An Afrocentric Analysis of Black Experiences in the Mental Health System

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Abstract

This paper explores mental health research in Black communities and racial disparities in the Canadian mental health system. The experiences of Black communities and Black scholars are explored to highlight and explore the roots of racial disparities, differences in outcome and popular attitudes towards the mental health system. Asserting that the western model of mental health creates a gap between perceived and real quality of care, the methodology uses Afrocentric paradigms, focusing on Black narratives and a literary and historical review to better understand the data and research available on the subject. The western paradigm of mental health care is critiqued for its historical relationship with black communities and pathologizing distress. Additionally, the historical evolution of the western mental health paradigm is contrasted in its historical development and care practices with alternative psychologies. To address racial issues, this research urges a critical analysis of the role, regulatory ramifications, and philosophy of the western mental health care system. The implications of this paper are that mental health services need to prioritize agency and alternative paradigms of care, rather than adaptations and cultural competency.

Key Terms: Mental Health, Black Canadian Communities, Racial Inequity, Afrocentric paradigm, Sankofa, Alternative Psychologies

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While this paper is a challenge and hopefully a guide for those in the research, practice and regulatory bodies of mental health work, this work is truly for my community, my family, and my loved ones.

To the incredible youth from The Space Youth Centre: To hold your truths sacred is my vow of accountability to you. Thank you for teaching me what can only be taught through the love of a community.

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Table of Contents

Introduction 4
Methodology 5
Rationale: Statistics 6
Historical Review: Sankofa 8
Analysis: Agency 11
Conclusion 15
Reference List 18

Introduction

As mental health becomes an increasingly pressing issue, Black Canadian communities have emphasized the need to address systemic racism in the mental health field. I have spent the last several years working towards this goal in both clinical and community-based settings. Working alongside brilliant and dedicated advocates, I have seen firsthand the genuine efforts being made to meet community needs and improve mental health care for Black service users. However, it is my experience as a Black service user that leads me to critically question the direction and approach of these efforts.

This is because there is a disconnection between what people want and expect from mental health care services and what they receive in a system based on the western model of mental health. Even well-intentioned anti-racism efforts remain limited by the western mental health model itself. In fact, many anti-racism efforts are on track to replicate the harms that originally created stigma around mental health in our communities. In an effort to interrupt these harms, this paper aims to provide an alternative analysis of black mental health statistics using afrocentric principles.

Discrepancies in access and quality of mental health care services are well documented in Black communities from research data. However, I reject the popular analysis, which concludes that this implies an urgent need for increased mental health services in black communities. What I conclude is that Black communities often rightfully do not trust mental health services and withdraw or distance themselves from them because the western mental health care model does not work for them or address their problems.

This data is often misrepresented and decontextualized to increase the presence of institutional intervention in black communities, often punitively.

Methodology

I begin by presenting a critical analysis of the existing research and data exploring race and mental health in Canada. Because research in this realm is limited, I supplement gaps in the data with data from the US and the UK, where similar trends between black communities and their engagement with mental health services can be found.

Although Black Canadians are a diverse demographic with varying backgrounds and origins, an Afrocentric methodology can be used to understand issues across the African diaspora, as I do in this paper. Molefe Kete Asante developed the theory of Afrocentricity to place African people at the center of their own narratives. He describes it as "an orientation toward data... that says that African people are subjects, rather than objects, and that in order to understand narratives of African history, culture, and social institutions, you must allow Africans to see themselves as actors, rather than on the margins." (Asante, 1987) Following this approach, I found it necessary to reference quantitative data and black scholarship to evidence black agency and self-determination.

I apply the concept of Sankofa as a methodology to trace the historical context between the western mental health model and its engagement with black demographics and service users. The West African Akan word "sankofa" refers to the idea that to move

forward, we must fetch the wisdom that comes from looking backward to the lessons of our past. In doing so, I trace the origins of the distrust that black service users repeatedly express towards mental health interventions. I conclude with a comparative analysis that contrasts the origins of institutional mental health care with the western model of mental health under the Eurocentric paradigm.

Rationale: Statistics

A higher prevalence of mental illness is predicted for people of African ancestry in Canada. This risk is assessed based on a documented overrepresentation in exposure to conditions classified as social determinants of health, including housing instability, poverty, and food insecurity. (Olanlesi-Aliu et al., 2023; Phelan et al., 2010). Yet, many of the most popular mental health interventions are behavioural interventions, such as cognitive behavioural therapy and emotional regulation therapy, that do not address social determinants of health at all. Interestingly, supporting data shows that despite the higher risk, the actual prevalence of mental illnesses among Black Canadians is only slightly higher or the same as the overall Canadian population. The diagnosis of schizophrenia in Black men is the only area in which Black people are significantly overrepresented (Anderson et al., 2015; Cénat et al., 2023; Schwartz, 2014). This is however, contextualized by studies which indicate that the criminal justice system, police intervention, or involuntary medical institutionalization are the most frequent ways that Black men obtain mental health services and diagnoses (Archie et al., 2010; Fante-Coleman & Jackson-Best, 2020; Halvorsrud et al., 2018; McLeod et al., 2019). Where disparities across Black demographics *are* much higher is in the utilization of mental

health services and attitudes towards the mental health system. Black demographics as a whole are least likely to utilize mental health services *voluntarily* and are most likely to have negative attitudes toward mental health services (Cadaret & Speight, 2018; Grace et al., 2016; Taylor & Kuo, 2020).

Statistics like these are frequently misinterpreted or used out of context to promote policies that would increase institutional involvement in Black communities. Unfortunately, context is lost when data is presented in isolation. For instance, rates of mental illness and distress continue to rise exponentially across all racial groups, even though white demographics use mental health care services more frequently. It is rarely acknowledged that rates of mental illness have not decreased significantly throughout any population, even those where there is an increased use of mental health services and systems in that population.

Even if the goal is to shed light on inequalities, we should use caution when putting numbers to work in the real world. In my experience as a practitioner, statistics are often associated with legitimacy, evidence, and empirical data in the mental health sphere. However, it is more important to center the experience of those being studied and represented in the data from their own perspectives that to simply collect those experiences. Even in my own experience as a black youth, my association with statistics came through the warning not to “be a statistic”. Black children and youth hear this message repeated frequently in a variety of settings. To be warned against being a statistic invokes the reminder that your life is always being measured and evaluated.

Rather than addressing the problems that lead to these outcomes, it teaches Black youth to internalize an expectation of failure and negative esteem towards their own futures. This is the introduction of a desensitized attitude toward Black death and distress. When we rely on measurements and statistics to predict outcomes devoid of context, the loss and suffering of community members is reduced to percentages and numbers, collective experiences are reduced to predictions and, solutions are reduced to reactionary reforms that hinder transformational change.

Historical Review: Sankofa

It is tempting to believe that the mental health care that is practiced widely today is an accumulation of the various knowledges, technologies, and advancements of the sharpest minds that have contributed to the study of the mind. We often believe that this knowledge is assembled to formulate the most effective treatments for the most complex and confounding intricacies of the human mind. It is also tempting to believe that at this time, when access to the extensive knowledge of the world is much vaster than in previous periods of time, we have surpassed our susceptibility to many of the problems that plagued those before us. Indeed, it is significant that people, especially those of us living in the Global North, are aware of the privileges and advancements that science has allowed. It might follow from this awareness a sense of privilege, and upon increased awareness of another's inability to access such things, that this is an injustice in need of correction. This pattern has allowed for the expansion of the western mental health paradigm that dominates today's world.

As a discipline, western psychology has a long history of using numbers to back up decisions that negatively impact Black communities, whether through legislation or societal norms. In the early formulation of contemporary psychology, psychologists used the study of racial disparities and differences to engage in an overstudy of Black populations. Black communities were more accessible as research subjects because of factors such as poverty, involuntary institutionalization, and incarceration. This exploitation of Black communities as research subjects acts as the discipline's foundation. It is important first to challenge the perception that the psychology and mental health care that are widely practiced today are natural progressions of psychological study and care for the mentally ill. This is not true. Institutional mental health care and the birth of psychiatric care in medical care a legacy tracing back to Islamic institutions as far back as the 7th century, alongside the introduction of psychiatric hospitals (Alexander & Selesnick, 1966). Even in their infancy, these institutions did not aim to cure people of their afflictions by changing their behaviours but instead offered shelter, basic needs, and dignified therapeutic treatment to people as they recovered, as well as monetary aftercare and community involvement in their care (Alexander & Selesnick, 1966; Yilanli, 2018). These mental health institutions were meant to be places of support where people could find the care that their families could not provide them on their own or at home.

In contrast, people experiencing mental distress or afflictions have been criminalized since Europe's earliest records (Foucault, 1973). The philosophies and early psychological research of western psychological and psychiatric care consisted entirely

of assuming that Euro-American behaviours, values, and knowledge were the norm and comparing others against them to conclude preconceived notions that served to justify inhumane treatment (Guthrie, 2004). Behavioural psychology, an outgrowth of experimental psychology, is credited with solidifying the discipline of psychology as a science (OpenStaxCollege, 2014). It is responsible for the divergence of psychology from "the study of the mind" to the "study of behaviour" and suggests that because there is no way to objectively measure the contents of the mind or the states of consciousness, only outward behaviours should be considered in assessment and treatment (Watson, 1913). Behavioural psychology is the foundation of many of today's most supported mental health approaches, particularly in relation to addressing behaviour in children and youth. This cannot be divorced from the objective for which it was created; military war efforts and national order (Grossman, 1996).

Behavioural psychology is a direct product of the United States military-funded incentive to employ psychological methods of behavioural conditioning for the use of war and national interests during and following World War II. Particularly to manage behaviours of dissent against the state. The primary motivation for this was to be able to send soldiers who were experiencing traumatic distress from the war back to active duty during World War II, but it was also used to curb political uprisings in minority populations, hence the rise of schizophrenia and psychosis during the civil rights movement. This is neither a theory nor an assumption, as it is blatantly documented by the founding psychologist of today's behavioural psychology, John B Watson. In his own writing, he introduces behavioural psychology as "neither an objective psychology nor a

modified system of psychoanalysis," but a pursuit towards "the formulation of laws and principles whereby man's actions can be controlled by organized society" (Watson, 1913). Shortly after his contributions to the field, the clinical psychology profession became a regulated field of practice and the assessment, diagnosis and treatment of mental illnesses became standardized. His contributions remain a core part of the clinical psychology curriculum adopted in Canada and throughout western mental health systems. The Eurocentric model of mental health may be built on a historical legacy, but it is not built on a legacy of care for the mentally ill.

Analysis: Agency

The evolution of Islamic mental health institutions follows a similar evolutionary development as African and Indigenous mental health care models worldwide, approaching afflictions of the mind as unknown sources of distress. In Fanon's psychiatric writings, he references the stark difference between the Eurocentric approach towards mental illness and the Islamic approach towards mental illness that he observed among the Maghrebi Muslims in North Africa. Maghrebi Muslims explain mental illness and abnormal behaviour through a religious lens of "possession". Fanon observes that because Maghrebi Muslims saw mental illness as a temporary state brought on by something that is beyond the control of the person who is experiencing it, mental distress and the abnormal behaviours that it brought on were met with empathy and invoked a collective responsibility from the community to care for the person affected (Fanon et al., 2019). Similarly, in Nwoye's approach to Africentric Psychology, abnormal behaviours are not measured or evaluated but approached as messages that

have a deeper meaning unknown to the practitioner (Nwoye, 2015). People are encouraged to decipher the meaning that underlies their affliction and are relieved of personal responsibility for their actions. Mental illnesses using these explanations, are circumstances that could happen to anyone. Because of this, a sense of empathetic responsibility is invoked, and people are cared for while their affliction is approached with curiosity and concern. In these cases, the person experiencing the affliction does not bear a punitive responsibility for their actions or behaviours while experiencing the affliction.

In the Eurocentric model, mental illness is understood through biological mechanisms or deficits and treatments seek to change the disruptive behaviours brought on by the illness and to reduce or stop the symptoms of the illness. Through this lens, mental illness explains abnormal behaviours. This results in a personal responsibility on the person experiencing the illness to exhibit less disruptive symptoms and a collective responsibility to categorize normal and abnormal behaviours (Fanon et al., 2019). Diagnosis is measured and evaluated through observable behaviour, and treatment is prescribed to change the behaviour. The success of treatment is then evaluated based on a lower prevalence of such behaviours. This approach ascribes an inherent meaning to behaviours unfamiliar to the evaluating practitioner. While this method aspires to be more objective or scientific, it instead just creates a power dynamic favoring the subjective perspective of the practitioner and diminishing the self determination of the person experiencing mental illness or distress.

When contextualized with the overdiagnosis of schizophrenia and stereotypes of criminality among Black men and youth, who, as noted above, are most likely to engage with the mental health system forcefully, it is a necessity of survival that Black people behave differently in white society than they do naturally. As explored in Franz Fanon's Black Skin, White Masks and by W.E.B Dubois' concept of double consciousness, this is because Blackness itself is constantly misread as immoral and cultural behaviours are either criminalized or punished. Distrust and social masking as well as "oppositional behaviour" follow logically from this. Responses from black youth in Ontario confirm that these worries affect how they interact with the mental health system. In recently collected research, Black youth in Ontario reported that they often keep information from mental health clinicians because they worry about how it will be interpreted (Fante-Coleman et al., 2023). One example cites that youth share warnings about mental health services with each other and refrain from sharing details of their personal and home life until they feel safe to do so (Fante-Coleman et al., 2023). Others worried about child protection services becoming involved because of clinicians' misinterpretations of cultural differences (Fante-Coleman et al., 2023).The persistence of punitive care pathways demonstrates that this threat is still current (Fante-Coleman & Jackson-Best, 2020).

Perhaps then, the mystery of distrust that Black communities show towards accessing mental health services can be understood, not as an avoidance towards care or an indicator that more intervention is needed, but as a logical response to the inherent objective of the mental health system to "fix" behaviours that are undesirable by the

state. It is important to recognize and name this amidst the tendency for distrust and avoidance to be manipulated, and for the agency of Black communities to be ignored. The overdiagnosis of schizophrenia in Black men began during the civil rights era and pathologized participation in protests of the police and government. Yet, avoidance of mental health care in Black men and youth is still attributed to stigma, a lack of vulnerability and overemphasized masculinity. This downplays the reality of criminalization that is enforced through these psychological diagnoses and interventions. Horace Mann Bond’s research debunked the validity of intelligence testing in its own time and brought attention to the relational aspect of psychological testing where he showed how the results of research on Black subjects changed based on the race and on the involvement of the practitioner in the community of the Black participants being tested (Guthrie, 2004). Similarly, Herman Canady addressed the reluctance of Black children to participate in testing, citing their distrust of white practitioners (Guthrie, 2004). These contributions were ignored throughout the historical progression of the western mental health system and continue to be ignored today. Black Canadians have repeatedly vocalized their distrust of mental health care services due to the historical legacy of racism in the western mental health model, yet this attitude is also associated with a stigma around mental health in the Black community and is currently being ignored. Perhaps the Western mental health model itself suffers from an anxious affliction toward that which it does not understand or recognize as human.

Conclusion

It is not my intention through the conclusions of this paper to suggest that there is not a need for mental health care services within the Black community, but rather to reorient the problem to one that exists within the approach and model of the mental health system and must be addressed by changing the system rather than changing the people who avoid it. Currently, Black behaviours are measured and evaluated towards the conclusion that our communities are inherently prone to violence, death, and, in the present case, mental illness. It is my hope that a critical shift in our understanding can help to make clear the criminalizing and punitive nature of mental health care in the western and can be useful in improving mental health access and services for all service users. While the western psy-disciplines grasp at bio-psycho, psycho-socio, and bio-psycho-social models of wellness to explain humanity and personhood, those of us who lie outside of statistical explanation cannot wait for empirical evidence to classify our distress or respect our agency. The western model does not diagnose illnesses, but behaviours and its diagnoses do not explain mental illness but prescribe what should be done to change behaviours we do not understand. This is not an accidental feature of the western model of mental health but an intentional aspect of it. To properly address issues of race in the mental health system, mental health services and clinicians would need to look more critically at their function, their regulatory and punitive implications, and the worldview from which they approach mental illness and differences.

It cannot and should not be concluded that Black communities are more in need of mental health interventions. These interventions pathologize behaviour, and by

addressing the needs of the demographic that is most at risk of mental illness, better approaches to care for all can be found. Social determinants of mental health already explain many of the sources that contribute to mental illness, and African, Islamic, and Indigenous paradigms already model empathetic interventions to care without having to adapt their core functions. It is a different model and approach entirely that is needed to transform mental health care services in Canada, rather than more cultural adaptations of treatments and diagnoses that come from assimilating Black communities into the existing model.

In order to provide imaginative inspiration and direction for broader future research and innovative practice, I have attempted through this research to disrupt certain patterns of practice that repeatedly insulate this area of research. Towards that end, this paper aimed to:

I. Interrupt the replication of historical patterns concerning harmful research extraction in Black communities and discourage further study of racial disparities in the mental health system,

II. Highlight the limitations of an inflated emphasis on quantitative data collection by contextualizing it within the existing qualitative data,

III. Prompt thoughtful consideration into the outcome and implications of increased service use among Black demographics within contemporary western mental health systems,

IV. And finally, build intentionally on Black scholarship and contributions in recognition of the pre-existence of alternative psychologies and psychiatric practices.

Most importantly, I hope through this analysis to challenge the passive cruelty of quantifying the value of distress by its statistical probability. I intentionally excluded statistical numbers from this because they are often dehumanizing and unimportant to addressing the root of the issue. I am a statistical improbability who is loved and cared for by other statistical improbabilities. Yet, as more research studies are conducted, my community continues to become smaller, and their needs continue to be unmet by a failing model of dehumanizing practices and policies.

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