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Guyanese American Mental Wellness: A Phenomenological Study of Rupture and Resilience

John J. S. Harrichand [1]* | Shainna Ali [2] | Aliya Subhit [3]

[1] Department of Counseling, Montclair State University, United States of America

[2] The Mental Wellness Practice, United States of America

[3] Clinician, United States of America

Correspondence Email:
harrichandj@montclair.edu*

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Abstract

Guyana has one of the highest suicide rates in the Western Hemisphere, yet the mental health experiences of Guyanese Americans remain underexamined. This study employed an interpretative phenomenological analysis and Relational Cultural Theory to explore how Guyanese Americans understand and navigate mental wellness. Thirty participants shared lived experiences through individual interviews and a follow-up focus group. Findings revealed two overarching themes: *relational rupture* and *relational resilience*, operating across interconnected personal, familial, and sociocultural levels. Relational rupture reflected experiences of emotional silence, stigma, and disconnection shaped by family dynamics, cultural expectations, and migration contexts. In contrast, relational resilience emerged through increased self-awareness, culturally responsive counseling, community connection, and generational boundary-setting. Implications are discussed for counselors seeking to provide culturally responsive, relationally attuned mental health care for Guyanese American clients.

INTRODUCTION

Suicide remains a critical public health issue, ranking as the tenth leading cause of death in the United States (U.S.) in 2019, with disproportionately high rates among younger populations, second among individuals aged 10-34 and fourth among those aged 35-44 (Centers for Disease Control and Prevention, CDC). In that same year, the U.S. experienced 47,511 suicides, more than twice the number of homicides (CDC). Globally, Guyana has long struggled with one of the highest suicide rates, holding the top spot in 2014 at 44.2 per 100,000, a ranking it has maintained in the Western Hemisphere for over a decade (World Health Organization (Review, 2023; WHO, 2014). Yet, despite these alarming statistics, the mental health needs of Guyanese people, particularly those living in the U.S., remain understudied. Research by (Arora & Persaud, 2020) highlighted the barriers to mental health help-seeking among Guyanese youth, including stigma, fear of adverse parental reactions, and limited knowledge of available services. This study, which employed a grounded theory methodology through focus groups with 17 adult stakeholders and interviews with 40 high school students, highlights the pressing need for culturally

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responsive mental health interventions. Given the growing Guyanese American population and their unique cultural and familial dynamics, understanding and addressing the mental health challenges within this group is crucial. Our study's primary objective was to explore the lived experiences of Guyanese Americans regarding mental wellness, focusing on 1) barriers to health and 2) catalysts that promote wellness.

The Guyanese American Demographic

A 2020 Forbes survey reported that Guyana had the most significant percentage of its population living abroad (36.4%), with the Caribbean holding the second-highest diaspora share globally (17.7%; (Buchholz, 2022). Research shows immigrants, including Guyanese Americans (estimated at 232,000 in 2019), are at higher risk for suicidal behavior and mental disorders like depression (Alliance & Inc, 2014). While many Guyanese immigrants reside in New York City, they are spread across all U.S. states and territories (Statimetric, 2022), underscoring the need for focused mental health research and support for this population.

Guyanese Americans have a history shaped by being enslaved, indentured servitude, and migration (Roopnarine, 2003). Africans were brought to Guyana through the transatlantic slave trade, while Indians arrived under British indentured contracts after slavery was abolished in 1834 (Roopnarine, 2003). These histories contributed to depression and maladaptive coping, such as substance use, leading to rising suicide and domestic violence rates. After the British Caribbean's 1917 emancipation, Indo- and Afro-Guyanese engaged in "acculturation" and "revitalization," reclaiming their Caribbean cultural heritage through "creolization" (Berry, 2008; Roopnarine, 2003; Sirin et al., 2019).

The migration of Guyanese people continued with relocation to countries like the U.S., and upon their arrival, like other immigrants, they faced the pressure of assimilation, often having to relinquish their identity and customs (Arvelo, 2018; Cavalcanti & Schleef, 2008). This acculturative stress can have a negative impact on mental health (Berry, 2008; Harrichand et al., 2020; Harrichand, Kirk, et al., 2025; Harrichand, Mwendwa, & Gummaluri, 2025; Sirin et al., 2019; Snow et al., 2021; Snow et al., 2020). Additionally, Guyanese immigrants experience assimilation and acculturation twice, first in Guyana and then in their new countries (Arvelo, 2018; Cavalcanti & Schleef, 2008).

Despite high adverse mental health statistics in the Guyanese diaspora, there is a significant gap in research on Guyanese American mental health. Hosler and Kammer (2018) identified only two studies in the literature focusing on the mental health of Guyanese Americans. Their research analyzed the health profiles of 1,861 Guyanese immigrants aged 18-64 living in New York. Many participants faced socioeconomic challenges that limited their access to health insurance and quality healthcare. The findings showed that Guyanese Americans were more likely to engage in binge drinking. They are among the least likely minority groups to have insurance, with barriers including ethnocentric stereotyping, cultural incompetence, unstable employment, and poor past healthcare experiences (Arvelo, 2018).

Hosler et al. (2019) also investigated the link between discrimination and depressive symptoms among urban Black, Guyanese, Hispanic, and white individuals aged 18 and older in Schenectady. One hundred and eighty participants identified as Guyanese. Logistic regression analysis revealed a significant association between the Everyday Discrimination Score (EDS) and major depressive symptoms among Guyanese Americans, consistent with findings for other racial/ethnic groups. These results highlight discrimination as a risk factor for depression.

Intimate partner violence (IPV) is a critical concern among Guyanese Americans, which is also seen in Guyana, where IPV is one of the most widespread forms of violence (Parekh et al., 2012). Although the country emphasizes gender equality, women primarily work in the tertiary sector (e.g., education, human services), and domestic responsibilities, marriage, and childbearing often limit their participation in the labor force (Nichols et al., 2021). Alarmingly, one in six Guyanese women, especially in rural areas, believe

IPV is justified, and suicide, frequently through pesticide use, is a significant issue for women facing poverty, domestic strife, and economic despair (Nichols et al., 2021). Additional challenges in Guyanese American communities include depression, cultural assimilation struggles, alcohol use, and limited healthcare access and coverage (Hosler & Kammer, 2018).

The Present Study

Previous research, although limited, has underscored the mental health impacts of the diasporic history experienced by Guyanese Americans. Despite the high prevalence of mental health issues and elevated suicide rates within this demographic, Guyanese Americans remain inadequately studied and notably underserved in terms of comprehensive healthcare (Ali et al., 2023). The current study was undertaken to gain a deeper understanding of the factors that adversely or positively affect the mental health experiences of Guyanese Americans.

Theoretical Framework

This research draws on Relational Cultural Theory (Jordan, 2017), which highlights the social and interconnected nature of human relationships, emphasizing that growth occurs through connection (Cannon et al., 2020). Genuine connections in relationships are characterized by mutuality and empowerment, leading to outcomes such as increased energy, productivity, self-worth, clarity, and a desire for deeper connections (Jordan, 2017; Miller, 1986). RCT provides a valuable framework for counseling Guyanese American clients by fostering relationships that promote safety and growth. Key principles of RCT in this context include authenticity, mutuality, addressing power dynamics to empower clients, and enhancing relational competence through culturally respectful and collaborative therapeutic interactions. Readers are encouraged to consult the cited literature for a deeper exploration of RCT.

METHODS

This research focused on understanding the mental health experiences of Guyanese Americans by exploring their perceptions of mental health. Guided by the counseling profession's emphasis on cultural understanding (Hays & Wood, 2011), a phenomenological approach was employed to capture participants' lived experiences from their own perspectives (Ali et al., 2023; Hosler & Kammer, 2018).

Participants

Before recruiting participants, Institutional Review Board approval was obtained from the university affiliated with the first author. Purposive criterion sampling was employed to recruit Guyanese Americans aged 18 and older who either self-identify as Guyanese American or have at least one parent born in Guyana. Recruitment materials were distributed through counseling listservs (i.e., ACA–AMCD Connect and CESNET), and social media platforms (i.e., LinkedIn, Facebook, Instagram). The second author contacted all participants via email to provide study details, informed consent documents, collect demographic information, and schedule interviews. Qualitative research guidelines suggested a sample size of six to 12 participants (Creswell, 2013). We aimed for 15-20 participants, considering potential attrition.

Our recruitment efforts attracted 73 interested individuals, 60 of whom met the inclusion criteria and were initially contacted, while 13 did not qualify. Scheduling conflicts prevented 43 individuals from completing an interview, resulting in 30 participants who finished the study. Among these, 17 took part in individual interviews, and 23 joined a one-time focus group to clarify data from the interviews. Notably, 10 of the focus group participants also completed individual interviews. Further recruitment was deemed unnecessary as data saturation was achieved with the existing individual interviews and focus group data.

We provide demographic data for the 30 participants involved in both individual interviews and the focus group (see Table 1). Participants' ages ranged from 20 to 50, with a mean age of 28. Gender

distribution was as follows: female (25), male (4), and transgender (1). Sexual/affectional orientation included non-respondent (1), queer (2), bisexual (5), and heterosexual (22). Educational attainment varied from high school diploma (1), some college (4), associate's degree (2), bachelor's degree (9), master's degree (13), to doctoral degree (1). Faith traditions were represented by non-respondents (3), atheist (1), agnostic (3), spiritual (1), Catholic (1), Christian (6), Muslim (2), and Hindu (13). Seven participants reported no experience with personal counseling, while 23 had engaged in some form of counseling.

Table 1 <Participant Demographic Characteristics (n = 30)>

Characteristic	**Category**	**n**
Age, years	Range = 20–50	
	M = 28	
Gender	Female	25
	Male	4
	Transgender	1
Sexual/affectional orientation	Heterosexual	22
	Bisexual	5
	Queer	2
	Did not respond	1
Level of education	High school diploma	1
	Some college	4
	Associate degree	2
	Bachelor’s degree	9
	Master’s degree	13
	Doctoral degree	1
Faith tradition	Did not identify	3
	Atheist	1
	Agnostic	3
	Spiritual	1
	Catholic	1
	Christian	6
	Muslim	2
	Hindu	13
Experience with counseling	No experience	6
	Some experience	24

Data Collection and Analysis

Participants took part in semi-structured interviews averaging 60 minutes, conducted by the second author of the research team. These interviews were conducted via Zoom, audio-recorded, and transcribed verbatim. The interview protocol included three primary questions, with follow-up questions to clarify and deepen responses: (1) How do you define mental health?; (2) Who in your life has had experiences with mental health?; and (3) What experiences have you had with mental health? Guided by Relational Cultural Theory (Jordan, 2017), the interviews were approached as mutual, growth-fostering encounters rather than neutral extractions of data. The interviewer emphasized authenticity, empathy, and mutuality to cultivate trust and connection, core RCT principles that support the co-construction of meaning. Participants were encouraged to reflect on their experiences of connection, disconnection, and reconnection related to mental health within their families, communities, and cultural contexts.

Following initial data analysis, the research team conducted a follow-up focus group (90 minutes) to extend relational engagement and collaboratively refine the interpretation of findings. This discussion invited participants to explore relational shifts in their understanding of mental health, to identify contextual and cultural factors that may have contributed to these changes, and to validate or elaborate on emerging relational themes. Data analysis was guided by RCT's emphasis on mutual empathy, authenticity, and the dynamics of connection. The first and second authors reviewed each transcript to immerse themselves in the relational nuances of participants' narratives. The team collaboratively developed a coding system that centered on patterns of relational growth, disconnection, resilience, and cultural identity. Multiple meetings were held to synthesize these codes into themes reflecting how Guyanese Americans understand, navigate, and transform their mental health experiences within relational and cultural contexts.

Member checking followed, allowing participants to review their transcripts and the findings section for accuracy and resonance. This process further aligned with RCT's commitment to mutuality and shared meaning-making. No errors were reported, though one participant provided additional clarification that enriched the interpretation. The third author acted as an auditor to ensure methodological rigor and to confirm that interpretations were consistent with the relational values underpinning the study.

Trustworthiness and the Research Team

Trustworthiness is a fundamental aspect of qualitative research, ensuring that the findings accurately reflect the data (Lincoln & Guba, 1985). To uphold research credibility, reflexivity is crucial, requiring researchers to critically examine their procedures in relation to power, privilege, and oppression. To mitigate researcher bias, our team worked collaboratively to maintain credibility throughout the data collection and analysis process. The research team included two Indo-Guyanese American female counseling practitioners and one Indo-Chinese-Guyanese Canadian male faculty member. The faculty member is affiliated with a CACREP-accredited counselor education program, and all three researchers have clinical experience with diverse populations and experience conducting qualitative research.

To address researcher bias, we employed bracketing to examine how our personal experiences might influence our research approach and expectations (e.g., challenges making sense of our Guyanese heritage, positive and negative messages around mental health in Guyana and the U.S., desire to better support Guyanese American community). Before data collection, we engaged in discussions about our experiences with Guyana, mental health within the Guyanese American community, and our roles as mental health leaders and advocates. We identified and acknowledged our biases and made efforts to bracket these biases throughout the data collection and analysis process. We practiced personal reflection and maintained analytic memos to document our reactions and initial thoughts about the data.

To enhance the credibility and confirmability of our findings, triangulation was employed to compare our themes from individual interviews with those generated during the focus group discussion. This methodological triangulation allowed convergence across participant experiences and ensured that the essence of the phenomenon was represented consistently. Points of convergence and divergence were reviewed collaboratively during analysis to deepen interpretive rigor and support trustworthy meaning-making aligned with phenomenological inquiry (Lincoln & Guba, 1985; Marshall & Rossman, 2006).

Before data analysis, we convened to establish and confirm consistent analysis procedures. Initially, the first two authors analyzed the data individually and then collaboratively determined codes and themes to minimize bias. Throughout the analysis process, we consulted each other to address any questions or concerns about the data. Additionally, the third author served as our qualitative research auditor, providing critical feedback on our analysis and findings (Marshall & Rossman, 2006).

RESULTS AND DISCUSSIONS

Our findings revealed two central themes: (a) *relational rupture* and (b) *relational resilience*. These themes were further explored across three levels, *individual, familial*, and *sociocultural*, where distinct subthemes emerged. Below, we examine these core themes in detail, highlighting the lived experiences of our participants.

Relational Rupture – Individual Level

Relational rupture at the individual level emerged as an internalized disconnection from one's emotional world, sense of worth, and capacity to voice pain. Through the lens of RCT, these early and often repeated disruptions limited opportunities for authenticity and mutuality, leaving participants to manage distress in isolation rather than connection (Jordan, 2017; Miller, 1986). Participants (N=30) described ruptures as deeply embodied experiences shaped by silence, uncertainty, mistrust, and self-survival strategies (i.e., four categories) that developed in the absence of attuned relational support.

Emotional Silence and Self-Suppression

Our participants (N=30) consistently described "learning" to be silent about their pain, developing psychological invisibility as a survival strategy. Sunita explained, that even when attempting to share distress, she quickly withdrew her disclosure because emotional honesty felt unsafe: I remember the first time when I was rushing out of the house, I told my dad [about feeling depressed] and he was like, 'Wait, wait, wait.' And he's like, 'Are you okay?' And I was like, 'Yes. I swear I'm fine.' He's like, 'Are you sure?' And I was like, 'I promise.' And then when I do say it to my mom, she kind of doesn't really respond. So, that's her way of being like, I hear you, but it's kind of still making me uncomfortable. But I still say it ...

Her experience demonstrated an authenticity rupture, being physically heard, but not emotionally received, a hallmark of relational disconnection in RCT. The lack of response communicated to Sunita that her interior world was unwelcomed, reinforcing silence instead of vulnerability.

Analogously, Anjali described how adults in her life shut down emotional expression through minimization rather than curiosity, stating that, "…all the adults around me, they were like, 'Well, what you got to be sad about?" Her narrative reflected not only dismissal but an absence of relational witnessing, what RCT identifies as a barrier that impedes growth-fostering connection (Cannon et al., 2020; Jordan, 2017).

Confusion and Mistrust Around Mental Health

Many participants (N=26) did not initially have language for their distress, which further intensified isolation. For example, Ramesh shared, "I knew it [mental illness] was problematic, but I didn't know to the extent that it actually was. I knew it wasn't something healthy, but I didn't know it was as bad as it was." His experience reflected disconnection not just from others, but from one's own internal experience, an intrapersonal form of relational rupture. Sunita later recognized her emotional collapse after the death of her mother, reflecting: I wanted to lay in bed all day, and I didn't want to go to class, and I didn't have motivation to get any work done, now I look back on that. I'm like, 'Hello, that was a major depressive episode.' Her retrospective awareness underscores a lack of relational mirroring; no one in her environment helped her make meaning of her emotional experience when it was happening. Sunita was left without relational scaffolding, limiting opportunities for growth through connection (Cannon et al., 2020; Jordan, 2017).

Learned Avoidance and Maladaptive Coping

With little to no emotionally safe relational outlets, participants (N=16) turned inward or to numbing strategies. Anil described alcohol as his culturally modeled coping mechanism, sharing, "When you're struggling with things and you have nowhere to go to with them except alcohol and the bottom of a rum

bottle." His experience highlighted both disconnection from others and the absence of empowered relation, replaced instead by self-numbing.

Participants frequently expressed that these coping strategies were not chosen so much as inherited or absorbed from their environment; a form of learned relational disconnection. This aligns with RCT's premise that disconnection is relationally transmitted across contexts, not merely intrapsychic (Jordan, 2017).

Identity Disruption During Personal Transition

Periods of grief, loss, uprooting, or transition deepened rupture and exposed the delicate nature of participants' internal coping (N=11). Rita, reflecting on her parents' divorce, noted that everyone simply "went about their business," leaving her unsupported and emotionally alone. In her words, family system did not have "space or capacity" for her emotional self to exist.

Similarly, major life transitions, such as death, immigration shifts, or academic pressure, were experienced not as events, but as ruptures of connection. Without relational holding, participants internalized distress as a private burden rather than a shared human experience.

Across these subthemes, what is most salient is not simply distress, but disconnection. According to RCT, psychological suffering emerges when authenticity is sacrificed to preserve belonging, when emotional needs go unwitnessed, and when safety is replaced by silence (Jordan, 2017; Miller, 1986). Our participants were not "unaware" of mental health; they were unsupported in naming, feeling, or metabolizing it within a relationship. Their earliest wounds were not cognitive, but relational.

Relational Rupture – Family Level

At the family level, relational rupture emerged through patterns of invalidation, emotional unavailability, high control, silence, and intergenerational modeling of unhealthy coping. Drawing from RCT, these family dynamics disrupted mutuality, blocked relational agency, and reinforced power-over relational patterns, all of which eroded our participants' ability to experience growth through connection (Jordan, 2017). Home was frequently the origin point of disconnection, where participants learned that emotional needs were inconvenient, unsafe, or shameful. Four categories emerged to support this subtheme.

Modeling of Dysfunctional Coping in the Family

Several participants (N=10) described witnessing mental health distress in their family systems without acknowledgment or intervention. Francis reflected on how dysfunction was normalized: My mom's like the enabler in the sense of when he [dad] drinks. It's like, oh, he's stressed out. It's fine. It's okay. We'll be fine. And then my sister is kind of ... on …, my side, but just like on a smaller level. She doesn't voice it as much as I do.

Francis not only described his father's behavior, but he described his family's relational template: avoid, excuse, minimize. This is a rupture of mutual responsiveness; everyone is present, but no one is emotionally with one another. RCT holds that when connection requires self-erasure, children internalize disconnection as normal and inevitable (Miller, 1986).

Parentification and Emotional Role Reversal

Participants (N=22) frequently described being emotionally or practically responsible for others while their own needs were minimized or dismissed. For example, Rita shared that when her parents divorced, "everyone decided to go about their business," leaving her to emotionally interpret the rupture on her own. Similarly, several participants (N=6) became surrogate caregivers to younger siblings or distressed parents, losing access to childhood relational needs. RCT identified this dynamic as an inversion

of relational direction; children become regulators instead of receivers of care. Instead of mutual connection, they experience role-based obligation (Jordan, 2017).

High Expectations, Control, and Conditional Worth

Participants (N=11), like Shawn described feeling not only unsupported but actively pressured to perform as a condition of acceptance: Even though I could be doing great … I'll bring home one bad grade and they'll be like, oh, this is so disrespectful. I pay so much money for you to go to school, where's the laps? Why did you fail this?

This is not merely academic pressure; it is a relational economy in which love is contingent on achievement. This expectation blocks authenticity because the child cannot show struggle without risking rejection. The relationship becomes hierarchical, not mutual. Shawn also explained the emotional contrast he observed through media, "we were not never going to get that support and validation if we made a mistake … they [parents] controlled how we were supposed to feel and how we expressed how we felt." This reflected relational constriction; emotions are not co-regulated but controlled (Cannon et al., 2020).

Silence, Minimization, and Emotional Withholding from Parents

Many participants (N=19) described family environments where emotional expression was not only unsupported but actively discouraged. As Anjali explained, disclosure was regularly met with dismissal rather than relational presence: "All the adults around me, they were like, 'Focus on your school.' … It's not like, 'Oh, what's really troubling you? Can we talk?'" This represents a rupture in attunement, one of RCT's most fundamental growth-fostering capacities. When emotional pain is unanswered, the child learns not only that vulnerability is unsafe, but that they are alone in the relationship. Additionally, family rupture was maintained through cultural loyalty. To question or name distress was framed as betrayal. This created an internalized bind; attachment depended on silence. The consequence, consistent with RCT, was disconnection from both self and other (Cannon et al., 2020; Miller, 1986).

At the family level, rupture was relationally patterned and systemically reinforced. Participants did not simply lack support; they were socialized away from connection. Family dynamics communicated clear emotional rules: *do not speak, do not feel, do not need, and do not disrupt the hierarchy*. These messages embedded silence as survival and emotional invisibility as virtue. Under RCT, this reflects the "power-over" relational structure (Jordan, 2017), in which maintaining belonging requires submission rather than presence. As a result, disconnection became a form of family inheritance; silently transmitted, silently observed, and silently endured.

Relational Rupture – Sociocultural Level

At the sociocultural level, rupture was reinforced by broader Guyanese cultural norms around reputation, gender roles, religion, immigration narratives, and silence as strength. These cultural messages amplified the emotional disconnection begun at the personal and family levels, creating a collective context in which vulnerability equated to weakness and mental distress was reframed as moral failure rather than a health need. Drawing on RCT, these dynamics represent systemic disconnection where cultural scripts replace relational authenticity with culturally enforced compliance (Miller, 1986). Five categories emerged to support this subtheme.

Stigma, Cultural Respectability, and the Policing of Emotion

Nearly all participants (N=28) described feeling pressure to "hold it together" for the sake of family or cultural image. They noted that the community's priority was appearing functional, not being emotionally well. As Lionel shared, he was raised to believe "men are supposed to be strong" and that

acknowledging distress was a "sign of weakness." For men, rupture manifested as the disappearance of vulnerability from relational life.

Susanna expanded on this as a gendered cultural expectation: …anger in men is rooted in patriarchy … no one's talking to them about emotions … [or] how to process this… [Men] don't even recognize their own anger or emotions when they're younger and when it builds up when they're older.

Here, disconnection is not accidental, it is culturally trained, replacing relational depth with emotional constriction. RCT describes this as the *cost of belonging* in cultures where emotional endurance is equated with character (Jordan, 2017).

Religious Pressure and Spiritual Bypass

Afro-Guyanese participants in particular described expectations to "turn to God" as the primary or exclusive response to distress. Mental health was reframed as a lapse in faith rather than a relational or psychological concern. Several participants (N=8) shared being told to "pray about it" instead of receiving emotional attunement, reinforcing spiritual bypass rather than spiritual support. For example, Beatrice shared: My Grandmother came when I turned 16 and she kept trying to tell my Mom that was I was showing signs of depression. And my Mom was like, "No, she's like that all the time. Like, that's just how she is." And my Grandma was like, "That's not normal. You should get her checked out." And my Mom kept saying, "No" and kept denying it. And then my Grandma's like, "You have to do something." And then my Mom was like, "Oh, I'm going to pray for her." This represents rupture not with faith, but with relational nourishment; religion stands in place of connection rather than operating through connection (Jordan, 2017).

Silence Around Sexuality and Identity

Ray, and other participants (N=7), described the suffocating effects of sociocultural silence around queerness: "…being gay was … frowned upon … this hush-hush thing. If you're a gay male in Guyana, what choice do you have but alcoholism or suicide? … Nobody in the family will actually have a conversation with you." Here, relational rupture was not merely private, it was institutionalized. Ray demonstrated RCT's notion of cultural disconnection, where entire aspects of self must be buried to remain inside the community (Jordan, 2017; Miller, 1986).

Immigration, Cultural Misrecognition, and Outsider Status

Participants (N=6) also noted disconnection in American contexts, where Guyanese identity was misunderstood or erased. As Susanna reflected, others often "question what you are … [and] explain[ing] your entire heritage in ... a minute," leaving her unheard not just emotionally, but ethnically. This represented relational invisibility; the sense that one's full identity is perpetually unrecognized (Jordan, 2017; Miller, 1986).

The Cultural Burden to "Be the First" and "Break the Cycle"

Most participants (N=23) felt responsible for altering generational patterns while simultaneously carrying the psychological weight of cultural loyalty. As Waleema shared: …there is an incredible amount of pressure on us. We're the first to do a lot of things. And you're trying to break this cycle. You have to get married at a certain age, you have to get married to a man, you have to learn how to cook, you have to learn how to do all of these things. And the culture is, for me, a little bit toxic, and it's taken a lot to break out of that. It's not just my parents, it's about what they've learned and what their parents learned.

Waleema's experience illustrated a multi-layered rupture: she must choose between connection to self or connection to culture, a choice RCT identifies as inherently wounding, because growth-fostering relationships require neither erasure nor performance (Jordan, 2017).

At the sociocultural level, disconnection was enforced not by one relationship, but by cultural belonging itself. The message was clear: *to be accepted, you must be quiet; to belong, you must comply; to be "strong," you must not feel; and to be "Guyanese," you must endure*. Cultural identity became contingent on emotional restriction rather than relational authenticity. Drawing from RCT, this represented a rupture in mutual empathy, as the individual is never met, only the role they are expected to embody (Jordan, 2017; Miller, 1986).

Relational Resilience – Individual Level

While relational rupture was deeply embedded in participants' early emotional experiences, resilience emerged through increased self-awareness, personal agency, and a gradual reclamation of voice (i.e., four categories within this subtheme). Our participants began to shift from internalized disconnection toward relational empowerment, rebuilding their sense of self not through isolation but through new forms of connection, to self, to knowledge, and eventually to others. Personal resilience did not emerge as rugged individualism, but as re-connection: to emotional truth, dignity, and voice.

Self-Awareness as a Turning Point

All participants (N=30) described that personal healing began when they could finally name their internal world, something they were never supported to do earlier in life. Awareness itself became a relational act: a reconnection with self after years of silence. For Lionel, the ability to seek answers independently was empowering: "I can Google this stuff and I can do it. I'll figure it out on my own." Although informal, this self-directed learning marked a shift from relational depletion to relational agency; the belief that healing could be pursued rather than hidden. RCT defines this as the restoration of one's own relational voice (Jordan, 2017).

Rejecting Internalized Stigma

Most participants (N=19) also demonstrated resilience by undoing shame-based cultural conditioning. Beatrice articulated this shift clearly when she stated, "The 'what will people think?' mentality, I'm just not going through with that anymore. I'm not going to absorb that. I refuse it. I reject all of it." Her language reflected a reclamation of relational authenticity, no longer negotiating her worth through others' comfort. This moment is emblematic of what RCT described as transformative disconnection: the point at which a person recognizes that silence is not self-protection, but self-erasure, and chooses reconnection with self instead (Jordan, 2017).

Permission to Prioritize the Self

Participants (N=11) described learning, often for the first time, that attending to their own needs was not selfishness, but sustenance. As Waleema explained: I started to realize that it's okay to take time out for yourself and think about yourself and focus on yourself. I was really raised to think that putting yourself first is a selfish thing … this is something I'm learning.

This is a classic example of RCT's movement from power-over (i.e., self-sacrifice to maintain belonging) to power-within (i.e., self-honoring while remaining relationally grounded). Her learning is not individualistic; it is relational liberation (Jordan, 2017).

Rebuilding Emotional Literacy

Participants (N=9) also reported increased emotional competence as they accessed education, counseling, or personal reflection. Richard shared, "through growth in emotional vocabulary and insight, I was able to identify and interrupt harmful generational patterns rather than reenact them." This internal shift reflects RCT's assertion that resilience is not toughness, but relational growth, the movement toward deeper truth-telling with oneself first (Cannon et al., 2020).

At the individual level, resilience did not emerge from withdrawal or emotional self-reliance, but from reconnection with the self as a relational being. Participants began to name what they feel, validate their own emotional experiences, reject shame and secrecy, and reclaim their voice as a site of dignity. Drawing from RCT, this marked the emergence of relational authenticity, the foundational condition for growth-fostering relationships (Jordan, 2017). Rather than internalizing silence as a requirement for belonging, participants began to internalize permission; permission to feel, to speak, and to exist without performance.

Relational Resilience – Family Level

Although many participants (N=17) experienced family as the earliest site of disconnection, for several (N=6), family also became a space of transformation once they developed the courage, language, or emotional tools to initiate new forms of relationship. Through the RCT lens, these moments represent the beginning of relational repair, often sparked not by the older generation, but by the participant, a reversal of the rupture pattern into a *generative* form of connection (Cannon et al., 2020).

Elders who Evolved into Emotional Witnesses

In some cases (N=5), emotional support surfaced later in life through more open, reciprocal conversations with extended family members, particularly grandmothers and older relatives who softened in later adulthood. For example, Telisha shared: When she [grandma] was raising her kids, she ignored their feelings a lot … but, … [now she] listens to me, and she's not trying to tell me what's right and what's wrong. She just wants to know how I feel and stuff like that.

This shift is a powerful example of emergent mutuality, a once one-directional relationship becoming a two-way emotional exchange. In RCT terms, Telisha is experiencing being *received*, something she was denied earlier in life (Jordan, 2017; Miller, 1986).

Courageous Honesty as a Catalyst for Relational Change

Some participants (N=6) described taking the emotional risk to speak truth into their family systems. Gordon recounted a pivotal moment: “I did tell them I was walking down this like dark path where I don't see a light at the end of the tunnel, and that's what really scared them.” This disclosure created a moment of *rupture awareness*; the family could no longer minimize or ignore his distress. In RCT, this is the beginning of relational repair, where authenticity reopens the possibility of mutual presence (Jordan, 2017).

Sibling Connection as Relational Buffer

For a few participants (N=6), resilience also emerged through shared disclosure with siblings, particularly younger ones who were navigating the same cultural and relational barriers. Rita described this as a source of mutual healing, noting that speaking openly with her younger brother created “camaraderie, comfort, and validation.” Here, connection is not only emotional but *protective*; siblings became the first experience of emotionally attuned family. Drawing from RCT, this is a shift from surviving *within* the relationship to growing through relationship, a return to mutuality at the peer/family level (Miller, 1986).

Assertiveness as Generational Boundary Work

Some participants (N=12) developed the confidence to challenge emotional avoidance and introduce vulnerability as a family practice. For Sasha, this began through naming emotional absence directly: “Why don’t we say ‘I love you’?” She then pressed further, asking why love was treated as if it could “be overspent, used, or run out.” This is an RCT-consistent reworking of relational norms: she is moving the family from power-over withholding to power-with connection (Jordan, 2017).

Beatrice similarly described shifting her family culture of silence toward open relational dialogue: "We have very direct conversations. Nothing is covert anymore. If this is what this means, look me in the eye and say that. That's a huge step, at least for my bloodline." This is not simple communication, it is *restoration* of relational truth (Jordan, 2017).

Redefining Responsibility in the Family System

Shawn, like several participants (N=12), also demonstrated resilience when he began to confront, rather than absorb, family dysfunction. Reflecting on earlier years, he shared: When I was younger, I would just kind of let things be, but as I became a teenager …I would start arguing back with him in the state of it, so then I would obviously escalate… So there were many instances where I would argue back like, everything that you're doing is just shitty and we want you to get help, no matter how much we tell you to get help, … you just belittle us.

Although conflictual, this moment represented relational reclamation; Shawn moved from silent witness to truth-teller, demanding accountability. Drawing from RCT, this is the assertive edge of mutuality: naming harm to create the *possibility* of repair (Jordan, 2017).

At the family level, resilience emerged when participants began to introduce emotional language where none existed, model vulnerability that elders had never practiced, shift from absorbing pain to naming pain, and restore relational dignity through truth-telling. Importantly, these changes did not reflect assimilation into Western emotional norms, but rather *culturally compatible relational repair*, grounded in collectivistic values while expressed through newly reclaimed emotional voice (Arvelo, 2018; Berry, 2008). Participants did not abandon family to heal; they re-patterned the relationship. This reflected RCT's deepest principle: healing occurs through connection, not escape from connection (Jordan, 2017; Miller, 1986).

Relational Resilience – Sociocultural Level

While sociocultural norms initially functioned as barriers to emotional visibility and help-seeking, participants also described ways in which culture, community connection, representation, and culturally responsive support later served as healing forces (i.e., five categories emerged under this subtheme). Through the lens of RCT, these sociocultural experiences demonstrate relational recovery through belonging, not assimilation, and the power of culturally aligned connection in mitigating internalized shame. Resilience emerged not from distancing themselves from culture, but from reframing cultural identity in ways that made space for emotional truth (Arvelo, 2018; Berry, 2008; Jordan, 2017).

Cultural Community as a Healing Resource

For some participants (N=14), sociocultural connection outside the nuclear family became a buffer against isolation. Rita reflected on the healing power of cultural gathering spaces: "… that has been instrumental in building how I cope by making connections… by having a good time and being around people… my culture gave me that coping mechanism…, which is positive." Here, culture becomes a relational holding space, not through silence, but through presence, belonging, and shared humanity. RCT recognized this as a restoration of *connection-based resilience* (Jordan, 2017).

Access to Culturally Attuned Counseling

Participants (N=23), who encountered counselors who understood Caribbean culture, or at minimum demonstrated cultural humility, reported transformative outcomes. Sasha described the difference this made for her: "Having a Black woman therapist right now …She understands Caribbean life. She's not Caribbean, but she gets it …we don't have to spend time talking about the basics … that's been helpful." This reflected RCT's concept of relational competence; healing is made possible not by clinical technique alone, but by *cultural attunement and shared meaning-making* (Jordan, 2017; Miller,

1986). Sasha experienced, perhaps for the first time, a therapeutic relationship where she did not have to translate or justify her worldview.

Social Media and Representation as Gateways to Help-Seeking

Several participants (N=5) credited social media as their earliest encounter with psychoeducation and emotional vocabulary, particularly younger participants who lacked culturally safe adults to confide in. Telisha commented: I really researched myself. At the time [as a teenager] that I was going or looking to go [for counseling], I had already started to research anxiety attacks. I started to research my own symptoms and what it could be, type thing, and that's how I discovered BPD.

For them, digital connection preceded clinical connection. This reflected a shift from isolation to relational witnessing, even if indirectly.

Rethinking Cultural Loyalty

For many participants (N=12), resilience came not from rejecting Guyanese identity but from reframing it on their own terms; honoring culture without losing self and integrating mental health. Anjali shared: My cultural upbringing has a lot to do with my interest in psychology and seeing the intersection of culture and mental health has been really huge in inspiring me to do this in the first place … [M]y family did not have a positive relationship with mental health and mental health awareness, but the lack of such a relationship was something that I saw and inspired me to take that route [to study mental health] and heal the cultural divide.

Several participants emphasized that cultural evolution, not abandonment, was the goal. Their identity work was a relational *integration process*, not detachment.

From Silence to Advocacy and Legacy Repair

Some participants (N=6) reported feeling a responsibility to "be the first" in their family line to talk openly about mental health, not for assimilation, but to make future generations safer than their own upbringing. Rita described this as a driving force behind her academic and professional journey: My family background is the reason I am interested in counseling. Making connections between my culture and mental health was encouraging because my family lacked healthy communication processes. I wanted to change that for myself and hopefully my future family, which led me to this profession.

This represents RCT's highest stage of resilience: *relational generativity*, where growth is not only personal but *transmitted outward* to repair communities (Jordan, 2017; Miller, 1986).

At the sociocultural level, participants demonstrated resilience by shifting from silence to voice, secrecy to visibility, shame to legitimacy, cultural conformity to cultural reinterpretation, and mere survival to contribution. In this context, resilience did not require distancing from cultural identity but rather reshaping how culture is lived relationally. Rather than experiencing Guyanese identity as a barrier to mental wellness, participants began to experience it as a context for collective healing, where belonging could coexist with emotional honesty and self-recognition.

Differences in Relational Rupture and Resilience by Demographic Group

While rupture and resilience emerged across all narratives, the pathways through which they were experienced were not uniform; instead, they were deeply patterned by cultural identity, gendered expectations, and generational norms that shaped how connection was either constrained or restored. Afro-Guyanese participants most frequently described religiously enforced disconnection, wherein emotional distress was converted into spiritual obligation rather than relational care, a pattern consistent with prior findings that spiritual messages are often used to contain psychological pain rather than meet it relationally (Ali et al., 2023; Nicolas et al., 2021). In these accounts, "praying through it" functioned as a substitute for accompaniment, producing what RCT identifies as *relational bypass* (Jordan, 2017).

Gender also structured how rupture appeared. Male participants, including Lionel, described socialization into emotional hardness, where tenderness was culturally foreclosed while anger was permitted as the only sanctioned affective outlet: "men are told to 'be strong' and vulnerability is interpreted as weakness." As Susanna explained, "…anger in men is rooted in patriarchy … no one's talking to them about emotions … [or] how to process this…" This emotional displacement mirrors RCT's description of blocked authenticity, where core needs for connection are rerouted into culturally acceptable postures of toughness (Miller, 1986).

For women, rupture emerged more often through silencing and concealed harm, including IPV that was minimized or hidden to preserve family image, reflecting broader Indo- and Afro-Caribbean gender norms that prioritize reputation over safety (Baboolal, 2016; Despot, 2016; Parekh et al., 2012). In RCT terms, this reflected a "power-over" relational structure that blocks mutual empathy and enforces submission (Jordan, 2017). Healing began primarily when women accessed emotionally safe alternative networks, siblings, cousins, counselors, or chosen community, where voice and dignity could be restored. Age likewise shaped the direction of resilience: younger participants interpreted silence as inherited harm and turned to peer-based and digital networks for language and validation (Arora & Persaud, 2020), while older participants framed stoicism as cultural duty, expressing pride through endurance rather than emotional openness (Cavalcanti & Schleef, 2008). This generational divide reflected a broader relational shift within the Guyanese diaspora: connection was once preserved *through* suppression; younger adults are now reclaiming it *through* vulnerability.

This study builds on emerging scholarship documenting the mental health experiences of Guyanese Americans by demonstrating that distress is understood and experienced *relationally*, not individually. Participants consistently framed their mental health through interconnected personal, familial, and sociocultural dynamics, highlighting that psychological struggle is embedded in relational context rather than located solely within the self. This explains why, when asked to speak about personal mental health, participants frequently shifted toward family and cultural narratives, a reflection of the collectivistic nature of Guyanese American identity (Ali et al., 2023). Our findings aligned with Despot (2016) and Hosler et al. (2019), who similarly observed that well-being and distress among Caribbean diaspora communities are interpreted through broader relational obligations, gendered expectations, and communal scripts rather than exclusively individual interiority. From an RCT perspective, this suggests that Western models that focus narrowly on intra-psychic functioning risk misattuning to the relational foundation of meaning-making in this population. Counselors who emphasize the individual in isolation, for example, by treating the "child of an alcoholic" rather than the *relational system sustaining silence*, may inadvertently disrupt rapport or reinforce disconnection. Instead, interventions that include family or relational supports (when culturally safe) better honor the collectivistic cultural framework (Harrichand et al., 2020; Harrichand, Kirk, et al., 2025; Harrichand, Mwendwa, & Gummaluri, 2025; Snow et al., 2021).

Participants also described mental health as traditionally taboo, a finding consistent with Ali et al. (2023). This stigma is deeply rooted in the legacy of colonial trauma, which has historically shaped mistrust of institutions and mental health discourse (Arvelo, 2018; Nicolas et al., 2021; Roopnarine, 2003). In this context, silence becomes both cultural inheritance and survival strategy. Reliance on elders was a primary coping mechanism (Baboolal, 2016), yet those same elders frequently held stigmatized or pathologizing views of mental distress, reinforcing cycles of suppression (Baboolal, 2016; Hosler & Kammer, 2018; Parekh et al., 2012). Concurrently, supportive family responses, even when emergent later in life, served as a powerful protective factor, consistent with Hosler and Kammer (2018) findings that positive relational connection mitigates maladaptive coping. Thus, the same cultural systems that generate rupture can also serve as sites of repair when emotional visibility becomes possible.

Consistent with Arvelo (2018), participants reported turning to alcohol, avoidance, or emotional suppression when relational connection was inaccessible. However, as Balaram (2021) asserted, breaking

silence itself becomes a form of resistance, and this study demonstrated that disclosure is not simply cathartic but *relationally reparative.* Participants described courageously initiating emotional truth-telling within their families as a first step toward transforming inherited patterns of disconnection. In RCT terms, this represents movement from power-over silencing to power-with relational agency.

Immigration additionally functioned as a catalyst for resilience by widening relational worldviews. Exposure to diverse peers, language around mental health, and culturally affirming friendships helped participants reframe their distress and observe alternative relational scripts, echoing Despot (2016). However, some also encountered marginalization or cultural misrecognition in U.S. contexts, limiting their comfort in external help-seeking (Hosler et al., 2019). As Baboolal (2016) noted, this underscores the need to close knowledge gaps regarding culturally supportive services. Increasing community-facing education and resource awareness remains essential for accessibility (Harrichand et al., 2020; Harrichand, Kirk, et al., 2025; Harrichand, Mwendwa, & Gummaluri, 2025).

Building on previous scholarship (Ali et al., 2023; Arora & Persaud, 2020; Arvelo, 2018; Baboolal, 2016; Hosler & Kammer, 2018; Hosler et al., 2019), our findings suggest that culturally responsive counseling must center open dialogue and psychoeducation that honor relational, intergenerational, and collectivistic frameworks. Counselors must attune not only to the client, but to the *network of relationships* shaping their meaning-making (Harrichand et al., 2020; Harrichand, Kirk, et al., 2025; Harrichand, Mwendwa, & Gummaluri, 2025; Harrichand et al., 2022; Nicolas et al., 2021). Group counseling and family-oriented interventions (when appropriate) may be especially effective, aligning with collectivistic norms while fostering authentic relational repair (Yalom & Leszcz, 2005).

Partnerships with culturally embedded organizations, faith groups, and diaspora networks can expand community awareness and reduce structural mistrust (Ali et al., 2023; Arora & Persaud, 2020; Harrichand et al., 2020; Harrichand, Kirk, et al., 2025; Harrichand, Mwendwa, & Gummaluri, 2025). Participants also emphasized the value of early exposure to mental health concepts through school-based psychology courses, suggesting that educational institutions play a critical role in early stigma intervention (Baboolal, 2016; Despot, 2016). Meanwhile, social media emerged as an initial source of psychoeducation for younger participants, highlighting both promise and risk. Although unregulated information may perpetuate misinformation, it also represents a low-barrier entry point for identity-safe learning. Counselor educators may therefore consider extending culturally accurate content beyond the classroom to meet community needs in online spaces.

Finally, given the historical mistrust of Western institutions among Caribbean diaspora communities, counselors must attend to diversity gaps in the profession, Eurocentric curricula, and unexamined power dynamics that can replicate relational rupture in treatment settings (Singh et al., 2020). A multicultural orientation that privileges curiosity, humility, and cultural alignment (Davis et al., 2018; Harrichand et al., 2020; Harrichand, Kirk, et al., 2025; Harrichand, Mwendwa, & Gummaluri, 2025; Snow et al., 2021; Snow et al., 2020) is not ancillary but essential for attuned care.

LIMITATIONS AND FUTURE RESEARCH

Several limitations of the research should be noted. All interviews were conducted virtually via Zoom, which, while secure and acceptable for research, may have missed subtle verbal cues and contributed to video-conferencing fatigue. Despite efforts to enhance participant comfort and review informed consent before interviews, there remains the possibility that respondents censored their answers due to concerns about confidentiality. Additionally, most respondents were college-educated, female, first-generation, and of Indo-Guyanese descent, which may limit the representativeness of the findings for the broader Guyanese American population. Future research should aim to include a more diverse participant pool, encompassing a range of gender identities, ages, ethnicities, and durations of residence in the U.S. Studies should also investigate factors influencing Guyanese American mental health

and identify variables that may impede mental wellness. Additionally, perspectives from children, parents, and grandparents could offer deeper insights into family systems and cross-generational norms.

CONCLUSIONS

Our research identified relational ruptures (i.e., barriers) to mental health for Guyanese Americans and, more crucially, highlighted relational resilience (i.e., factors that support mental wellness) within this community. We believe this culturally informed knowledge is valuable for equipping counselors and mental health providers to more effectively address the needs of Guyanese Americans. We hope our findings enhance mental health outcomes within this community and the broader Caribbean population.

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