CHALLENGING THE AMERICAN MENTAL HEALTH CARE PARADIGM:
ACKNOWLEDGING COLLECTIVE EXPERIENCE

by

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Abstract

Mental health remains one of the most neglected areas of American healthcare. By now, many are aware that the COVID-19 pandemic led to a sharp increase in cases of anxiety and depression, thereby exacerbating the outcomes of a long-standing mental health crisis. In this thesis, I address a pressing concern: racial and ethnic minority populations are experiencing disproportionately worse mental health outcomes, yet are less likely to have access to, seek out, and utilize effective resources. Modern mental health care has had devastating consequences on the health of minority populations. Although it is well documented that structural racism underlies the inequities experienced across all areas of healthcare, the current mental health paradigm is not meeting the needs of communities disproportionately affected by the mental health crisis. The purpose of this thesis is to reframe mental health from a sociopolitical lens and address the unique barriers that prevent people of color from utilizing mental health resources. In this paper, I argue that we ought to rethink the current mental health care paradigm by shifting from an individualistic to collective understanding of mental health, and challenging traditional roles of psychotherapists where I offer the view that psychotherapy can serve as a form of social activism.

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Introduction

The American Mental Health Crisis remains one of the most overlooked and underprioritized health emergencies the United States has faced in the last several decades. Currently, there are at least 50 million U.S adults living with a mental illness, and each year, it is estimated that nearly 45 million adults experience mental illness symptoms (*State of Mental Health in America*, 2022). The Centers for Disease Control and Prevention reports that, since 2000, the number of suicides has increased by nearly 36% (2023). A 2023 Gallup survey reports that about 31% of U.S. adults considered their mental health as “excellent”, which is down 43% in the last two decades (Brenan, 2023). Yet, the need for better mental health care (MHC) is not being met; in the U.S., it is estimated that only one mental health provider is available for every 350 individuals (*Mental Health America*, 2023). Additionally, reports show that nearly 30% of all adults with a mental illness are not able to receive treatment (*State of Mental Health in America*, 2023).

By now, it is well-recognized that the social and economic impacts of the COVID-19 pandemic have exacerbated long-standing mental health problems. The U.S. Bureau of Labor Statistics reports that the number of unemployed Americans rose from 6 million to nearly 21 million in May of 2020 (Sargent Jr, 2017). Alongside social isolation, other social and environmental risk factors have had significantly negative impacts on psychological well-being. In the first two years of the pandemic, cases of depression and anxiety among adults nearly tripled across the country (Ettman, et al., 2022). One study found that individuals who lost their jobs during the pandemic had a higher risk of perceived stress and risk of anxiety compared to those who maintained their job (Ruengorn, et al., 2021). Previous studies have demonstrated a strong
correlation between economic anxiety and mental health consequences (Marjanovic et al., 2013; Fiksenbaum, et al., 2017).

In 2022, the World Health Organization (WHO) released its largest report on mental health which identifies three ‘paths to transformation’ to address and strengthen MHC systems; they are (1) deepening value and commitment, (2) reshaping environments that influence mental health, and (3) strengthening health care systems by reshaping how care is delivered and received. American efforts to achieve these goals have accelerated in the last several years. Historically, the U.S. treated mental illness according to the distinct needs of a given community, keeping them separate from the general health care system. Today, behavioral health accounts for about six percent of health care spending (Figueroa, et al., 2020). The Biden-Harris Administration recently announced more than 200 million dollars allocated toward several projects, including the following: developing infrastructure to promote mental health, increasing access to trauma-informed and school-based support services, and increasing the number of trained behavioral health providers (Room, 2022). But what impact does federal funding genuinely have on the mental health of different communities across the country?

Mental illness is generally experienced at an equal rate across all racial groups (Maguire, 2008). However, Black, Indigenous, and People of Color (BIPOC) communities and other marginalized groups are less likely to have access to, seek out, and benefit from proper care than their White counterparts. For example, studies show that, compared to non-Hispanic whites, Black/African Americans with any mental illness have lower rates of mental health service use, including outpatient services and prescription medications (Motley, et al., 2018). Similarly, they are less likely to receive guideline-consistent care and more likely to use emergency rooms over mental health specialists. Therefore, structural interventions are essential to address multilevel
determinants that systemically perpetuate health inequities in all areas of healthcare, including mental health. Examples of structural interventions aimed at reducing mental health disparities include implementing greater legislative measures aimed at reducing self-harm, integrating specialized psychosocial care in basic health delivery packages, and raising public awareness to promote health literacy (WHO, 2015).

However, aside from resource accessibility, low use of resources among BIPOC is an issue that does not receive enough attention. Not only do racial and ethnic minorities have less access to mental health services but they are also more likely to delay or fail to seek care even when services are accessible (Miranda, et al., 2008). For example, African Americans are more likely to terminate treatment prematurely than their white counterparts (Sue, et al., 1994). Asian Americans are the least likely of any racial/ethnic group to seek mental health services and are three times less likely to access services than their white counterparts (CDC). Similarly, American Indians/Alaska Natives (AI/AN) have disproportionately higher rates of suicide than the rest of the U.S. population but are less likely to utilize mental health services (CDC). Furthermore, in 2019, nearly one fifth of AI/AN experienced mental illness, and suicide was noted as the second leading cause of death between the ages of 10 and 34 (CDC). Additionally, the suicide death rate for American Indian/Alaska Natives is 20 percent higher compared to non-Hispanic White populations. The current mental health care system is not set up to acknowledge, let alone address, reasons for low resource utilization.

Poor utilization of mental health resources, limited success of structural interventions aimed at improving accessibility, and the rising number of mental illness diagnoses each year suggest that current strategies are not working. There is thus an urgent call to rethink our society’s long-standing mental health paradigm and change the way mental health care is framed,
delivered, and received. Mental health care in the U.S. is widely criticized for holding onto values and principles originating from a historically abusive and discriminatory health care system (Drake, 2012; De Young, 2014). Along with the prominence of the biomedical model, which assumes that mental illnesses are brain diseases that can be treated with medication, the current paradigm has been shaped by the mistreatment, exclusion, and coercion of people with mental illness. Furthermore, because the paradigm fails to address specific needs of people of color, immigrants, LGBTQ+ individuals, and other marginalized groups, millions of people are forced to accept culturally insensitive, discriminatory systems of care. Instead of patching up problems, what we need is a radical transformation of our mental health care system.

The purpose of this thesis is to reframe mental health from a sociopolitical lens and address the unique barriers that prevent people of color from utilizing mental health resources. In this paper, I argue that we ought to rethink the current mental health care paradigm mainly in two ways: (1) shifting from an individualistic to collective understanding of mental health and (2) challenging traditional roles of psychotherapists and the function of therapeutic practice, where I offer the view that psychotherapy can serve as a form of social activism. This paper is broken down into two main parts. In the first part, I will first give a brief overview of the history of mental health care in the U.S. and the historical events that have led to and shaped our current mental health paradigm. Next, I will discuss the ways we ought to shift from an individualistic to collective understanding of mental health in the following order: introduce the individualism-collectivism theory, evaluate the relationship between collectivism and self-stigma, and discuss self-stigma as a unique barrier to mental health care. In the second part of this paper, I will discuss the ways therapy and other interventions can serve as a form of social activism. I will do this by evaluating current cultural competence practices, discussing alternative solutions such as
cultural humility and challenging the traditional role of the therapist. I will end the discussion by briefly mentioning ways mental health professionals, researchers, and activists have worked together to deconstruct contemporary therapeutic practices, improve mental health services for BIPOC, and utilize decolonizing frameworks.

A History of American Mental Health Care

The Asylum Movement

The stigmatization and discrimination of people with mental disorders can be traced back thousands of years. According to the ancient Greeks and other early civilizations, suffering from mental illness was thought to serve as punishment for angering the gods; during ancient times, it was widely believed that psychological distress was brought on by the possession of demons and required healing from sorcerers, mystics, and other healers (Laios, et al., 2020). Centuries later, philosophers like Hippocrates began to teach the principles of naturalism, introducing the notion that, as opposed to the demonological model, mental diseases could be explained by studying the brain’s central nervous system and were ultimately caused by chemical imbalances (Horwitz, 2020).

The spiritual underpinnings of mental illness emerged once again during the Middle Ages when priests and Christian physicians began to investigate the prevalence of hysteria, the first mental illness attributed to women and characterized by emotional outbursts, rage, and anxiety; it is estimated that over 100,000 women were persecuted as witches in the case of mass hysteria and burned at the stake (Rössler, 2016). Ultimately, the spread of Christianity between the 16th and 18th centuries revived the demonological model, normalizing “treatments” such as whipping, exorcisms, and bloodletting (Libiger, 2016). It was not until roughly the 17th century
of the Enlightenment period that mental illness was accepted as having a physiological cause again.

The late 18th century marked the rise of mental health hospitals known as asylums, which, particularly in Europe and the Americas, were designed to confine the rapidly growing number of “mentally ill” people declared too violent and disruptive to society. Asylums became notoriously known for their poor sanitary conditions, abusive superintendents, and overcrowding, which became a problem after they began to house the homeless and unemployed together with asylees (Moon & Kearns, 2016). Days in the asylum were unbearably long and torturous; asylees were given strict schedules to follow that usually were comprised of strenuous chores and treatments such as electroshock therapy, forced drugging, and the occasional lobotomy (Moon & Kearns, 2016).

By the 19th century, reformers like Dorothea Dix and William Tuke worked towards improving asylum conditions by advocating for a humane, rights-based approach called “moral treatment”. The moral treatment movement was aimed at helping patients grow spiritually by treating them with more kindness, freeing them from physical abuse, and providing opportunities for recreation and light manual labor. Other methods like occupational therapy and physical exercise were also used to rehabilitate patients and create structured, daily routines (Broussolle, 2014). However, by the middle of the century, asylums became more focused on confining rather than treating the mentally ill, leading to the pushback and eventual decline of moral treatment. This shift was largely driven by asylum overcrowding and ongoing societal prejudice toward people with mental illness (Scull, 2018). It is worth noting that, up until this point, people of color were rarely treated for mental health issues. Physicians like John Galt hypothesized that Black people were immune to mental illness because they were not capable of owning property
or participating in civic affairs and therefore not exposed to life stressors associated with profit making (Hughes, 1992). However, even when mental illness was recognized in the Black community, medical professionals argued that these conditions were attributed to the insanity former slaves displayed from being unable control their “appetites or passions” (Mays, 1897). The harmful psychological effects of slavery, segregation, poverty, and lunching were not recognized.

By the 20th century, asylums were replaced with community-based psychiatric care approaches. In the 1920s, Mental hygienists were tasked with developing treatment plans that emphasized prevention, early intervention, and holistic treatment of mental illness (Crossley, 2006). During this time, psychoanalytic theory was becoming widely accepted; for example, Sigmund Freud’s theory on early childhood development states that early life experiences determined mental well-being later in life (Freud, 1970). Treatment plans were designed by a team of psychiatrists, psychologists, and social workers and based on a child’s background, home life, intelligence, and natural abilities. Educational programs were designed to foster emotional intelligence among young children and raise awareness about the harms of historically controlling, abusive practices of mental health care. However, by the 1950s, psychiatric medications like chlorpromazine became increasingly popular as well as procedures like lobotomy and insulin shock therapy. Activists began to question the validity of psychiatry as a medical specialty, advocating for patient rights and mental health care reform.

The Anti-psychiatry Movement

The anti-psychiatry movement of the 1960s emerged from the aftermath of the asylum era. Thomas Szasz, the “grandfather of anti-psychiatry” and critic of the Diagnostic and Statistical Manual of Mental Disorders (DSM), argued that diagnoses falling under the term
“mental illness” are actually “judgements of disdain” passed off as medical categories. In his book *The Myth of Mental Illness*, he argues the following:

“...today, the notion of a person "having a mental illness" is scientifically crippling. It provides professional assent to a popular rationalization—namely, that problems in living experienced and expressed in terms of so-called psychiatric symptoms are basically similar to bodily diseases. Moreover, the concept of mental illness also undermines the principle of personal responsibility, the ground on which all free political institutions rest. For the individual, the notion of mental illness precludes an inquiring attitude toward his conflicts which his "symptoms" at once conceal and reveal. For a society, it precludes regarding individuals as responsible persons and invites, instead, treating them as irresponsible patients.”

Szasz’s work can be summarized in three points; first, mental illness is not real because there are no illnesses of the mind. In order for something to be considered a disease, there has to be a malfunction in the body that can be pathologized and explained at the cellular level. At the time, little was known about the biological underpinnings of conditions like schizophrenia. However, Szasz points are pertinent when it came to “conditions” such as hysteria or drapetomania. Szasz argued that “psychiatry wrongfully pathologizes and punishes rational human behavior that appear to deviate from the norm” (Szazs, 1961) Second, the language surrounding mental illness is dangerous because it takes away individual autonomy and dignity; it gives people the sense that they cannot “recover” from their condition and takes away any sense of personal responsibility they have in order to improve their condition. Third, psychiatry is pseudo-science that reinforces the social control and abuse associated with the asylum era. Szasz was committed to ending coercive psychiatry entirely.
Examining the origins of mental health care in the United States offers insight into how challenging it has been to conceptualize mental illness throughout history and how easily it has led to mistreatment. There has never been a more urgent time to change the way mental health care is framed and delivered than after the covid pandemic. For years, treatments have originated from the biomedical model such as psychotropic medications and other non-consensual measures. Slowly, society has collectively begun to realize the severe inadequacy of the biomedical model. The reductionist nature of the model has contributed to the abuse, exclusion, and coercion of people with psychosocial disabilities. Current treatment approaches are largely based on the biomedical model, which places greater priority on individualism and individualistic treatment. Ultimately, the model overlooks collective impact on individual well-being along with other social determinants of mental health among BIPOC.

The Collective Impact on Individual Mental Health

Individualism-Collectivism Theory

The individualism-collectivism theory is written about extensively within social psychology, cultural anthropology, and other disciplines (Kim et al., 1994; Triandis, et al., 2012). One of the earliest definitions of individualism is the placement of one’s own autonomy, self-fulfillment, and personal rights above the duties, responsibilities, and expectations found in our relationships with others (Hofstede, 1980). In contrast, collectivist cultures place greater value on mutual obligations and benefits found in relationships and other social units within the group to which they belong (Singelis, 1995). In collectivist cultures, group membership is central to individual identity such that the norms, values, and traditions shared between members are what shape individual identity; this social way of being is oriented toward the in-group, whether that is
a family, religion, or ethnic group, thereby prioritizing harmonious relationships, self-sacrifice for the common good, and reciprocity (Markus & Kitayama, 1991; U. Kim, 1994; Kwan & Singelis, 1997). The individualism/collectivism distinction is relevant to BIPOC mental health in two ways. The first way deals with individual experience and mental health challenges as a product of collective culture. The second way focuses on socioecological impacts on collective mental health.

Collectivism and Stigma Interventions

A value set – a collection of values held by a group – of a given racial/ethnic group is influenced by whether its culture is more individualistic or collectivist. In cultures oriented toward collectivism, such as Japanese, Indonesian, and most other Asian countries, values such as honoring and caring for the elderly, sacrificing personal freedom and interests for the sake of family prosperity, and educational achievement are central to the growth and stability of a community (De Bary, 2010). These values shape group attitudes and perceptions which, in turn, can encourage positive group behaviors such as cooperation, collaboration, and loyalty. A study by Papadopoulos et al. (2013) was the first to investigate whether the collectivism-individualism paradigm is a useful model for understanding causes of mental illness stigma. Researchers aimed to collect samples of mental illness attitudes from participants belonging to traditionally ‘individualistic’ cultures and ‘collectivist’ cultures. Participants described themselves as belonging to the white/American cultural group, Greek/Greek Cypriot group, or the Chinese group. Participants were asked to complete questionnaires to assess participants’ knowledge of mental illness and attitudes toward mental illness. In addition, survey questions were used to determine community measures such as levels of authoritarianism, benevolence, and social restrictiveness. The results demonstrated significant differences in stigmatizing attitudes between
cultural groups. Additionally, they found that high scores of individualism in participant groups correlated to lower stigmatizing attitudes, while high scores of collectivism correlated to higher stigmatizing attitudes. Lastly, the study demonstrates that it is likely that collectivist cultures hold stigmatizing attitudes toward mental illness due to there being (1) lower levels of racial/ethnic diversity, (2) lower levels of fragmentation, which is the absence of connections between a group and its individual members, and (3) greater visibility when people deviate from the norm. The results of this study support the hypothesis that the collectivism-individualism paradigm is an effective explanatory model for understanding mental health attitudes between cultures. More importantly, the study “extends to the idea that collectivist cultures will be more stigmatizing… and the associative theory that people who deviate from the norm are more visible to the community due to higher surveillance levels”.

All racial/ethnic groups have varying degrees of collectivism and individualism. Additionally, although the overarching value set of a cultural group may be identified as collectivist- or individualist-leaning, this does not imply that these values apply to every individual within the group. As with any group trait, there are variations in a population, and other influencing factors need to be considered. With that being said, many BIPOC sub-populations within the United States are identified as collectivist communities living within the larger individualistic American culture (Han & Pong, 2015); for example, studies have identified Mexican-American and most Asian-American communities as predominantly collectivist, sharing the community values of their family’s cultural roots. In Asian cultures, “mental illness often is not considered as an individual problem…[it] represents a negative reflection on the immediate family as well as their ancestors” (Han & Pong, 2015). However, for Native-American communities, there is greater variation in collectivist tendencies, particularly between
men and women (McDonald, 2014). Therefore, it is unsurprising that mental illness stigma is experienced by individuals in some racial/ethnic groups more than others. However, it has been argued that making these comparisons are irrelevant because all cultural groups experience mental illness stigma (Abdullah & Brown, 2011; U.S. Department of Health and Human Services, 2001; Yang et al., 2007). Ultimately, BIPOC experience stigma at much higher rates than their White counterparts (Papadopoulos, 2013). The relationship between stigma, collectivist culture, and mental illness are important considerations when designing and implementing different therapeutic frameworks.

*Cultural Competence and Stigma Interventions*

In recent years, greater priority has been placed on cultivating cultural competence in MHC settings to reduce stigma and increase therapist awareness of their own assumptions made toward BIPOC clients, but more importantly, to find ways to deliver treatment more effectively according to a client’s specific needs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) cultural competence guidelines, “cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together… that enables effective work in cross-cultural situations”. Furthermore, it is suggested that counselors should engage with their own heritage to understand multiple worldviews, address issues of power and trust early in the client-counselor relationship, be as knowledgeable as possible about client cultural attributes, and allow for more flexibility in clinician roles and practices while maintaining professional boundaries.

However, researchers have demonstrated that cultural competence training presents a risk of further stereotyping, stigmatizing, and fostering racist attitudes and behaviors toward clients (Lekas, et al., 2020). Others have raised the point that the idea of cultural competence suggests
culture is homogenous and can be reduced to teachable skills – a list of “dos” and “don’ts” (Kleinman, et al., 2006). Alternatively, researchers have proposed training in ‘cultural humility’ – care that is centered on self-reflexivity and an overall appreciation for patient expertise (Lekas, et al., 2020). For example, using the cultural humility approach, a therapist may learn about their own power and privileges instead of trying to achieve a high level of knowledge about a culture to which they do not belong. In addition, therapists may begin a session by acknowledging the client as the authority figure when it comes to decision-making relating to their lived experiences (Moncho, 2013). Ultimately, cultural competence training is not entirely effective and appears to serve as a bandage fix for deeper rooted issues.

Complementary Approaches and the Role of the Therapist

Broader discourse surrounding the relationship between mental health and social activism has surfaced in recent years. For example, in light of the recognition of Black Lives Matter as a global movement and the increased media coverage capturing and exposing the ways Black people disproportionately experience racial bias and police violence in the U.S, academics and mental health professionals have aimed to improve therapeutic guidelines that consider the interconnectedness of structural racism, history, macro-level contexts, and the dehumanization and exclusion of Black lives. For example, therapists have begun to complement traditional interventions and rebuild practices by directly addressing race-related trauma with Black families through racial socialization and critical consciousness (Boyd-Franklin, 2013; Kelly, et al., 2020). According to Sanders (2006), “race socialization is defined as the verbal and nonverbal messages parents provide children about their race in relation to other racial groups within society”. For example, teaching children to take pride in their identity in the face of negative media representation is a protective buffer against negative messages that are damaging to self-esteem.
and mental health in adulthood. Although previously criticized by other models, socialization also entails preparing children to acknowledge their position in racial hierarchies as a way to deal with stigmatization, racial prejudice, and discrimination (Harris, 2011). Although these strategies are mainly documented in child rearing, therapists are encouraged to integrate these practices into their sessions by creating space for storying survival and encouraging parents to foster sociopolitical awareness in their children (Kelly, et al., 2020).

Critics have raised concerns over whether psychotherapists ought to politicize their practice or involve themselves in politics altogether. In their book, We’ve Had a Hundred Years of Psychotherapy—and the World’s Getting Worse, Hillman and Ventura (1992) argue that psychotherapy has had negligible impact on addressing inequities or injustices found in the world. Samuels (2004) offers a middle ground, examining the existing boundaries between therapy and politics; on one hand, he argues that therapists “so much want and need to be right” and “reduce everything to this special knowledge that they have”, expressing skepticism about a therapist’s ability to create social change. On the other hand, he argues that there are clinical opportunities to develop clinical principals that allow for meaningful political discussions within the “sealed vessel of ordinary therapy relationships.” In a final commentary, Ingle (2021) states the following: “psychotherapy is not a substitute for social activism and political change, though it may support and complement other forms of transformation”.

In response to these criticisms, I offer an alternative view by suggesting that therapy can serve as a form of social activism in the fight to dismantle oppressive social structures that perpetuate systemic racism and other injustices in mental health care. Social activism and mental health care do not have to be mutually exclusive; not only can therapists become activists, but therapy in itself can serve as a catalyst for social change. Brenman and Sanchez (2012) define
social activism as “working with other people to bring about a change in society…the idea that the activism fosters opportunities for participation. It reflects a personal choice to engage in society”. While therapy does not appear to share similarities with other forms of activism like marches or strikes, critics may be underestimating the impact the therapist-client relationship can have on the larger community. As previously discussed, adopting cultural humility guidelines and utilizing shared decision-making frameworks like racial socialization are examples of ways to engage in discussions about race with clients and their families. At the same time, therapists are trained to “self-evaluate, self-critique, and redress power imbalances in the therapist-client relationship” (Foronda, 2020). Therefore, the therapeutic setting provides opportunities for both the counselor and client to tackle root causes of social issues as they work on improving the client’s mental health. Critics may be underestimating the impact this relationship can have on the client’s community and the ability for clients to bring their knowledge to the broader society.

In line with this view, many scholars have argued that problems arise when activism and mental health are kept separate both conceptually and in practice. For example, Schmid (2012) argues that a political understanding is inherent to person-centered therapy (PCT). Furthermore, they argue that psychotherapists or counselors who do not care about politics do not take their client seriously and create harm. Therefore, acknowledging the political underpinnings of the American mental health establishment that have led to the abuse and mistreatment of BIPOC and other marginalized communities, therapists ought to use their best judgement to determine how best to politicize their practice. In the following section, I provide more examples of the ways mental health professionals, researchers, and activists have worked together to deconstruct contemporary therapeutic practices, improve mental health services for BIPOC, and utilize
decolonizing frameworks. In recent years, mental health advocates have worked together to address the effects of cultural and intergenerational trauma on the mental health and resilience of marginalized communities.

**Collective Trauma**

*Post-traumatic Stress and Intergenerational Wounds*

Population-based studies provide considerable insight into the importance of assessing mental health in BIPOC communities suffering from collective trauma. Collective trauma is defined as the “psychological reactions to a traumatic event that affects an entire society… [suggesting that] tragedy is represented in the collective memory of the group” (Hirschberger, 2018). The story of Bophal Phen, a Cambodian therapist who investigated the occurrence of hundreds of Cambodian patients experiencing sleep paralysis, demonstrates how poor collective mental health can be overlooked as a result of numerous misdiagnoses, a lack of cultural understanding, and a failure to account for personal trauma (Reicherter, et al., 2015).

In a study led by Mollica et al. (2013), researchers conducted the first community study comparing conflict-affected and non-conflict affected Cambodian civilians to determine whether survivors of the Pol Pot genocide experienced ongoing mental health problems decades later. Approximately two-thirds of participants reported post-traumatic stress (PTSD) symptoms within clinical range. The study utilized the Hopkins Symptom Checklist (HSCL-25) as a diagnostic tool to measure symptoms of anxiety and depression. The Harvard Trauma Questionnaire (HTQ) was used to evaluate lifetime exposure to 38 extreme violence events and 19 potential torture events. The results demonstrated a strong association between trauma events and both PTSD and depression diagnoses. Additionally, they found that traumatic events among Cambodian populations contribute to the development of serious health consequences, although
cultural and socio-economic factors were not accounted for and may have played a role. They concluded that future population-based studies with similar groups should consider the ways in which Cambodians make decisions about their health and the factors that influence their choice of either traditional or western treatment.

The shared trauma experienced by BIPOC, immigrants, and refugees that has led to collective suffering and mental instability is directly tied to the intergenerational wounds of social inequity and historical trauma: slavery, segregation, police brutality, and mass incarceration of Black people in the U.S.; the deportation, discrimination, and family separation of Latinx people; the colonization, land dispossession, and cultural erasure of Indigenous people; and the hate crimes, model-minority myth, and xenophobia of Asian communities. Racial violence, climate change, genocide, war, and mass shootings, are responsible for the poor physical, mental, and emotional health of BIPOC communities in the United States.

The view that mental health is a sociopolitical problem opposes traditional, medicalized, Western views of mental illness. The latter are rooted in biomedical reductionist models which state that “mental illness and other diseases can be reduced to biological causes in the body, and treatment of those diseases are also biological in character, such as surgery or medications” (Ghaemi, 2009). Along these lines, the biomedical perspective is responsible for reinforcing the notion that 1) healthcare services are equally accessible to all and 2) individuals have an awareness and freedom to access these services. Furthermore, individuals are responsible for accessing those services on their own (Horrill, et al., 2018). These views permeate every aspect of healthcare, and mental health is not an exception. Western, colonial views assess causes, treatment, access to treatment, and success of mental health treatment in isolation, placing most healthcare burdens on the individual. Although systemic and structural inequalities, trauma, and
injustices are becoming recognized as contributors to mental illness and other diseases around the globe, the U.S. healthcare system is not designed to recognize them.

*Healing from Collective Trauma*

In their book *Inflamed* (2021), Dr. Rupa Marya and Raj Patel discuss how decolonizing work helps to heal and restore the bodies and communities of indigenous people. They write, “there is a medicine that is mindful and active in resisting colonial cosmology… that we call ‘deep medicine’… it starts with the act of repairing those relationships that have been damaged through systems of domination”. In this final section, I will discuss some ways mental health professionals, researchers, and activists have worked together to deconstruct contemporary therapeutic practices, improve mental health services for BIPOC, and utilize decolonizing frameworks.

In the mental health space, many practitioners have already started this work; Dr. Jennifer Mulan, clinical psychologist and director of the peer education group Decolonizing Therapy, is reimagining the mental health paradigm by challenging traditional Eurocentric approaches, centering her work on the intersection of historical and ancestral trauma, colonial violence, and psychological enslavement (Mullen, 2023). This work is more than cultural competence; it tends to the roots of collective suffering. The purpose of decolonizing practice is to unlearn and deprogram frameworks shaped by a violent, oppressive past.

As mentioned earlier in the discussion, in many ways, AI/AN populations experience worse mental health outcomes compared to any other racial/ethnic group. Reflecting on the history of Indigenous populations is necessary for understanding the population’s high rates of mental illness and cultivating practices that people will benefit from. Previous governmental policies concerning this population have led to mistrust of services and care by White
practitioners. Historically, extreme effort was made to eradicate Native culture, separate children from their families, and remove them from their land (Pritzker, 2000). The consequences have led to extreme poverty, poor physical health, and high rates of mental illness.

Lewis et al., (2018) designed a multicultural training program for Indigenous clients rooted in multicultural counseling competencies, cultural humility, and a decolonizing framework. The program objectives were to 1) increase Indigenous knowledge on the effects of socioeconomic influences on their culture, 2) increase awareness of personal biases and its interference with clinical treatment, and 3) provide ethical and effective skills for health care workers to work with clients. Researchers utilized a decolonizing framework aimed at criticizing dominant paradigms like the biomedical model, and centering liberatory healing methods. Researchers also highlighted the importance of adapting evidence-based treatments to fit Indigenous belief systems; for example, Indigenous cultures value the relationship between feelings, emotions, and physical reactions; finally, it is recommended that this program is adopted in various settings.

Conclusion

In a press release, WHO Director-General Dr. Tedros Ghebreyesus states the following: “The inextricable links between mental health and public health, human rights and socioeconomic development mean that transforming policy and practice in mental health can deliver real, substantive benefits for individuals, communities, and countries everywhere.” (WHO). The shift from a traditional, western, reductionist paradigm of mental health to one that recognizes the collective, tackles systemic injustices, and prioritizes holistic healing is long overdue. Lewis (2018) makes the point that “mental health is no longer simply an act of implementing psychological diagnoses and treatments… mental health is an inherently political
practice to create mental health equity.” Therapists, psychiatrists, and other mental health professionals mirror systemic injustices and the ways in which those injustices are perpetuated in society and reflected in the health of clients. In this discussion, I have challenged the current mental health paradigm and discussed where current MHC strategies fall short. I have addressed strategies to improve interventions in such a way that aligns with a new paradigm, specifically, one that prioritizes the collective.
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