



NO NEW WARS
NO TO NATO

ABOLITION
ECOLONIZATION
LIBERATION

NO NO
MATE

DEFUND
NYPD

BLACK
LIVES
MATTER

STOP
DISPLACING
PEOPLE WITH
MENTAL
DISEASES
PROTECT
OUR
CHILDREN

NO JUSTICE
NO PEACE

FREE
PALESTINE

I CAN'T
BREATHE

RESIST

YOU ARE ON
STOLEN LAND

DECOLONIZE YOUR
MIND!

WE CANNOT BIRTH THE NEW WORLD WITH A COLONIZED MIND

DRA. ROCÍO ROSALES MEZA

A Tri-Country Analysis of the Effects of White Supremacy in Mental Health Practice and Proposed Policy Alternatives

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ABSTRACT

The goal of this paper is to take a closer look at mental health care policies in Nigeria, China, and the United States. These nations were selected for their demographic diversity as well as for the shared influence that European colonization, imperialism, and white supremacy culture have had on their equally diverse mental health policies and practices. How do historical and cultural perspectives affect different nations' mental health policies and approaches (via a multi-nation comparison)? This analysis aims to tackle this question, discussing how cultural humility both currently and historically informs mental health treatment for non-white populations within the United State. In addition it examines imperialist and colonial mental health treatment of local populations in China and Nigeria. Finally, a global policy strategy is presented to promote the practice of cultural humility on a multinational scale.

Keywords: Cultural humility, Decolonization, White Supremacy, Global policy, Global mental health

Western-oriented psychotherapy¹ and mental health treatment have long held a dominant global position, while practices rooted in non-white cultures have been diminished or erased. As such, modern psychotherapy, dictated primarily by Anglo-Americans and Europeans, is inadequate to meet the needs of a diverse clientele in many countries and creates a gap between the intent of mental health policies—to provide mental health services that meet the unique needs of all people—and their practice (Koç & Kafa., 2019). With a culturally humble clinical approach, we can recognize the impossibility of fully comprehending all cultural nuances and traditions and respect therapeutic alliances between clinicians and culturally diverse clientele. We use this frame to discuss the negative impacts of Westernized mental health policies and approaches in Nigeria, China, and the United States (U.S.), and provide suggestions to address these issues.

This paper posits that the current mental health policies and practices of Nigeria, China, and the U.S. do not fully support the mental wellbeing of their citizens. The colonial and imperialist histories of Nigeria and China, respectively, have fostered perspectives built upon white supremacist ideas which have had lasting effects. Nigeria’s lack of updated mental health legislation and funding for state-operated Western psychiatric hospitals leave a backlog of patients with a limited number of providers to help (Abdulmalik et al., 2016). China’s underfunding of traditional mental health practice and dearth of eligible providers in rural locations leave citizens in those areas without accessible mental health care. These phenomena are the result of increased hospital-based care following the introduction of Western-style psychiatric hospitals by 1898 and the gradual diminishing of community mental health programs

¹ “Western psychotherapy” is a term used to refer to the influence that Western cultures, specifically the U.S., have had on psychotherapy practice. This practice is influenced by such historical and cultural values as individuality, reductionism, measurement, materialism, and objectivity. It also historically emphasizes a focus on psychopathology and reliance on a medical model of alleviating symptoms (Koç & Kafa, 2019).

during the 1966–76 Cultural Revolution (Liu et al., 2011).² The United States struggles with a lack of culturally conscious providers for those who are non-white, due to the high number of white providers in the field as well as education influenced by white supremacy. Many non-white researchers and practitioners are actively working to incorporate culturally humble practices, but still the majority of mental health practices in the three focal countries undermine alternatives (e.g., non-Westernized practices and culturally traditional practices; Gopalkrishnan, 2018).

Cultural humility is a critical consideration, both currently and historically, for mental health treatment for non-white populations within the United States, as well as for those living in nations with imperialist and colonist roots, such as China and Nigeria. Current practice in each of these countries prioritizes white-centric mental health values, consequently delegitimizing traditional mental health practices. This paper reviews policies put in place by multinational organizations, analyzing their impact on direct practice in the United States, China, and Nigeria, as well as the extent of such policy implementation within these countries. The term “traditional” will be used to encompass any mental health practice that is not “Westernized” or practiced by colonizers and that does not center white supremacist values. The term “Western” will be used to describe any practice that is eurocentric in nature and centers/is the result of white supremacist values.³

BACKGROUND

NIGERIA

Historically, psychiatry practiced in colonized countries, or colonial psychiatry, represented the first attempt to systemically interpret

² *Mental health system in China: History, recent service reform and future challenges* is a source used for historical information and context. This source is not used for statistical data or present-day information.

³ “Eurocentric” refers to the tendency to interpret the world from the perspective of European or Anglo-American values and experiences (Merriam-Webster). As an example, 95% of the mental health research published in the top six American Psychological Association journals have focused on either Americans or Europeans (Koç & Kafa, 2019).

psychiatric symptoms through the lens of white supremacy in cultures that were traditionally non-western in nature (Studer, 2015). Colonial psychiatry served as one of the first instances of political control, as the British used reports from Nigerian psychiatric hospitals to maintain dominance over the colonies (Buoli, 2021). The introduction of Western culture and medicine produced an ideological culture clash and subsequent unequal power dynamics between Western and indigenous Nigerian medicine (Searight, 2014). Individuals with mental health challenges often sought care from traditional healers known for treating clients holistically and reconnecting people with social and emotional resources rooted in community rules and relationships (Searight, 2014). However, mental health challenges were frequently attributed to supernatural or religious causes—causes colonial powers perceived as unscientific (Odebiyi, 1998).⁴ Over time, Western methods dominated.

Beginning with British colonization in Nigeria, people with mental health illness were made invisible and were restrained or detained (Onyemelukwe, 2016). Asylums⁵ were introduced in 1906, aimed to house the growing number of houseless so-called “lunatics”⁶ in urban centers (Faleye, 2017, p. 137). Today, the Nigerian government is unable to commit to the utilization of traditional methods. Though Nigeria achieved independence from Great Britain in 1960, colonist influence persists (Searight, 2014). The government has made great efforts to train health personnel and provide modern health facilities, largely disregarding their country’s traditional healers (Gureje et al., 2015). Westernized psychiatric facilities with clinicians trained in methodologies rooted in white supremacist ideas are inadequate to meet the needs of all Nigerians. These inadequacies include a lack of recognition of the way religion and spirituality influence the psychosomatic experiences of many people. Research has found that citizens experience feelings of alienation and dissatisfaction toward government policies, including

⁴ *Appraisal of the Mental Health Care Policy in Nigeria* is a source used for its historical information and context. This source is not used for statistical data or present-day information.

⁵ Centers for those with mental health challenges were historically referred to as asylums, which is now acknowledged to be a derogatory term.

⁶ A derogatory term used to define those with mental health challenges.

healthcare policy, a result of decades of economic exploitation during British colonization (Odebiyi, 1998, p.11). This cultural disregard discourages Nigerians from seeking mainstream therapeutic facilities (Odebiyi, 1998).

Though mental healthcare-promoting bills have been proposed, such as the Mental Health and Substance Abuse Bill in 2020, there have ultimately been few positive legal developments (Ugochukwu et al., 2020). A 2017 World Health Organization (WHO) report showed that about seven million people in Nigeria are suffering from depressive disorders, and 4.8 million people are suffering from anxiety disorders (*Depression and Other Common Mental Disorders: Global Health Estimates*, 2017). Further findings have shown that fewer than 10 percent of those with mental health challenges have access to healthcare due largely to the country's outdated laws and poor budgetary allocation that can be tied back to the economic exploitation and management of the colonial era (Soroye et al., 2021).

CHINA

Traditional Chinese medicine encourages individuals to keep a dynamic balance of Yin and Yang to achieve a psychological and physiological state of stability (Zhang & Chi, 2013). Many traditional methods were developed to maintain this balance, such as massage, acupuncture, and physical and breathing exercises (Zhang & Chi, 2013). In the 19th century, traditional methods diminished from mainstream practice in China. After losing the Second Opium War, China was unable to resist the economic, political, and cultural influence of white imperialist forces (Borg, 2020). Overwhelmed by Western imperialism, Chinese reformers held events like the "Hundred Days' Reform" in 1898 and advocated reforming previous political systems and, instead, studying Western ideology and technology (Kerr & Wright, 2015).

During the 19th century, facilities for individuals with mental health challenges did not exist. Due to limited resources and a lack of access to mental health support, many families in China confined relatives with mental health challenges to their homes (Chiang, 2016). In 1898, American medical missionaries established and funded a

psychiatric hospital. This set the stage for a consolidated Westernized medicalization and institutionalization of mental health (Li & Ran, 2021). Starting in 1966, the Cultural Revolution informed China's building of psychiatric hospitals throughout the country and the closure of many community-based programs (Li & Ran, 2021). As a result, traditional Chinese mental health practices continued to decrease, and Westernized methods expanded. In 2015, the General Office of China's State Council issued a National Mental Health Work Plan which proposed a comprehensive coordination strategy focused on the improvement of the service system as a whole (Wang, 2017).

In addition to value discrepancies across mental health services, China also faces an inequitable distribution of mental health resources. In well-resourced areas, the mental health system is rapidly reforming, whereas in under-resourced areas, such reforms are lacking (Liu et al., 2011). Over the last two decades, the Chinese government has prioritized community-based mental health practice, allocating funding to rural provinces. However, the country still faces issues of stigma attached to mental health providers, and general physicians lack the knowledge and skills for basic mental health treatment (Liu et al., 2011).

UNITED STATES

The U.S. is considered a melting pot, with a populace of diverse racial, ethnic, religious, and cultural backgrounds. However, the ubiquity of racism in the U.S. guarantees policies deeply entrenched in white supremacist perspectives and values. In mental health settings, non-white communities are underrepresented, clinicians lack proficiency in culturally humble practice, and academic and training institutions fail to adequately integrate culturally attuned pedagogy (Gopalkrishnan, 2018). Mental health resources are distributed unequally and traditional approaches are seldom applied in treatment.

U.S. mental healthcare has been historically shaped by white-centric practices, with the majority of treatment occurring in asylums and hospitals until the early 20th century. In the early 1800s, patients with mental health challenges were punished by practitioners who tied

their suffering causally to sin. Such practices date back to Protestant traditions that determined the worth of and punished those in poverty. As a result, people with mental health challenges suffered inhumane confinement and continued stigmatization (Floyd, 2019; Anglin et. al, 2006). Until the emergence of mental health institutions, families often sent relatives with mental health challenges to almshouses: residential accommodations belonging to charity organizations (Wilson, 2021). In the mid-1800s, the federal government responded to ongoing advocacy efforts by setting up 30 state psychiatric hospitals. However, these hospitals were often understaffed and underfunded, subjecting patients to human rights violations including a severe lack of informed consent, unclean living quarters, maltreatment, and abuse (Mfoafo-M'Carthy & Huls, 2014). In response, advocates (including social workers) collaborated with policymakers to establish more humane mental health services, ultimately deinstitutionalizing psychiatric hospitals and diverting funding to community-based mental health services.

The 1963 Community Mental Health Act cemented the closure of these hospitals, instating a policy that reserved admittance to state facilities for patients who posed imminent danger to themselves or others (Testa & Wilson, 2021). While this legislation marked progress, the standards for those within the aforementioned high-risk demographic continue to pose concern today. Many social workers and activists believe these standards of imminent danger are harmful to individuals admitted to state facilities, citing a lack of informed consent and autonomy (Substance Abuse and Mental Health Services Administration, 2019).

Colonial mental healthcare, and resulting Western psychotherapy practices, continue to dominate U.S. practice, despite their failure to attend to diverse lifestyles and ideologies. An example is the use of diagnostic criteria in clinical settings, which often fails to account for cultural and social class differences across racial and ethnic groups. Gambrill's work has supported this argument, asserting that the Diagnostic and Statistical Manual of Mental Disorders (DSM, 2014) dehumanizes individuals by stripping their lived experience and trauma from environmental (social, political, and economic) context.

In addition, mental health clinicians in the U.S. are disproportionately

white and their perceptions of non-white patients tend to be limited, often causing inaccurate stereotypes regarding type and degree of mental health challenges to be imposed (Luona et al., 2018). Black patients are often on the receiving end of these under-qualified clinicians' services, and are perceived as less intelligent, more likely to abuse alcohol and substances, and less likely to be rational and comply with prescriptions (Yeager et al., 2013). White clinicians are also more likely to conceptualize non-white mental health challenges as rooted in individual shortcomings rather than social-structural inequities (Yeager et al., 2013).

Tendencies favoring white supremacist views on mental health challenges have deleterious effects on the mental health outcomes of non-white individuals in the United States. In white-centric mental healthcare, non-white individuals often encounter microaggressions they do not encounter with clinicians from similar cultural, racial, or ethnic backgrounds. Many patients of color report that they are not carefully listened to or given proper explanations, are denied respect, and struggle to communicate with white clinicians (Yeager et al., 2013). This lack of cultural humility in services further causes non-white communities to lose confidence in mental healthcare services.

Though mental health treatment has continued to improve, about one in five American adults suffer from mental health challenges each year and about 1 in 20 experience serious mental health challenges. Despite these alarming statistics, only 45% with mental health challenges and 66% with serious mental health challenges receive treatment in a given year (Mental Health by the Numbers, 2020). Additionally, as of 2020, approximately 134 million Americans (~41%) lived in areas with scarce access to mental healthcare, highlighting an urban-rural resource divide (Mental Health by the Numbers, 2020). In the same year, 55% of U.S. counties did not have a single practicing psychiatrist (*Mental Health by the Numbers*, 2020). Though the U.S. boasts a wide variety of mental health providers (psychiatrists, psychologists, licensed social workers, etc.), most are concentrated in and around urban areas.

COUNTRY VARIATION IN POLICY

Nigeria's government is based on democratic principles, with balanced power at the federal, state, and local levels. Mental health treatment is overseen by the federal government's National Health Policy, from which mental health is largely excluded (Abdulmalik et al., 2016). Given the country's status as a low- to middle-income country, health spending is small and largely prioritizes noncommunicable diseases (NCDs), which are responsible for 73% of deaths worldwide (NCDs do not include mental health challenges; Prynne et al., 2019). As a result, mental health is not a priority. Abdulmalik et al. (2016) found that unlike China, which provides coverage for 95% of its citizens, Nigeria's national insurance coverage only covers about 5% of the population, with minimal coverage for mental health conditions (Finch, 2013). Although community-based insurance schemes and state and local social welfare interventions exist, most mental health treatment requires out-of-pocket payment. Treatment also most often occurs within primary care facilities, supplied by general practitioners trained to prescribe a limited array of psychotropic medications (Abdulmalik et al., 2016).

In China, prior to the introduction of psychiatric hospitals, community-based healthcare in the form of support from families, friends, and/or community healers was common practice (Liu et al., 2011). Today, most Chinese mental health treatment remains hospital-based. With a highly centralized government, China has both private and public healthcare facilities and insurance providers; however, more research is needed to determine the true extent of mental health coverage from both public and private insurance. According to the most recent data in 2013, the costs for inpatient and outpatient psychiatric treatment was an average of \$971.70 per individual and 57% of those with severe mental disorders in China were unable to afford the necessary treatment, as they lived below the poverty line of \$1.00 per day (Liang et al., 2017).

Obstacles to care in China are exacerbated by the gap between the magnitude of mental health needs and available treatment. Close to 92% of Chinese citizens report never having received mental health care (Liu et al., 2011). With psychiatric hospitals receiving a majority of the

government's budget for mental health care, individuals experiencing more common mental health challenges such as depression and anxiety are left with few resources to access treatment. China has less than a quarter of the number of psychiatric providers the U.S. has, and virtually no counselors or social workers, as "social work" constitutes an entirely different field in China than in the U.S. (Fang et al., 2020).

The capitalistic system in the U.S. impacts mental healthcare through high treatment costs only occasionally covered by insurance. Mental health costs are primarily associated with outpatient care and psychotropic medication rather than hospitalization, addressing the symptoms of mental illness but failing to address its root causes. U.S. mental health treatment has largely been built around such "quick fixes," individual treatment, and high medication costs (Larson, 2018). In 2020, approximately 91% of Americans had either public or private health insurance (Keisler-Starkey et al., 2020). However, only 56% of psychiatrists in the U.S. accept commercial insurance, and government-sponsored insurance plans like Medicare only cover about 23% of psychiatrists (Leonhardt, 2021). This phenomenon renders mental health treatment only accessible to those with economic means.

In the U.S., differential access to treatment often intersects with racial identity. Systemic oppression inhibits many Americans of color, most notably Black Americans, from accessing effective mental healthcare (Cook et. al, 2017). In this country, mental health challenges often coalesce with housing insecurity, incarceration, and racism, yet mental health treatment remains unacknowledged as a social justice issue. Instead, it is viewed as a privilege to which only some have access. Further indicating the extreme need for increased access to mental healthcare, a study published in 2018 revealed the staggering statistic that 25-40% of Americans with mental health challenges will be incarcerated in their lifetime (Larson, 2018). Comparatively, 37% of people in state and federal prisons have been diagnosed with a mental illness (*Prison Policy Initiative, 2022*). These statistics demonstrate the serious risk that uninformed, inadequate mental health care policy can pose to the lives of individuals in the United States.

When compared to the U.S., Nigeria and China experience a greater

shortage of resources. While Nigeria lacks an adequate number of mental health clinicians, China struggles with the stigmatization of the profession as a whole, making people hesitant to enter the field of mental health (Zhou et al., 2019). Across all three countries, an extreme disparity in access to care exists between urban and rural areas.

One element unique to Nigeria is that, according to its constitution, mental health treatment is seen as a right and a social justice issue (Abdulmalik et al., 2016). The Nigerian government acknowledges that mental health challenges often intersect with disability to impact quality and length of life. Conversely, the Chinese government has not deemed mental healthcare a right and views involuntary hospitalization as a part of patient care (Nigeria, by contrast, considers such hospitalization a human rights violation; Abdulmalik et al., 2016). Finally, though organizations like the APA in the U.S. have recognized mental health as a human right, the U.S. government has yet to recognize health as a human right, let alone mental health (Gerisch, 2018).

CURRENT GLOBAL INITIATIVES

Multinational organizations such as the United Nations (UN) and the WHO have developed initiatives spanning multiple continents to support the expansion and development of mental health policy (*Department of Economic and Social Affairs*, 2015; *MHAP*, 2013). In 2013, the WHO initiated a Global Mental Health Action Plan (MHAP) to be completed in 2020 with the purpose of guiding nations to increase the availability and quality of mental healthcare (*MHAP*, 2013). Dr. Margaret Chan, Director-General of the WHO, stated that “this comprehensive action plan recognizes the essential role of mental health in achieving health for all people” (*MHAP*, 2013, p.5). This approach focuses on the interconnections of both biological and social factors in one’s life in order to understand the broader context of mental health needs, and is intended to result in more accurate diagnosis and treatment with a social justice lens (Susser et al., 2013). The MHAP is founded on the principle that mental health is a core element of individual and community health and is intrinsically linked to physical health (*MHAP*, 2013). This plan addresses the disparities between nation preparedness

and execution of mental health treatment plans and legislation, primarily focusing on low- and middle-income nations such as Nigeria and China. Alternatively, high-income nations, such as the U.S., see greater progress in mental health care legislation (*MHAP*, 2013).

Nearly every aspect of the MHAP incorporates collaborative programs, community-based initiatives, and integrated care (*MHAP*, 2013). This plan calls on legislators to incorporate mental healthcare into efforts toward poverty reduction and development strategies and practices, providing a collaborative and comprehensive approach to improving global mental healthcare. Comprehensive by nature, the plan incorporates “religious leaders, faith healers, [and] traditional healers” into policy guidelines and practice criteria (*MHAP*, 2013, p. 14). This practitioner inclusion acknowledges the significance of traditional healing methods and provides lawmakers and leaders with tangible reasons to incorporate centuries-old practices into modern-day legislation and programming. Additionally, it highlights the importance of cultural humility in addressing the mental health needs of populations negatively impacted by white-centric approaches.

In addition to the MHAP, in 2015 the UN added mental health to its Sustainable Development Goals and included in its declaration a call to envision a world where equitable access to care is the norm (Votruba et al., 2016). In order to achieve this globally-inclusive, equitable access, the UN divided its mental health approach into three major areas: reducing premature mortality via care for mental well-being, preventing and treating drug use disorders, and achieving universal effective, quality health coverage (Votruba, et al., 2016). The UN also called for collaborative approaches, encouraging NGOs and civil society organizations to work with national governments to devise equitable mental health legislation (Votruba et al., 2016).

Currently, global foundations of mental health education are based on Western practice and methodology, inhibiting non-Western nations from normalizing traditional systems of practice and care. To address global mental health care inequities most effectively, mental health education and treatment should integrate traditional and Western practices in a fashion that best supports the mental and social liberation of those

being served. For multinational approaches to effectively improve mental healthcare, it is imperative that they emphasize diversity of practice, legitimacy of traditional care, and disruption of institutionalized oppression and social stigma across the globe.

POLICY ALTERNATIVES

To respond to the influences of colonization, Westernization, white supremacy, and racism present in mental health treatment in Nigeria, China, and the U.S., governments must respond with new policies and approaches to training mental health clinicians. In Nigeria and China, this includes centering traditional cultures, values, and methods. In the U.S., this includes more culturally humble and inclusive mental health practices centering non-white clientele.

Possible policy alternatives in these countries are vast. Increasing behavioral healthcare options in rural, under-resourced communities is one proposed approach. This could be achieved through government incentive programs for mental healthcare specialists to allocate time and resources in these areas. However, such programs will be costly, requiring a governmental commitment to long-term funding, especially in lower-to-middle income countries like Nigeria.

Increased home- and community-based services, commonly found to be cost-effective, is also encouraged (Newcomer et al., 2016). One example would be implementing family-run groups that would support individuals with mental health challenges and their family members. Still, this approach could be challenging due to hospitals' incentives to provide costly inpatient care: legislation allocating sufficient funds would be necessary.

Given these policy alternatives, a policy recommendation is proposed to address a combination of the outlined global needs. We recommend that a health-focused multinational organization, such as the UN or the WHO, invest in an evidence-based resource system allowing countries around the world to bolster their mental treatment plans. This is especially important for middle- to low-income countries to build upon their existing resources and ensure their most vulnerable populations experience increased access to mental healthcare.

This policy recommendation would require mental health experts of diverse identities to collaboratively gather baseline evidence on needed country-specific resources. Needs would then be categorized according to priority, and treatment plans outlined for countries to access based on their own needs. Countries with low funding but high religious association, such as Nigeria, could access a plan that recommends collaboration between government entities and religious leadership to address baseline mental health issues. Countries who have prioritized psychiatric care as opposed to outpatient care, such as China, could access a plan to increase investment in community-based mental health treatment. Countries with a history of racial, ethnic, or religious oppression, such as the U.S., could access recommendations on how to dismantle such systems.

With collaboration between international clinicians, researchers, academics, and other health personnel, this policy recommendation aims to integrate Western and traditional practices. Beyond a moral incentive for countries to support this initiative, countries would also be incentivized to institute more effective mental health treatment among their citizens toward the goal of preventing future and long-term healthcare costs associated with mental health disorders and their resulting physical side effects. Throughout implementation it will be especially important to assess the power dynamics of those involved in the planning and research process.

Careful consideration would need to be given to identifying global mental health “experts,” including entities such as the American Psychiatric Association, whose votes determine the disorders and criteria included in the DSM. It is essential that marginalized populations, voices, and lenses beyond national borders be centered throughout the implementation process. All parties involved would have the power and agency to determine criteria for evidence-based practice and diagnosis in different cultural contexts.

The proposed system will need to be nimble and responsive to global population shifts and constantly changing mental health issues and priorities. This policy recommendation offers a potential solution encompassing a decolonization framework while maintaining a strong

sense of cultural humility in its approach. The result would be a global mental health equity tool that establishes practical treatment and access to plans for individual populations.

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