for Service Access to Care for Black People

The findings from the study highlight several key areas of disparities and areas of improvement for decision makers. The inequities uncovered directly impact the health outcomes of Black people in the GTA. Several bodies of research have recommended that addressing some of the biases and discrimination that exist within healthcare requires education, culturally competent care providers, collaboration, diversity in cardiology, anti-Black racism policy's and a shift towards viewing the SDOH as a contributor to adverse health outcomes (Banerjee et al., 2021; Javed et al., 2022; Raphael et al., 2020). The recommendations categorized below are reported from participant and researcher feedback.

### *Community Safe Spaces*

Black people within the GTA are looking for safe spaces where they can access healthcare resources surrounded by people who share similar experiences and racial identities. These spaces can include but are not limited to fitness circles, talk therapy circles, and affordable mental health counselling. When creating these safe spaces, policymakers must remove the existing disparities that prevent services from being accessible to those in need. Several participants have recommended making centres more geographically accessible across the GTA. Participants encouraged awareness campaigns to promote these programs within the Black community to reduce care provider biases. Previous studies, like Kogan et al. (2022), found that having community support acted as a buffer when dealing with overt racism, and having a social support system in the community buffered the effects of microaggression. The RNAO recommends collecting continuous feedback to make improvements (2015).

### *Collaborative Care*

The second recommendation is to engage in collaborative care. Black people would like to be active participants in making decisions about their health. They would like to be appropriately assessed to identify the root causes of their presenting symptoms and/or comorbidities. They would like individualized treatment plans, not just generalized ones across mixed and within ethnicities. In the

Person-and Family-Centered Care BPG, recommendations 2.1 and 2.1 are to partner with the person to facilitate goal setting and decision making (RNAO, 2015). To address limited knowledge and improve communication patterns, Black people are recommending that more awareness campaigns talk about the risk factors for developing hypertension, the adverse effects of living with undiagnosed and untreated hypertension in Black people. Moreover, the study findings revealed that some individuals living with hypertension do not fully understand the scope of their diagnosis, and further education is required to remain adherent to treatment recommendations. It has been reported that hypertension rates can decrease with education and self-management behaviours (Connell et al., 2008).

### *Representation*

The final recommendation is for the representation of Black people at the systems level. Black people need to engage in developing anti-Black racism policies that remove the existing inequities in place for Black people. Additionally, more Black therapists and social workers should be available who can engage in culturally competent mental health care to remove some of the stigma and barriers that exist for Black people when seeking care. Additionally, representation at the physician level is important to ensure adequate communication and referrals, which are important to ensure adequate communication, referrals, and treatment available to Black people. This study recommends that mental health providers consider these results when providing care because of the IR associated with cultural stigma that is attached to mental illness. Culturally competent education should be mandatory and provided to all healthcare providers. Kinbb-Lamouche (2012) states that a lack of culturally sensitive care “can affect the ability of health professionals to assist their clients or patients in achieving optimal health”.

## Recommendations for Patients Living with Hypertension and Anxiety

### *Self Determination*

The first recommendation for patients living with hypertension and anxiety is for self-determination. Patients are encouraged to engage in self-determination practices such as, speaking up and asking questions. They are encouraged to join support groups and speak with families and friends to empower themselves with knowledge. Patients are encouraged to be assertive, take up space, and not allow the existing barriers to give up on themselves. Gainsburg et al. (2022) found that when patients were taught the skills required to advocate for themselves, it reduced the effects of implicit bias from the provider. Additionally, patients are encouraged to take a trusted friend or family member to their doctors' appointments to be able to listen and ask questions on their behalf when needed.

### *Lifestyle Changes*

The second recommendation is for lifestyle changes. Culturally, Black people enjoy the taste of flavours and spices; however, they are encouraged to find alternative options and substitutions for healthier meal choices. If patients are overweight, they are encouraged to exercise and lose weight. One participant shared that they must become intentional about small habits, such as choosing alternative food choices, meal prepping, and consistency. Patients are encouraged to limit behaviors that may worsen their health outcomes, such as drinking alcohol and smoking.

### *Seek out Knowledge*

The final recommendation is for patients to seek out knowledge and educational resources. They are also encouraged to utilize their support network, which has proven to be an effective way for Black people living with chronic diseases to cope. Patients are also encouraged to use their support network as an outlet to manage everyday stressors and share encouragement with each other. One participant shared, "People who don't talk or they don't know they have struggles."

## Chapter 6: Conclusion

This qualitative study provides valuable insight into the complexities of Black people's lives when accessing and utilizing the healthcare system in the GTA for hypertension and anxiety. The study employed existential phenomenology to understand the participants lived experiences, and the participants' data were interpreted using the CRT and Levels of Racism Theoretical Framework.

The findings suggest that systemic and institutionalized racial inequities and disparities continue to impact the level of care that Black people receive directly. These significant findings are that Black people often have to self-advocate to receive better care, and they experience inadequate communication from their care provider, their care needs are repeatedly dismissed, and many lacks the knowledge they need to access additional community health resources.

The findings of systemic and institutionalized racism are consistent with previous literature; additionally, racism, was identified as an underlying factor that may have influenced how many of the participants interacted with the healthcare system, but it needs further exploration. A few key recommendations for decision-makers are to create community safe spaces for Black people, engage Black people in collaborative care, include representation of Black people in policy making and care, and implement mandatory cultural training for all healthcare providers. Despite the challenges experienced by these participants, they shared several recommendations to encourage others. Black people living with hypertension and anxiety are encouraged to participate in self-determination activities, make lifestyle changes, and seek out knowledge.

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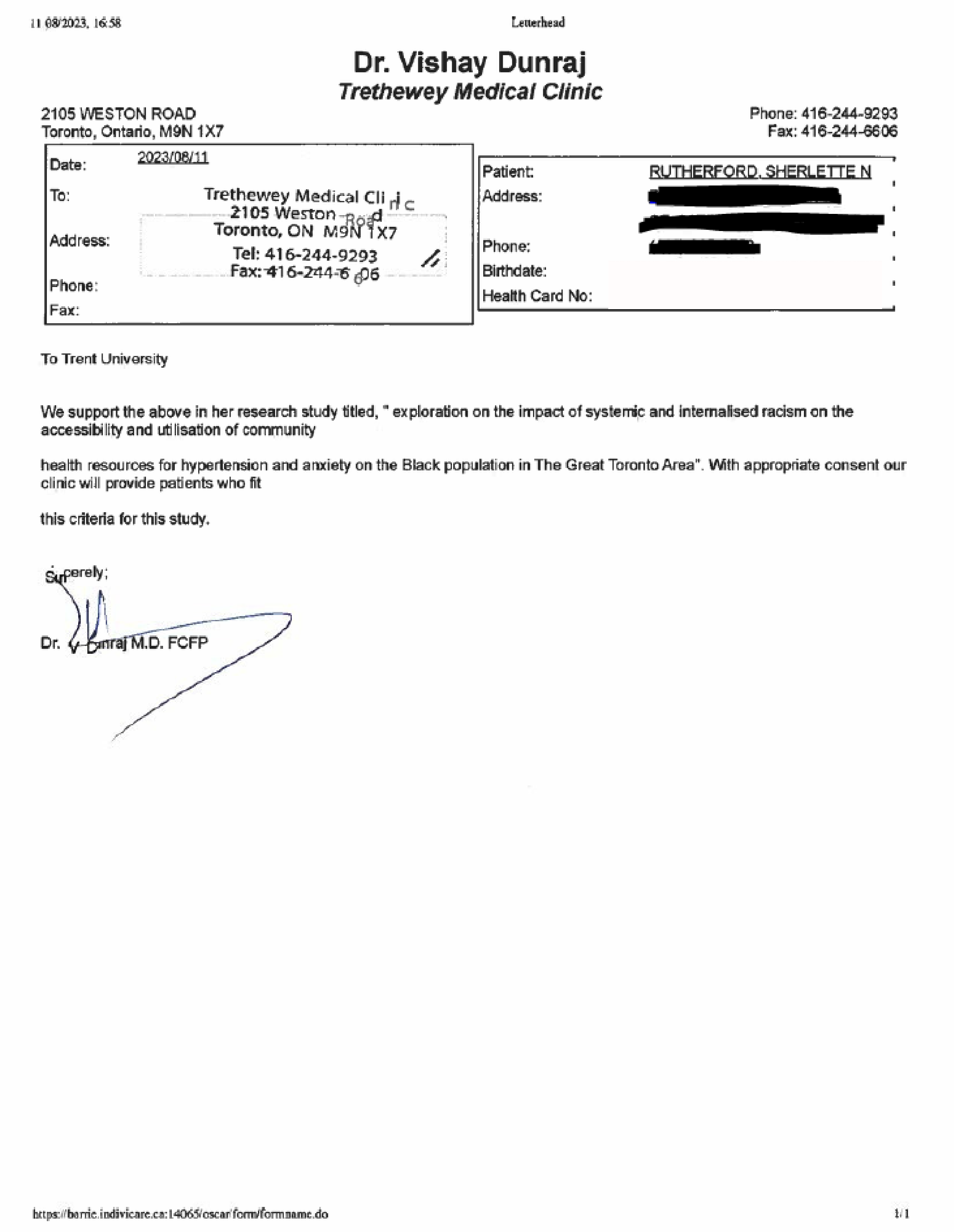
# Appendix A

| | | |
|---|---|---|
| **S** | Sample | Black people living with hypertension and anxiety |
| **P** | Phenomena of Interest | The association between IR and systemic racism on access and utilization |
| **I** | | |
| **D** | Design | Lived experiences |
| **E** | Evaluation | Black people's experiences |
| **R** | Research | Qualitative |

## Appendix B



11 08/2023, 16:58 Letterhead

**Dr. Vishay Dunraj**
*Trethewey Medical Clinic*
2105 WESTON ROAD
Toronto, Ontario, M9N 1X7
Phone: 416-244-9293
Fax: 416-244-6606

Date: 2023/08/11
To: Trethewey Medical Clinic
Address: 2105 Weston Road
Toronto, ON M9N 1X7
Tel: 416-244-9293
Fax: 416-244-6606
Phone:
Fax:

Patient: RUTHERFORD, SHERLETTE N
Address: [redacted]
Phone: [redacted]
Birthdate:
Health Card No:

To Trent University

We support the above in her research study titled, " exploration on the impact of systemic and internalised racism on the accessibility and utilisation of community

health resources for hypertension and anxiety on the Black population in The Great Toronto Area". With appropriate consent our clinic will provide patients who fit

this criteria for this study.

Sincerely;

Dr. V Dunraj M.D. FCFP

https://barrie.indivicare.ca:14065/oscar/form/formname.do 1/1

## Appendix C

### Version 1

TRENT UNIVERSITY

# RESEARCH STUDY

## Volunteers Needed

2105 Weston Rd, Toronto,
Ontario

**Compensation**

You will recieve $25 gift card

The purpose of this study is to explore the impact of systemic and internalized racism on the accessibility and utilization of community health resources for hypertension and anxiety for black people in the GTA.

**Participant Requirements:**

- ✓ Age 18+
- ✓ Diagnosis of hypertension
- ✓ Self identify as black
- ✓ Able to provide consent
- ✓ Available for a 1 hour interview
- ✓ Want to contribute to change

I will add here the REB approval by Trent U REB file #28556

**JOIN US NOW!**

**If you meet the requirements listed and are willing to volunteer your time for this study please email Sherletteruthertford@trentu.ca for more information.**

August 2023

**Version 2**

## RESEARCH STUDY

To explore the impact of systemic and internalized racism on Black people's accessibility and utilization of health resources for hypertension and anxiety in the Greater Toronto Area (GTA).

Are you over 18 years of age?

Do you idenitfy as a black person?

Are you able to provide Consent?

Do you have high blood pressure?

Do you have anxiety?

Do you have 90 minutes to talk?

If you have answered YES to all the above, we want you!

You will receive a $25 gift card

Call/ Text: 416-835-0753
or
Email: sherletterutherford@trentu.ca

Approved by the Trent University Research Ethics Board (REB)
REB file #28556

## Appendix D

## Interview Guide

**<u>RESEARCH TITLE</u>: The Impact of Systemic and Internalized Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA)**
REB file number (28556)

### Opening

(Smiling) Hello, thank you for joining me today. My name is Sherlette and I am a registered nurse enrolled in the Master of Nursing program at Trent University. I currently practice in acute care as a nurse educator, but I have prior community care experience. As previously discussed, I am researching the experiences of Black people living with hypertension and anxiety and how they access care within the Greater Toronto Area (GTA). This interview aims to discuss your care experiences that will provide the needed knowledge and understanding to advocate for improved access to care for people within the Black community.

This interview should take no more than 90 minutes of your time. If at any time I ask an unclear question, please feel free to ask for clarification. During the interview, I will be making notes in addition to recording only the audio portion of this interview. I also want to remind you that everything discussed here today will remain confidential. If you choose not to participate or withdraw, you can do so at any time without any negative implications for yourself or access to care. If you have further clarifying questions about the ethics of this interview, listed on your consent form is a contact information for the REB committee advocate.

You will be assigned a participant number to which you and all related documents will be referred by. The risk associated with this study is minimal; however, if you experience any emotional upset or discomfort because of this study, a psychotherapist, Dr. Rasha Wahid, will be accessible to you. Dr. Rasha's contact information can be found in the risk section on your consent form.

Let’s take a moment to review the participants' consent. (Allow 10 minutes for Sherlette to assign the participant's number, and provide a pen and participant consent form to be signed.)

Before we get started, do you have any additional questions for me?

### Body

I will now have you complete a short questionnaire that will provide me with some general background information about your medical diagnosis and age. (provide a questionnaire and allow 10 minutes for completion)

(Transition: Thank you for completing the questionnaire. We will now begin the interview. Just a friendly reminder, your participation in this study is completely voluntary and you may withdraw at any time. You may also choose not to answer questions if you prefer not. Please let me know if you need me to stop the interview at any time. The next several questions will focus on your hypertension diagnosis)

**Topic:** The Perception of hypertension diagnosis

1. Tell me your perception of living with hypertension?
2. How was your experience with the care or treatment you received from your healthcare provider? (probe where family physician, ED, satisfaction)
3. Can you share any challenges you may have in following your current treatment plan?

**If participant answers yes to question 18 ask question 4**

4. How was your experience with the counseling/ education you received from your healthcare provider?

**Ask question even if participant answers no to question 18**

5. Can you share any barriers you may have in accessing services for your hypertension? Eg. Awareness, referral, transportation, income etc

**Topic**: Understanding the correlation between hypertension and Anxiety

(Transition: the next set of questions will be specific to your mental health and your hypertension)

1. What is your understanding of the association between anxiety and hypertension?
2. How do you know you have anxiety?
3. What are some barriers you've identified that make it challenging to address concerns about your hypertension or anxiety when visiting the doctor?

**Topic:** Racism and access to care

(Transition: I am now going to ask you specific questions about racism and how it may affect access to care. Before I do, I will provide you with the definition to be used. If at any time during these questions you need me to pause or choose not to continue, please let me know.)

1. How do you perceive the effects of systemic racism on accessing resources for hypertension and anxiety?
2. Can you tell me about your experience with systemic racism?

(Transition: Thank you. I will now ask you some questions about internalized racism and access to care)

**The definition** to be used for internalized racial oppression is the "process by which Black people internalize and accept the dominant White culture's oppressive actions and beliefs toward Black people (e.g., negative stereotypes, discrimination, hatred, falsification of historical facts, racist doctrines, White supremacist ideology), while at the same time rejecting the African worldview and cultural motifs" (Bailey et al., 2011).

1. Can you tell me about your experience with internalized racism? This can be based on interactions with friends or family.
2. How do you perceive the effect of internalized racism on access to healthcare resources for hypertension and anxiety?

(Transition: Thank you. I will now ask you some questions about recommendations for service access improvement)

**Recommendations for service access improvement**

1. Can you share some recommendations to decision makers to improve access to care for Black people when seeking care for hypertension and anxiety?
2. Can you share some recommendations to patients like you living with hypertension and anxiety to improve their access to care?

**Closing**

Thank you for taking the time to participate in this research study. This information will be of great assistance in advocating for improved access to healthcare for Black people or similar. Once again, everything discussed here today will remain confidential. As a token for your participation, here is a $25 gift card you can use at your local grocery store. If you leave here and choose to withdraw from the study, please contact me at your earliest convenience. Your information will be removed from the study and destroyed.

## Appendix E

TRENT UNIVERSITY

### Demographic Quantitative Survey: Please Answer the Following Questions

**RESEARCH TITLE: The Impact of Systemic and Internalized Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA)**

REB file number (28556)

**1. Do you self-identify as a Black Canadian?**

☐ Yes
☐ No

**2. Have you been diagnosed with hypertension (high blood pressure)? This is blood pressure 140/90 or greater?**

☐ Yes
☐ No

**3. Do you remember your last blood pressure reading?**
**If yes, please record the reading and approximate date**

____________________

**4. Have you been diagnosed with anxiety?**

☐ Yes
☐ No

**5. Do you have any additional medical diagnosis? Please list.**

____________________

6. **What region do you live in?**

☐ Toronto
☐ Peel
☐ York
☐ Durham

☐ Halton
☐ Other (please specify) ___________

**7. What is your gender?**
☐ Male
☐ Female
☐ Transgender
☐ Other (please specify)
☐ I prefer not to say

**8. What is your age?**
☐ 18-29
☐ 30-39
☐ 40-49
☐ 50-60
☐ 60+
☐ I prefer not to say

9. **What is your employment status?**
☐ Full Time
☐ Part Time
☐ Retired
☐ Not Employed
☐ I Prefer not to say

**10. What is your marital status?**
☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed
☐ Other (please specify) ________
☐ I prefer not to say

**11. What is your level of education?**
☐ Highschool
☐ Less than high school
☐ University/ College
☐ Other ____________________

**12. What is your income?**
☐ Less than $50 197
☐ $50 197-100 392
☐ 100 392- 155 625

☐ 155 625+
☐ I prefer not to say

**13. What is your living status?**
☐ Rent
☐ Own
☐ Subtenant
☐ Other (please specify) _____________

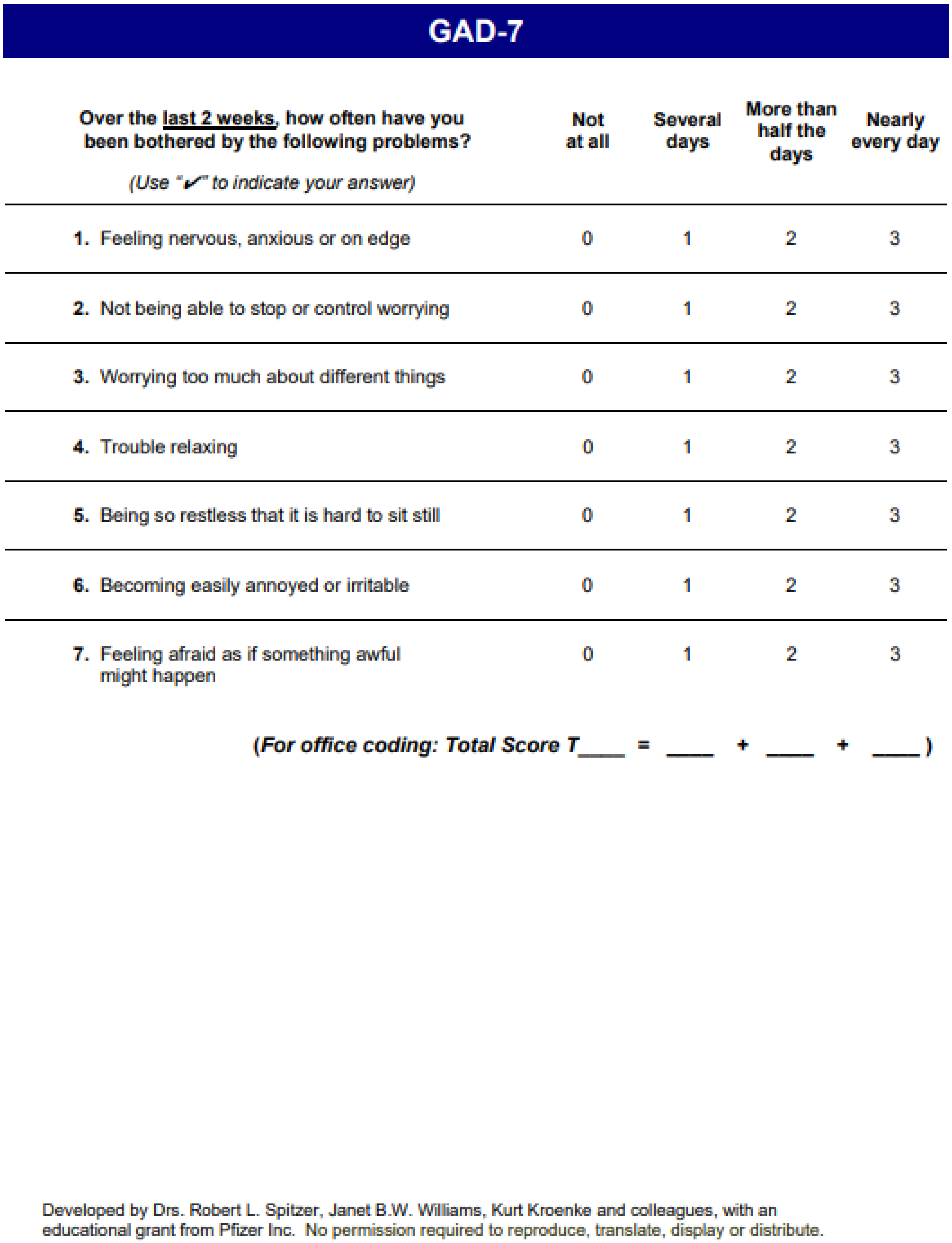
**14. Who shops for groceries in your home?**
☐ Self
☐ Other (please specify) __________
☐ I prefer not to say

**15. Who prepares the meals in your home?**
☐ Self
☐ Other (please specify) __________
☐ I Prefer not to say

**16. What community resources do you access for your health (for example; family physician, counseling services, community health centers, others – please specify)?**
**_____________________________________________________________________________**
**_____________________________________________________________________________**

**17. How often do you access community resources for your health?**
☐ Weekly
☐ 1-2 times per month
☐ Several times per year
☐ I don’t access resources for my health.

## Appendix F



### GAD-7

| Over the **last 2 weeks**, how often have you been bothered by the following problems?<br>*(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| **2.** Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| **3.** Worrying too much about different things | 0 | 1 | 2 | 3 |
| **4.** Trouble relaxing | 0 | 1 | 2 | 3 |
| **5.** Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| **6.** Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| **7.** Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

**(*For office coding: Total Score T____ = ____ + ____ + ____*)**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

## Appendix G

Participant Number: ___________________________ Date:______________________

| | |
|---|---|
| The following questions ask about your hypertension (high blood pressure) self-care activities during the past 7 days. For each question, <u>circle</u> the number of days that you performed that activity. | |
| ***<u>Medication Usage</u>***<br>***How many of the past 7 days did you:*** | **<u>Number of Days</u>** |
| 1. Take your blood pressure pills? | 0 1 2 3 4 5 6 7<br>☐ I have not been prescribed blood pressure pills. |
| 2. Take your blood pressure pills at the same time everyday? | 0 1 2 3 4 5 6 7<br>☐ I have not been prescribed blood pressure pills. |
| 3. Take the recommended number of blood pressure pills? | 0 1 2 3 4 5 6 7<br>☐ I have not been prescribed blood pressure pills. |
| ***<u>Diet</u>***<br>***How many of the past 7 days did you:*** | **<u>Number of Days</u>** |
| 4. Eat nuts or peanut butter? | 0 1 2 3 4 5 6 7<br>☐ I am allergic to nuts. |

| | |
|---|---|
| 5. Eat beans, peas, or lentils? | 0 1 2 3 4 5 6 7 |
| 6. Eat eggs? | 0 1 2 3 4 5 6 7 |
| 7. Eat pickles, olives, or other vegetables in brine? | 0 1 2 3 4 5 6 7 |
| 8. Eat five or more servings of fruits and vegetables? | 0 1 2 3 4 5 6 7 |
| 9. Eat more than one serving of fruit (fresh, frozen, canned or fruit juice)? | 0 1 2 3 4 5 6 7 |
| 10. Eat more than one serving of vegetables? | 0 1 2 3 4 5 6 7 |

| ***Diet***<br>***How many of the past 7 days did you:*** | **Number of Days** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 11. Drink milk (in a glass, with cereal, or in coffee, tea or cocoa)? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. Eat broccoli, collard greens, spinach, potatoes, squash or sweet potatoes? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. Eat apples, bananas, oranges, melon or raisins? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. Eat whole grain breads, cereals, grits, oatmeal or brown rice? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| ***Physical Activity***<br>***How many of the past 7 days did you:*** | **Number of Days** | | | | | | | |
| 15. Do at least 30 minutes total of physical activity? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. Do a specific exercise activity (such as swimming, walking, or biking) other than what you do around the house or as part of your work? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. Engage in weight lifting or strength training (other than what you do around the house or as part of your work)? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. Do any repeated heavy lifting or pushing/pulling of heavy items either for your job or around the house or garden? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| ***Smoking***<br>***How many of the past 7 days did you:*** | **Number of Days** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 19. Smoke a cigarette, e-cigarette, vape, cigar or hookah, even just one puff? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. Stay in a room or ride in an enclosed vehicle while someone was smoking? | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

The following questions ask about your efforts to manage your weight during the last 30 days. If you were sick during the past month, please think back to the previous month that you were not sick. Circle the one answer that best describes what you do to lose weight or maintain your weight.

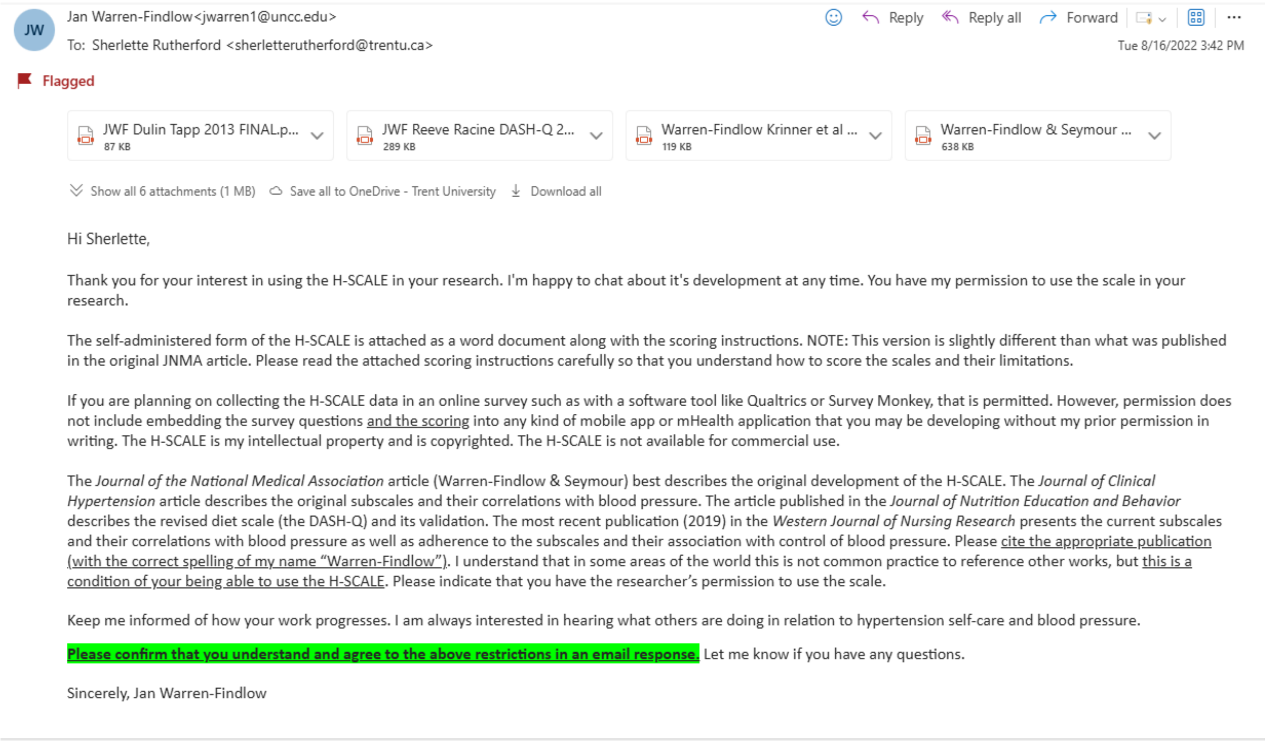
| ***Weight management***<br>***In order to lose weight or maintain my weight…*** | **Strongly Disagree** | **Disagree** | **Not Sure** | **Agree** | **Strongly Agree** |
|---|---|---|---|---|---|
| 21. I am careful about what I eat. | 1 | 2 | 3 | 4 | 5 |
| 22. I read food labels when I grocery shop. | 1 | 2 | 3 | 4 | 5 |
| 23. I exercise in order to lose or maintain weight. | 1 | 2 | 3 | 4 | 5 |
| 24. I have cut out drinking sugary sodas and sweet tea. | 1 | 2 | 3 | 4 | 5 |

| | |
|---|---|
| 25. I eat smaller portions or eat fewer portions. | 1 2 3 4 5 |
| 26. I have stopped buying or bringing unhealthy foods into my home. | 1 2 3 4 5 |
| 27. I have cut out or limit some foods that I like but that are not good for me. | 1 2 3 4 5 |
| 28. I eat at restaurants or fast food places less often. | 1 2 3 4 5 |
| 29. I substitute healthier foods for things that I used to eat. | 1 2 3 4 5 |
| 30. I have modified my recipes when I cook. | 1 2 3 4 5 |
| ***The next three questions are about alcohol consumption. A drink of alcohol is defined as:***<br>***One, 12 oz. can or bottle of beer;***<br>***One, 4 ounce glass of wine;***<br>***One, 12 oz. can or bottle of wine cooler;***<br>***One mixed drink or cocktail;***<br>***Or 1 shot of hard liquor.*** | |
| 31. On average, how many days per week do you drink alcohol? | 0 1 2 3 4 5 6 7 |
| | |

| | |
|---|---|
| 32. On a typical day that you drink alcohol, how many drinks do you have? | 0 write in # ___________ |
| 33. What is the largest number of drinks that you've had on any given day within the last month? | 0 write in # ___________ |

Thank you for your time. Your participation is very important to us.

# Appendix H



Jan Warren-Findlow<jwarren1@uncc.edu>

To: Sherlette Rutherford <sherletterutherford@trentu.ca>

Tue 8/16/2022 3:42 PM

Hi Sherlette,

Thank you for your interest in using the H-SCALE in your research. I'm happy to chat about it's development at any time. You have my permission to use the scale in your research.

The self-administered form of the H-SCALE is attached as a word document along with the scoring instructions. NOTE: This version is slightly different than what was published in the original JNMA article. Please read the attached scoring instructions carefully so that you understand how to score the scales and their limitations.

If you are planning on collecting the H-SCALE data in an online survey such as with a software tool like Qualtrics or Survey Monkey, that is permitted. However, permission does not include embedding the survey questions and the scoring into any kind of mobile app or mHealth application that you may be developing without my prior permission in writing. The H-SCALE is my intellectual property and is copyrighted. The H-SCALE is not available for commercial use.

The *Journal of the National Medical Association* article (Warren-Findlow & Seymour) best describes the original development of the H-SCALE. The *Journal of Clinical Hypertension* article describes the original subscales and their correlations with blood pressure. The article published in the *Journal of Nutrition Education and Behavior* describes the revised diet scale (the DASH-Q) and its validation. The most recent publication (2019) in the *Western Journal of Nursing Research* presents the current subscales and their correlations with blood pressure as well as adherence to the subscales and their association with control of blood pressure. Please cite the appropriate publication (with the correct spelling of my name “Warren-Findlow”). I understand that in some areas of the world this is not common practice to reference other works, but this is a condition of your being able to use the H-SCALE. Please indicate that you have the researcher’s permission to use the scale.

Keep me informed of how your work progresses. I am always interested in hearing what others are doing in relation to hypertension self-care and blood pressure.

**Please confirm that you understand and agree to the above restrictions in an email response.** Let me know if you have any questions.

Sincerely, Jan Warren-Findlow

### Appendix I

## Internalized Racial Oppression Scale (IROS)

The following questions will ask you about racial oppression and how it is internalized and replicated by Black individuals.

**Please select a number below that best represents how you feel about the following statements**

| | **Strongly Disagree 1** | **Disagree 2** | **Neutral 3** | **Agree 4** | **Strongly Agree 5** |
|---|---|---|---|---|---|
| 1. There were no institutions of higher learning in Africa | | | | | |
| 2. Earlier Egyptians were either White or Arabic | | | | | |
| 3. The earliest civilizations were in Africa | | | | | |
| 4. The first mathematicians and scientists were European | | | | | |
| 5. There were universities and other learning centers in Africa more than 2,000 years ago | | | | | |
| 6. There were Africans in the Americas prior to Europeans | | | | | |
| 7. Cannibalism was widely practiced in Africa | | | | | |
| 8. I do not tend to associate myself with an African heritage | | | | | |
| 9. I identify with African values and beliefs | | | | | |
| 10. I value respecting elders in my community | | | | | |
| 11. Being a part of family celebrations is not important | | | | | |
| 12. I would never date someone with a natural or an Afro hairstyle | | | | | |
| 13. I hesitate to do business with Black-owned companies because of their mismanagement | | | | | |
| 14. I don’t attend any cultural programs with African-centered values | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 15. Harmony and balance are important values in my life | | | | | |
| 16. I wish my nose were narrower | | | | | |
| 17. Having full lips is not attractive to me | | | | | |
| 18. I wish my skin was lighter than it is now | | | | | |
| 19. I would like a partner with lighter skin, to ensure that my children will have lighter skin | | | | | |
| 20. African people have no written history | | | | | |
| 21. It is fine to use skin care products to lighten skin color | | | | | |
| 22. Lighter skin is more attractive | | | | | |
| 23. It is okay for Black people to change their appearance through surgery | | | | | |
| 24. I wish I looked more White | | | | | |
| 25. Black women are controlling | | | | | |
| 26. Black women are confrontational | | | | | |
| 27. Money management is something that Black people cannot do | | | | | |
| 28. Black men are irresponsible | | | | | |
| 29. Most criminals are Black men | | | | | |
| 30. Black people are lazy | | | | | |
| 31. Most Black people are on welfare | | | | | |
| 32. It is okay to straighten or relax my hair | | | | | |
| 33. I prefer my hair to be natural | | | | | |
| 34. I like it when my partner wears his/ her hair natural | | | | | |
| 35. I texturize my hair | | | | | |
| 36. Straight hair is better than my natural hair texture | | | | | |

Original Citation

Bailey, T. K. M., Chung, Y. B., Williams, W. S., Singh, A. A., & Terrell, H. K. (2011). Development and validation of the Internalized Racial Oppression Scale for Black individuals. Journal of Counseling Psychology, 58(4), 481.

# Appendix J

## REB Study Approval

November 15, 2023

File #: 28556
Title: The Impact of Systemic and Internalized Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA).
Dear Ms. Rutherford,

The Research Ethics Board (REB) has given approval to your proposal entitled "The Impact of Systemic and Internalized Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA).".

When a project is approved by the REB, it is an Institutional approval. It is not to be used in place of any other ethics process.

To maintain its compliance with this approval, the REB must receive via ROMEO:

An Annual Update for each calendar year research is active;

A Study Renewal should the research extend beyond its approved end date of January 31, 2024;

A Study Closure Form at the end of active research.

This project has the following reporting milestones set:

Renewal Due-2024/01/31
Annual progress report-2023/12/31

To complete these milestones, click the Events tab in your ROMEO protocol to locate and submit the relevant form.

If an amendments to the protocol is required, you must submit an Amendment Form, available in the Events tab in your ROMEO protocol, for approval by the REB prior to implementation.

Any questions regarding the submission of reports or Event forms in ROMEO can be directed to Anna Kisiala, Coordinator, Research Conduct and Reporting, at annakisiala@trentu.ca

On behalf of the Trent Research Ethics Board, I wish you success with your research.

Best Wishes,

Dr. Liana Brown
REB Chair
Phone: (705) 748-1011 ext 7238
Email: lianabrown@trentu.ca

**Appendix K**

# Informed Consent

CONSENT TO PARTICIPATE IN RESEARCH

**RESEARCH TITLE**: **The Impact of Systemic and Internalized Racism on Black People's Accessibility and Utilization of Health Resources for Hypertension and Anxiety in the Greater Toronto Area (GTA)**

REB file number (28556)

**PRINCIPAL INVESTIGATOR**: Sherlette Rutherford (RN, BN, MScN student), Abeer Omar, RN, MSN, PhD (Assistant Professor, Trent University, supervisor), Rasha Wahid Ph.D., MSN, RN, RP (Assistant Professor, Trent University, committee member)

**PURPOSE**: This study aims to understand the experience of Black people with systemic and internalized racism and how they affect their usage of community healthcare services.

## WHAT WILL I DO IN THE STUDY:

This study will be a one-time meeting and will take a maximum of 90 minutes from me. I will participate in a face-to-face interview or virtual Zoom interview audio-taped by the primary researcher.

I will be asked questions such as:

- My medical diagnosis of hypertension and anxiety
- Background information such as my age, income, and education level.
- My understanding of the association between anxiety and hypertension
- My thoughts about the effect of racism on accessing community health resources for care for my hypertension and anxiety

If at any time I have any questions regarding the research or my participation, I can contact the researcher at sherletterutherford@trentu.ca or by phone at 416-835-0753. Also, the research supervisor, Abeer Omar, can be reached at abeeromar@trentu.ca.

## RIGHT TO WITHDRAW FROM THE STUDY:

- I understand that my participation in this research is voluntary. I may refuse to participate or withdraw at any time without any negative effects on my treatment.
- Refusing or withdrawing will not impact my access to medical care in the future or any relation with the researcher and/ or Trent University moving forward.
- If I choose to withdraw, I will contact Sherlette by phone/ email or in person. I can withdraw from the study at any time before the interview, during the interview, and up to one month after the interview has been completed. If I choose to withdraw, my information will be destroyed and not included in the results.
- During the interview, I have the right not to answer questions I prefer not to.

**CONFIDENTIALITY:**

- For safety and confidentiality, the informed consent forms will be kept separate from the notes, questionnaires, and taped audio recordings. Your name will not be identified in the questionnaire or interview. This information will be used only to arrange the interview place and time.
- Your information or audio recordings will include the study codes. Your name will not be linked to any of your data.
- The data will be destroyed 5 years following the original publication.

**RISKS:**

The risk associated with this study is minimal. The level of harm I may experience is not more than I would experience in my everyday activities.

- I may be exposed to Psychological discomfort (including feeling demeaned, embarrassed, worried, or upset).
- If my psychological well-being is affected because of this study, a psychotherapist Dr. Rasha Wahid, will be accessible to me. I can contact Dr. Wahid at rasha.wahid@trentu.ca.

If at any time I have comments or concerns regarding the research or questions about my rights as a research participant, I should contact Anna Kisiala, Coordinator at the Trent University Review Ethics Board (REB), at annakisiala@trentu.ca. I will use the REB file number (28556) if I decide to contact the REB coordinator.

**BENEFITS:**

There are no direct benefits to me. However, the findings of this study may benefit a similar population in the future when the gaps are addressed by the practitioners or decision-makers. The results will be used to improve access to care for hypertension and mental health resources.

**PAYMENT:**

I will receive a $25 Gift card to a local grocery store for my participation. I will still receive the $25 gift card even if I choose to withdraw my participation after the interview.

**FEEDBACK OF THE RESULTS OF THIS STUDY TO YOU**

The results will be disseminated through the thesis and potentially academic journals, conferences, community presentations, or LinkedIn.

I may contact the study's primary researcher at sherletterutherford@trentu.ca to request copies of the report.

- I will receive a copy of the signed Consent Form.
- I (     ) consent to be audio-taped. The written and taped audio materials will be viewed only by the principal investigator and members of the research team.
- I (    ) consent to the use of written and audio-taped materials to be used in an educational setting outside the research.
- By checking the check box, I agree to participate in this study.

By checking the following box, I declare that all my questions and concerns are answered by the interviewer/researcher.

☐ I agree to the above terms and consent to participate in this study

Date: ______________________________

Participants Signature: __________________________

Participants Study Number: ______________________

Witness (Primary researcher): ____________________

REB file number (28556)