From Palliative Practice to Transformative Praxis: A Black Feminist Psychology Framework on Black Canadians' Mental Healthcare Service Delivery

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Abstract

My dissertation proposes a Black Feminist Psychology Framework (BFP) to reframe how we examine Black Canadians' mental healthcare service delivery. BFP offers a theoretical mode of inquiry to interrogate broader structural forces —political economies, hegemonic discourses, cultural patterns, and a larger pool of social relations— that interrelate to shape Black communities' relationship to the mental health field. BFP aims to expand understandings of service use disparities for Black Canadians and create more culturally responsive mental healthcare. My framework is ontologically grounded in a constructivist paradigm, with a Black feminist and critical psychology ideological axiology.

Applying BFP to my central research question: "What is transformative mental healthcare for Black Canadians in the afterlife of slavery?," I look at the intersections of colonialism, neoliberalism and theism. I specifically examine colonial epistemologies in psychology, neoliberal mental health discourses and the socio-cultural values of religion and spirituality (R/S) structuring Black Canadians' mental healthcare service delivery. Employing diverse qualitative research methods, including historical tracing, reflexive thematic analysis, and thematic literary analysis of novels, my findings offer strategies for strengthening service delivery and advancing a socially just mental health praxis.

The interview data with parish ministers and psychotherapists helped me to identify the role of neoliberal discourses in mental healthcare service provision, and the policy's attempts to circumvent societal interventions for systemic change. Additionally, my findings from the interviews define the contours of a holistic mental healthcare strategy that is inclusive of R/S perspectives and committed to developing individual *and* community-level mental health responses. Examining my study participants' reflections against fictional reimaginings of mental healthcare strategies for Black communities, my literary analysis presents a "spiritual praxis of healing." A spiritual praxis of healing transcends the limitations of neoliberal logics and biomedicine in mental healthcare and offers a discursive map for Black mental healthcare premised on freedom-making practices and emancipation.

My dissertation presents transformative mental healthcare service delivery as encompassing historically attuned, politically engaged and culturally responsive care. It is a promising first step on the path towards stronger mental healthcare for Black Canadians and a confident stride in the long march to freedom.

Dedication

Aidyn Yeboah-Hines

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Acronyms

American Psychological Association (APA)

African Initiated Churches (AIC)

Black Feminist Psychology Framework (BFP)

Black Lives Matter (BLM)

Critical Psychology (CP)

Female Genital Mutilation (FGM)

Greater Toronto Area (GTA)

Reflexive Thematic Analysis (RTA)

Religion and Spirituality (R/S)

Snowball Sampling (SSM)

Thematic Analysis (TA)

Chapter 1- Introduction

Research Inquiry

My dissertation bridges a critical knowledge and service gap on Black Canadians' contemporary mental healthcare. In an effort to address Black Canadians' mental healthcare service underutilization (Black Health Alliance, 2015; Fante-Coleman & Best, 2020; Taylor & Kuo, 2019) and offer more culturally responsive mental healthcare, I propose A Black Feminist Psychology Framework (BFP). A Black Feminist Psychology Framework offers a theoretical mode of inquiry to interrogate the historical, political and socio-cultural factors that shape Black[1] communities' relationship to the mental healthcare field and their mental healthcare service delivery. In so doing, I map out the interactive relationship between anti-Black, colonial frameworks in psychology, neoliberal mental health discourses, and Black socio-cultural practices of wellbeing, such as spirituality and religion, to animate the faults and futurity of mental healthcare for this underserved population. The glaring disparities between Black Canadians' mental healthcare service use and their reported low mental health scores, renders this investigation a critical area of study and intervention (Mental Health Commission of Canada, 2021).

Black Canadians, which include individuals and communities that identify as having African or Caribbean ancestry, are the third largest immigrant grouping in Canada (Statistics Canada, 2022). Accounting for 4.3% of Canada's total population and 16.1% of the population defined as a visible minority, Black Canadians have doubled their presence from 1996 to 2016 (Statistics Canada, 2022). Projections from Statistics Canada estimate an increase in the Black population from 1.5 million in 2021 to more than 3 million by 2041 (Statistics Canada, 2022).

[1] The term "Black" will refer to people of African descent in continental Africa and in the African Diaspora.

Marginalized communities, such as Black Canadians, are routinely underrepresented within the mental health system, and are more likely to experience misdiagnoses, premature treatment drop-out rates, and longer wait times within mental health institutions in comparison to their white counterparts (Carter et al., 2022; Curling, 2013; Fante-Coleman & Jackson-Best, 2020; Pascoe & Richman, 2009). In a study by Ottawa Public Health (2020), Black Canadians' reported experiences within the mental healthcare system include discrimination, racism, financial barriers, misdiagnoses, lack of cultural competency, and limited representation in the mental health workforce.

Unsurprisingly then, Black communities' mental healthcare service utilization is poor. In a study by Chiu et al. (2018), Black Canadians were found less likely to pursue mental health supports and services compared to white Canadian residents. In fact, between 2001-2014, "38.3% of Black Canadian residents with poor or fair self-reported mental health used mental health services compared with 50.8% white Canadian residents" (Mental Health Commission of Canada, 2021). A study by Grace et al. (2016) affirmed the above findings as it found after surveying over 8,000 Ontario residents that despite Black Canadians reporting more stressful life events than white Canadians, Black Canadians reported less mental health service use than their white counterparts. Anderson et al. (2015) found Black-Caribbean populations who did utilize mental health supports experienced an average wait time of sixteen months, compared to white residents who faced an average seven month wait to receive mental healthcare. Fante-Coleman et al. (2023) reported Black youth experienced systemic barriers to care and difficulty accessing Black mental healthcare service providers due to anti-Black racism in Ontario. Indeed, for some Black community members, access to mental healthcare occurs primarily through involuntarily hospitalization or the criminal justice system, rather than through

voluntarily access to mental health therapists or mental health organizations (Anderson, 2015; Archie, 2010; Taylor & Richardson, 2019). The aforementioned data points to an urgent need to improve Black Canadians' relationship to the mental health field. I contend stronger mental health service delivery for Black Canadians requires: a) Expanding understandings of service use patterns and treatment preferences. b) Curating culturally compatible mental health interventions.

Expanding Understandings of Service Use Patterns and Treatment Preferences. Greater research is required to investigate professional psychological help-seeking in the Black community (Taylor & Kuo, 2019). In Canada, limited scholarship exists concerning Black Canadians' use of mental health services and the factors shaping their help-seeking patterns (Taylor & Kuo, 2019). The existing literature presents a paradigm in which physical barriers and social determinants are the metric of mental healthcare access and service use disparities. For example, insurance coverage, financial costs, practice location and accessibility are routinely cited as logistical reasons for the disparity in service use (Taylor & Kuo, 2019); however, emerging data suggest these challenges do not account for all the factors at play (Cénat, 2020; Cummings & Druss, 2011; Substance Abuse and Mental Health Services Administration, 2015; Taylor & Kuo, 2019). The exclusive focus on physical and social determinants, with occasional attention to cultural determinants in the scholarship (Campbell & Long, 2014; Patel et al., 2008; Stevens-Watkins et al., 2014), has masked considerations of historical or political factors structuring Black communities' participation in the mental health field. I aim to expand understandings of Black Canadians' service use patterns by examining the relationship between psychology's colonial history, neoliberal mental health discourses and socio-cultural values, to offer a new refined approach to an age-old concern. Specifically, I intend to model a renewed

commitment to an intersectional, historically and politically informed analysis to a problem that has been treated with scientific sterility and political neutrality. Clients, practitioners, researchers, and policymakers alike will benefit from a careful examination of the macro level forces influencing Black Canadians' mental healthcare service use patterns and service delivery.

Curating Culturally Compatible Interventions. Black Canadians' under-utilization of mental health services signals the need for more culturally informed and culturally responsive treatment interventions (Black Health Alliance, 2015; Fante-Coleman et al., 2023; Jackson-Best & Fante-Coleman, 2020). Canadian psychology scholarship neglects considerations about the influence of Afrocentric worldviews and socio-cultural practices on Black Canadians' help-seeking patterns and service use preferences. For example, socio-cultural influences, such as religion and spirituality (R/S) can play a significant role in Black Canadians' healing traditions, and coping mechanisms, revealing alternative approaches to maintaining wellbeing (Avent-Harris, 2021; Black Health Alliance, 2015; Whitley, 2012). By carefully considering how these socio-cultural practices can be mobilized to curate treatment interventions, I will foreground more culturally responsive mental health supports and resources to improve mental healthcare service delivery for this underserved population. This dissertation engages with religious faith leaders to gauge their willingness to collaborate with professional mental healthcare service providers to enhance mental health support within their institutional settings. It also spotlights the role of spirituality and its protective factors. The influential role of religious leaders and spirituality in health promotion for Black communities has a long history of documentation (Avent-Harris, 2018; Robinson, 2018). The existing literature on clergy-clinician collaboration will serve as a point of departure for the exploration of theism in formal mental healthcare services to create more culturally compatible interventions for Black Canadians.

Research Questions

My dissertation presents the application of my proposed framework, Black Feminist Psychology (BFP), which serves as an integrated research investigation into a set of relations structuring Black Canadians' mental healthcare service delivery. Specifically, I study the impact of colonialism, neoliberalism and theism on Black Canadians' mental healthcare to create more culturally responsive mental healthcare service provision. My research unpacks how psychology, a discipline born at the height of colonial expansion and the violences of transatlantic slavery, has influenced mental healthcare inequity and Black Canadians' psychological help-seeking. As such, I carefully attend to colonial-epistemological methods and paradigms that underpin psychology's research and clinical practice. I discuss how these historical patterns persist in contemporary neoliberal mental health discourses that a) downplay the role of pathogenic socio-political conditions that produce deprivation, and oppression for racialized communities; and b) reinforce a bio-medical approach to mental healthcare that negates the radical potential of communal mental healthcare efforts. Applying my Black Feminist Psychology Framework, I draw on several early and contemporary Black feminists to leverage their activism and "oppositional knowledge" (Collins, 2016, p.133) to create an epistemological rupture with traditional psychology and help improve mental healthcare service delivery for Black communities.

To achieve this objective, I extend my research to include knowledge producers typically excluded from psychology's scholarship to think through nuanced ways of fostering culturally relevant programming, and social justice efforts within mental healthcare for Black Canadians. I conduct 20 semi-structured interviews with Black parish ministers and Black therapists to explore the role of religion and spirituality in mental healthcare service delivery for Black

Canadians, and to more broadly, improve Black mental healthcare. Additionally, I mobilize Black women's creative fiction to help envision new spiritual healing discourses that defy rigid biomedical dichotomies that obscure other ways of knowing. To conclude, I argue that a Black Feminist Psychology Framework, which is deployed to interrogate the impact of colonial-political dynamics *and* socio-cultural practices on Black communities' mental healthcare service delivery and treatment preferences, can be applied to foster a more transformative and decolonized mental healthcare strategy for Black Canadians. In this context, decolonized mental healthcare refers to mental health supports and services that recognize and reckon with the enduring effects of colonialism. This means reframing mental healthcare to center indigenous African knowledges and practices of wellness by creating space for holistic culturally responsive interventions, and social justice efforts within mental healthcare policy, research, and service delivery (Bryant, 2023). Epistemically, my theoretical framework and pluralistic investigative approach helps to reveal how colonial-political dynamics contribute to Black Canadians' underutilization of mental healthcare services, and the impact of socio-cultural practices, such as religion and spirituality, on treatment preferences. My research is practically relevant as it helps to creatively think through new collaborations and therapeutic interventions that may improve Black Canadians' psychological help-seeking, treatment outcomes and mental health supports. Below are the research questions guiding my investigation on transformative mental healthcare for Black Canadians:

1. How does naïve empiricism[2] in psychology emerge as a site where racism and racial inequalities are constituted, actively managed, and reproduced, and what is the impact?

[2] Naïve empiricism is the refusal to "look at the social function of psychology, the social formation of facts, and the historical nature of the psychological subject matter" (Teo, 2011, p.240).

2. How do Black parish ministers participate in the production of mental wellbeing for Black Canadians and how might collaboration with formal mental healthcare service providers[3] improve service delivery?
3. To what extent does mental healthcare collude in and/or work against a neoliberal agenda?
4. How may a focus on Black feminist creative texts inspire new forms of healing and recovery?

Dissertation Outline

A Black Feminist Psychology Framework (BFP) offers a theoretical mode of inquiry to ensure Black Canadians' diverse histories, political realities, and cultural beliefs are meaningfully addressed in the field. Using my framework, I will carefully attend to the relationship between historical, political, and socio-cultural factors that interrelate to shape Black Canadians' relationship to the field and their mental healthcare service delivery. By expanding understandings of service use patterns and treatment preferences, I aim to curate culturally responsive treatment interventions and strategies to improve mental health service delivery for Black Canadians. I begin by historically tracing how naïve empiricism in psychology emerges as a site where racism and racial inequalities are constituted, actively managed, and reproduced, and the impact of naïve empiricism on Black Canadians' participation in the mental health field. Next, I consider how the exclusion and denigration of Black communities within the field of psychology more generally, and the mental health field more specifically, has resulted in Black communities' preference for their own traditional forms and personal practices of self-care as a mode of resistance. I delineate Black communities' religious and spiritual beliefs as one of these practices and use religion and spirituality (R/S) as a point of departure for thinking through

[3] "Formal mental healthcare service providers" refers to trained and certified professionals who work in inpatient and outpatient facilities and can assess, refer, and treat patients suffering from emotional or psychological distress.

culturally responsive mental healthcare services and resources. I interview Black parish ministers and Black mental health practitioners to outline contours of a collaboration strategy to advance the level of care provided in sacred institutions and improve culturally compatible programming in therapeutic spaces. Examining my participants' responses against fictional imaginings of mental healthcare strategies for Black communities, I explore a small selection of Black feminist literary texts that attend to nuanced and culturally responsive forms of healing and recovery. I carefully attend to the ways in which these creative texts position spirituality as a mode of resistance to neoliberal mental healthcare and consider spirituality's implications for community and clinical interventions. I conclude affirming that to advance a transformative approach to mental healthcare that addresses the unmet psychosocial needs and concerns of Black Canadians, my Black Feminist Psychology Framework offers a promising approach. In particular, BFP's shift towards a holistic, epistemological paradigm on mental health that transcends neoliberal logics of mental healthcare and the dichotomies of religion/science, individual/communal, formal/informal care, will help to ensure historically attuned, politically engaged and culturally responsive mental healthcare for Black Canadians.

Chapter 2- Literature Review

Psychology's Phantoms

The adversarial relationship between Black communities and the mental health field is rooted in psychology's origin story (Jones, 2016). In the second half of the nineteenth century (1879) during the social and political climate of "unmitigated racism, empire building [via European conquest] and white dominance," psychology was officially born as a discipline (Howitt & Owusu-Bempah, 1994, p.143). In line with the Natural Sciences, empiricism[4] governed the study of "behavior, mind and human consciousness" (Henriques, 2019, p. 220). Piloted studies were supported by methods of observation and experimentation, each purporting scientific rigor and acuity. Yet, while psychology's gatekeepers insisted on the field's scientific enquiry and 'apolitical neutrality,' the discipline was not separated from the external dynamics of the science (Adams, 2017). Serving as a backdrop for the research questions posed, and interpretations of the data gathered, was colonial activity and exploitation in the Global South[5] and active participation in the Trans-Atlantic slave trade (Teo, 2008; 2011). "Naïve empiricism" conveniently gave way to colonial sentimentalities, reproducing the concerns and interests of the state (Teo, 2011). These historical processes resulted in a plethora of studies that manufactured race differences to justify the mistreatment and enslavement of Black persons (Teo, 2008; Winston, 2004).

Psychoanalytic practice led to several 'findings' of Africans as primitive, underdeveloped or the 'damaged Negro' (Bulhan, 1985; Frosh, 2013; Richards, 2012). Psychologists used objective-neutrality, a championed ideology of the empirical method, to produce racist studies on

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[4] Empiricism is a deterministic framework that values a "highly abstract, decontextualized, rationalist" inquiry of mind, behavior and human consciousness" (Henriques, 2019, p. 220). This framework does not consider the impact of historical forces, socio-political contexts and power dynamics influencing research findings.
[5] Global South refers to "communities defined by the colonial violence that made possible the affluence of Global North" (Adams et al., 2017, p.532).

Black people that negated the role of discrimination, marginalization and exclusion on their lives. These studies served to reinforce myths of Africans' dependency (Howitt & Owusu-Bempah, 1994). Ethnographic studies based on field observations relied on WEIRD[6] frames of reference that pathologized and disparaged African historical and socio-cultural "kinship patterns, marital arrangements, child rearing practices, diet, religion and other elements of Black peoples lives" (Howitt & Owusu-Bempah, 1994, p.11). The valorized use of psychometric measurements, such as IQ tests,[7] contributed to an array of studies that proposed Blacks' intellectual inferiority, and promulgated racial stratification (Guthrie, 2004; Howitt & Owusu-Bempah, 1994). Further, phrenology studies, which relied on 'precise' measurements of the weight and shape of the skull, were used to reflect relative levels of evolutionary advancement between Blacks and whites to endorse race prejudice (Richards, 2012). These "empirical" studies worked to fuel Race Psychology in the 1920s and 1930s, which took eugenics and scientific racism[8] under its right wing (Richards, 2012; Teo, 2011; Winston, 2004).

The impact on Black communities ranged from misrepresentations of their racial suffering to exclusion from the field of psychology to recommendations of discriminatory practices such as segregation, sterilization or physical extermination[9] (Howitt & Owusu-Bempah, 1994). The discipline's structurally embedded emphasis on "empirical difference" produced

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[6] The acronym WEIRD refers to western, educated, industrialized, rich, and democratic societies (Henrich et al., 2010).
[7] "The 20th-century course of scientific racism in North American psychology was closely related to the development and deployment of intelligence testing" (Winston, 2021, p.2)
[8] Scientific racism refers to "the use of scientific concepts and data to create and justify ideas of an enduring, biologically based racial hierarchy" (Winston, 2020, p.1-2).
[9] A list of grievances of inappropriate care and treatment of Black people within psychology include but are not limited to: allegations of inherited mental deficits (Guthrie, 2004); misdiagnoses (Burack, 2004); critiques of brain size and cognitive development (Fine, 2006); and the barring of gates to Black persons entering the professional field (Guthrie, 2004).

epistemological violence,[10] and worked in service of mainstream psychological science's racist posture. The field's commitment to pathologizing Black identities and racial suffering under the guise of scientific progress and empirical study rendered the discipline ineffective at best, and gravely irresponsible at worst towards those of African descent. Indeed, therapeutic spaces negated the socio-political injustices Black communities experienced in their assessments and treatment of mental illness for racialized clients and served only to reproduce colonial dynamics (Fanon, 2008). The historical exploitation and maltreatment of Black persons must register as contributing to the contemporary cultural distrust of professional mental health services (Campbell & Long, 2014; Meyer & Takeuchi 2014; Neighbors & Jackson, 1984). In *Healing Identities, Black Feminist Thought and the Politics of Groups,* Cynthia Burack states, members of marginal social groups who have historically suffered from the abuse of psychological interventions and study are likely to "locate themselves in opposition to the knowledge power of psychoanalytic interpretation" (2004, p.10). The failure of mainstream psychology to accept accountability for its subjugation of Black life, its estrangement from studying the psychological violence of racial oppression, and its reluctance to challenge societal structures of inequality to incite social change, maintains a barrier for radical transformation of the mental health field.

To redress the harm experienced by racialized clients in psychiatric care, efforts to challenge the colonial, white supremacist and racist foundations of the field of psychology were undertaken by a small number of multi-racial practitioners. Most notably, the pioneering work of Frantz Fanon, the Martinique born "revolutionary anticolonial activist and intellectual," and his contemporaries, demonstrated the imperative for a socio-political and cultural approach to

[10] "Psychologists have produced and distributed interpretations, presented as knowledge, that have negatively shaped the life, health, and opportunities of minorities" (Teo, 2008, p.23).

mental health (McGee & Stovall, 2015, p. 496). Through his work as a psychiatrist at Hôpital Psychiatrique de Blida-Joinville, Fanon examined societal factors that contributed to the psychological assault, alienation and dehumanization of his patients (Gordon, 2015). Mental illnesses and psychic wounds were assessed against the backdrop of colonial violence, occupation and enterprise, and he declared treatment demanded interventions that extended beyond the medical institution to include political reform. His incisive critique of the colonial order impacting psychological wellbeing, structured his political activism, reconceptualising healing as inextricably tied to liberation[11] (Bullard, 2005). His insistence on empowering the oppressed through his therapeutic strategies, and engagement in social struggle for Algeria's independence from France, informed his psychiatric efforts, and imbued his practice with a spirit of de-colonial praxis. His work served as a precursor for subsequent branches of psychology that developed in opposition to mainstream psychology to tackle its white supremacist foundations, exclusionary practices, and colonial racism.

Various branches of psychology, such as, African Psychology, Liberation Psychology, Feminist Psychology, and Critical Psychology, attempt to tackle the deeply Eurocentric, biomedical, ahistorical and apolitical errors within dominant psychology. Each subdiscipline has experienced its own level of success in addressing these concerns through the pursuit of different

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[11] Fanon proposed the *North African Syndrome* as the result of oppression and racism experienced under colonialism (Bulhan, 1985). His attention to the ways in which one's emotional and psychological wellbeing were influenced by wider social forces, and the shortcomings of colonial psychiatry in treating these ailments, led him to conclude important findings regarding mental health and racialized communities. Fanon purported that colonialism created inhumane social conditions for the colonized, which gravely impacted their quality of life and mental stability. He argued the "antagonist, alienating, materialistic, dualistic, dichotomous, divisive and hostile" nature that shaped the colonial social order, resulted in a "systematic negation" of the colonialized person, and denied the "person all attributes of humanity" (Winfield, 1999, p. 9). This in turn was understood by Fanon to provoke mental illness among the ruled; he argued treatment demanded more than medical attention, it required political change (Bullard, 2005). His prognosis that one's social context must be considered in the exploration of mental illnesses, and psychiatric efforts must not reproduce colonial sentiments, was fundamental to his decolonial praxis. Fanon desired a humanistic approach to psychiatric medicine that would accord human freedom to the patients (Gordon, 2015, p. 81).

approaches. Some branches have focused on redefining mental wellbeing and pathology within cultural centers outside of WEIRD settings (i.e. African psychology, Black psychology, cross-cultural psychology). Others have emphasized social justice activism through the study of disempowered and disenfranchised individuals (i.e. liberation psychology, community psychology). Some have integrated feminist approaches within their helping frameworks to tackle questions of sexuality, gender-based discrimination and violence (i.e. feminist psychology). And other approaches critiqued psychology's oppressive operations of power and medicalization of distress (i.e. critical psychology, mad studies). The development and execution of these approaches has varied across time and geographic locations. Although it is beyond the scope of the dissertation to describe each of these at length, I offer a cursory review of a few of these disparate branches to demonstrate the imperative for a framework that integrates their most critical 'tenets.' This melange of ideas will then be mobilized to create a framework that theorizes how to improve Black Canadians' mental healthcare service delivery.

Branches of Psychology

The field of African psychology examines the influences of intellectual and cultural imperialism on the field of psychology, while working to provide racially and culturally congruent models for those of African descent (Myers & Speight, 2010). Through its methodological rigour,[12] it has discounted and re-evaluated identity development models, challenged inferiority narratives concerning Black people's cognitive and behavioural thinking, culture and self-concepts, and has demanded white racism and racial bias are treated as pathological constructs with enduring psychological consequences (Cokley & Garba, 2018). Initially developed as a "protest

[12] Banks (1982) identified African psychology's critical methods as "deconstructive, reconstructive, and constructive" (Ebede-Ndi, 2016, p. 72).

psychology" to refute and reconstruct the Western image of the African (Nwoye, 2015, p.97), African Psychology undertakes the "systematic and informed study of the complexities of human mental life, culture and experience in the pre- and post-colonial African world" (Nwoye, 2015, p. 104). Responding to the current realities and needs of Africa's multiracial clients as well as redressing historical inaccuracies and scientific myths concerning Africans' human condition and mind is central to its operation (Nwoye, 2015). Thus, it serves not only as a corrective to mainstream psychology, but also critically engages in "helping the post-apartheid and contemporary African people to recognize and appreciate the triumphs and the threats, and the opportunities and dilemmas of inhabiting present-day African environments" (Nwoye, 2015, p.104-105). The field has experienced pioneering success in restoring the humanity and dignity of Black persons by working to eliminate racial bias in traditional psychology, reject deficit models about Black people, and return to Afrocentric worldviews and epistemologies in its treatment interventions, therapeutic exercises and diagnostic assessments (Cokley & Garba, 2018; Nwoye, 2022).

However, despite its powerful import, the field's praxis has not received significant uptake and mobilization within mainstream psychology, or within more critical subdisciplines.[13] African Psychology has yet to significantly cross the borders of the continent or extend past African universities to enter the West's psychology departments, despite its advancement of

[13] There are some exceptions; some prominent scholars in Black psychology are recognized and honored for their contributions to multicultural psychology: "Indeed, prominent leaders in multicultural psychology (e.g., Derald Wing Sue, Janet Helms, Thomas Parham) cite the influence of Joseph White in their own professional development." (Cokely & Karenga, 2018, p.714-715). However, Black psychology's influence and contribution to positive psychology and mainstream psychology is often overlooked or undermined. For example, Cokely and Garba (2018) argue Joseph White's original work paved the path for positive psychology: "For White, Black psychology was characterized by basic African American psychological concepts, such as resilience and spirituality. Thus, a strengths-based Black psychology predates modern positive psychology and should be considered as the original positive psychology rooted in the positive human functioning of Black people in the midst of dehumanization and racial oppression" (Cokley & Garba, 2018, p.713).

human understanding within psychology (Nwoye, 2015). As Cokely and Garba aptly note: "Black students (and, in fact, all students) remain largely unaware of the historical and contemporary influences of Black/African psychology, and how these influences have impacted the discipline of psychology" (2018, p.714). Furthermore, the field's internal contradictions have impeded its development: disagreements concerning the definition of African/Black psychology;[14] disputes over the demarcation of the schools of thought within the field,[15] as well as an inflated emphasis on a united African identity[16] rather than on methodological praxis, has prevented the field from actualizing all its objectives (Cokely & Garba, 2018; Ebede-Ndi, 2016). Therefore, despite the field's innovation to challenge Eurocentric psychological theories about Black people and create new avenues to assess, document and understand Black lives and material realities, greater work is needed to "continue the legacy of Black/African psychology in perpetuity" (Cokely & Garba, 2018, p.715).

Liberation psychology (LP) was first proposed by Ignacio Martín-Baró and aims to address the needs of those disempowered through matrixes of oppression (Comas-Diaz & Rivera, 2020; Martin, 1996). The field shifts the discourse from individual to societal factors on

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[14] Nwoye contends, "African Psychology is not synonymous with Black psychology. For, although the study and understanding of the psychology of Black Africans (in continental Africa and in the Diaspora) is implicated in the notion of African Psychology, African Psychology is also the psychology of the multiracial Africans and their worlds" (Nwoye, 2015, p.112). Black Psychology was born at the height of civil rights and Black Power movements in the United States and sought to "address the significant social problems affecting the Black community and to positively impact on the mental health of the national Black community through planning, programs, services, training, and advocacy" (Nobles, 2015, p.399).

[15] "Maulana Karenga identifies three schools of thought in Black psychology: traditional, reform, and radical. The traditional school of thought focuses on criticizing White psychology but supports using Eurocentric psychology with minor changes (e.g., eliminating racial bias)… The reform school of thought typically attacks racism in White psychology and identifies the limitations of White psychology while recognizing the existence of a distinct Black psychology…. The radical school of thought adopts an African-centered conceptual framework for Black psychology by emphasizing African culture and philosophy" (Cokley & Garba, 2018, p.700). The different schools of thought have resulted in an accompanying division of attention and funding in the field.

[16] "Diasporic and continental African relationships are nuanced and finding a historical, political, and cultural unity can be challenging" (Ebede-Ndi, 2016, p.68). See Ebede-Ndi (2016) for a complete discussion on the shortcomings of African/Black Psychology.

mental health, introduces diagnoses and treatment methods that depart from colonial or exclusively Western diagnostic measures, and implements therapeutic interventions that empower the oppressed (Duran et al., 2008). Rooted in emancipatory movements in Latin America, Paulo Freire's conscientización[17] and liberation theology[18] the field foregrounds marginalized community members' oppressive historical, systemic, cultural, socio-political conditions and advocates for critical consciousness raising to help clients recognize one's role as an agent of change (Crethar et al., 2008, p. 270). Within this field, practitioners' counselling strategies direct clients to understand the gravity of systems of oppression on human development to help promote psychological liberation. Drawing on community psychology's action-oriented research, liberation psychologists enable clients from disenfranchised communities to have access to advocacy services, and resources to promote social-environmental changes and distributive justice (Martin, 1996; Prilleltensky, 2008). Despite LP's close resemblance to Fanon's decolonial praxis, its lack of attention to women (Lykes & Moane, 2009), and LGBTQ+ communities (Singh, 2016), has prevented this framework from maximizing its potential. Some branches have tried to counter this shortcoming by more squarely privileging women and gender issues within its framework.

During the 1960s and 1970s, feminist-counselling therapies developed in parallel to second wave women's movements (Evans et al., 2005). The increasing influence of women's protests for greater equality, spurred changes in the therapy room that demanded psychologists'

[17] "A pedagogical process between educator and student that promotes the development of one's critical consciousness (conscientización,) through dialogue, collaboration, and social action to fight against oppression" (Comas-Díaz & Rivera, 2020, p.4).
[18] "Integrating Christian theology and socioeconomic analyses, liberation theologians focus on the emancipation of marginalized and oppressed communities (Gutierrez, 1973). Indeed, liberation theologians predicate a preferential approach for the poor and the oppressed" (Comas-Díaz & Rivera, 2020, p.4).

reevaluation of the patriarchal norms of mental illness and wellness dominating the mental health discourse. The approach is informed "by feminist political philosophies and analysis, and incorporates the psychology of women (Miller, 1986), developmental research (Gilligan, 1982), cognitive–behavioral techniques (Worell & Remer, 2003) multicultural awareness (Comas-Daz & Greene, 1994), and social activism (Brown, 2010) in a systematic platform" (Jones & Sheftall, 2015, p. 343). Its focus on alternating the top-down nature of the therapy room, redistributing power between physician and patient, identifying one's social ills as endemic to one's sociopolitical and cultural contexts, and linking individual change to social change for liberatory empowerment, served as a departure from traditional counselling theories[19] (Remer & Oh, 2012). Indeed, feminist therapy aimed to provide a transformative platform for all; however, it has faced backlash in the literature for prioritizing the experiences of "white middle-class women" (Carter et al., 2022; Jones & Sheftall, 2015, p. 343). These interventions are critiqued for its limited focus on gender as the "only salient category of oppression," and its overall exclusion of women of color, (Brown, 2010; Comas- Daz & Greene, 1994, p. 201) whose experiences of racial and sexual discrimination are once again overlooked (Jones & Sheftall, 2015, p. 344; Jones & Sheftall, 2019). Consequently, "scholars argue that feminist therapies have historically excluded and devalued the experiences of Black women and that there have been misguided interpretations of their realities at the conceptual, theoretical, and methodological levels" (Jones, 2015, p. 248).

[19] Remer & Oh (2012) summarize feminist counselling therapies as promoting: "1. The belief that clients know what is best for their own lives. 2. An emphasis on the importance of educating clients about the counselling process 3. A focus on educating clients about the need to be engaged in social action 4. The perspective that individual problems exist in sociopolitical and cultural contexts 5. The assertion that individual change best occurs through social change 6. A perspective that highlights the view that clients are not passive recipients of counselling services but active agents who are encouraged to implement new action strategies aimed at having a positive impact in their environmental contexts" (p. 275).

Hoping to learn from its predecessors, critical psychology has gained steady traction in psychology for its inclusive *and* interrogative approach to mental health. Critical psychology (CP) contests operations of power within the field to prioritize social justice for marginalized communities (Teo, 2019). Investigating the relation between power and psychology, the domain acknowledges psychology's historical and conceptual record of problem-making (instead of problem-solving), in addition to its onto-epistemological shortcomings (Teo, 2018, p. 277). Here, history is understood as central to recognizing that psychological variables and concepts are not neutral, but involve power, and therefore must be subjected to greater ethical and political scrutiny (Teo, 2015). By examining underlining assumptions of the paradigms, methodologies and variables that drive the discipline, there is greater emphasis on epistemic responsibility and social equality. Additionally, CP challenges neoliberal understandings of mental wellness and wellbeing, recognizing the impact of a culture that emphasizes individualism to the exclusion of structural barriers constraining human agency (Fine, 2016; Sugarman, 2015). The field's acknowledgement that neoliberalism results in "ameliorative, person-centered interventions that contribute only marginally to social change" offers a departure from traditional psychology, which is generally invested in equipping clients with coping resources to adapt to their environment rather than transform it (Prilleltensky, 2008, p.131).

Yet, despite offering a paradigm "replete with conceptual resources, sensitive to ideology, [power] history, [and] innovative in its methods of inquiry," CP as a critical scholarship and practice struggles to combine intellectual analysis and practical political engagement (Gergen, 2001, p. 813). The need "to engage with and develop concepts that have the potential to transcend merely abstract…analysis, and point the way to practical . . . political engagement" is still a working progress for this promising field (Hook, 2005, p. 478). Greater

contribution to social change that strengthens economic, and social justice is necessary for the field to achieve optimal critical efficacy (Teo, 2018). Thus, while CP provides a theoretical perspective from which to contest operations of power in the field for marginalized communities, its inability to close the gap the between theoretical and political engagement has rendered the discipline stagnant on political issues and limited in scope.

Therefore, despite the various branches' objections to the reigning ethnocentrism, biomedical, apolitical, and ahistorical approach to mental health within traditional psychology, and their important advances in professional counselling for marginalized communities, many of these approaches still fall short in addressing the lived realities and experiences of Black people and their communities. Thus, a Black Feminist Psychology Framework that expands on Fanon's decolonial praxis, attends closely to psychology's critical subdisciplines, *and* foregrounds Black communities' lived histories, political realities and socio-cultural healing practices, can help to create a more nuanced framework for those of African descent.

I have outlined the climate of anti-Blackness that colours the origin story of psychology. I observed that mainstream psychological science methodologies are rooted in colonial and racist foundations, and that the field requires greater receptiveness to more democratic research methods and decolonial frameworks. I have noted that despite the creation of distinct sub-branches of the field to address the critiques of mainstream psychological science, Black communities continue to be overlooked and experience compromised mental health service delivery (Ottawa Public Health, 2020). In the following section, I explore how Black feminism(s)' intersectionality, transdisciplinary orientation, and scholar-activism can offer nuanced ways to think about fostering inclusive, social justice efforts within the mental health field. I contend that the scholarship and liberatory praxis of the tradition can accent new sites of

healing to advance mental healthcare for Black Canadians and will serve as the conceptual foundation for my framework. Lastly, I will conclude with my framework, Black Feminist Psychology (BFP), which builds on Black feminism(s) *and* psychology's most critical subdisciplines to expand understandings on Black Canadians' mental healthcare service delivery, and offer more culturally responsive interventions that meaningfully privilege Black communities' socio-cultural healing practices.

Black Feminism(s)

In the preceding section I discussed the disparate branches of psychology that have offered more critical approaches within the field for addressing mental health theory and treatment. Despite their distinct differences, common threads cut across these frameworks, and when sewn together, can fashion a new helping model that privileges the strengths of each respective subdiscipline. This practice of patchwork between African, liberatory, feminist and critical psychology, allows me to piece together and imagine new ways to resist anti-Black racism[20] in psychology and strengthen mental healthcare service delivery for Black Canadians. However, an integrated model still requires a philosophical and theoretical foundation that offers a more critical, inclusive, and radical enterprise than mainstream psychology. I propose Black feminism(s) as the missing, vital piece. As a scholarship and praxis, Black feminism(s) can uniquely work to create an epistemological rupture with psychology's colonial past, close the gap between intellectual and political activity in the field of psychology, serve as an impetus for broader social action to

[20] Anti-Black racism refers to policies and practices rooted within institutions that perpetuate and reinforce prejudice and/or discrimination towards people of African descent. It was originally coined by Dr. Akua Benjamin to address how the histories and experiences of colonization and slavery, shaped the unique nature of systemic racism that Black people face (Black Health Alliance).

transform structural arrangements in society, and inspire humanitarian and ethical efforts within counselling therapies for Black peoples; ultimately, sponsoring a decolonial, anti-racist and holistic mental health framework.

Building on the works of "Toni Cade Bambara, Ntozake Shange, Angela Davis, Toni Morrison, June Jordan, Alice Walker, Audre Lorde and other Black women who 'broke silence' in the 1970s," these women, and their notable contemporaries, bell hooks, Patricia Hill Collins, Beverley Guy Sheftall, the Combahee River Collective,[21] and countless others, have created a distinctive Black women's standpoint (Collins, 1996, p. 57). Through their works they used their marginalized and disenfranchised positions[22] within society to raise individual and social consciousness, foster self-determination and articulate dreams of freedom from sexist, racist and classist oppression. Serving dual functions as artists and activist-scholars, Black feminists have worked to target hegemonic discourses that misrepresent or neglect Black life and its complexity and have demanded an end to exploitative political and economic systems. This tradition will serve as the philosophical and conceptual groundwork from which to build my framework, in union with psychology's critical subdisciplines, to create a multifaceted interrogation of Black Canadians' service delivery, treatment preferences, and therapeutic interventions.

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[21] "In 1977 the Combahee River Collective, a group of mainly Black lesbian feminists such as Audre Lorde, Pat Parker, Margaret Sloan, and Barbara Smith released a statement that attempted to define Black feminism, as they saw it (first published in Eisenstein, 1978). The collective's work was grounded in a feminist perspective, addressed homophobia, and called for sisterhood among Black women of diverse sexual orientations" (Jones & Sheftall, 2015, p.345).

[22] "As a group, Black women are in an unusual position in this society, for not only are we collectively at the bottom of the occupational social ladder, but our overall social status is lower than that of any other group. Occupying such a position, we bear the brunt of sexist, racist, and classist oppression. At the same time, we are the group that has not been socialized to assume the role of exploiter/ oppressor in that we are allowed no institutionalized "other" that we can exploit or oppress" (hooks, 2000, p.16).

Black Feminism(s), as an intellectual and activist movement is a critical social force and viable praxis that is adaptable and applicable to mental health settings. In particular, Black Feminisms' intersectionality, trans-disciplinary orientation, and scholar activism, offers nuanced ways of thinking about fostering inclusive, ethical and social justice efforts within mental health. Although "Black feminism is not a monolithic, static ideology…. certain premises are nevertheless constant" (Jones & Sheftall, 2015, p. 345), one of which is its intersectional approach. The field's intersectional lens demonstrates a commitment to reflect an integrated analysis of racism, sexism, classism, and other "isms" (Davis, 2011; Crenshaw, 1991; Jones & Sheftall, 2015, p. 346). This method of interrogation provides a means to view the "multiplicity and simultaneity of oppressions and emotional struggles that Black American women experience" (Jones & Sheftall, 2015, p. 346). In turn, it carries the transformative potential to reshape the mental health field's response to and care of Black people by accounting for these matrixes of oppressions in diagnostic assessments and treatment measures. Indeed, "antiracist mental healthcare recognises issues related to racial discrimination and racism and addresses their potential consequences, and the racialised experiences of Black individuals" (Cénat, 2020, p.929). As such, Black Feminisms' commitment to intersectionality is one of the primary reasons it should serve as the epistemological groundwork for the BFP framework. Kimberle Crenshaw's seminal article, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color" (1991) coins the term "intersectionality," and demonstrates the importance of employing this approach to reveal the interlocking systems of oppression that afflict women of colour. Her examination indicates the necessity to traverse additive models of identity to address structural barriers experienced within material, historical, and political conditions (Crenshaw,

1991). Despite Crenshaw's coining, attending to the interconnected nature of multiple systems of oppression has been a central concern of Black feminism(s) from its early beginnings.

Black feminists such as Claudia Jones (1915-1964), Amy Ashwood Garvey (1897-1969), Grace Campbell (1883-1943), and others have fought for the recognition of their interlocking oppressions due to their multiple social locations.[23] While social movements such as Communism and pan-Africanism offered a platform and training for early feminists in the British Caribbean colonies and the United States, Black women largely maintained a precarious position within these contexts. Despite their contributions to advancing the aims of these early movements, Black women continued to face neglect and exclusion. Whether through the delegation of administrative work, an outright refusal to acknowledge women in trade unions, or staunch unwillingness to appoint women to policy-making positions, many of these spaces tried to marginalize their efforts (Jones, 1985, p. 119). Consequently, many of these women were forced to carve out spaces in these male-dominated, classist and Leftist movements (Reddock, 2014, p. 59).

Black women's historical struggle for acknowledgment and recognition in settings that only privileged one identity marker (i.e. race in Black nationalist parties, class in socialist movements, gender in first wave feminism protests), mirrors Black peoples' exclusion in mental

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[23] Claudia Jones' "An End to the neglect of the problems of Negro Women!" drew attention to the rhetoric of equality, bourgeois ideologies and white chauvinism, espoused by trade unions and the women's suffrage movement (Jones, 1985, p. 113). She noted how these discourses actively worked to subjugate Black women and exclude them from experiencing equality and freedom (Jones, 1985, p.113). Amy Ashwood, for example, divorced her affluent and prominent husband, Marcus Garvey, in order to step out of his shadow and forge her own path towards liberating her people. She called for the unionization of Black female domestic workers and emphasized the need for their struggles to be understood as part of the "larger, worldwide struggle against capitalism, imperialism and white supremacy" (McDuffie, 2011, p. 46). Grace Campbell severed her political ties with the Workers Party (W.P) and the Harlem Tenant's League (HTL), when she realized it overlooked the specificity of race and gender in its political agendas (McDuffie, 2011, p. 48). Other Black feminists not only discursively, but also physically disrupted "masculine political terrain" on Harlem sidewalks and street corners to evangelize their visions of equality and their Black Left feminist sensibilities to all within earshot (McDuffie, 2011, p. 40).

health research and policy. Hence, using Black feminism(s) as a theoretical groundwork for a mental health framework will help identify and rectify "gaps that address the life concerns and possible futures" of Black peoples (Jones & Sheftall, 2015, p. 344). Early Black feminists' ability to adapt, subvert and transgress the political movements, organizations, and alliances they were affiliated with to address their "triple oppression," suggests the same can be performed and applied within the mental health sphere (Jones, 2015). Black communities require an approach within mental healthcare that understands single-axis analyses fail to capture those who are living at the interstices of multiple axes. New methods are required in the mental health field to address the "multiplicative oppressions" faced by Black communities within their social–political contexts (Jones, 2015, p. 248).

Moreover, Black Feminism(s)' transdisciplinary orientation "creates new conceptual, theoretical, methodological, and translational innovations that integrate and move beyond discipline-specific approaches," which can be used to address questions of wellbeing (Aboelela et al., 2007). By drawing on interdisciplinary *methods* of engagement to explore the socio-historical, political, and cultural conditions of slavery and colonialism on Black life, Black Feminism(s) can influence and reshape the questions, concerns and direction of the mental health field (Jones & Sheftall, 2015). Combining plural knowledge, expertise, and personal accounts from scholars across different fields, Black Feminism(s) can generate new ideas regarding how to study, diagnose and empirically test mental wellbeing for Black communities underrepresented within the mental health system (Thomas, 2004, p. 290). Psychology must draw on Black feminist epistemologies and advance interdisciplinary methods of inquiry into intersectional forces of oppression, to inform therapeutic practices, the patient-service provider relationship, and psychosocial resources, if it intends to give space to unorthodox healing

interventions that have either been untapped, neglected or deemphasized in mainstream psychology. The discipline's refusal or unwillingness to validate non-quantitative work or affirm "oppositional knowledges" will reproduce the oversights committed in the field during the peak of the Enlightenment (Collins, 2016, p.133). For example, the Black feminist recognition of collective lived experiences and creative texts as a form of theorizing, and its orientation to and leveraging of ancestral traditions, will help to enrich theoretical understandings of wellness and accent sites of healing within traditional psychology. Nuanced cultural expressions of healing can reveal new ways to theorize coping and resistance that escape bio-medical and neoliberal renditions of mental wellbeing, from which "new themes, approaches, and questions [can] become visible" (Collins, 2000, p.44).

Black Feminism(s) is intimately tied to activism, and my application of Black feminist thought within psychology will embrace the tradition's activist moorings and teachings of resistance. Despite the various historical and political trajectories of Black Feminist thought, its engagement with social justice and commitment to praxis remains emblematic of its political project (Collins, 1990; Jones & Sheftall, 2015). Black feminists merge theory and praxis to protest police brutality against Black communities, lobby for prison abolition, fight national liberation struggles, advocate for equal wages. Challenge to forms of inequality and to totalitarian systems of domination has been central to its vision and success.

The interview, "Black Feminism in the 1980s," conducted by Itumeleng Mafatshe and Zanele Hlope with Rozena Maart, remarks on the multifaceted political objectives adopted by Black Feminism(s) to advance its project (2014). Maart narrates that in South Africa, during the 1980s, a Black feminist agenda included not only fighting against capitalism and apartheid, but racism and sexism as well (Maart, 2014). Kia Q. Hall's (2016), "A Transnational Black Feminist

Framework: Rooting in Feminist Scholarship, Framing Contemporary Black Activism," similarly explores the trope of Black feminism(s) as a formidable and transformative political construct. Hall documents how Black Feminist thought is used as a beacon for contemporary Black activist movements, such as Black Lives Matter (BLM), for its organization and operation. She lists four principles of Black Feminism(s), "intersectionality, scholar-activism, solidarity building, and attention to borders/boundaries," that formed BLM's activist social justice foundation (Hall, 2016, p. 97). Further, several key Black feminists, including, Cathy Cohen (1962-), Audre Lorde (1934-1992), Patricia Hill Collins (1948-), speak to raising the political consciousness of groups, improving intra-group dynamics and banding together across intersections. Thus, underpinning the tradition's incisive edge is coalition building and expanding critical consciousness for political mobilization and organization.

These examples offer important insight into the methodological implications of Black Feminism(s) for mental health. Black Feminism(s) offers a mental health framework that theoretically aligns itself with the tradition's scholar-activism and can enact "both the changed consciousness of individuals and the social transformation of political and economic institutions" (Jones, 2015, p. 246). Mamie Phipps Clark (1917-1983) and Kenneth Clark (1914-1995), two prominent Black psychologists, have already set the precedent. The couple's work on racial identity[24] resulted in overturned segregation policies in the US South (Teo, 2008). Rescuing scholar-activist work from the margins of the field, and re-envisioning mainstream psychology through social action against racist, white supremacist structural arrangements can disrupt

[24] The 'doll test' found Black children were more likely to prefer white dolls and assign positive traits to these dolls, in comparison to Black dolls, which they assigned negative traits to. The Clarks concluded the children had internalized racism as a result of prevailing racist social norms and prejudice. The study would play an instrumental role in several school desegregation court cases. Including the historic *Brown v. Board of Education of Topeka* in 1954 (Teo, 2008).

psychology’s role in feigning political neutrality and target socio-political forces for concerted change (Barlow & Dill, 2018). The tradition’s activist origins will ensure the profession and discipline carries ramifications that reverberate past the four walls of mental health institutions and insulated ivory towers.

Theoretical Framework: Black Feminist Psychology Framework (BFP)

Black Feminist Thought’s intersectional, transdisciplinary, and activist orientation makes it uniquely well suited to serve as the overarching and philosophical foundation of my Black Feminist Psychology Framework. Together, in collaboration with psychology’s most critical subdisciplines, I outline a paradigm that not only attends to the intersections of historical and political forces that perpetuate anti-Blackness in the field, but also seeks to disrupt these conditions and imagine new interventions to improve mental health service delivery for Black Canadians. While some of these factors have been invoked in the scholarship, to date, no effort has been made to draw these domains: (a) historical (b) political and (c) socio-cultural into an integrated research project on Black Canadians’ mental healthcare service delivery. By attending to the colonial history of psychology, neoliberalism and theism, this framework offers a comprehensive approach to enhancing the current knowledge of psychological help-seeking and service use for this target population, while embracing inclusive epistemological traditions to offer new directions for treatment interventions.

By converging psychology’s critical subdisciplines and Black Feminism(s), which I will refer to as a “Black Feminist Psychology Framework” (BFP), I will explore the larger forces at work structuring Black Canadians’ mental healthcare to articulate new grammars of healing.

Although Black feminist *perspectives* exist in therapy[25], my framework represents a broader intellectual and practical mode of inquiry. Indeed, the growing empirical literature on Black feminism in psychology seeks to use Black feminist ideas to improve therapeutic treatment modalities (Carter et al., 2022; Jackson, 2010; Jones, 2015; Jones & Harris, 2019; Oliphant et al., 2022, Spates, 2012); however, missing from the literature is the application of Black feminism as a *theoretical lens* to investigate mental health service utilization, service disparities and treatment preferences. My dissertation aims to address this gap.

Through the lens of Black Feminist Psychology, I aim to offer a more complex understanding of the abstract relations of power structuring Black peoples' participation in the mental health field. Thus, my focus extends beyond infusing a set of Black feminist therapeutic techniques into clinical practice, to also capturing the study of historical, political and socio-cultural forces at work in the maintenance and persistence of mental health service use disparities and exploring the role of socio-cultural values on treatment preferences. Applying A Black Feminist Psychology Framework to investigate Black Canadians' mental healthcare service delivery will help to facilitate historically attuned, politically engaged and culturally responsive mental healthcare. It achieves the first objective by bearing witness to the damage inflicted in the field under the veils of scientific 'progress,' 'healing' and political neutrality (Howitt & Owusu-Bempah, 1994; Fine, 2006; Winston, 2021).

Historical Attentiveness. I use my framework to situate mainstream psychology within the context of colonial violence, slavery, and racial oppression, to interrogate the genealogy of degraded mental healthcare service delivery for Black Canadians. Building on critical

[25] Black feminist perspectives "assists Black women in viewing their reality from a positive standpoint and in forging a greater understanding of their struggles, strengths, and resilience" (Jones & Harris, 2019, p.252).

psychology's efforts, I use my framework to invite researchers to critique the "political economy of knowledge production" (Bhavnani, 1994, p.27) and consider how psychology's ideologies, methodologies and data analysis have historically served as an instrument of social control and surveillance for its multiracial clients (Fine, 2006; Jones, 2015, Teo, 2011). Within BFP, lack of participation in formal mental health programs registers as inextricably tied to intergenerational experiences with the mental healthcare system and as a mode of resistance (Burack, 2004). A historical attentiveness creates space to trace patterns of inequality and perform practices of "Black annotation"[26] on the erasures and oversights of Black suffering in the field (Sharpe, 2016, p.117). For example, Black communities' reticence to access mental health supports can be, in part, attributed to the role of harmful stereotypes. Stereotypes, such as the bestial Brute, which originated in the trans-Atlantic slave trade were reinforced through psychoanalytic studies and perpetuated the belief that Black people can withstand extreme adversity given their "inferior" mental capabilities. Unsurprisingly then, a field which has dismissed Black pain, and in fact has encouraged it, is unlikely to carry significant appeal for this racialized group (Burack, 2004).

Moreover, the field's participation in the perpetuation of hegemonic stereotypes may have contributed to the internalization of these beliefs, resulting in some Black communities' acceptance of mental distress and suffering as normative (Taylor & Kuo, 2019). The ramifications of stereotypes on help-seeking behaviours are wide reaching, as mental illness stigma may be particularly heightened for communities that have historically been regarded as impervious and invulnerable to mental illness or mental health concerns[27] (Taylor & Kuo, 2019,

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[26] For Sharpe, Black annotations offer "ethical viewing and reading practices" that can disrupt and counter the colonial project of violence (Sharpe, 2016, p.116-117).
[27] "Conner et al. (2010) found that depressed Black Americans believed that many people in their community

p.327). Historical scientific racism and its enduring work[28] warrant careful scrutiny in an investigation on Black Canadians' mental healthcare service use disparities. In line with African psychology's objectives, BFP illuminates how enslavement, colonialism, segregation and racism have historically and presently influence Black Canadians' mental healthcare service utilization. By annotating the ways in which these events have influenced mental healthcare inequity, BFP refuses ideological neutrality and adamantly adopts an anti-racist approach to its investigation. Thus, BFP views its epistemic responsibility as prioritizing accountability, transparency, and targeting anti-Black racism in its investigation of Black Canadians' mental healthcare service delivery through its historical lens.

Political Engagement. BFP's political moorings highlight the work of political structures and policies to reveal how they condition Black communities' engagement with mental health programs, and government responses to Black Canadians' mental healthcare concerns. Neoliberalism has masked its role in contributing to the pathogenic social-political conditions it has fostered with its market-rationality and taxing autonomy (Sugarman, 2015). The policy's emphasis on individualism serves to position mental health challenges as the product of idiosyncratic choices rather than the result of systemic factors, ultimately, placing the responsibility on the individual actor to fix, instead of society's obligation to redress (Fine, 2012; Prilleltensky, 2008). Counselling professionals help to maintain this neoliberal posture by offering coping strategies to their clients to *adap*t to their environmental stressors, rather than

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endure "hard times" and they therefore concluded that they must not be very strong because they need professional help. Participants reported blaming themselves for being depressed and associated having depression with personal weakness" (Taylor & Kuo, 2019, p. 327).

[28] "Despite careful, scholarly criticism in every era since the early 1900s, scientific racism in psychology has proven remarkably resilient. Although Arthur Jensen and Philippe Rushton both died in 2012, a small but very active community of researchers continue to pursue questions of race in relation to intelligence, brain size, crime, sexuality, reproduction, and dysgenics, with new work appearing in *Personality and Individual Differences, Intelligence*, and other journals" (Winston, 2021, p. 16).

transform them (Toporek et al., 2010). However, similar to liberation psychology's aims, my theoretical framework works to reframe psychological help as the promotion of systemic and political change. Applying BFP to studying Black Canadians' mental wellbeing necessitates identifying political arrangements that establish exploitative conditions for Black Canadians and participating in community engaged efforts to address them. BFP aligns itself closely to social justice enterprises by embracing collaboration with grassroots and community-based organizations to foster activism against institutional and structural oppression.

Socio-cultural compatibility. A framework that explores service use patterns for Black Canadians must also work to create more culturally informed mental healthcare initiatives. I will use my framework to amplify voices typically silenced or overlooked in formal mental healthcare settings and foreground their experiences. Collapsing value-laden distinctions between "scientific" and "non-scientific" sources,[29] I attend explicitly to Black feminist thought. Extending feminist psychology's scope, I will use my framework to affirm Black women's constructions of knowledge, drawing on Black feminist texts, traditions, and epistemologies to inform analysis, therapeutic practices, and psychosocial resources (Carter et al., 2022; Jones & Harris, 2019; Oliphant et al., 2022). In particular, Black women's writings across the global diaspora offer an interesting starting point to engage explorations of resistance and empowerment as part of larger conversations about Black mental health and wellbeing. These texts present an epistemological base distinct from the dominant scholarship, which can point towards innovative coping strategies, interventions and broaden theoretical understandings of transformative mental health praxis.

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[29] "Western psychology lays emphasis on the use of objective, quantitative measuring or data gathering instruments in its study of the psychology of human beings" (Nwoye, 2015, p. 107). BFP rejects this emphasis and extends its framework to other ways of knowing to encompass a more holistic study of mental health for Black Canadians.

Applying my framework, I will validate and prioritize Black feminist creative texts to challenge the existing scholarship on mental healthcare and creatively imagine new possibilities to achieve mental wellbeing and healing for Black communities. In a world which has denied Black peoples their humanity, creative literature on Black life has uniquely engaged with the question of the human and reimagined new ways for Black communities to resist psychic scars and live meaningfully. Furthermore, creative writing functions as a reminder to study Black persons typically outside the categorical purview of scientific study (for example, Black children, elderly Black men and women, the criminalized, the demonized, etc.) and account for these subjectivities in our investigations of healing and holistic care. As an alternative medium to interviews, case studies, or statistics, novels can function as a "curative domain" by envisioning healing discourses, rewriting scripts about wellness, challenging stereotypes that perpetuate Black peoples' mistreatment in the mental health field, and defying dichotomies that obscure other ways of healing[30] (Wilentz, 2000, p.54). For instance, the binary of 'magic and science' within the empirical medical health literature has dismissed the role of spirituality, which is widely celebrated and emphasized in creative texts as a source of healing (Day, 2016; Jones, 2016; Wilentz, 2000). The negation of spirituality and religion, central to ancestral African practices, has contributed to a less inclusive mental health paradigm for African descendants[31] (Nwoye, 2015; Oliphant et al., 2022). Black feminist creative writers often present ancestral healing as a spiritual and communal enterprise for Black diasporic communities experiencing

[30] "Drawing from a diversity of traditions, womanists may use prayer, rituals, meditation, collective visualization, and a host of other means to draw spiritual energy toward social, political, and even physical problem solving and healing" (Phillips, 2006, p.xxviii).
[31] Western psychology defines humans only in material, measurable, or observable terms, ignoring attention to human religiosity and spirituality, which belong to the invisible realm and which in African Psychology are an important source of influence in human beings" (Nwoye, 2015, p. 107).

trauma (Jones, 2016). Their insights remind readers that alternative pathways to care should include Indigenous-healing traditions, and alliances with informal mental health service providers traditionally accessed by Black communities (e.g. religious leaders, clergy, spiritual counsellors). Faith and spirituality are commonly documented as a protective factor for strong mental health (Ottawa Public Health, 2020), and BFP demonstrates renewed efforts to merge theistic considerations within mental healthcare and consider approaches to mental wellness that have not historically dominated the scholarship but have socially prevailed in community practice.

In Canada, approximately 82% of Black Canadians report religious affiliation compared to approximately 65.4% of all Canadians (Statistics Canada, 2022). The main reported religious affiliations among Black Canadians were Christian (69%) and Muslim (11.9%) (Statistics Canada, 2022). Therefore, despite more than one third of Canadians reporting no religious affiliation, a closer breakdown of the numbers reveals that this total masks Black Canadians' relationship to religion (Statistics Canada, 2022). While it is important to note that not all Black Canadians have a relationship with religion, and in fact, may understand religion as perpetuating trauma, abuse and exclusions (Winks, 1997), the significant number of Black Canadians who do report religious affiliation suggests that religion is an important site for exploration (Brown & Keith, 2003; Taylor et al., 2000; Wilson, 2001). This is especially true given that spirituality and religiosity have been identified as important factors influencing professional help-seeking (Njiwaji, 2012) and may yield important implications for thinking through alternative forms of mental healthcare and tackling the stigma surrounding professional help-seeking. Greater interrogation of the significance of spiritual belief systems and religion for Black Canadians, who have historically been shut out of formal institutions of care, is necessary if practitioners are

to create effective interventions that are culturally congruent with Black communities' beliefs and improve mental health service delivery for this population.

To summarize, my Black Feminist Psychology Framework aims to address the knowledge gap on Black Canadians' mental healthcare service use disparities by attending to historical, political and socio-cultural factors influencing this target population's mental healthcare service delivery. By intimately exploring the (a) colonial history of psychology, (b) neoliberal mental health discourses, and (c) socio-cultural practices of wellbeing, such as religion and spirituality, I aim to contribute to a 'paradigmatic shift' in understanding Black Canadians' mental healthcare service use patterns whilst generating new strategies and interventions to advance their mental healthcare service delivery. The strength of BFP serves as a corrective and sharpening of previous paradigms by closing the chasm between "intellectual and political activity," and centering Black feminist epistemologies and Afrocentric worldviews (Prilleltensky, 2008, p.116). Indeed, my theoretical framework is attentive to power dynamics within and outside the field of psychology; can be applied to assess and actively combat interlocking systems of oppression; and deployed to create culturally responsive mental health therapeutic interventions.

Chapter 3- Methodology

Overview

Black Feminist Psychology inspires the methodological programming of my project. In accordance with my theoretical framework, I apply diverse methods of qualitative research across “disciplinary, thematic and scholar-activist boundaries” (Weber, 2007, p.204). This is in line with many feminists works, which employ various methodological approaches to capture the lives and concerns of their participants rather than prescribing to any singular research method (Collins, 2000; DeVault, 1996; Fine, 2012). I use Black Feminist Psychology to interrupt ahistorical, essentializing, and fixed accounts of objective[32] truth in favour of a more partial, situated and fluid construction of reality (Harding, 2020). My framework directs attention to Black Canadians' mental healthcare service delivery and treatment preferences as "socially produced through the historical, socio-economic and political processes of colonization" and neoliberalism (Anderson, 2002, p.14). Thus, my Black Feminist Psychology Framework requires methodological approaches that are flexible and make space for the nuance and diversity of lived experiences, while still carefully attending to the historical and socio- political forces that structure existence.

By incorporating reflexive thematic analysis (RTA) and thematic literary analysis into existing psychology scholarship, I will offer examinations of macro and micro level forces shaping Black Canadians’ mental healthcare. Together, these modes of inquiry can expand understandings of Black Canadians’ mental healthcare service delivery to include a larger pool of social relations, political structures, hegemonic discourses and cultural patterns. By centering

[32] This departure from objective truth is in fact a movement towards “stronger objectivity” (Harding, 2020, p.22). It is a call for research that “is more objective than the conventional supposedly universally valid research that was grounded only in dominant groups’ experiences” (Harding, 2020, p.22).

the perspectives and concrete experiences of informal and formal mental healthcare service providers[33] and channeling the literary-cultural imaginary on communal healing, I can work to help produce more culturally responsive and holistic mental healthcare for Black Canadians. The following section is divided into three main parts. In the first section I present a critically reflexive account of my time conducting qualitative interviews with Black parish ministers and Black psychotherapists. In the second part I discuss performing reflexive thematic analysis with the interview transcripts, which resulted in me identifying two threads in the data[34]: themes and discourses. The last section concludes with my discussion on thematic literary analysis, the final methodological approach undertaken in my study.

Critical Reflexivity

I present a critically reflexive[35] account of my time conducting interviews for two main reasons. In line with the Black feminist and critical psychology tradition, I wish to foreground a self-awareness concerning how my social location and background may have influenced my research process including, but not limited to, how these factors may have influenced my access to the field, the nature of the researcher- researched relationship, or how personal values and worldviews may have co-constructed meaning and interpretation of the conclusions drawn (Berger, 2015; Lumsden, 2012, p.3). I reject the positivist notion that a singular, universal truth

[33] "Formal mental healthcare service providers" refers to trained and certified professionals who work in inpatient and outpatient facilities and can assess, refer, and treat patients suffering from emotional or psychological distress. I use the term "informal mental healthcare service providers" to refer to a wide range of actors that can broadly be understood as engaging in social and political activities to help improve and sustain an individual's spiritual and social welfare needs.

[34] "A data set does not "hold" a single thematic analysis (TA) within it. Multiple analyses are possible, but the researcher needs to decide on and develop the particular themes that work best for their project" (Braun & Clarke, 2022, p.10).

[35] "Reflexivity is commonly viewed as the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger, 2015, p. 220). To enhance the accuracy and credibility of the findings in a research study, one must monitor and account for their "values, knowledge and biases" (Berger, 2015, p.221; Cutcliffe, 2003, p.137).

exists in data to be unearthed through the application of a valid 'scientific method,' and instead direct attention to the ways in which my subjectivity has influenced the dissemination of my findings (Braun & Clarke, 2022). Secondly, I opt for a reflexive review to reflect on how my theoretical training in critical psychology and Black feminist thought, inadvertently or advertently, influenced decision-making regarding my research methodology (Lumsden, 2012; Braun & Clarke, 2022). For instance, my decision to pursue thematic literary analysis is intended to challenge institutionalized knowledge in psychology by extending the issue of mental health service use disparities and treatment preferences to Black creative writers, who are rarely, if ever, inserted into these conversations. These literary works are broader than conventional mental health epistemologies and ontologies in that they encompass new collective strategies for wellbeing and illuminate the need for new political resources and ancestral knowledge for survival. Creative texts, born out of historical realities and political truths, present a unique opportunity to gain insights on cultural healing practices, and modes of resistance. I contend creative texts offer potential lessons and alternate narratives that might help practitioners develop new tools to strengthen Black Canadians' mental healthcare service delivery.

My decision to pursue thematic analysis[36] (TA) of the interview data similarly stems from this motivation to advocate and include subordinated voices that have been muted in the knowledge production on mental wellbeing, such as Black parish ministers and Black therapists (Lumsden, 2012). My training would have it that I contest "epistemological assumptions" concerning how we arrive at 'truth' by including these neglected actors and privileging their standpoints (Anderson, 2002, p.18; Collins, 1990). Moreover, my decision to pursue the very

[36] Thematic analysis (TA) is also considered a "transtheoretical tool," which aligns with the interdisciplinary theoretical orientation of my work (Braun & Clarke, 2022, p.3).

specific approach of *reflexive* thematic analysis (RTA) as proposed by Braun and Clarke (2022) was consistent with my Black feminist commitments as well. In contrast to traditional TA approaches such as "coding reliability TA" or "codebook TA" that emphasizes systematic coding in pursuit of an "objective truth" (Braun & Clarke, 2022); reflexive thematic analysis values "thoughtful and artful" interpretation of data (Braun & Clarke, 2022, p.3). Inherent in reflexive thematic analysis then is the acknowledgement of the creative labour of interpretation (Braun & Clarke, 2019; 2022). This approach provides me with the flexibility to pursue lines of inquiry that are both overt and latent.[37] Therefore, in addition to generating themes related to R/S in mental healthcare service delivery, reflexive TA also allows me to meaningfully explore how the responses I received from my participants are informed by larger discourses and ideological mechanisms. In sum, my decision to perform thematic literary analysis and reflexive thematic analysis is determined if not demanded by my theoretical framework. The fit between my theoretical framework, research design, analytic practice, and research goals contributes to my study's methodological integrity (Levitt et al., 2017).

I am aware that by adopting a reflexive approach, I pose the risk of "privileging excessive self-analysis and deconstructions at the expense of focusing on the research participants and developing understanding" (Finlay, 2002, p.212; Lumsden, 2012, p.4). This is a critique leveled at reflexive work, to which I respond by offering a concise but robust discussion of some of the most notable considerations during the interview stage, while still allotting attention to other aspects of the research process. I am also aware that exposing biases or "confessing to methodological inadequacies," can serve to undermine the rigorous qualitative work undertaken

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[37] Overt refers to "semantic or descriptive meanings— the meanings directly observable on the surface of the data," and latent refers to "the implicit or conceptual meanings —the meanings that underlie the data surface" (Braun & Clarke, 2022, p.5).

in this project (Finlay, 2002, p.212). However, I hope that my audience and wider academic community can recognize how my aim for transparency and accountability of my "values, beliefs, knowledge and biases" (Cutcliffe, 2003, p.137) serve to aid the credibility, legitimation and representation of the data, and that these important epistemological outcomes ought to outweigh any objections to reflexive work (Berger, 2015, p.221; Brewer, 2000; Buckner, 2005, Macbeth, 2011; Lumsden 2012; Wasserfall, 1997). Thus, having considered the benefits and disadvantages of reflexive analysis,[38] I forge ahead with the conviction that this is the best way forward.

I performed 20 semi-structured qualitative interviews with my participants. Qualitative interviews place lived experiences, perspectives, marginalized voices, and stories of the participant at the foreground of analysis (Levitt, 2018). By incorporating qualitative interviews in my study, I ensured voices excluded from the canon and the general scholarship were included in the conversation, challenging what is constituted as "legitimate social knowledge" and extending the number of "experts" qualified to discuss Black Canadians' mental healthcare service delivery and treatment preferences (Anderson, 2002, p.12). I conducted twelve interviews with Black parish ministers, community leaders who rarely feature in the mental health scholarship (Avent-Harris, 2021), and eight Black psychotherapists, who are marginally represented in the mental health field. I chose these two groups of informal and formal mental healthcare service providers to examine the issue from multiple social locations and through different kinds of expertise

[38] "Reflexivity can be viewed as either the problem or the solution to issues of legitimation and representation (Brewer, 2000). It can be conceived of as problematic in that the knowledge produced by social researchers is situated and partial, thereby threatening the legitimation of data and their representation. Alternatively, it can be the solution via researchers: 'making explicit the partial nature of the data and the contingencies into which any representation must be located', hence improving the legitimation and representation of the data" (Brewer, 2000, p. 127; Lumsden, 2012, p.4). I am of the opinion that the latter is most accurate.

(Anderson, 2002; Collins, 1990). This choice was deliberate and intentional given these participants subordinated status in the field. As Anderson (2002) aptly remarks:

> Recognizing these voices and treating them as legitimate is not a neutral academic exercise: it compels us to question what is taken for granted and to scrutinize the social and historical location from which dominant discourses have been produced. This challenges the foundations of dominant intellectual discourses, even those coming from a critical interpretive stance that run counter to positivist science (p.9).

In contesting dominant discourses on Black Canadians' mental healthcare service use disparities, I include voices from outside the academy to shed light on an issue that is still largely understudied or understood. All my interviews were semi-structured using open-ended questions,[39] lasting approximately 30-45 minutes (Cohen & Crabtree, 2006). The pool of applicants for the study was drawn from Toronto.[40] Part A describes the recruitment and interview process with parish ministers, while Part B outlines the process I undertook with the therapists.

Qualitative Interviews

Part A: Interviews with Parish Ministers

First, I conducted in-depth interviews with 12 Black parish ministers of primarily Black Christian congregations to assess their role as informal frontline mental healthcare service providers. I was interested in understanding how parish ministers understood their role in promoting and advancing mental wellbeing in Black communities and the concerns,

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[39] Semi-structured interviews can capture a nuanced and comprehensive understanding by employing a straightforward approach of posing topic-initiating and follow-up questions. Topic-initiating questions guide the conversation towards specific areas of interest, while follow-up questions facilitate in-depth exploration and elaboration on those particular topics. (Rapley, 2001).

[40] The Greater Toronto Area (GTA) is home to the largest Black population in Canada (Statistics Canada, 2016) and therefore offers the most representative pool of Black parish ministers and Black therapists in Canada.

roadblocks, and suggestions parish ministers raised in relation to their role. I was also interested to learn whether they would be open to collaboration with formal mental healthcare service providers. All participants, with the exception of two pilot interviewees, lived and practiced in the Greater Toronto Area. Interviews were conducted over the course of two months (April 2021—May 2021). The first parish minister was recruited via convenience sampling and the remaining parish ministers were recruited via snowball sampling[41] (Valdez & Kaplan, 1999). The names and contact information of the referred respondents were contacted via email and/or telephone and participants received a meeting invitation and a copy of the consent form. Interviews were conducted over telephone[42] or Zoom,[43] based on the participant's preference, and

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[41] My interest in a specific population, Black parish ministers of Christian denominations within Ontario, gave rise to an intimate social network; thus, recruitment of future participants was attainable via introduction of acquaintances and colleagues (Valdez & Kaplan, 1999). I selected the first priest via convenience sampling. The names and contact information of the referred respondents were then contacted. Those who agreed to the invitation were scheduled for an interview and received a copy of the consent form in advance of the interview. My goal was to build a representative sample of Black parish ministers within the Greater Toronto Area (GTA) who minister to a largely Black congregation. Although snowball sampling (SSM or chain referral sampling) has been largely critiqued as biased due to its reliance on social networks, my project endeavored to explore a particular profession that can be inaccessible or "hard to reach for research purposes" via traditional forms of recruitment, i.e. flyers, online platforms, etc. (Cohen & Arieli, 2011, p. 427). In this particular case, a circle of acquaintances within the profession, does not equate to lack of representativeness. Black parish ministers are not a homogenous group; differences can range widely from religious denominations (Methodist, Baptist, Protestant, Anglican, etc.), education (university degree, college degree, Master of Divinity, etc.) to lifestyle choices (dietary restrictions, marital status, etc.). Thus, diversity within these networks remains plausible (Cohen & Arieli, 2011). SSM has also been cited as highly useful "if the aim of the study is explorative, qualitative or descriptive," and requires minimum time and money (Cohen & Arieli, 2011, p.427). All of which proved beneficial to the project. More importantly, when working with closed social networks, such as parish ministers, gaining access and involvement may be difficult. SSM can thus help to facilitate cooperation (Cohen & Arieli, 2011). Lastly, it is my contention that the absolute elimination of sampling or selection bias is impossible, and in line with my theoretical framework, I problematize generalizability or 'pure' samples. As such, SSM has the strong potential to yield valid research outcomes (Valdez & Kaplan, 1999).

[42] The telephone can serve as a "time-efficient and researcher-friendly" alternative to in-person interviews (Holt, 2010; Deakin & Wakefield, 2014; Trier-Bieniek, 2012). While building rapport "may be more challenging without visual cues, it is argued the anonymity can allow for more honest conversation" Trier-Bieniek, 2012 p.641).

[43] Zoom is a free software platform available for download to smart phones, tablets or desktops, and provides audio and video calling with other Zoom users. Video calling was used with all the participants that opted to use Zoom, which closely mirrored a traditional interview, as I was able to converse and view them in real time (Deakin & Wakefield, 2014). "Online interviews [I.e. skype/zoom] can produce data as reliable and in-depth as produced during face-to-face encounters" (Deakin & Wakefield, 2014, p.604). While online interviews may have limitations such as "the need to have technological competence required to participate, obtain software and to maintain Internet

lasted between 30 and 45 minutes. Zoom offered the greatest flexibility and eliminated the associated health and safety risks of conducting a traditional interview during a global pandemic. Almost all my participants were familiar and comfortable using Zoom, as most had switched to using this software platform for their church services during the height of the Covid-19 pandemic. Overall, online interviews presented an opportunity for rich data and rapport building.[44] Participants who raised technological concerns, or preferred an alternative interview mode, were given the option to have the interview over the telephone. Only two of the twelve interviewees required this accommodation. The interview guide was developed using sensitizing concepts,[45] based on my understanding of the related literature, with prompts and follow up questions to help facilitate clarification of the questions posed and elicit in-depth responses (Breakwell, 1995). I posed questions pertaining to the parish ministers' conceptualization of mental wellness, how they provide mental health resources for their

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connection for the duration of the discussion" fortunately, this was not an issue for 80% of my participants (Deakin & Wakefield, 2014, p.604).

[44] The largest problem I encountered conducting interviews online was that participants were at home during the time of the interview. This often resulted in greater noise disruptions and distractions then would have likely been experienced in an in-person interview (Deakin & Wakefield, 2014). While this was not particularly problematic in and of itself, because I was recording our conversations over computer speakers (which already impacted the sound quality), the background noise captured on my hand-held recorder contributed to a more laborious effort transcribing the interview. Deakin and Wakefield (2014) encourage researchers to ensure their participants are located in a "suitable location," free from "controllable distractions" as to guarantee the concentration of their participant (p. 609); however, the pandemic had forced many to stay indoors to stop the spread of the virus, resulting in new at-home routines with partners and children. Thus, demanding an empty house or for background activities to be silenced was largely out of the question and an inappropriate request or expectation. Another slight inconvenience I encountered conducting interviews online was freeze frames and dropouts. Deakin and Wakefield (2014) argue that time lags and dropouts, which is when "conversation would have to stop because the video froze or where the other person was unable to hear" can negatively impact rapport (Deakin & Wakefield, 2014, p.611). However, I found that these instances typically led to greater rapport building. Once the connection was restored, it gave the respondent and I a common enemy, technology, and it became an easy point of conversation.

[45] "Sensitizing concepts," coined by Herbert George Blumer (1900-1987), "gives the user a general sense of reference and guidance in approaching empirical instances. Whereas definitive concepts provide prescriptions of what to see, sensitizing concepts merely suggest directions along which to look" (Blumer, 1954, p. 7).

congregation, address their limitations of treating mental health issues, and relate to formal mental healthcare professionals (see Appendix for interview questions).

An acquaintance of my mother served as my first point of contact. Given the time constraints of my dissertation, I felt it was the most efficient option to connect with someone who met the criteria and was most easily accessible to me. The participant served as a pastor of a medium sized Methodist Ghanaian congregation, boasting close to 50-75 congregants.[46] I explained the purpose of the study and offered flexible availability to accommodate his busy work schedule. In hindsight, requesting to speak with Black Christian parish ministers during the season of Lent and Easter was a poor calculation on my part. While many agreed to volunteer irrespective of this difficult timing, choosing a less active period on the Christian calendar would have likely resulted in more interview acceptances. Beginning my interviews with a familiar face helped me to develop my footing. Mixed personal feelings of nervousness, excitement and fear were present as I conducted my first interview, but they eventually gave way to feelings of inspiration and gratitude by the end of the session. I realized that for my interviewee, there was a genuine interest in the research questions I had posed. In turn, I had felt reassured in the objectives of my work. I had skillfully deferred to the participant as the expert on the issues discussed. I was careful to avoid "pushing" or "leading" the participant in certain directions by refraining from offering too many conciliatory or affirmative remarks (Berger, 2015; Padgett, 2008). I was impressed by my initial interview, and used the enthusiasm and positivity of my first meeting to guide me through the remaining interviews; however, as I look back through my notes (which I kept in effort to maintain reflexivity throughout this process),[47] there

[46] The size of the parish ministers' congregations varied from one another, but on average, parish ministers had at least 50 registered congregants as part of their church, with some hosting hundreds.

[47] Strategies for maintaining reflexivity include, "keeping a diary or research journal for 'self-supervision', and creating an 'audit trail' of researcher's reasoning, judgment, and emotional reactions" (Berger, 2015, p.222).

were many aspects that I took for granted. Most notably, my “insider/outsider” status (Berger, 2015; Best, 2003).

In retrospect, despite my impulse to credit my rapport building to a good-natured sense of humor and friendly demeanor, I think it was likely attributed to at least three main causes, one of which was my status as a ‘young Black woman pursuing a doctoral degree.’ Many of the participants either stated explicitly or implied that they were proud of my scholarly pursuits and felt that as a member of the Black community, I was an important role model to the youth in their church. This, in turn, likely fueled parish ministers’ decision to participate in the study, which was perceived as something difficult and valuable, and worth aiding. Secondly, there was a level of trust (typically not afforded to social science researchers) that I attained despite little work done to build this confidence. It felt as though there was an unspoken agreement that I would present my findings from the interview in a manner that would be positive. There was an assumed alliance between the participants and myself, and thus a confidence that I would not negatively or antagonistically represent them. And, while I had no intention of misrepresenting the data or my participants, I felt a personal responsibility to the stories and vulnerabilities that were expressed among the parish ministers. My intention from the outset was to foreground voices undermined or overlooked in the psychology literature; however, this did not prepare me for the personal responsibility I would feel to safeguard my participants from stereotypes or a secular dismissiveness.[48]

I realize now I was battling two contradictory forces. Despite my adamant stance to unapologetically challenge knowledge production on Black Canadians' mental healthcare, I also

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[48] "The feminist researcher should find ways of recognizing and revealing to audiences the micropolitics of the research situation and should take responsibility for representing those who participate in ways that do not reproduce harmful stereotypes" (DeVault, 1996, p. 42).

felt compelled by the expectations of my field to explain why their voices were necessary and detail why religion and spirituality still warrants consideration for some Black communities.[49] Indeed, I made sure to carefully trace the scholarship on the importance of The Black Church as a preemptive attempt to prevent the undermining of parish ministers' inclusion in the study, and accord an "academic legitimacy" to their contributions. Hunter (2002) captures this tendency more succinctly through her discussion of "conceptual imperialism." She states:

> "When we write a thesis or a paper, we learn that the first thing to do is to latch it on to the discipline at some point. This may be by showing how it is a problem within an existing theoretical or conceptual framework. The boundaries of inquiry are thus set within the framework of what is already established" (Smith, 1987, p. 88). Smith highlights the problem of dominant epistemologies: they set the parameters for the way social life may be understood and made sense of. Experiences or knowledge that may not fit within the existing conceptual schema must be fit into them in someway to become legitimate pieces of social knowledge, or risk being excluded altogether. Clearly, neo-liberal positivism, limits the kinds of knowledge scholars can produce (p.132).

Contesting dominant discourses within "neo-liberal positivism" makes it incredibly challenging to create work that is innovative and inclusive, as it runs the risk of being dismissed if it fails to engage or speak back to prevailing discourses, or "accredited" knowledge producers of the discipline (Hunter, 2002, p.132). However, including the parish ministers, while daunting given the level of responsibility I felt, encourages a rupture from this practice, and allows me to pursue other lines of inquiry as my starting point. Equally important, it forces the wider research

[49] "Connections to our disciplines are among the most vexed questions that occupy feminist sociologists. Some argue convincingly for a strategic 'disloyalty to the disciplines' (Stacey 1995), while others advocate strategic uses of disciplinary authority and legitimacy" (Risman,1993 as cited in DeVault, 1996, p. 46).

community to recognize other actors, “theories and analytical categories organic to the Black experience” require further consideration when addressing Black mental healthcare and service delivery (Hunter, 2002, p.121).

Thirdly, rapport building was likely facilitated by drawn conclusions about my religious status. Only two of the twelve interviewees asked if I was a religious person or believed in God.[50] The remaining participants operated as if my religious status was an already established fact. I imagine that my consideration of religion and spirituality in my study led them to believe that I must be religious or at the very least, a spiritual person. While I'm certain parish ministers would not have been opposed to participating in the study if the principal researcher was a declared atheist, I imagine there would have been more skepticism about the aims of the work. And perhaps, more passing remarks advocating for a belief in God, particularly during the Covid-19 pandemic, which served as the global backdrop for these interviews. In turn, my status as an ‘insider’ served to help facilitate quick, strong, and friendly rapport with my respondents;[51] however, it also had its limitations. I found as I was analyzing the interview data with Black parish ministers, issues of race and racism were discussed with such great familiarity and understanding that I had to make sure I drew out the connections in my analysis for those who may be following from a different racial standpoint or historical positioning.

During the interviews, it was assumed that I understood histories of racism, colonialism and slavery as inextricably tied to the social and economic inequities experienced by their

[50] It was only under these circumstances that I disclosed my religious status. I personally did not feel it was relevant to share my own religious beliefs or lack thereof to justify the merits of my exploration.
[51] In addition to my ‘insider’ status helping to facilitate rapport building, it was likely also facilitated by my recruitment method of snowball sampling. Given that I came as a referral to these parish ministers, I was regarded as an "insider" who was granted ‘special’ internal access, and as such, I was met with greater acceptance and enthusiasm then I would have experienced if I were cold calling participants. In fact, attempts to cold call parish ministers for my study were extremely unsuccessful.

congregants, which then aggravated or prompted mental health conditions. But, in the absence of explicit discussions about these histories, I often took great care to illuminate how other beliefs, for instance, a holistic worldview, would contribute to such reflections. For example, my interview question, "do you see a relationship between individual wellness and community wellbeing?," resulted in more direct examples from the respondents of how communal trauma (i.e. police state-sanctioned violence against Black people) profoundly influences the wellbeing of individual members in the community. I also found that my inclusion of the question, "Is there anything else you would like to add or circle back to?" posed at the end of each interview with the parish ministers, served as a strategic approach to draw out unspoken "shared" [52] realities or lived experiences (Berger, 2015). In asking this question, I hoped to counter the participants' impulse to presume my familiarity on these topics, and to encourage them to straightforwardly express and clarify their insights.

Part B: Interviews with Black therapists

My experience interviewing therapists was similar to that of the parish ministers, with three main notable differences. I will recall the recruitment process first and subsequently elaborate on the interview process. I conducted eight one-on-one interviews between April 2021 and June 2021 with self-identifying Black psychotherapists in the Greater Toronto Area (GTA). Therapists were recruited via Black Therapist List, a free virtual directory, advertising Black therapists practicing in Canada. The platform showcases Black therapists with different designations and expertise,

[52] "It has been recognized, especially in the context of studying minority groups, that a 'dual identity' of a researcher and a member of the community being studied shape the research process (Brayboy, 2000; Chaudhry, 2000; Delgado Bernal, 1998; Motzafi-Haller, 1997; Villenas, 1996, 2000). For example, when researcher and participants share experiences, the assumption of researcher's familiarity with participants' realities carries the dangers of participants withholding information they assume to be obvious to researcher and researcher's taking for granted similarities and overlooking certain aspects of participants' experience" (Daly, 1992 as cited in Berger, 2015, p.224).

including but not limited to: therapists designated as Registered Social Workers with the Ontario College of Social Workers and Social Service, Counsellors, Lifestyle Coaches and Registered Psychotherapists. I narrowed my search to registered psychotherapists with the College of Registered Psychotherapists of Ontario working within the GTA. I contacted 20 potential interviewees via email and received 10 responses consenting to an interview. Unfortunately, two interviewees had to cancel due to unforeseeable circumstances.[53] I interviewed a range of Black therapists across their career spans (early-mid-late career participants) that worked within private, community, hospital and school settings. The purpose of this set of interviews was to explore the experiences of therapists' interactions with clients who rely on religious or spiritual practices to address mental health issues, as well as gather their perspectives on improving service delivery for Black Canadians. Interviews were conducted over Zoom, and lasted between twenty and thirty minutes. Participants were prompted with questions about the role of spirituality and religion in their clinical practice, the impact of religion and spirituality on mental health coping and treatment outcomes for their expressly religious clients, potential strengths and weaknesses of collaboration with parish ministers, their understanding and application of holistic care, and their strategies and recommendations for creating culturally appropriate mental health interventions for Black Canadians (see Appendix for interview questions with psychotherapists). Through these interviews, I aimed to identify gaps in service provision, and barriers to collaboration with parish ministers to make recommendations for change.

The interview process with the therapists ran quite smoothly. The most difficult part was recruitment. Compared to the parish ministers who came referred, cold calling or emailing

[53] One therapist withdrew due to a family emergency, another therapist had a scheduling conflict.

therapists presented a greater challenge. I sent many introductory emails that I later learned were rerouted to therapists' junk mail, since my email address was not on their contact lists. Or, if my emails were received, they were vetted through receptionists, which resulted in twice the number of email exchanges as I reiterated my purpose for reaching out. As a result, there was a longer turnaround time between sending my invitations and waiting for a response. In the end, I had a response rate of 50%. Under ideal circumstances, I would have liked more time to recruit a greater number of therapists, but academic deadlines and the financial precarity of my degree constrained my efforts. While I wasn't aiming for "saturation," a highly contested term in qualitative research,[54] I hoped to have a more representative pool of interview participants[55] and a number that more closely matched the number of interviews I held with the parish ministers. Despite this small setback, the data from the interviews were still very rich and descriptive and proved incredibly useful for my exploratory analysis. While future studies may aim to increase sample size for generalizability, exploring patterns in the data provided a strong foundation for addressing my research questions.

In addition to recruitment being harder to attain, building rapport also required a more sustained effort. While the participants agreed to my study, I was met with more questions and

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[54] Data saturation is the collection of data until "there are no more emergent patterns in the data" (Gaskell, 2000; O'reily & Parker, 2012, p.192). However, saturation is a contested notion in qualitative research with many challenging its potential to serve as a marker for sample size adequacy. Researchers have argued that the lack of practical guidelines to assess saturation (Bowen, 2008; Guest et al., 2006) and the diverse nature of qualitative research, prevents saturation from being uniformly applied to all qualitative approaches (Barbour, 2001; O'reily & Parker, 2012). Given that my intention was not to "count opinions or people but explore the range of opinions and different representations of an issue" I was less concerned with the number of participants and more interested in the "richness of information" shared (Gaskell, 2000; O'reily & Parker, 2012, p.191-192). I did feel at the end of my interviews, a strong level of "depth as well as breadth" on the topic had been achieved, reinforcing my "sample adequacy" (Bowen, 2008; O'reily & Parker, 2012, p.191-192).

[55] None of the therapists I interviewed were Black men; however, the gender of my interviewees was relatively representative of the field, as the counselling profession remains largely women dominated. For example, in the United States, 64.8% of all therapists are women, while 35.2% are men (Zippia, 2023). A CBC report titled "Black psychologists say there are too few of them in Canada-and that's a problem" discusses the staggering shortage of Black counselling professionals in the field (Williams, 2021).

reservations about the study at the onset of each interview.[56] However, I did find that any restlessness or reservations from the therapists about my study dissipated after I restated the objectives of my research, the ethics protocol[57] I would follow, including the use of pseudonyms in my report, and the allotted time I would spend with each of them. I think the difference in reactions can largely be attributed to therapists' concerns of confidentiality and time. Regarding the former, while parish ministers operate more openly and maintain a public facing role, most of the therapists were used to working within the private sphere, with their work carefully tucked away from the watchful critique, attention, and examination of the masses. Recording the interviews posed a risk to the comforts of their confidentiality. Thus, concerns regarding breaches of confidentiality required that I firmly reassured their anonymity in all public reports and disseminations of my findings. This assurance, I believe, strengthened their trust in me as an interviewer. Additionally, while parish ministers may provide additional free services as part of their profession, therapists are remunerated for their time and labour. Given that I was not compensating participants for their involvement in my study, I recognized that my requests for their time might result in potential income lost. Therefore, I chose to keep my interviews within a twenty to thirty-minute time frame.[58] I felt that by honoring this time commitment, I would display a level of respect for their schedule, energy, and expertise. This effort helped to facilitate my rapport with the therapists.

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[56] As with the parish ministers, I made sure to acquire informed verbal and written consent. While "gaining informed consent verbally can make the beginning of the interview feel very formal and may not set the right tone for an interview" (Deakin & Wakefield, 2014, p. 613), I used this time to create space for the participants to ask me any questions they may have before we began the formal interview, and found it a particularly useful way to encourage transparency and trust between the therapists and I.
[57] York University's Research Ethics Board granted ethics approval.
[58] Many of the therapists I interviewed offered a complimentary 20-minute consultation for new incoming clients, which allowed patients to assess compatibility and/or if the therapist offered the treatment they required.

Lastly, the main difference I observed between my interviews with the parish ministers and the practitioners concerned power dynamics. In these set of interviews, I did not feel I had to take great efforts to address power imbalances between researcher and participants. Given the therapists' area of specialization in mental health, I was not treated as the "all-knowing" expert on the matter. In fact, their credentials arguably made them more of an 'authority' on the topics we were discussing than myself. Consequently, it was easy to adopt the position of the uninformed novice and "outsider" during our time together, which allowed me to draw out many taken for granted assumptions, encourage them to expand on thorny topics and request clarification on interesting points of departure (Best, 2003). Overall, my interviews with the therapists were incredibly rewarding and reaffirming. All the interviews concluded with encouragement to maintain my efforts pursuing this line of inquiry, which they felt was very important work, albeit expansive. Many participants also expressed an interest in reading my final report, which I had promised to share.[59]

Data Analysis

Reflexive Thematic Data Analysis

In sum, I conducted 20 interviews. I audio recorded each of the interviews, and transcribed, coded, and anonymized the raw data.[60] I archived the data with dates and stored it in password protected files on a secure computer (Nowell et al., 2017). To analyze the data, I employed Braun and Clarke's reflexive thematic analysis (RTA). Although I present it as a linear six phased method, in practice, it was an iterative and recursive process. I carefully read the

[59] "Collins (1991) states that in order for something to be considered Black feminist thought, it must be confirmed and validated by the majority of everyday Black women. This belief is also reflected in the trend of many feminist researchers to bring their research findings back to the community they studied for feedback" (Hunter, 2002, p. 128).

[60] I use pseudonyms to maintain my study participants' confidentiality.

transcriptions repeatedly in an effort to familiarize myself with the data. As I engaged with the interviews, I began to document potential codes,[61] textual units, that were most relevant to my research questions and that presented interesting patterns in the data (Braun & Clarke, 2020). I created an audit trail of generated codes and eventually finalized my selection once I ensured the codes were not "interchangeable or redundant," and had "captured the qualitative richness of the phenomenon" (Attride-Stirling, 2001; Nowell et al., 2017, p.5-6). An external auditor confirmed the codes were representative of the raw material (Hill et al., 2005). Codes that addressed the same concept, issue or idea were grouped together as a theme (King, 2004). Braun and Clarke (2020) define a 'theme' as "patterns of shared meaning underpinned by a central organising concept" (Braun & Clarke, 2019, p.589). My themes were generated inductively from the transcriptions and direct quotes were compiled to express the data classified within each theme[62] (Braun & Clarke, 2006; Breakwell, 1995). It was important that the themes were "specific enough to be discreet and broad enough to capture a set of ideas contained in numerous text segments" (Nowell et al., 2017, p.8-9). While I created distinctive categories, the themes still intertwine and speak back to and across each other. This became increasingly apparent as I began a detailed analysis of each of the themes and wove them together in a story that addressed and engaged with my research questions. The objective was to offer an interrogation of the role of

[61] Qualitative coding is an interpretive process of reflecting on the data and interacting with it so that you can identify important sections of the text that relate to a theme or issue (Braun & Clarke, 2019).
[62] I created a table to help organize the codes and themes that emerged from the raw data set. Some of the codes were used to form themes, others were grouped in a "miscellaneous" category if I was unsure of their immediate relevance (Nowell, Norris, White, Moules, 2017, p.8). Some of the themes "collapsed into each other," while other themes required that they were broken down or separated into another distinctive category (Nowell, Norris, White, Moules, 2017). My table was shared with two external members to help review and refine the coded data extracts and themes (King, 2004; Lincoln & Guba, 1985). Through this peer review process, any inconsistencies or incongruities were discussed and revised.

religion and/or spirituality in mental healthcare service delivery for Black Canadians, and to explore conditions to create a collaborative strategy for parish ministers and psychotherapists.

My reflexive thematic analysis of the interviews with the parish ministers generated five key themes:[63] (a) Mental healthcare as a holistic enterprise; (b) Healing in community for communal healing; (c) Creating a culture of collaboration (d) Hope as a psychosocial resource and protective factor across generations; (e) Black faith community leaders as mediators between Black community members and the police. My reflexive thematic analysis of the interviews with the therapists also generated five themes:[64] (a) Holistic care as contextually situated and provisional; (b) The Great Beyond; (c) Lived experiences as the bedrock of culturally responsive interventions; (d) Gender Variance; (e) Religious pluralism. The aim was not to merely report on the themes that I generated from the data, but to consider the broader significance and implications that each of these themes possessed in relation to my research questions (Braun & Clarke, 2006). Specifically, I explored how these themes could be applied to outline a collaborative strategy for pairing parish ministers and psychotherapists to create more holistic, decolonized and culturally compatible mental healthcare.

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[63] Thematic analysis of the interviews with the parish ministers revealed willingness and a need to work towards greater collaboration with formal mental healthcare service providers for stronger mental health promotion, intervention and outreach in Black Canadian R/S communities. Further, my analysis demonstrated that a decolonized approach to mental healthcare for Black Canadians must include political and systemic reform to oppressive structures, holistic care that meaningfully encompasses R/S, and increased cultural competency among counselling professionals, to achieve transformative change in mental healthcare service provision.

[64] Holistic care as contextually situated and provisional: This theme encompasses therapists' fluid and diverse approaches to applying holistic mental healthcare in practice; b) The Great Beyond: This theme encapsulates interviewees' reflections on how the "afterlife of slavery" impacts their clients. Participants also recognize healing from systemic racism requires resources and communal support that extend beyond their clinical practice; c) Lived experiences as the bedrock of culturally responsive care: This theme captures the knowledge base participants draw from to create unique approaches to wellbeing for their Black clients; d) Gender Variance: This theme addresses participants' experiences of the gender gap in caregiving and help-seeking, and the necessity of amplifying gender-neutral mental health discourses; e) Religious Pluralism: This theme refers to therapists' attempts to hold space for R/S' polarizing nature. It encompasses three sub-themes: religious trauma; superstition; and variability.

Verification and Trustworthiness. Inherent in Braun and Clarke's RTA is the acknowledgement of the creative labour of interpretation (Braun & Clarke, 2019). In line with this approach then, meaning is understood as always partial, situated, and multiple. This positioning is at odds with established positivist procedures which demand objectivity and accuracy. Indeed, RTA recognizes that research findings are always inflected with a researcher's subjectivity and theoretical training, which artfully co-construct the meanings and interpretations of the conclusions drawn (Braun & Clarke, 2019; 2022). Therefore, while demonstrating "accurate" or "reliable" coding is outside the paradigmatic and epistemological scope of RTA, I did undertake a few measures to achieve a level of "fairness" and "trustworthiness." Fairness refers to "…representing participant viewpoints equitably and avoiding lopsided interpretations that represent the biases of the researcher or only a few participants" (Morrow, 2005, p. 255). I enhanced fairness by keeping field notes throughout the recruitment process, data collection, interviews and data analysis stages. This "self-reflective" journal allowed me to reflect on and account for my values, beliefs and disciplinary knowledge that may be influencing my engagement with the data (Hays & Singh, 2012; Morrow, 2005, p. 254). Throughout the interview process, I also found that my inclusion of the question, "Is there anything else you would like to add or circle back to?" posed at the end of each interview with the participants, served to enhance credibility (Berger, 2015). By urging respondents to clarify their insights and be direct, I worked to minimize the number of implications I had to infer. I also shared my findings with two external auditors to solicit feedback on my data analysis to increase reflexivity and credibility (Hays & Singh, 2012; Lincoln & Guba, 1985). Through this peer review process, any inconsistencies or incongruities were discussed and revised. To ensure meaningful interpretation of the data and enhance transferability, I selected detailed quotes from the

participants to ground my analysis (Whiffin et al., 2021). Together, these efforts served to aid the trustworthiness of the data.

2 Threads: Themes and Discourses

My reflexive thematic analysis of the interviews was necessary to prioritize the voices of Black community faith leaders and psychotherapists who are often overlooked in the mental health scholarship. It helped me to foreground their experiences cultivating mental wellbeing in Black communities, highlight their strategies for advancing mental wellness and feature their personal commitments and beliefs on improving mental healthcare service delivery for Black Canadians. After drawing out themes from the data set and considering their implications for creating a collaborative holistic strategy with formal mental healthcare service providers, I developed more research questions: A) How do hegemonic norms about healing and care within a neoliberal context impact parish ministers' mental healthcare service delivery? B) How do parish ministers negotiate their identities as mental healthcare service providers?[65] The constructivist orientation of RTA allows me to attend to discourses that capture larger political processes, ideological mechanisms and power relations at work structuring parish ministers' mental healthcare service delivery. This in turn will help to expand understandings of the barriers and bridges to creating holistic mental healthcare.[66]

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[65] These questions map on to Braun and Clarke's 2022 *A Typology of Suitable Research Questions for Reflexive Thematic Analysis* by exploring: 1) implicit rules and norms that regulate particular phenomena 2) the social or discursive construction of particular social objects, subject positions, or social phenomena (Braun & Clarke, 2020, p.11). This line of inquiry will help to unpack one of my main research questions, which seeks to examine the impact of neoliberalism on Black mental healthcare service delivery.

[66] I did not need to attend to discourses with my interview data with the therapists because their approach to mental healthcare service provision maps on to hegemonic norms of healing and care. Additionally, their line of work is consistent with a neoliberal logic of mental healthcare: Individuals pay for one-on-one appointments to address their idiosyncratic issues and receive personalized treatment plans. Conversely, parish ministers are not largely regarded as mental healthcare service providers and their communal and holistic approach to mental healthcare is at odds with service delivery interventions. If we want to create space for holistic care it is helpful to attend to the larger forces

Discourse refers to “a web of meanings, ideas, interactions and practices that are expressed or represented in texts (spoken and written language, gesture, and visual imagery), within institutional and everyday settings” (Bischoping & Gazso, 2016, p. 129). I draw on Foucault's theoretical approach that situates language beyond linguistics and mere representation and focuses on the constitutive effects of language (Foucault, 1980; Gazso, 2020). As a result, the role of language in the “creation and maintenance of social and political inequalities can be exposed, highlighting (rather than ignoring) power relations” (Wilson, 2001, p.295). As Foucault states in *Power/Knowledge: Selected Interviews and Other Writings*:

> [E]ach society has its regime of truth, its `general politics' of truth: this is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (1980, p. 131).

Through my analysis of the interview data, I examined internal contradictions, absences, and ideological assumptions to highlight the parish ministers' concerns, tensions and barriers to providing mental healthcare service provision to Black communities. The objective is to draw attention to how power and privilege are reproduced to shape Black parish ministers' mental healthcare service delivery for Black Canadians.

My reflexive thematic analysis is primarily based on three constructs: power, subjectivity and ‘technologies of the self’ (Foucault, 1978; 1988; Mama, 1995). My

— political contexts, power dynamics and ideological assumptions — that parish ministers perceive as preventing holistic mental healthcare from materializing.

understanding of power is derived from Foucault's conceptualization of power as a relational, productive, and transformative force (Foucault, 1978). Foucault understands power and knowledge as interdependent, and by extension argues that "discourses are embedded within power-knowledge relations that manifest in institutional contexts and other disciplinary structures" (Foucault, 1978; Gazso, 2020, p.134; Mills, 2004). This power can dictate and gate-keep what is said, by whom, and what is validated as truth. My analysis aims to draw out hegemonic, taken for granted assumptions as perceived by Black parish ministers, to uncover power-knowledge relations within the mental healthcare field, and discern what forms of knowledge are privileged and validated or denigrated and silenced.

In line with The Black Radical tradition, in particular, within Black Feminism(s), subjectivity is understood as a dynamic, relational, cultural construction that resists rootedness (Boyce-Davies, 2002; Brand, 2020; McKittrick, 2006; Mama, 1995). The mutability of subjectivity attracts competing discourses, which at any given moment can result in multiple and at times competing discursive positions (Gazso, 2020; Henriques et al. 1998; Mama, 1995). My analysis aims to reveal how individuals govern themselves in accordance with discourses: "How do individuals take up, negotiate or resist discourse...what are the constraints to taking up subject positions? How are the individuals interpellated or 'hailed' by discourses- how do they recognize themselves within?" (Lupton, 1992, p.302). How do individuals create subject positions in different historical and social contexts? (Gazso, 2020; Henriques et al., 1998). Therefore, my analysis attends to the broader, historical, political, and cultural contexts informing the constitution of subjectivity and power relationships in the field, and how Black parish ministers position themselves within or outside a particular discourse in the process of their subjectification.

‘Technologies of the self,’ a Foucauldian concept (1988), refers to the way individuals self-regulate and discipline themselves, via practices and instruments to generate a sense of oneself (Foucault, 1988; Gazso, 2020). Two “principle elements” make up technologies: theory and operations (Burrell et al., 2010; Foucault, 1988). ‘Theory’ refers to one’s attitudes and beliefs of who they are, and ‘operations,’ refers to the actions that align with their desired attitudes (Burrell et al., 2010).

> [T]echnologies of the self… permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988).

These technologies are constantly in motion, and reshaping themselves according to available discourses, making them susceptible to “culturally determined performances of subjectivity” (Burrell et al., 2010, p. 529). However, through these technologies, individuals can also self-discipline, and use them to serve as a site of resistance (Burrell et al., 2010; Foucault, 1977, 1982, 1984, 1994). Therefore, my analysis codes for the ways in which Black parish ministers actively participate in self-disciplinary procedures to resist historical and cultural constructions of mental health service providers, and instead produce mental healthcare service in line with their own understandings of ideal care. In sum, power, subjectivity, and technologies of the self, inform my analysis in Chapter Four to demonstrate how power-knowledge relations, disciplinary powers and resistance structure Black parish ministers' mental healthcare service provision for Black Canadians. My findings identify four discourses: a) credentialism, b) essential work(er), c) democratic racism, and d) the supernatural. These discourses shape, constrain and/or undermine mental health efforts performed by parish ministers. My conclusions center on the implications

of these hegemonic discourses and disciplinary power relations on Black Canadians' mental healthcare service delivery.

Thematic Literary Analysis

In Chapter Six, I undertake a thematic literary analysis, as novels offer a conceptual space to pose difficult queries, imagine new realities and by extension, new responses to age-old questions and concerns. The depth and complexity of novels offers me limitless space to examine innovative social and political resistances, study interlocking oppressive forces, observe inaccessible or overlooked subjects, and investigate the human condition from different vantage points. It is my contention that there are unique characteristics of Black feminist fiction[67] that make this genre well suited for an interdisciplinary investigation of Black mental health. I will discuss four noteworthy characteristics of the genre. The first concerns Black fictional writers' consideration of historical and social-political conditions structuring Black peoples' wellbeing. For instance, while a Eurocentric biomedical mental health discourse may fail to adequately address the numerous social factors underlying a mental illness, a Black feminist novel may narrate and explicate the multiple competing factors and intersecting historical-political and socio-cultural conditions that may contribute to the onset or severity of a mental health disorder. In turn, these texts directly address gaps left in the wake of a traditional mental health discourse.

[67] As noted by Chikwenye Okonjo Ogunyemi, who writes on "Womanism: The Dynamics of the Contemporary Black Female Novel in English" (1985), the "feminist novel is still evolving" (p.64). Therefore, my statements concerning Black feminist writings are tentative and intend to "serve as a working base" (Okonjo Ogunyemi, 1985, p.64). Black feminist novels can attend to "the impact of racism, neocolonialism, nationalism, economic instability, [sexism] and psychological disorientation on black lives;" (Okonjo Ogunyemi, 1985, p. 79). Additionally, Black feminist novels can offer a careful explication of interlocking social markers and the privileges and constraints that accompany these social identities, and creatively imagine an "ethics of survival" (Okonjo Ogunyemi, 1985, p. 79).

Beloved (1997) by Toni Morrison (1931-2019), for example, explicates how the trans-Atlantic slave trade yields interminable psychological consequences on her protagonist, Sethe. In the novel, Sethe tries to escape a Southern plantation with her children. However, her plans are thwarted by the plantation's overseer, who sends slave-catchers to find them despite the family having escaped to the Northern "free" states. Sethe tries to kill her children in a resistant act of infanticide in protest of returning them to slavery, but is only able to murder her eldest daughter before she is apprehended. Years later, Sethe is confronted with the incarnation of her deceased daughter and must find a way to process her grief or suffer madness. In her writings, Morrison links the historical and socio-political conditions of her novels' settings to her protagonists' storylines and character development, which immediately offers a different starting point through which to examine mental health issues. Therapists, working within a Eurocentric framework, may traditionally assume the individual operates within a vacuum or a very tight knit relational group. As a result, the broader historical and political landscape shaping the individual's actions or behaviors is often lost, obscured or deferred to a much later session. Black feminist novels can foreground historical conditions and draw attention to the ways in which the "psychic roots of racism" and its "historic persistence" has an impact on a person's total wellbeing (Burack, 2004, p.11). This can change what counselling professionals prioritize and emphasize in the therapy room when they are diagnosing an illness or proposing a treatment plan (Burack, 2004).

Secondly, while the aim of much social science research on mental health is to generalize findings that extend to the larger general public, Black feminist novels encourage the exploration of marginalized groups. This emphasis allows us to explore the particulars in search of the universal (Fine, 2006). The specificity of the novel and its corresponding cast of characters encourages a nuanced understanding of different social positions within a target

population. Matrixes of domination are more easily captured within a Black feminist novel, which can give rise to more universal understandings of how certain social markers, for example, gender, sexual orientation and race, impact an individual's existence and livelihood. The consideration of the emotional and psychological experiences of intersecting identities eloquently articulated by Black authors, may be useful for strengthening lines of questioning in empirical research and developing more appropriate mental health services that meet the diverse needs of Black community members (Brown & Keith, 2003). In the same vein, the power of creative works to represent harder to reach and more inaccessible sub- populations, heightens the significance of these texts for inclusion within mainstream psychological science. For example, depictions of Black boys and girls in childhood and the anxieties and pressures encountered in these formative years, such as concerns regarding body image, skin complexion, athleticism, attractiveness, can offer profound insights on how these experiences may shape or guide one's thoughts, actions and behaviors later in life. In Toni Morrison's *God Help the Child* (2015), the protagonist, Bride, experiences early rejection of her "blue-Black" skin color by her "high yellow" mother (Morrison, 2015, p. 4). The negative socialization of her complexion contributes to her depression in adulthood. Her success as a high-end model, in which her tenuous acceptance of her skin color is based on the global market's exploitation and appropriation of Black features, prevents her from experiencing true self-actualization and contributes to her descent into madness. The novel illustrates how this childhood trauma had enduring effects on Bride, which impacted her ability to confidently navigate her social environment in adulthood. Black feminist novels can uniquely present a longitudinal space to ethically query how childhood traumas, often unabridged in empirical data on Black mental health, may influence one's later life; ultimately, centering new avenues of exploration for Black mental health studies.

Thirdly, Black feminist novels are unapologetically intended for Black audiences. Indeed, authors such as Toni Morrison, Gloria Naylor and Zora Neal Hurston, firmly position Black characters, voices, and perspectives in their work with little regard for how they or their writings are viewed by a wider, white readership (hooks, 1992; Morrison, 1993). For example, these writers deploy southern dialects, African American vernacular (AAV) and creole in their work, or will often recompose African parables and proverbs, plantation hymns and spiritual sermons in their fiction as a technique to connect to their desired audiences and represent the lived realities of their intersectional communities. Black feminist writers' decision to opt out of including glossaries, bible passage references, or translations in their writing makes their intentions clear: the intended recipients of their work will understand. The "power to name one's own reality," is a fundamental principle of Black feminist thought, and serves as a tool of resistance. (Collins, 2016, p.15). Theorists such as bell hooks and Patricia Hill Collins have passionately campaigned for narrating one's own story on one's own terms so that Black women can serve as agents of knowledge for their own multilayered experiences whilst working to defy society's false controlling images and negative stereotypes (Collins 2016; hooks, 1994). Thus, in order to make sense of Black life, including all its complexity and intrigue, Black writers harness the power of self-definitions and self-representation to authentically create stories that explore the most salient concerns and interests of their communities. Therefore, in contrast to social science research, which relies on existing Eurocentric models, such as the DSM to uniformly document and impose meaning on the experiences of all people; Black feminist novels generate their own lexicon and modes of knowledge creation to uniquely represent the intricacies of Black communities' experiences and interiorities.

Lastly, Black feminist creative fiction is more accessible to broader audiences. Psychological studies on race and culture are often published in academic journals that may circulate exclusively online to those with an institutional membership or member association, consequently, excluding many from the general population from accessing these works. Conversely, the cultural production and mass distribution of fiction makes it accessible to those outside of academia and can generate greater discussion from a broader audience. What is particularly noteworthy about the accessibility of novels is that it leaves room for audiences' critiques and authors' accountability. Many erroneous studies are published about Black populations with little room for recourse or comment (Howitt-Owusu & Bempah, 1994). The burden often falls exclusively on critical psychologists in the field to counter the scientific racism evidenced in a scholarly article. Left unchecked, offending researchers never have to accept accountability for "findings" that are epistemologically violent (Teo, 2010; 2011). In contrast, a novel elicits social commentary from the general public. The social commentary generated from a novel (goodreads.com, lectures, tutorials, book clubs, radio shows, podcasts, etc.) creates a large platform to discuss the diverse concerns, criticisms and celebrations of a work. This uptake can serve as an important site of investigation for future mental health studies. For example, Morrison's *The Bluest Eye* (1970), which chronicles Pecola Breedlove's fervent desire to trade her Black features for white, corresponded with a spike in studies on racial identity development models in the 1970s (see Helms 1990; Carter, 1996). Given the wider reach of Black feminist novels, they also can serve to challenge broader, hegemonic stereotypes about Blackness. Novelists can create works to challenge controlling images about Black life and Black peoples, often produced and re-circulated in psychological research (Comaroff & Comaroff, 1992) and offer historical context, cultural competency and a consideration of

material circumstances, typically absent in academic studies. For example, Morrison's *Beloved* suggests that Sethe's murder of her daughter is not in fact an "insane" transgression by an unfit slave suffering from 'drapetomania,' but rather a humane response from a mother living under the mad institution of slavery who believes in freedom at all costs (Burack, 2004).

Thus, Black feminist stories have unique characteristics that make them a useful forum to engage in the study of Black Canadians' mental healthcare service delivery within traditional psychology. Indeed, their attentiveness to historical, political, and material realities impacting Black lives, careful explication of interlocking social markers and the privileges and constraints that accompany these social identities, and their ability to creatively imagine new modes of resistance and survival, can assist in creating more culturally responsive mental healthcare service delivery. However, it is important to make the distinction that although stories are not case studies, fictional stories can still present a powerful interrogation of our realities. Morrison, the literary African-American giant who has transformed how we represent Black life, stated this of the function a story:

> It should be beautiful, and powerful, but it should also work. It should have something in it that opens the door and points the way. Something in it that suggests what the conflicts are, what the problems are. But it need not solve those problems because it is not a case study, it is not a recipe (2287).

Morrison, along with several Black feminist literary writers have the potential to 'open the door' and 'point the way' to new ways of thinking about how we conceptualize mental wellbeing and healing. As explained throughout the chapter, varied methodological approaches are undertaken to examine how we might move towards more holistic and culturally responsive mental

healthcare service delivery for Black Canadians. The following chapters in the dissertation present the detailed findings of my investigations.

Chapter 4- Pairing Parish Ministers and Psychotherapists

The application of BFP requires that mental health researchers extend their knowledge base on mental healthcare to include actors and variables often excluded from the counselling scholarship. As such, I work to counteract colonial dominant narratives informing psychological research and therapeutic interventions by intentionally incorporating Black marginalized voices and the role of religion and spirituality into the discussion on mental health service provision. One way in which we see "forms of coloniality"[68] at work in psychology, is in the discipline's continued disavowal of religion and spirituality (R/S) in mental healthcare service delivery (Adams et al., 2017, p. 532; Bryant, 2023). This chapter is divided into three parts: The S Word: Spirituality and Religion in Psychology; The Black Church and The Black North; and Pastoral Perspectives. "The S Word: Spirituality and Religion in Psychology" offers an overview of spirituality and religion's contested position within the field of psychology. Religion and spirituality's negation can be traced to psychology's Enlightenment influences, naïve empiricism and colonial attitudes. In this section, I discuss the imperative for including R/S within psychological care, particularly for racialized communities that typically report higher levels of religiosity and spirituality than their white counterparts. I identify Black Canadians as one of the racialized communities that would benefit from the consideration of theism within mental healthcare. The following section, "The Black Church and The Black North," offers a historical survey on the role of The Black Church within American and Canadian contexts. I argue that the role of religion in the lives of Black Canadians, coupled with the scholarship on health promotion within religious contexts, marks religious institutions and their religious leaders' useful points of

[68] Coloniality refers to "ways of thinking and being associated with Eurocentric global domination" (Adams et al. 2017, p.532)

contact for combatting mental health issues and help-seeking disparities for this ethno-racial group. Lastly, "Pastoral Perspectives" include my interviews with Black parish ministers. I delve into my participants' role in fostering mental well-being within religious Black communities, their willingness to collaborate with formal mental healthcare service providers, and their provision of mental healthcare. The findings from my interviews help to define the contours of a collaborative strategy to offer more culturally responsive mental health service delivery for Black Canadians.

The S Word: Spirituality and Religion in Psychology

Within the last ten years, there has been a substantial growth in the scholarship, and an increase in awareness among the larger public, concerning the necessity of spirituality and religion within the mental healthcare system. Pargament, Exline and Jones (2013) revealed a growing number of citations for "religion" and "spirituality" on the PSYCINFO database within the last 5 decades: "1,051 (1960s); 2,290 (1970s); 4,205 (1980s); 5,501 (1990s); and 11,629 (2000s). A comparable search for the term spirituality revealed an even more striking rise: 5 (1960s); 22 (1970s); 543 (1980s); 2,680 (1990s); and 7,894 (2000s)" (Pargament et al., 2013, p.xxiii). Further, the World Psychiatric Association (WPA) and World Health Organization (WHO) conducted a systemic review of the scholarship and found more than 3,000 empirical studies investigating the relationship between religion, spirituality, and health (Moreira-Almeida et al., 2016). Most recently, the American Psychological Association (APA), 2023 president, Dr. Thema Davis-Bryant, has been using her public post to affirm the necessity of prioritizing religion and spirituality within psychological research and intervention (Bryant, 2023). As an ordained minister and psychologist, her position at the head of APA's 130,000-member organization, symbolizes a renewed commitment from the field to address and integrate theism. Therefore,

despite the growing secularism of the West (Cornelissen, 2019), these trends indicate religious and spiritual values remain a point of interest for a number of people across the globe and for a number of people within the discipline of psychology (Pargament et al., 2013).

The growing popularity of the subdiscipline, 'Psychology of Religion,' serves as a point of departure from the reigning biomedical model in psychology; or, perhaps more aptly, a point of *return*[69] to the complex and nuanced constructs of religion and spirituality in mainstream psychological sciences. Although the two terms, religion and spirituality, are often used interchangeably, and their definitions have yet to receive formal acceptance by all researchers and psychologists, for the purposes of my discussion, spirituality will refer to "a dimension of human experience related to the transcendent, the sacred, or to ultimate reality" (Moreira-Almeida et al., 2016, p.87). Spirituality often "connotes an individualized, experientially based pursuit of positive values, such as connectedness, meaning, self-actualization, and authenticity" (Pargament et al., 2013, p.11). Conversely, religion will refer to "the institutional aspect of spirituality, usually defined more in terms of systems of beliefs and practices related to the sacred or divine, as held by a community or social group" (Moreira-Almeida et al., 2016, p.87).

Despite R/S "long distinguished history" within psychology, theistic considerations have always been a site of contestation (Jones, 1984, p.184; Maier, 2004, Slife & Reber, 2009; Whitley; 2012). The discipline's insecurity about its scientism facilitated a strong disavowal of metaphysical claims or contributions to healing. This stance was supported by a rousing chorus of astute psychologists, who in post-Enlightenment fashion, critically abhorred the function of religion, casting it as a repressive, neurotic psychopathology: "Religion is an opiate," "religion is a crutch," "religion is the root cause of violence in the world," and "religion is a form of denial,"

[69] Religion and spirituality dominated the psychology discourse in the 1800s until the 1930s (Jones, 1984).

were only some of the widely popular, damning critiques of R/S (Pargament, Exline & Jones, 2013, p.7; Whitley; 2012). Thus, in addition to psychology and its key players' naïve empiricism, and the growing influence of the Enlightenment, psychologists' colonial attitudes also contributed to traditional psychology's distancing of religion and spirituality.

Colonial rhetoric in the discipline denigrated indigenous cultures' interpretative frameworks and ways of knowing (Slife & Reber, 2009). Psychology characterized religious and spiritual mental health practices as regressive methods of healing that were spearheaded by "crazed" religious shamans and "demonic" witch doctors (Comaroff & Comaroff, 1992). These stereotypes were not only erroneously misrepresented and misunderstood in the Western medical canon, but facilitated the continued negation and conceptual problematization of R/S. The devaluation of indigenous African healing traditions, which were viewed as "backwards" and "barbaric," compared to Eurocentric medicine and methods, functioned as a roadblock to R/S inclusion in psychological research and interventions, and fostered a particular "methodological atheism" (Comaroff & Comaroff, 1992; Porpora, 2006, p.57; Slife & Reber, 2009). The pursuit of positivism and 'empirical studies' were dominantly applied to understand and explain psychological phenomenon, leaving little room for R/S considerations.

Additionally, R/S complexity contributed to its estrangement from the field; its polarizing effects made it difficult to capture within the scope of psychological research. R/S is documented as yielding important implications for mental health disorders' prevalence, diagnosis, treatment outcomes and prevention for religiously observant service users (Moreira-Almeida et al., 2016). In fact, religious involvement in the scholarship is presented as a protective factor against depressive symptoms and suicidal behaviours (Dein et al., 2012; Lukachko et al., 2015; Nguyen et al., 2016; Taylor et al., 2011). R/S has also been found to enhance wellbeing,

encourage social connectedness and altruism (for a summary of this literature see Lee & Newberg, 2005). Yet, R/S is also linked in the literature to extremist behaviors, pathology (hyper-religiousness), bigotry, cruelty, increased feelings of guilt and shame (Crips, 2011; Pargament et al., 2013;). And while the complexity of R/S may have at one point in time sparked impassioned debates within theoretical psychology, it has now fizzled into a "don't ask, don't tell" disinterestedness within clinical psychology that is deserving of critique.

Over the years, R/S negation has been institutionalized and therefore has largely escaped mainstream critique and condemnation (Slife & Reber, 2009). McMinn et al. (2009) reported in "a survey of APA leaders, only 40.3% strongly agreed that religion and spirituality are important topics for psychologists to consider, 36.5% strongly agreed that religion and spirituality are important to consider when providing professional services, and 30.6% strongly agreed that religion and spirituality can be studied with scientific rigor" (Pargament et al., 2013, p.9). Additionally, Jones (1996) found mental health professionals were more likely to be agnostic or atheist than the general public (Constantine et al., 2000) and maintain either a posture of neutrality or silence towards R/S (Jones, 1994). Consequently, psychologists are often advertently or inadvertently maintaining systemic bias when they fail to make space for theistic inquiries or interventions within their practice or challenge the colonial rhetoric of "nonpartisanship" with religion and spirituality (Slife & Reber, 2009; Whitley, 2012). It is important to note that my concern presently is not whether religion is subjectively *good* or *bad.* As Crips (2011) states:

> It is not easy to discuss religious beliefs and practices without running the risk of wrath from [psychology] students who are anti-religious, especially those who regard any non-negative mention of religion as some form of proselytising. Nor is it easy to discuss how

> religion can play a positive role in some people's lives at a time when religious institutions are regularly in the news due to scandals such as abuse of children or when it is claimed that terrorist acts have been associated with fanatical or fundamentalist religious beliefs (p. 70).

These visceral reactions and provocations are expected when discussing religion; there are no definitive answers to this debate: R/S will remain polarizing. However, rather than focusing attention on the *nature* of R/S, what I believe is more useful for the direction of empirical psychology is the utility of R/S for enhancing mental healthcare service delivery and wellbeing for those who identify as religiously observant or spiritual. The potential for curating historically sensitive and culturally responsive treatment plans to improve and extend mental health service delivery, must outweigh the fear of "intruding on sacred ground" (Pargament et al., 2013, p.9).

Many studies have demonstrated the need for spiritually integrated approaches within psychological care. Rose et al., (2001) found "in one survey of clients at six mental health centers, 55% reported that they would like to discuss religious or spiritual concerns in counselling" (Pargament et al., 2013, p.9). Yarhouse and Fisher (2001) found there was a growing reluctance among individuals to seek mental health treatment out of "concern for how that professional will respond to their religious beliefs and values" or being viewed as "inherently pathological" for expressing their religious beliefs (p. 171). Richardson and June (1997) reported some African Americans avoid counselling because they feel their religious or spiritual issues will be ignored (Constantine et al., 2000). The National Comorbidity Survey found a higher proportion of Americans turning to clergy for mental disorders (23.5%) compared with psychiatrists (16.7%) or general medical doctors (16.7%) (as cited in Wang et al., 2003). This finding is consistent with several studies that have found religious providers as a "key entry

point into the formal mental healthcare system" (Harris et al., 2006 p.396; Wang et al., 2003; Young et al., 2003). Together, these findings suggest many people perceive mental health within the jurisdiction of R/S, as opposed to mental healthcare specialists (Lukachko et al., 2015). Presently, there is still a lack of "specialist curricula" to provide formal training for psychiatrists to learn about the evidence available and its applicability (Boyd-Franklin, 2010; Constantine et al., 2000; Jones, 1994; Yarhouse & Fisher, 2001). Overlooking the role R/S impacts understanding community life, political commitments, inter and intrapersonal conflict, personal development narratives, coping mechanisms, and the human condition more broadly, which can severely compromise the practice of psychology. Researchers and practitioners must engage with R/S not in spite of its thorniness but because of it.

Focusing on religion and spirituality in mental healthcare may yield important implications for addressing service use disparities, close the chasm between 'science and religion', and assist in rewriting narratives about holistic wellbeing and the actors who can provide these services. While joint declarative statements have been issued by WHO and WPA (2016) to act on the evidence and growing literature to include religion and spirituality as a part of the "Core Training Curriculum for Psychiatry," the slow integration to address the gap in research on R/S within clinical practice contributes to the decreased "ethical-political quality of its practice" (Moreira-Almeida et al., 2016; Teo, 2011, p.252). As Constantine (1997) reports "attending to clients' spiritual and religious issues is an important aspect of being a multicultural competent counsellor" (Constantine et al., 2000, p.35). Failing to do so, disproportionally impacts racialized bodies that historically prioritize religion and/or spirituality in their worldviews (Slife & Reber, 2009; Whitley 2012). Black communities are strongly represented in a number of religious and spiritual traditions, including but not limited

to Christianity, Islam, and Judaism (Boyd-Franklin, 2010; Pew Research Center, 2018). Pew Research Center (2014) found "eighty-three percent of Black Americans believe in God and consider religion as important, pray daily, and attend religious services at least once a week in higher numbers than Whites and Hispanics.... [and] although Black millennials are less religious than previous generations, they are reportedly more religious than their non-Black counterparts" (Avent-Harris, 2021, p.6). In Canada, as reported on the 2021 Census, approximately 82% of Black Canadians report religious affiliation compared to approximately 65.4% of all Canadians (Statistics Canada, 2022). Thus, negating R/S is particularly problematic for Black communities, who historically and traditionally are more likely to rely on religious or spiritual devotional practices as an active coping strategy (McRae et al., 1999; Taylor et al., 2000; Whitley, 2012).

The Black Church and The Black North

There exists a longstanding relationship between Black communities, religiosity and spirituality in the Global North (Avent-Harris, 2022) This relationship bears reciting within the critical psychology literature to foreground the importance of theistic interventions for culturally and historically attuned mental healthcare service delivery for Black Canadians. I outline The Black Church as an American *and* Canadian cultural touchstone, highlighting the significant role it has played in Canada's history for Black residents. In particular, the role of religion as a mental health support for Black communities facing hostile racism and white supremacy in the North. I argue The Black Church's significance, despite operating on a smaller scale than it once did historically, can still serve as an important site of intervention to address mental health issues and help-seeking disparities for Black Canadians. I review the promising scholarship on physical health promotion within religious contexts to support my position and contend the same is

plausible for mental health advocacy and support within religious spaces. I conclude with the provocation to include traditionally accessed religious leaders within the scope of mental healthcare service delivery for Black Canadians.

The term “Black Church” refers to predominately Black Christian congregations that have historically provided material resources, emotional, spiritual, and mental health support to community members (Lincoln & Mamiya, 1990). Despite the heterogeneity of Black churches (denomination, worship style, Sabbath, etc.) they singularly share historical and cultural import (Avent-Harris, 2021). Calhoun-Brown (2000) captures the powerful force of The Black Church in the excerpt below:

> Black churches have been aggregated into the singular institution called "The Black Church" to the extent that they are united by their cultural, historic, social, and spiritual missions of fighting the ravages of racism by “buoy[ing] up the hopes of its members in the face of adversity and giv[ing] them a sense of community”-regardless of denominational distinction, geographic location, or class composition (Myrdal [1944] 1962, 946). Although some denominational and congregational distinctions can be drawn, most Black churches share a very similar religious culture. Similar scriptural analogies, messages, songs, prayers, symbols, rituals, oratorical styles, and themes of equality and freedom-even the “sanctuary red” carpeting of many of the facilities- are familiar from church context to church context (p.169).

In its inception, The Black Church functioned as a physical and discursive space of healing, liberation, and refuge from the racist society in which it was established (Brewer & Williams, 2019). The segregation in white churches and theological lack in orientation towards the “emotional, spiritual, and material needs of Black parishioners” had ushered a wave of

discontent among its Black constituents and instigated the formation of The Black Church (Banahene Adjei, 2019, p. 316). In the US, during the nineteenth and twentieth centuries, The Black Church developed as a site to celebrate and freely express African religious traditions and styles of worship and praise, "free from the interference of whites" and the humiliation of being cast to the rear of the church (Banahene Adjei, 2019; Perry 1998; Tomlinson, 2011, p.1176). Publicly challenging the hypocrisy of the Roman Catholic Church's support of slavery and condemning the passivity and apathy of its faithful adherents, The Black Church offered an oppositional space whereby a political and social consciousness could cultivate among its members (Billingsley & Rodriguez, 1998; Gillard 1999). It quickly became a platform to voice anguished protests against the chattel economy of slavery and the corresponding Jim Crow and segregation laws that compounded Black peoples' suffering, exploitation and exclusion in the North. Bonded by kinship and hardship, the church promoted a strong sense of cultural identity, social connectedness, mutual aid, social support and resilience (Brewer & Williams, 2019).

A cornerstone of the African American community, "one could find politics, arts, music, education, economic development, social services, civic associations, leadership opportunities, and business enterprises" sponsored and spearheaded by religious leaders and parishioners alike (Callhoun-Brown, 2000, p.169). As Chang, Williams, Griffith, Young (1994) observed, The Black Church was a "multifunctional institution" (p.92). Serving as the nucleus for the disempowered and disenfranchised, it brought the fight for survival and liberation to the pulpit (Perry, 1998). Sermons promoted "spiritual renewal alongside mental resiliency and coping against societal racism," pairing God's salvation with "social liberation from systemic racism and social injustices" (Banahene Adjei, 2019, p. 316). In fact, it was one of the first institutions to mobilize community-based resources to lobby against economic exploitation, advocate for

abolition, and demand equal educational opportunities and affordable housing (Billingsley & Rodriguez, 1998). Whether it was acting as a "natural training ground" for leaders to speak out against the iniquities of their time,[70] posing as an underground railroad destination stop for fugitive slaves, or outright aligning itself with activist organizations or abolitionist movements, The Black Church was a forum for radical change and activism (Chang et al., 1994; Constantine et al., 2000; Tomlinson, 2011).

While The Black Church is typically regarded as an African American cultural legacy, its presence, influence, and dominance in Canada is often overlooked (Este, 2004). Indeed, The Black Church occupies a significant position within Black Canadian history and Black people's presence in this country.[71] Documented in the archives on *Black Canada*, a series of publications by James Walker (1979, 1992, 1995) are featured describing The Black Church "as the anchor that held the Black community together in the face of racist assaults in that country" (Banahene Adjei, 2019, p.312). Other prominent historians have supported these pronouncements, including Dorothy Shreve (1983), who denoted The Black Church in Canada as a "stabilizer" in the community (p.13), and the Black Canadian historian Daniel Hill, who described The Black Church as "the earliest and most important institutions in all Black Upper Canadian communities" (Hill, 1981, p. 130).

Similar to the American context, white racism, forced segregation, and racist oppression against Black persons was the springboard for the formation and necessity of The Black Church in Canada (Banahene Adjei, 2019, p. 314; Murphy & Perlin, 1996; Winks, 1971). Struggling with "resettlement and integration" into a cold and hostile environment, The Black Church

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[70] "A majority of the slaves executed for slave uprisings were ministers or other religious leaders in their communities" (Billingsley & Rodriguez, 1998, p. 39).
[71] Sylvia Hamilton and Claire Prieto's documentary, "Black Mother, Black Daughter" (1989) documents the importance of the Black Church to the Africville community located in Halifax, Nova Scotia.

offered a retreat for Black communities to receive social and material support, dignify their humanity and work towards spiritual and mental wellbeing (Banahene Adjei, 2019; Este, 2004; Gillard, 1999; Smith, 1978). The seeds of The Black Church were sown into the cold and hostile soils of Canada's landscape, and its flowers burgeoned in Black settlements across the nation.

While the operations of The Black Church differed widely across one geographical location to the next,[72] its emphasis on addressing the experiences of slavery and discrimination and cultivating community remained paramount to its significance and central to its mission (Banahene Adjei, 2019, p. 314). Initially taking root in Nova Scotia, with Black Loyalists and free slaves largely comprising its membership, The Black Church later was established in large city centers, such as Montreal (1907-1940) and Toronto (1820s) (Banahene Adjei, 2019; Winks 1971). In Ontario alone, Oro-Medonte, Amherstburg, North Buxton, Chatham, Windsor and St. Catharines are home to prominent historic Black Church sites. Today, we still see a number of Black churches in operation throughout the country.[73] These churches vary widely from one another, reflecting the unique diversity of the Black Canadian population. Mensah (2009) divided African Canadian Christian churches into two distinct camps. The first group of Black Churches were created with the intent to reflect places of worship that similarly existed in the home countries of newly arrived African immigrants (Mensah, 2009). These institutions typically took the form of "mainstream mission churches like the Catholic, Methodist, Presbyterian, Anglican, and Seven-Day Adventists" (Banahene Adjei, 2019, p. 317; Mensah, 2009). This finding is in line with the transnational migration literature that shows that

[72] "The Black Church operated with "high degree of ecclesiastical, theological, liturgical independence, marked by broad socio-economic and regional particularities" (Banahene Adjei, 2019, p. 314).
[73] In a study by Baffoe (2013), there were less than ten Ghanaian churches in Toronto during the 1990s; however, by 2010 one hundred churches were established (Banahene Adjei, 2019). This growth trend in The Black Church only captures the Ghanaian community, which suggests other Black Canadians may have witnessed similar religious institution expansions (Banahene Adjei, 2019).

immigrant communities, including those from the African Diaspora, are likely to use religion as a "major conduit" to stay connected to their homelands (Mensah, 2008, p. 326). Newer African Canadian immigrant populations from either Africa or the Caribbean are found to regularly attend church services and actively participate in spiritual and community building initiatives (Tomlinson, 2011). The second group of Black Churches, referred to as "African Initiated Churches" (AICs) were established by "African immigrants rather than foreign missionary organizations" (Baffoe, 2013, p.307; Banahene Adjei, 2019; Mensah 2009). Presently, more Black Canadians belong to AICs than to the former mainstream mission churches (Banahene Adjei, 2019).

It is estimated that approximately 82% of Black Canadians report religious affiliation compared to approximately 65.4% of all Canadians (Statistics Canada, 2022). The main reported religious affiliations among Black Canadians were Christian (69%) and Muslim (11.9%) (Statistics Canada, 2022). While it is important to note that not all Black Canadians have a relationship with religion,[74] and in fact, may understand religion as perpetuating trauma, abuse and exclusions (Winks, 1997), the substantial number of Black Canadians who expressly report religious affiliation, functions as an important site for exploration (Brown & Keith, 2003; Taylor et al., 2000; Whitley, 2012; Wilson, 2001). The growing body of empirical data showcases a positive relationship between religion and both psychological and physical wellbeing, and R/S impact on healthy decision making (Koenig, 1997; Mattis & Grayman-Simpson, 2013; McRae, et al., 1999). Greater interrogation of the significance of spiritual belief systems and religion for Black Canadians, who have historically been shut out of formal institutions of care, is necessary to create effective interventions that are culturally congruent with Black communities' beliefs

[74] 18% of Black Canadians report no religious affiliation (Statistics Canada, 2022).

and to improve mental health service delivery for this population (Avent-Harris, 2021; Harris et al., 2006; Lukachko et al., 2015).

The centrality of religion and spirituality in Black Canadian communities offers rich ground for re-envisioning mental healthcare service delivery. The longstanding literature on the role of religion in the lives of these communities, coupled with the scholarship on health promotion within religious contexts, marks religious institutions as significant agents for combatting mental health disparities for this ethno-racial group (Brewer & Williams, 2019; Chang et al., 1994). Emerging data on "health interventions involving The Black Church have been successful in promoting positive health behaviors by engaging those at the forefront of influence in the community in co-developing and implementing interventions" (Brewer & Williams, 2019, p. 385). Health promotion initiatives such as church-based diabetes education programmes and cardiovascular awareness projects were found to significantly decrease the risk of these health conditions among congregations that participated in hosting these events:

> A church-based diabetes education programme known as Fit Body and Soul, for example recorded significant weight loss among its African American participants. Similarly, Project Joy, a cardiovascular health education programme that targeted African American women yielded positive results like lowered blood pressure and body weight and improvement in blood pressure knowledge (Tomlinson, 2011, p. 1175).

These successful attempts bode well for Canadian health agencies, organizations, and practitioners to partner with Black Churches in Canada to promote mental health in the community and collaborate on mental health therapeutic interventions (Brewer and Williams, 2019). In doing so, it would help to "facilitate community engagement and enhanc[e] the cultural

relevance and uptake of health initiatives by linking them to religious tenets and contexts" (Brewer & Williams, 2019, p. 385).

While most of the literature on health promotion addresses physical health—diet, physical activity patterns, diabetes and cardiovascular health—there is room to presume that extending these efforts within the scope of mental health contexts may produce similar positive health outcomes (Brewer & Williams, 2019). For example, Gikes (1980) identified The Black Church as presenting four therapeutic functions within its church services similar to that of a community mental health resource.[75] Ellison and Taylor (1996) found prayer and scriptural study enhanced African Americans' ability to cope with life stressors (McRae et al., 1999). Thus, spiritually oriented interventions have been effective and can serve to enhance wellbeing if properly endorsed and supported. In fact, given how well religious preoccupations bleed into mental health concerns, finding common ground to speak across these disciplines may prove less challenging to accommodate. Browning (1987) argues any system "used as a guide to shape, heal or reform human life cannot avoid metaphysics or ethics," and psychotherapy, which aims to similarly perform these functions is not exempt from grappling with religious and spiritual commitments (Jones, 1994, p. 192).

The current state of mental healthcare for Black Canadians remains dire. Black Canadians' reported experiences within the mental healthcare system include discrimination, racism, financial barriers, misdiagnoses, exorbitant wait times, lack of cultural competency, and limited representation in the mental health workforce (Ottawa Public Health, 2020; Curling 2013). Moreover, Afro-Canadians experiencing psychosis are more likely to be admitted to the

[75] The four identified therapeutic functions of the Black Church were: " (1) articulation of suffering, (2) location of persecutors, (3) provision of asylum for "acting out," and (4) validation of experiences " (Gilkes, 1980; McRae et al., 1998; p.781).

hospital by the police or ambulance compared to other racial groups (Taylor & Richardson, 2019). This is likely due to systemic barriers to mental healthcare such as social and physical determinants—e.g., financial costs, insurance, practice location, and cultural barriers— which remain prominent issues for treatment access for Black Canadians (Fante-Coleman & Jackson-Best, 2020). A report by The Mental Health Commission of Canada (2021) stated that ninety-five percent of Black Canadians expressed poor access to mental healthcare needed to be addressed. Taken together, these disturbing realities reinforce the stakes of the following investigation. Formal mental healthcare services, federal mental health initiatives and funding commitments have fallen short to provide resources and improve mental healthcare outreach and service delivery for Black Canadians' wellbeing. New paths must be tried, and alliances with informal mental health service providers traditionally accessed by Black communities (e.g., religious leaders, clergy, spiritual counsellors) offers an alternative avenue to therapeutic care (Avent-Harris 2021; Harris et al., 2006; Lukachko et al., 2015). The call for renewed and reimagined care for Black life reverberates loudly; a gold bell tolling forcefully in the halls of a church.

Pastoral Perspectives

The Holistic Trinity: Community-based Faith Leaders, Black Canadians and Counselling Professionals

In order to understand the challenges, benefits, and strategies of integrating religion and spirituality (R/S) in formal mental healthcare services,[76] I conducted interviews with parish ministers as a step towards unifying faith and wellness for Black Canadians. The scholarship has

[76] Formal mental healthcare services include any mental help supports offered by accredited mental health counselling professionals.

indicated that Black communities are likely to be more religious and /or spiritual than their white counterparts, view religious or spiritual ideology as vital to their psychological health and more inclined to turn to religious advisors or God in times of desperation and emotional despair (Avent-Harris & Wong, 2018; Avent-Harris et al., 2019; Constantine et al., 2000; Mattis & Grayman-Simpson, 2013). These religious attitudes are considered "strong predictors of religious advisors usage" rather than formal mental healthcare services[77] (Kovess-Masfety et al., 2017, p.353; Lukachko et al., 2015). Studies have shown religious clients have greater receptiveness to therapy when it adopts religious values and concerns (Harris et al., 2006; Jones, 1994). Further, The Black Church has been identified as a source of influence, credibility and trust, as well as a site to disseminate health information and administer healthcare services in the community (Mattis & Grayman-Simpson, 2013; Tomlinson, 2011).

In line with the health promotion literature, and scholarship on Black communities' R/S, faith leaders can prove instrumental in combatting the stigmatization of mental illness, prompting participation in secular interventions and fostering "supportive attitudes and initiatives that promote psychological well-being as part of spiritual well-being" (Brewer & Williams, 2019, p. 386; McRae et al., 1999; see also Tomlinson, 2011). Indeed, the data has brought us to this point of collaboration, yet the range of development strategies needed to facilitate this alliance, the appropriate training and collaboration required with formal mental healthcare systems, and the unique services and resources necessary for this partnership remains unexplored. The following section will contribute to the literature of psychology of religion,

[77] "Because high church attendance and religious importance are associated with decreased service use, seeking professional mental healthcare may clash with sociocultural religious norms and values among African-Americans" (Lukachko et al., 2015, p.578).

critical psychology, and traditional psychology more broadly by giving voice to faith leaders to address how they wish to engage and advance mental wellbeing in Black communities.

In Jones' (1994) seminal article "A constructive relationship for religion with the science and profession of psychology: Perhaps the boldest model yet," he aptly notes: "almost every trend and movement in the mental health field has been mirrored in pastoral psychology, as even the most cursory review of courses in pastoral care at seminaries or of pastoral care textbooks will show" (p.184). Failure to acknowledge faith leaders' role in offering psychological care, neglecting to mobilize pastors to assist in decolonizing the mental health field, or downplaying the professional application of R/S in clinical psychology, only serves to undermine the important changes that can be made via collaboration (Jones, 1994). I have aligned myself with the emerging scholarship that negates the incommensurability or incompatibility of R/S in psychology and picked up the torch to examine what conditions, circumstances, and considerations are necessary for active collaboration. In choosing to speak with parish ministers of primarily Black congregations in the Greater Toronto Area, I hope to illuminate the barriers and obstacles preventing successful collaboration between parish ministers and practitioners. I aim to identify gaps the mental health field has failed to respond to concerning this ethno-racial group and offer future directions for conceptualizing and enhancing outreach and delivery of mental health services as informed by these community-based faith leaders. While this effort will require multi-party collaborations between the government, academic community, formal mental healthcare service providers and other stakeholders for its successful materialization, this first step, engaging community faith leaders and foregrounding their insights, marks the beginning of transformative and culturally responsive mental healthcare for Black Canadians.

Findings and Discussion. The objective of my study was to determine how a group of self-identified Black parish ministers understood their role in cultivating mental wellbeing in Black communities and to gauge their receptiveness to collaboration with formal mental healthcare service providers to advance mental healthcare. Parish ministers expressed a willingness and need to work towards greater collaboration to better serve Black Canadians' mental health needs. Participants felt that honoring each service provider's strengths would allow for successful collaboration and tailored treatment plans that were culturally responsive and meaningfully encompassed a holistic mental healthcare approach. As discussed by the participants, holistic mental healthcare was generally understood as inclusive of religious perspectives *and* social justice efforts that address inequities to achieve transformative change in mental healthcare service provision.

a) ***Mental wellbeing as a holistic enterprise***

A consistent finding in the interview data is parish ministers' recognition and conceptualization of mental health as a holistic enterprise. When questioned, "what does mental wellbeing mean to you?" References to harmony and balance in "all dimensions of life," and establishing an "equilibrium between spiritual, psychological, social, emotional and physical needs," were recurrently used to describe optimal wellbeing. For these participants, strong mental health was inextricably tied to a synergy among "all aspects of life." As Araba states:

> *I believe that as a pastor, my role is, in addition to, it's not just spiritual, but it's also to enhance the development of the holistic being, which includes the mental development. So as a pastor, not only do you offer counselling, but the spiritual aspect of it is enabled to bring hope, bring security, you know, faith in a higher being, supernatural being, and*

that to me helps or should help to take care of whatever stress or trauma somebody may face. It may not be the whole thing, but at least it plays a significant role.[78]

This finding is in line with Afrocentric scholarship, which views wellbeing as a harmonious balance between the spiritual and the physical realm (Jackson-Lowman, 2004; Mariette, 2013; Somé, 1993). While this emphasis on holistic wellbeing is not new to the mental health scholarship, what is particularly noteworthy is that religion and spirituality are understood as *central* to holistic wellbeing for these participants. Positioning religion and spirituality as central to holistic wellbeing runs contrary to the literature, in which holistic wellbeing often takes on secular overtones in the West (Chidarikire, 2012). Although in its initial conception, 'holistic' was meant to refer to an individual's emotional, physical, social and spiritual needs, in practice, it has yet to equally prioritize spirituality or religiosity (Chidarikire, 2012). Holistic healthcare has come to embody practices of mindfulness, alternative therapies such as acupuncture, chiropractor care, neuropathy, massages, yoga, etc. without meaningfully tackling religion and spirituality. While energy therapies such as Reiki, begin to explore spirituality more broadly, the majority of holistic interventions, categorized under either "mind-body interventions," "alternative medical systems," "biologically based therapies" or "manipulative and body-based methods" avoid addressing or including R/S.

A decolonized approach to mental healthcare must value the holistic enterprise as inclusive of spirituality and religion. If holistic healthcare fails to engage with humanitarian and spiritual needs, then it remains inadequate as an all-encompassing approach to mental healthcare. Assessing one's spiritual and religious beliefs is imperative for working with communities who

[78] I have used pseudonyms to protect my participants' confidentiality and have italicized direct quotes from the interview transcripts.

are expressly religious and/or spiritual to assist with treatment (Anandarajah & Hight, 2001; Crips 2011; Culliford, 2007; Māori Health, 2011). Therefore, it is essential to create an environment within formal mental healthcare services whereby therapists can prioritize learning a patient's spiritual and religious history, and account for how their clients' spiritual or religious concerns impact their distress, coping and recovery (Constantine et al., 2000). In turn, faith community leaders can develop trust in a system that won't pathologize or denigrate religion, and confidently refer congregation members to external mental healthcare services.

b) *Healing in community for communal healing*

The following question: "Do you see a relationship between individual wellness and community wellbeing?" was posed to explicate participants' definitions of holistic wellbeing. The question elicited a resounding confirmation, healthy communities were deemed necessary to create and foster healthy individuals. Sister Marie Noel expressed this on the matter:

> *Yeah, I think obviously individual wellness will directly affect the wellness of one's community because it's like - from the micro to the macro, right? ...So, if you have healthy families, you have a healthy church. If you have healthy individuals in a community, you should have a healthy community.*

Araba similarly agreed that there was a symbiotic relationship between individual wellness and community wellbeing. He states:

> *So if there is an individual who is affected, then the whole community becomes responsible, and if the whole community is also struggling then the individuals within that community experience individual problems. So I more or less see it as, society affects an individual, and an individual affects the whole of society.*

As the participants explain, holistic wellbeing was generally understood as impacted by the social, physical, and emotional needs of the community. By that logic, promoting community wide and far-reaching holistic interventions is a necessary step for improving Black Canadians' mental wellbeing. Presently, holistic mental healthcare interventions currently fail to significantly include community initiatives and volunteer organizations that help address socio-political factors that contribute to psychological distress and poor mental health. Tackling poverty, unemployment, food insecurity, police violence and other oppressive factors that disproportionately impact Black communities was flagged as a necessary requirement for improving the mental health of Black peoples. Holistic mental healthcare approaches must work towards initiating more communal, grassroots interventions to incite systemic and political change and foster activism against structural oppression (Grills et al., 2016; Prilleltensky, 2012). Dean I uses George Floyd's murder to demonstrate the relationship between individual and community wellbeing, and the imperative to address both for healing:

> *It took almost 10 minutes for him [George Floyd] to be killed in public view. That brings back all the traumas that Black people have suffered over the years that has gone unreported and undiagnosed. We need to talk about the trauma that we experience in our communities because there is a correlation with individual wellbeing.*

As indicated, the pastors view the mental health struggles of individual Black community members as reflective, if not endemic, of the discord, harm and violence impacting Black communities more generally. He suggests Black individuals' experience of mental distress is triggered by Black people's mistreatment and subordinate position within society. Based on this logic, mental healthcare service delivery that is merely invested in individualistic growth rather than social change, will continue to fall short of producing long-standing wellbeing for its Black

clients. In line with my Black Feminist Psychology Framework, identifying socio-political arrangements that maintain and perpetuate exploitative and oppressive conditions for Black Canadians, marks an important step towards improving mental healthcare service delivery. Dean I's response reinforces the necessity of addressing systemic and structural issues, such as anti-Black racism and police violence as a commitment to mental healthcare for racialized communities. For Black Canadians, an ethno-racial group that shares historical trauma and is still entangled with the vestiges of slavery and colonialism, it is imperative that healing aims to move beyond just the individual and extends to the entire community (Akbar et al., 1980; Chioneso et al., 2020; Grills & Rowe, 1998; Myers, 1993).

The parish ministers' responses also highlight the need for mental healthcare service providers to participate in community engaged efforts to lobby support against political and social injustices that are impacting their most vulnerable clients. Currently, formal mental healthcare settings are not positioned to move beyond individual approaches to wellness (French et al., 2019); however, collaboration with sacred spaces can serve as sites for intervention for community healing. Indeed, hearkening back to the legacies of The Black Church, the interviewed parish ministers work to coordinate events to address systemic disparities and by extension, facilitate restorative healing. Addressing the psychological effects of collective trauma requires a collective approach, and the parish ministers interviewed, whether advertently or inadvertently, have prioritized this in their ministries. Lady T, and Young P detail some of their largest and most popular community events below. Lady T hosts annual back-to-school barbeques tackling food insecurity and encourages Black students, often marginalized in educational settings, to devote themselves to their education:

Every year in August, we have an annual back to school barbecue and what this includes – we offer free meals, like barbeque chicken, rice, coleslaw and we give out backpacks to the community. It's just a way to say that we really support the education of our children and youth - that we really believe in their future ... we show them that we care, we want to encourage them, we want to uplift them and empower them to do well in life.

Young P discusses offering parental support during the Covid-19 pandemic for Black parents and community members who were disproportionally overrepresented in frontline work with lower Covid-19 protections due to structural racism (Goldman et al., 2021):

And so what my wife and I did is that we held two seminars within I would say an eight month window. The first one was "parenting during covid" and the other one was "let's talk," and it was just very open and conversational...we got to a point where we were talking about what good mental health looks like in such unprecedented times, and some strategies that you can do in order to boost yourself when you might be feeling low.

Community functions such as food drives, educational fairs, free tax clinics and several others listed by the ministers, shared the common objective of providing emotional and material care for Black community members. As informed by my participants, mental healthcare provision must extend to countering systemic disparities their communities face and offering resources and outlets to address these matters. Black communities still experience heightened food insecurity, educational inequality and remain disproportionally impacted by Covid-19. Throughout the talk data, faith leaders presented their community events as facilitating and sponsoring healing by inspiring resilience, offering tangible material support, celebrating joy and emotionally caring for their community members. When questioned: “How can the government and/or public health

researchers assist you in your mental health efforts for the community? What resources do you require?" Interviewees discussed the need for funding and more culturally competent mental health personnel to help host community events to support their mental health initiatives and empower their communities. Sweet Tea's request for funding was to help create in-house programing for her congregation and community:

> *What I think is missing, especially on the side of the government, is maybe support and funding. Yeah, so that we can do more for our individuals in-house so that we don't have to send them out. For some, they have a level of comfort in the house, they have a level of comfort with the community that they are in, and for us to be sending them out, it almost can work against them- because the fear, the stigma, concerns about safety- they may not follow through on those external referrals, whereas I think that we are well positioned and have great rapport and influence with those in our community. I think the government should resource us better so that we can be sort of like a solution centre. To help those who we serve in our community of course.*

For Lady T, funding was listed as a priority to hire mental health professionals to assist with programing and workshops:

> *Definitely funding, and if they could even offer us various people to come in time and time again, especially now more than ever- once they get the covid restrictions laid out. We could have certain programs set up within the church, because we would definitely take it on. As I said, I am very passionate about mental health.*

As such, greater research is required to explore how government agencies can partner with Black Churches to create grants for 'in-house' community services that promote mental wellbeing and how these applications might be fairly assessed and allocated. These efforts and resources could

help to significantly inspire wellbeing, promote empowerment, and counter service use disparities for expressly religious Black Canadians.

c) Creating a Culture of Collaboration

Three questions were posed to explore parish ministers' receptiveness, willingness and need for collaboration with formal mental healthcare service providers. The responses gathered from this line of inquiry revealed three findings: a) Parish ministers have at times felt ill-equipped addressing a mental health concern; b) Parish ministers have rudimentary training in mental healthcare but participate in continuing education on mental health; and c) Collaboration with formal mental healthcare service providers must begin with mutual respect. Taken together, these findings demonstrate the necessity and readiness of parish ministers to work towards collaboration.

Almost uniformly, parish ministers admitted to experiencing moments where they felt either ill-equipped to address a mental health concern, or that a mental health issue was beyond their level of care and expertise to address. Under these circumstances, parish ministers discussed recommending members to seek external help and referred them to mental health professionals. These admissions demonstrate the number of unique cases that are brought to community faith leaders (Chang et al., 1994; Chatters et al., 2000; Wang et al., 2003), and while the use of spiritual expressions and tools, such as prayer, biblical or scripture readings, meditation, and music would help in some instances to alleviate the suffering of their congregation members, when it was not enough, external secular help was encouraged. As Young P elaborates:

> *What I would say is that when I do feel ill-equipped, for example, when someone wants to commit suicide, that's something that's outside of my jurisdiction. I can't deal with that. I*

have a duty to report at that point. If someone is experiencing sexual abuse, especially when it involves minors, I'm ill-equipped to deal with something of that nature, and so referral or reporting is what I generally do when I I'm dealing with something that I'm ill-equipped to deal with.

Indeed, Dean I was quite specific with an example that apparently occurred a day prior to my interview, to wit:

More often than not, yes, I have felt ill-equipped. Just yesterday I was dealing with a young person who was experiencing a mental health crisis: the person was expressing suicidal ideations. And you know, to be able to deal with that, you're always feeling ill-equipped, you wonder if just listening and being there for that person is going to be able to help- but often more is needed.

First Lady attributed feeling ill-equipped to her pastoral training:

....as a pastor right, you may not be trained in areas that a person who trained in mental health, at the university level has, so I do believe that sometimes we lack the skills to meet certain needs.

The most varying responses were elicited from the question, "Have you ever undertaken specialized clinical training in mental health? Why or why not? (Specialized training can include mental health first aid, mental health rehabilitation courses, crisis and trauma training programs, suicide and crisis and training programs, etc.)." The participants had different exposure to mental healthcare training. Only one of twelve interviewees specialized in mental health during pastoral training and seminary school. Others had experience working in crisis and trauma centers before they were called to serve as parish ministers. However, most of the participants enrolled in continuing education opportunities, such as mental health seminar training courses, mental health

conferences or mental health counselling at the graduate level. Dean II's specialization in social work offered him a foundation in mental health; yet, as he playfully exclaims, there remains much more to learn on the topic:

> *I also did a double major in theology and in social work. So because of that it kinda, helped me to form a clinical perspective, you know, at that time, it was DSM four. God knows where it's at right now.*

Some of the pastors discussed participating in continuing education opportunities and professional development courses that focus on mental health and wellbeing. Lady T discusses her experience:

> *I'm just about to finish my course in stress management, about a week left. So, this is how I am educating myself, and if I can help somebody with some practical tips, then you know, all the better.*

For Young P, the increasing prevalence and importance of mental health concerns in his ministry encouraged him to pursue a post-secondary degree in psychotherapy:

> *So, I've done some mental health stuff, like grief training and things of that nature. Depression, things of that nature... but I have been exposed to mental illness, so much so that I've just applied for my Masters in spiritual care and psychotherapy.*

My study participants' various engagements in mental health educational opportunities further discount conventional narratives that maintain faith leaders are unwilling to dismantle stereotypes about mental health, address stigma or actively work to promote help-seeking behaviors. The intent, interest, and investment in studying mental health was evident among the interviewees. Of course, it is possible that the parish ministers who agreed to participate in the

study were naturally more inclined to make space for mental health concerns and prioritize it within their religious institutions. Although the study would need to be replicated and extended to draw any final conclusions, the pattern of responses from the ministers strongly endorses a commitment to mental healthcare in their ministry.

Direct questions addressing collaboration between parish ministers and formal mental healthcare service providers were posed to the participants to expound their stated commitment: "Do you think there is space for collaboration between the Church and professional mental health services? If so, what would collaboration look like? What do you imagine would be the strengths and weaknesses of collaboration?" The question was unanimously met with confirmation: space for collaboration was conceived not only as possible but desirable. Dean I enthusiastically expressed the need for collaboration. He believed mental health professionals were messengers from God and believed them to be doing God's work:

> *Definitely. The professionals are sent to society by the Lord. He knows exactly what's happening to the people, especially during this time of the pandemic, when so many people are experiencing mental health issues because of the lockdown and the isolations and so forth, there is definitely a need for the church and mental health professionals to collaborate together for the wellbeing of the people*.

Similarly, for Sweet Tea collaboration was understood as the manifestation of God's will and necessary to provide parishioners with the extra support they require:

> *The Bible says, if they're sick, lay hands on them, pray for them. You know, we have a solution for that. If you're thirsty, the Bible says give them something to drink. We have a solution for that. If they're hungry, the Bible says give them something to eat. If they have*

no clothes, the Bible says to clothe them. If they're having mental health issues, the Church has to have a solution for that. One that is practical, real, instead of just saying "God bless you" and sending them on their way, we need to have a practical solution to help walk them through their mental illness. It is part of what we should be doing as the spiritual body of Christ.

First Lady's passionate endorsement for collaboration stemmed from her hope of reducing the gaps in mental health service delivery for her parishioners:

Somebody is reaching out to a source that they believe can help them, but you don't have the resources to help them because you don't have the skills, you don't have the training, and so you use what you are used to, you use the scripture, you use experiences, you use the testimonies of others who have been through it. But there has to be- there ***should*** *be some collaboration. To bridge that gap because there is a gap.*

Many of the parish ministers had already started collaborating with formal mental healthcare service providers. For instance, some had an informal referral system, a list of trusted experts to refer congregation members to in times of crisis. As Young P states, this was incredibly useful during the pandemic:

During this pandemic, I've had congregational members come to me and say that they're dealing with depression. My role at that point is to find someone that can help them beyond just the spiritual aspect of it. So I've amassed, during the pandemic, and even before that, mental health practitioners that I can call on at any moment and refer people to. If you can't deal with the situation, then the referral is the best thing that you can do in that situation.

Others had a more formalized process in place wherein expert mental healthcare professionals were asked to volunteer and serve as a point-person when issues were beyond the training and capacity of the parish minister. PHC elaborated on what this process looks like within his church:

> *So we formalized an actual Department in our Ministry... It's an established structure in our ministry, or as I would call it, it's an established* ***wall*** *in our ministry to really highlight mental health. 'Cause we have the tendency in the church to focus on the spiritual aspects, but I believe that you can't be spiritually whole, if you're not emotionally, mentally whole as well, so collaboration is necessary and I've always partnered with, or at least as best as I can with other personnel within my city to bring greater awareness to that.*

A few parish ministers hosted mental healthcare events as part of their church services or sometimes as stand-alone events. Ministers would bring in specialists to discuss various mental health topics, including but not limited to grief, depression, anxiety, etc. Lady T discusses mental health awareness campaigns that she hosted in the past with counselling professionals, and expresses interest in arranging more events in the near future:

> *So I think as a church, we just need to collaborate more with health experts- what we used to do is on some of our Sunday morning services we would have guest speakers come in, medical experts come in, and talk about for example, stress, and how you can live and maintain a healthy lifestyle.*

The mental health initiatives discussed reinforce the health promotion literature that views religious institutions as a site for cultivating wellbeing (Harris et al., 2006; Koenig et al. 2010;

Lukachko et al., 2015; Wang et al. 2003). Their initiatives also add to the scholarship by offering a Canadian and mental health lens on religious institutions' health promotion efforts. Thus, many of the parish ministers interviewed were amenable to collaboration and had thought of creative and engaging activities to stage important dialogues on mental health and provide transparency on this highly stigmatized issue in Black communities.

When questioned about weaknesses of collaboration, phrases such as "mutual respect or lack thereof," "conflicting world views," and "doctrine clashes" popped up over and again throughout the interviews. The responses illuminate parish ministers' tension around whether counselling professionals will truly acknowledge and respect faith community leaders to assist individuals in their mental health journey, and value them as complimentary to the work, as opposed to an appendage to it. For Araba, a practitioner's dismissal of spiritual struggles impacting an individual's wellbeing or the negation of spiritual exercises within the treatment plan could prove challenging for collaboration:

> *Maybe you are a clinical practitioner, and I'm a chaplain. I try to let you know how I understand his or her situation spiritually, you are not likely to be on the same wavelength with me because you might not see how the issue is related to spiritual concerns. And you may not understand spirituality as I do, right? So, it's very, very, challenging.*

Pastor NJ echoes his peers' concerns and had this to say on the matter:

> *Yes, there is space [for collaboration] but it has to be one of mutual respect, because sometimes I think the gap occurs when the so called "experts or professionals" look down at those that are giving spiritual leadership as if they don't know what they're*

> *doing, and they almost talk down on them. So, the collaboration has to be a collaboration of mutual respect and equality to realize that these two parties can come together for the purpose of helping people. Especially within the Black community, there's a lot of trust for pastors and leaders, so if we can empower pastors and leaders, we may get through some of the issues that the Black community experiences.*

Parish ministers ultimately felt respect and honoring each service provider's strengths and capabilities would allow for successful collaboration and tailored treatment plans that meaningfully encompassed a holistic mental healthcare approach. Therefore, despite the potential barriers listed, all were generally enthusiastic about the comprehensive support banding together with formal mental healthcare service providers could yield for their members.

d) *Hope as a psychosocial resource and protective factor*

In line with the scholarship on R/S and psychology, hope was delineated not only as a psychosocial resource that parish ministers worked to instill and foster within their communities, but also what they viewed as a reliable protective factor against mental illnesses such as depression and anxiety. Several of the participants, when asked: "How do you understand your role as supporting and maintaining mental wellness in the Black community?," stated that offering hope to their members was integral to their role as parish ministers, and often, the missing piece for those who experienced existential dread or despair about their present circumstances and futures. According to Sweet Tea:

> *And that's something that we have the opportunity to do as religious leaders- help people find a place of hope and I think that the foundation of a healthy self-perspective or a healthy world perspective is having hope and so as believers and as pastors we help to re-establish peoples' identity in Christ and regardless of their*

circumstances, we try to point them to a greater hope that is beyond their current circumstance.

A similar sentiment is quite discernable in the words of Dean II. He states:

> *As a Minister of the gospel, my role is to try and point a person towards hope because hope is the only thing that will allow a person to continue...That's the thing that helps us to be so resilient as a people, and has been passed down by our ancestors... in the Bible we find that God works for people who have been abused, neglected, poor, and so we know that there is a great hope that we hold on to that has made us very strong, even in adverse circumstances.*

Hope, a radical belief that goodness will prevail, has a long history in the psychology literature for serving as a source of inspiration, wellbeing, and effective coping (Benzein & Saveman 1998; Herth, 1990; Stotland, 1969). However, what was particularly interesting about parish ministers' conceptualization of hope was that it was described as a psychosocial resource that works across generations. Religious institutions are one of the few remaining spaces in the West in which multiple age groups congregate and interact with one another at the same time. Thus, parish ministers identifying psychosocial resources that speak across widely different age groups is a useful tool, with promising implications for the counselling field. Greater investigation is required to uncover what other psychosocial resources parish ministers utilize to transcend age, gender, class and regional differences within Black communities. This in turn can help the mental health field offer more culturally competent care and help service providers to draw on psychosocial resources that effectively speak to their clients' diverse needs.

Clearly, parish ministers have their pulse on attending to central preoccupations that relate to and speak across generations for faith-based communities. However, when asked directly: "How do you counsel community members who are not religious?" The majority of them stated they would rely on what they understood as "universal principles," to relate to the individual in need. Sweet Tea offers the following remarks:

> *What we have found is that the principles and the truths of the Word of God are transformative. Whether you're quoting the Bible or whether you're just telling the truth, we have seen it transfer into a secular realm because truth is truth, right?...You have to understand, our perspective will always be from a spiritual perspective, but what we've found is those truths do not change. Whether you are believer or you are not, the principles are the same.*

For PHC, he too recognizes Biblical teachings colour his counselling, and similarly to Sweet Tea, he relies on "universal" axioms and principles to counsel non-religious members:

> *Well obviously as a pastor, my starting point will always begin with the Word of God or what we refer to as the Bible, but nevertheless, I believe that there are universal, ethical, and moral principles, that we all can agree on, such as, love, peace, hope, fellowship, community. So I begin with these particular tenets, fundamentals of the individual that we can find a common ground on and we build from there.*

I highlight these responses because while this universalist approach may be useful for faith-based community members who share similar worldviews and beliefs, it may not always be equally successful or applicable to those who are not religiously affiliated. Ethics and morality, which presumably make up "universal principles" and guide one's individual choice and behavior is

largely subjective. And in this instance, what is good or morally correct is likely to be imbued by a pastor's religious background. Controversial subjects, such as abortion and/or LGBTQ rights in the Christian faith have the potential to be mishandled in these cases. Here, collaboration with formal mental healthcare service providers can help parish ministers to stage these conversations in a way that affirms and respects individuals' choices, even if they depart from biblical teachings.

e) *Black faith community leaders as a mediator between Black community members and the police*

An important finding in the data that has yet to garner significant attention in mainstream psychology is the necessity of addressing anti-Black racism as fundamental to improving Black Canadians' mental wellbeing. This finding was most evident when parish ministers discussed anti-Black racism and the police. When questioned, "do marginalized/minority communities require unique approaches to wellbeing?" At least half of the pastors interviewed shared that they had to either step in to mediate interactions with police forces or offer counselling to their members after a discriminatory encounter with the police. I highlight this finding because it is labour that is not widely recognized in mainstream psychological science as mental healthcare service provision or deemed necessary work for formal mental health professionals to perform; yet, it is undeniably essential for providing mental healthcare in Black communities. Pastor NJ shares a memory serving as a mediator between a parishioner and a police officer:

> *To give you an example, there was a lady that was taken into the hospital. The police actually arrested her. It was just a mental illness episode. It was nothing. You know she wasn't that destructive, but they just thought there was potential. She was taken to the hospital and she was not allowed to leave, but they noticed that there was only one phone*

number that she wanted to call all the time, and that was my number. So she called and we talked and talked and that kind of helped the process of getting her medication... I was able to advise and encourage her to take the medication, and she was able to go back on the medication because of the trust, right? So I may not have the ability to prescribe the medication, I may not have the ability to diagnose- but I can help in this way.

The quote illuminates NJ's role as a mediator and how he was able to protect and safeguard the wellbeing of his parishioner, whose mental illness episode was heightened by police presence. Moreover, he was able to use his position as a trusted confidant to encourage her to take her medication for her mental health. Araba also shares a story of a parishioner who reached out to him following a stressful encounter with the police:

I have a friend here in Canada who was arrested and when he was arrested on the bus they took him straight to the mental hospital because they said he was making a 'murmuring sound.' He can't speak English and he doesn't understand English. He was speaking Twi and the police thought he was making a murmuring sound and unwell, so they took him to the mental hospital and he called me.

These stories serve as reminders of the looming presence of police brutality and discrimination against Black people and their dangerous impact on victims' mental wellbeing. Parish ministers use their positions of trust, credibility and cultural competency to work with Black community members and help them to navigate federal services and systems that fail to recognize the humanity of Black people. Several of the parish ministers condemned the police violence that their community members faced and described stepping in to serve as a conduit to help individuals access resources to combat unlawful lawsuits and predatory court cases. These parish

ministers instill a level of care and comfort for those who feel targeted and alienated by the climate of anti-Blackness. This finding forces us to expand our conceptualizations of what mental healthcare entails, and to critically attend to what it excludes and the consequences of those exclusions. The increasing number of Black mentally ill persons killed in police custody or in police interactions warrants the urgency of mainstream psychological science and counselling professionals to take a stand (Maynard, 2017; Meerai et al., 2016). Sweet Tea remarks that these fatal encounters are the result of officers' prejudice, which enables them to further discriminate against Black people who are suffering from a mental health emergency:

> *I think it's a different animal with the Black community. Historically speaking, I think that there's a lot more stigma around mental illness. So I think it's highly unreported in our community. I think that it is undertreated. I think it's misunderstood. And I have examples of that - So I have a close family member who had, you know, a mental illness episode. The police showed up and the police treated him as if he were a criminal as opposed to assessing and understanding the situation was a mental health issue, and not a "Black youth issue."*

The compounded effect of anti-Black racism and mental illness in Canada has exacerbated Black peoples' vulnerability and proximity to death by the hands of the state (Meerai et al., 2016). Therefore, anti-Black police forces remain a grave mental health issue, and call for immediate policy change to strengthen service provision for Black communities. This finding demands a reckoning that reverberates loudly in the public arena through public policy reform and proposes accountability for the lives lost, and the imperative for mental health researchers and counsellors to work towards abolition.

Significantly, it is not only parish ministers' credibility and activism that allows them to handle these cases of anti-Blackness with sensitivity and urgency, but cultural competency as well. It is no surprise then, that, when questioned, “Do you think traditional academic approaches to mental healthcare are capable of addressing the needs of Black community members?” or “Do Black communities require unique approaches to wellbeing?” the most consistent answer was the need for more culturally competent mental healthcare professionals to provide nuanced mental health support in the Black community. Dean I had this to say on the matter:

> *Someone who does not live our lives, can't understand what it feels like to be a Black person walking down the street and see a Caucasian person crossing the street to avoid you. Or a woman clutching her purse underneath her arms because she is afraid of you being around her. Or you walk into a store and people follow you along because they're thinking that you're going to shoplift. Or you're driving down the street and the police officer stops you for no apparent reasons but just to harass you. Well, those are real experiences, but those who are privileged cannot understand.*

Elaborating on her aforementioned point on how society perceives Black people and mental illness, Sweet Tea had this to add:

> *If somebody in our community seeks mental health assistance, I don't know that it's viewed the same because of our intersectionality.... whereas if it was a different intersection they may be quicker to help. I feel like in our community we have to ask over and over, we have to advocate over and over before we get, maybe, the help that we need. That's why we're in the best position sometimes I think to be able to serve our community and if we had better resources, we could do that in a place of trust where we will see it as*

it is, and we will have the compassion required, and we will have the insight required to be able to assess the situation and provide help.

Interviewees felt that mental health professionals working with Black communities need to understand how racial trauma and historically rooted systems of oppression impact how Black people are (mis)treated by federal services, and how that influences Black community members' mental health and help-seeking behaviors. Therefore, parish ministers agreed that counselling professionals that have Black lived experiences are uniquely suited to identify and understand matrixes of oppression that structure Black life. Many expressed a need for more Black mental health professionals to enter the mental health field. PHC believed Black counselling professionals could increase parishioners' level of trust in formal mental healthcare services and improve treatment compliance for expressively religious patients:

What I mean by highlighting Afro descent therapists and practitioners is intentionally having these individuals come into Black spaces and be able to work within these Black spaces. I'm not saying that you know any other group can't, I believe they can, but I believe there's a sense of security that Black churches will have when they see Black therapists, Black counsellors or Black practitioners, working with them and will be more responsive to their help.

Sister Marie Noel expressed a similar sentiment:

For example, resourcing the Black community to have more Black individuals involved in it [mental healthcare] because sometimes trust issues will worsen the situation more. Cause you know, when somebody you don't trust, tells you something that you don't want to hear, it worsens the whole situation.

As expressed by my study participants, Black counselling professionals' ability to address the social realities of community members, coupled with their intimate knowledge of anti-Black racism, can help to build trust and security with parishioners, in turn, empowering members to begin their mental health journeys. This finding is in line with a 2018 study conducted by the Mental Health Commission of Canada that reported 60% of Black Canadians (n=328) would be more willing to use mental health services if administered by a Black counselling professional (FAMHAS, 2020). Indeed, studies have shown Black clients prefer Black therapists (Cabral & Smith, 2011; Fante-Coleman et al., 2023; Goode-Cross & Grim, 2014; Townes et al., 2009). However, the number of Black Canadian counselling professionals is sparse (Williams, 2021). Although the Canadian Psychological Association does not track the number of Black psychologists in Canada, data collected across the border offers a portrayal of the devastating shortage. In the US, 86% of psychologists are white compared to 4% percent of Black psychologists (Lin et al., 2018). These statistics offer important implications for service provision. Most notably, the statistics raise concerns about barriers preventing Black people from pursuing careers in the mental health field. Attending to the roots of this disparity can allow for greater participation among Black people in the counselling field that are willing and able to support their communities (Fante-Coleman et al., 2023; Goode-Cross & Speight, 2014; Salami et al., 2021).

The preceding discussion joins the chorus of voices calling for reimagined mental healthcare service delivery for Black Canadians. My analysis indicates a willingness from parish ministers to work towards greater collaboration with formal mental health service providers to better serve the mental health needs of Black Canadians. As informed by the Black parish ministers interviewed, nuanced strategies, interventions, and concerns were identified to improve

mental healthcare service provision within Black communities: community engagement for collective healing, political and systemic reform of oppressive structures, particularly of the police force; increased cultural competency and familiarity for service providers working with Black communities; and holistic care that meaningfully encompasses religion and the religious leaders who can contribute their expertise and services to this end. Thus, collaboration aimed at stronger political mobilization and advocacy against anti-Black racism, increasing referral processes within religious organizations, and the timely development of educational training tools for pastors and counselling professionals respectively, were all understood as offering more culturally competent, decolonized and holistic mental healthcare to expressly religious Black Canadian communities. Engaging community faith leaders and foregrounding their perspectives offers important insights into service delivery for this underserved group and marks an important step forward towards culturally responsive, holistic and transformative mental healthcare for all Black Canadians.

Reading Between the Scripts

Promoting a more inclusive acceptance of religious leaders' role in mental healthcare service provision for Black communities, requires an-in-depth investigation into the hegemonic discourses that reinforce mainstream norms about healing and 'care.' In this section I explore parish ministers' understandings of the ideological, political and economic discourses that shape, constrain and/or undermine their mental health efforts. Four discourses were identified in the study: a) credentialism, b) essential work(er), c) democratic racism and e) the supernatural. I reveal how the distinct discourses of 'essential work(er)' and 'credentialism' operate to exclude religious leaders and situate them outside the jurisdiction of knowledge producers and service providers of mental healthcare. I demonstrate how the discourse of 'democratic racism' obscures parish ministers' activist and community oriented mental healthcare service provision. Lastly, I identify how 'the supernatural' discourse works to discredit The Black Church and its leaders by ascribing a colonial primitiveness to its institution. Taken together, I contend these discourses reinforce a neoliberal, colonial rhetoric constitutive of a biomedical mental healthcare model, which permeates the delivery of mental health treatment and services.

The biomedical model's stranglehold on mental healthcare service delivery has a longstanding history in the health scholarship (Morrow, 2017; see Whitaker, 2010). The framework is a biologically focused approach to mental illness that emphasizes psychiatric medicine as the primary treatment method for mental disorders (Deacon, 2013). The model posits that chemical imbalances and brain diseases are the root causes of mental health issues (Deacon, 2013). By presenting mental illness as "an objective material biological problem, located within the individual, and separate from culture and society," healing is exclusively tied to individualized pharmaceutical treatment plans (Morrow, 2017, p. 6). Despite contestation in

the literature of the model's limitations, particularly, its inability to consider psychosocial factors and the behavioural, cultural, and historical dimensions of illness, the biomedical model remains a privileged framework in western healthcare settings (Deacon, 2013, p. 847; Engel, 1997). There are many external factors that have protected the model's dominance, including but not limited to, giant pharmaceutical interests, educational institutions, and a ubiquitous neoliberal climate. The biomedical model's reliance on the development, production and sales of psychiatric medication results in a lucrative partnership for pharmaceutical companies. As such, pharmaceutical companies maintain an invested interest in the model. Educational institutions' endorsement of the biomedical model allows universities to continue accrediting counselling professionals through expensive programs, while maintaining intellectual legitimacy and hegemony on knowledge production (Whitaker, 2010). Lastly, neoliberalism, which is comprised of a set of governmental practices and economic policies that promote the 'free market,' privatization and deregulation in lieu of welfare state activities, reinforces the biomedical model, which is similarly invested in individualized approaches to care (Morrow, 2017). Both the biomedical model and neoliberalism view mental distress as the responsibility of the individual to redress, regardless of the structural and systemic inequities that have given rise to one's impaired condition. Thus, a neoliberal political climate endorses privatized fixes through pharmaceutical drugs to detract from investing in social welfare programs and community based mental health supports (Morrow, 2017). As such, these factors contribute to an overreliance on the biomedical model, which creates significant roadblocks to holistic care and anti-racist mental healthcare service provision.

The implications are particularly concerning for disenfranchised members of society who require a totalizing approach to wellbeing that includes social justice efforts within mental

healthcare. Black Canadians' mental healthcare can largely benefit from a holistic model that accounts for greater consideration of *all* social determinants that contribute to psychological distress and poor mental health outcomes, including social and political injustices inimical to wellbeing. A paradigmatic shift from the biomedical model can help to target social inequities and center the efforts of informal mental healthcare service providers who foster holistic wellness through community driven interventions, outreach programs and activist informed care. The biomedical model's dominant grasp on mental healthcare service delivery forces us to consider how informal mental healthcare service providers, such as parish ministers, cultivate and deliver alternative mental healthcare in the face of opposition and resistance from the biomedical model. Indeed, it is this line of inquiry that frames the following discussion.

Findings and Discussion. My aim was to uncover parish ministers' understandings of the ideological, political and economic assumptions that impact their mental healthcare service delivery and how parish ministers negotiate their identities and ministries to provide holistic and anti-racist mental healthcare to expressly religious Black Canadians.

a) **Credentialism**

Many of the interviewees, when questioned if they consider themselves "informal mental healthcare service providers," a term I chose intentionally to include a wide range of actors that could broadly be understood as performing activities to improve and sustain an individual's mental health, were skeptical about the designation. Many felt their lack of specialization and credentials in the mental health field excluded them from such a title. Parish minister PHC believed that an informal frontline mental health worker fell outside his jurisdiction of expertise:

> *Obviously, number one, that's not my level of expertise at all. I do believe I have some basic knowledge, but I wouldn't call myself an expert in it.*

Young P also distanced himself from the "informal mental healthcare worker" designation as he felt addressing mental health concerns corresponded with advanced specialized training. His repetition of the word "specialized," served to emphasize his position:

> *So, I've done some mental health stuff, like grief training, learned about depression, things of that nature, but I would never classify myself as a mental health clinician or that I'm an expert in any of those things. It's such a specialized, specialized, discipline that I would never classify myself as being that.*

Terms such as 'expertise' and 'specialization,' which were echoed in the rest of the participants' responses, signaled the shared sentiment of participants' preoccupation with credentialism, which was revealing of ideological assumptions and disciplinary power relations within the mental health field. The first discourse, "credentialism," coined in the 1970s, refers to an ideology that privileges formal education and its accompanying certificates, over alternative ways of understanding and producing knowledge, such as relevant practical and lived experiences (Collins, 1990). The reduction of one's qualifications and competency to a conferred piece of paper, particularly in the mental health field, is rather constraining. There are many actors, apart from formal mental healthcare service providers, who significantly contribute to individuals' wellbeing and whose efforts should be acknowledged and validated. Historically, those who trained in western educational spaces and received formal qualifications within the counselling field, were the gatekeepers of mental healthcare and access. Psychiatric institutions, mental health hospitals, rehabilitation centers, became designated spaces for receiving care, while prescription drugs were the privileged mode of intervention (Deacon, 2013). Consequently, other forms of knowledge and approaches to treating mental illnesses, such as indigenous African healing and spiritual traditions, as well as non-traditional service providers,

were undermined under a colonial rhetoric of witchcraft, sorcery, and primitiveness (Comaroff & Comaroff, 1992). Disciplinary and institutional barriers within the mental health field dictated not only *how* one might be treated, but by *whom.* To date, who is recognized as administering mental healthcare, and what practices are accepted as mental healthcare service provision, remains tightly regulated on a westernized, biomedical-individual-centered approach to mental healthcare.

I flag this discourse as it appears to underpin parish ministers' adamant stance to delineate the work they perform as separate from that of counselling professionals. As parish minister Sweet Tea staunchly affirms: "*Like I said we're not psychiatrists, psychologists or therapists."* Interestingly, their adamant refusal is at odds with other responses shared throughout their interviews in which parish ministers uniformly stated their commitment to and provision of holistic mental healthcare. The contradiction is evidenced below in the following excerpts. PHC understands his pastoral role as offering a healing balm to 'wounds' caused by emotional and psychological distress:

> *My role as a pastor is to provide and create space for people to have that environment to experience rest, healing, restoration. And also, reparations too. It is to provide an environment that addresses wounds and I use the word "wounds" to refer to emotional, psychological and spiritual wounds.*

First Lady explicitly refers to her pastoral work as responsible for fostering holistic wellbeing:

> *I believe that as a pastor, my role is not just spiritual, but it's also to enhance the development of the holistic being, which includes mental development. So as a pastor, not only do I offer counselling, but the spiritual aspect of it is enabled to bring hope, bring*

security, faith in a higher, supernatural being, and that to me, helps-should help to take care of whatever stress or trauma somebody may face.

Sweet Tea candidly reflects on her duty to help individuals reach their full potential and achieve spiritual and personal flourishing:

So as faith believers and as faith leaders, we are able to establish communities where people can feel like they belong, where they can get support, where they can get spiritual development and even personal development to be honest with you. It's not just spiritual, there's an opportunity for inclusion that we create, so people can feel like they belong, and I think that we also give opportunities for people to be able to grow in their purpose.

As shared by the parish ministers, cultivating optimal mental health includes inspiring strong spiritual health and facilitating holistic wellbeing. The above excerpts illustrate the work performed by parish ministers should be comparable, at some level, to that of an 'informal mental healthcare service provider.' However, for the parish ministers interviewed, the term reactively dredged up hegemonic understandings of mental healthcare service provision that was premised on "specialized," expert, university-educated practitioners, and relied on a biomedical understanding of mental illness. Lack of credentials from within the mental health field made parish ministers discount and undermine the communal, holistic, and spiritual efforts they undertake to enhance wellbeing in Black communities. Their insistence on their differences from formal mental health service providers and distancing from the term "informal mental health worker," reinforced a binary of 'expert and non-expert' and highlighted an existing hierarchy of labour performed within the mental health field.

It is evident that parish ministers are relying on the prevailing discourse of credentialism, which has shaped how they understand themselves as doing this work. While there may be

practical reasons as to why parish ministers may want to separate what they do from the 'experts,' such as imposter syndrome, fear of overstepping or mishandling a mental illness, I argue the greater motive for this internal contradiction is the overbearing presence of the biomedical construction of mental illness and its corresponding dependency on a class of western-educated mental health professionals. This, in turn, has sidelined activist and community-oriented efforts by racialized faith leaders to improve wellbeing. Once we understand and validate that mental illness extends beyond biomedical disease and individual dysfunction, to include socio-historical conditions, communal trauma, economic disparities, and social and political injustices, then we can acknowledge the contributions of other actors within the disciplinary and institutional halls of psychology to inform new forms of service provision.

b) **Essential Work(er)**

The terms and importance of 'essential work and worker' were reestablished during the Covid-19 pandemic. Rising infection rates, tied to an increasing number of fatalities, forced the Canadian government to announce a lockdown and designate which work was 'essential' to the continuing functioning of society. Although it is not clear the exact criteria used to assess essential work, it was likely based on hegemonic assumptions about critical operations and services deemed instrumental to the fabric of society. It is unsurprising then that popular capitalist, secular commitments would result in the government overlooking the role of religious faith leaders as essential workers.[79] Places of worship were closed and barred from operating, religious gatherings were banned, and parish ministers were advised against meeting in person with their congregation members. Many of the individuals interviewed raised discontentment

[79] It is important to note that non-essential work that could be performed from home was mandated to continue (particularly in the corporate sector), often saving corporations millions, and increasing profits astronomically in some cases.

with this mandate as they viewed themselves as essential to their communities, and to the maintenance of their wellbeing. This idea was expressed in the data through the metaphor, "the church is a hospital," which was repeated in several of the interviews. Likening the church to arguably the most important institution during a global pandemic, affirmed the parish ministers' stance on their work as essential to the 'health' of their communities. A few of the responses are recorded below.

Lady T's perception of the church as a hospital, serves as the blueprint for her ministry of salvation:

> *A lot of people use a church "**like a hospital,"** right? So we're supposed to be there to help those that are looking for a way, I guess you can say, a way out, and help them get through the difficult times or dark moments in their life, and really be that source of support, encouragement, community, as well as light at the end of the tunnel. So that when they feel like "oh my goodness, I don't know what to do" they know they can come to the church at any time and feel like we will accept them with open arms and help them get through what they are going through.*

PHC believes the church operates similarly to a hospital given the institution's unique and varied therapeutic functions:

> *Pastors are not considered essential service and I find that interesting because I would argue that the **Church is also a space just like the hospital** or any sort of particular institution that provides some level of therapeutic reconciliation to the individual, right? And so that space that a church provides is definitely an essential service. A pastor can occupy the business of a counsellor, therapist, preacher, he or she wears all those hats.*

And so maybe redefining the language of what essential service is considered as- I think that's something I believe the government should probably look into reforming.

Echoing PHC's sentiments, Sweet Tea believes the Church can model its practice closely to that of a hospital by offering restorative healing services to address life's major plights:

I think as the church- ***some people refer to us as a hospital-*** *we should be able to provide the right resources and be supportive to our community. This should be like I guess you could say like a "one stop shop" for healing in a sense.*

These examples demonstrate efforts from parish ministers to discursively locate themselves and their work within the discourse of essential work(er), despite mandates from the government that ruled otherwise. We see this tactic again through the parish ministers' "technologies of the self," which encompass several activities and actions directed towards their communities to offer mental healthcare service delivery. Sweet Tea offers an example of staging conversations in her congregation to improve mental health literacy and create conditions for collaboration with formal mental healthcare service providers:

So for example, last year our women's ministry did an annual event called "Matters of the Heart" and at these events we deal with different issues- relationships, friendships, last year it was mental wellness. That day we had some psychologists join the panel and they discussed mental wellness in a Christian setting. Afterwards, we sent out referrals to everybody.

Young P discusses performing wellness checks with his congregation members during the pandemic:

What I tried to do and what I managed to successfully do over five and a half months is I called every member of my church. And that took me forever! And I called them, and

asked how they're doing, what's going on with them, things of that nature, you know. How's the family, is everyone alright? And I would ask them if there was anything that the church could help them with.

These excerpts recount efforts undertaken by parish ministers to firmly root themselves within the discourse of an essential work(er). In addition to the above listed activities, food drives (Lent and Easter), substance abuse programs, grief and pastoral counselling were also enumerated as essential work performed by parish ministers and identified as important services for their respective communities. During the lockdown, church-sponsored programs were suspended, preventing parish ministers from administering help to their parishioners and serving as a source of strength, comfort, and aid. In contrast, counselling professionals were not asked or expected to suspend their work; rather, they were encouraged to remotely deliver their sessions over online platforms. In fact, the Canadian government announced a $240.5 million dollar budget to fund, create and launch virtual care and mental health digital platforms for Canadians to access professional mental health services during the pandemic (Prime Minister of Canada, 2020). Additionally, mental health agencies received emergency funding to "hire and train more staff and purchase necessary equipment, appropriate technology and additional licenses" (Office of the Ontario Premier, 2020). Such measures, directed exclusively at bolstering formal mental healthcare services, failed to address disparities in health-seeking behaviors to foster widespread use of these new service offerings. Moreover, funding commitments did not offer comparative resources to community-based and grassroots organizations specializing in mental health, or assist in capacity building of informal mental healthcare workers to help meet the increased demands for support.

I argue that the emphasis of a biomedical-neoliberal construction of mental health prevented thoughtful consideration of the communal and holistic work necessary for wellbeing, and performed by actors, such as parish ministers, to advance wellbeing. Although sanctions to limit crowds and indoor gatherings to minimize the transmission of the novel coronavirus were necessary, the lack of attention and support to ensure Black parish ministers could still offer services to their community members was not prioritized. These decisions, or lack thereof in this instance, impact Black Canadians' provision of mental healthcare. The data has indicated that Black Canadians are less likely to use formal mental healthcare services compared to their white counterparts, and more likely to rely on their faith community leaders to sustain their mental wellbeing (Brewer & Williams, 2019; Chatters et al. 2011; Kovess-Masfety et al., 2017). Removing this outlet without communicating or funding culturally appropriate alternatives places them: a) at a loss of community and material support from the church during a time of crisis and b) at an overall increased risk of poor wellbeing. The oversight is particularly noteworthy considering Black and racialized communities were disproportionally impacted by Covid-19 and were facing heightened awareness of anti-Black racism sparked by the George Floyd murder (Goldman et al., 2021; Morneau Shepell, 2020). The discourse of essential work(er) does not extend itself to include culturally appropriate services that may be essential for Black communities, calling in to question which groups benefit from "essential work," and who is recognized or credited as providing essential labour. These decisions are informed by power relationships within the government and the disciplinary and institutional boundaries of the counselling field that continue to dictate what forms of care are validated.

c) **Democratic Racism**

Democratic racism refers to “the retention of racist beliefs and behaviors in a democratic society... democratic racism demonstrates continuing faith in the principles of an egalitarian society while at the same time undermining, and sabotaging those ideals” (Henry & Tator, 1994, p. 6). Parish ministers interviewed observed how democratic racism results in a lack of state-interventions to alter policies that can change the “existing social, economic and political order,” (Henry & Tator, 1994, p.10). According to Dean I, surface level changes to address Black Canadians' mental health has left unequal economic structures, divisive social relations and an overall “climate of anti-Blackness” intact (Sharpe, 2016, p.104).

> *The government has to begin to look seriously at systemic racism and not just talk about it or have a Black History Month, where people get all high and emotional about it and don't do anything to address the wider issues ...Systemic racism is set to hold down a certain group of people, which unfortunately is young Blacks.*

Parish ministers also noted democratic racism detracts from alleviating mental health concerns for Black Canadians. PHC recounts the unjust state of affairs disproportionately impacting Black communities that are not adequately targeted by the government:

> *Not only do they have to deal with being Black, they gotta deal with the other areas, you know, systemic racism, prejudice, the risk of being profiled by the police, police brutality. They gotta deal with the reality of their last name or their first name being a deciding factor on whether they receive a job. They gotta deal with racism and/or other prejudice and discrimination in the workplace.*

Dean II explicitly addresses how social injustices create cycles of abuse and contribute to intergenerational trauma:

40% of youth in care are Black- foster care, detention facilities, children's aid and all those things ... so what effect does that have on people's mental wellbeing when they are taken from their homes?....Because if young people are not feeling cared for, safe and protected, then when they grow up, their children are going to feel the same - the anger they feel is going to be carried forward- and that anger is compounded when they see a Black man lying in the street with a police officer kneeling on his neck- the rage they carry has to have a traumatic effect on any Black person... So that has to well up in each Black person a sense of anger, and where is that anger released? How do we release that anger without becoming disruptive?

The illustrative excerpts point to educational and employment disparities, policing, and other institutional forms of racism that create and contribute to deleterious mental health effects for Black Canadians and adverse social and political outcomes for Black communities. These factors are conveniently obscured within a biomedical-neoliberal model of mental health. As such, the model maintains a symbiotic relationship with democratic racism: a biomedical-neoliberal model of mental health dictates the parameters of 'necessary' mental health measures; and democratic racism justifies a biomedical-neoliberal model of mental health that negates radically restructuring unequal social and economic arrangements to improve societal wellbeing. Thus, performative care sponsored by surface-level federal initiatives allows the government to maintain its posture as a helpful and concerned governing body, while it evades creating changes in discursive spaces (educational institutions, courtrooms, political government offices, etc.). The government's reluctance to contest organizational and professional norms that maintain inequality, or challenge positions of power or privilege in society that perpetuate social hierarchies, contributes to an overall climate of anti-Blackness.

Further, the discourse of democratic racism minimizes the activist-oriented and community approach to mental healthcare performed by parish ministers. Through democratic racism, the government veils its inactivity by paying lip service to the importance of multicultural faith-based communities. Indeed, by boasting the rhetoric of Canada as a multicultural and religiously accommodating nation, the government detracts from addressing the increased social responsibilities religious communities have had to adopt in response to the growing number of social programs and services cut by neoliberal policies. As described in the interview data, the delivery of holistic community care was a recurring trope. Parish ministers work to redress food insecurity by hosting monthly food drives, offering temporary shelter for those unable to afford housing, providing free pastoral counselling, offering subsidy for tuition and textbooks to offset student debt, and more, in efforts to provide community aid and relief. These activities are at odds with the government's neoliberal market rationality which forces individuals to assume sole responsibility for providing for themselves, while reducing investments in welfare spending and insisting on the privatization of the state. Thus, in addition to democratic racism obstructing change against power inequalities and unjust social conditions, it concomitantly prevents supporting and resourcing communal care.

d) **The Supernatural**

The final discourse, 'the supernatural,' is a familiar trope in the scholarship on religion and mental health. The belief that mental illness is the result of supernatural causes has been studied and recanted in the literature with varying implications (DeHoff 2015; Dempsey et al., 2016; Mercer, 2013; Wesselmann & Graziano, 2010). Perhaps, the most controversial implication is that The Black Church mishandled the treatment of mental illnesses in their communities by adopting hostile and punitive stances towards those reporting severe mood

disorders or exhibiting psychosis or catatonic behavior (Montgomery, 2020). These actions and behaviors were mislabeled as demonic, the result of divine punishment or immorality and contributed to the stigmatization of mental illness among Black communities throughout the global African Diaspora (Mercer, 2013; Montgomery, 2020). Speaking to a West African context, Araba had this to state on how mental health issues were conceptualized and dismissed:

> *Within the African context, we sometimes see it [mental illnesses] as being haunted either by witchcraft or people who don't wish us well. So sometimes we neglect the mental health issues.*

PHC addresses the fear and trepidation surrounding mental health issues in The Black Church throughout the African Diaspora:

> *One of the issues that I find within The Black Church is that, number one, we're afraid to address mental health issues because we have the tendency to affiliate it with some supernatural effect. I've heard, in my experience that those who were growing up in The Black Church, those who had mental health issues, were demonically possessed, or influenced by some other supernatural spirits whatever the case may be.*

Many participants acknowledged the role The Black Church played in perpetuating stereotypes about mental illness and the church's malpractices when addressing mental health concerns (I.e., exorcisms). Words such as 'magic,' 'demons,' 'witches/wizards,' 'possessed,' and 'diabolical' were littered throughout the data as parish ministers summed up historically popular views about mental illness from their respective contexts. The popularity of the 'supernatural' discourse has endured over time despite significant changes in institutional leadership and practice in The Black Church to address mental health issues (Avent-Harris, 2021; Dempsey, 2016; Robinson, 2018).

I argue the biomedical model's established legitimacy has recruited this discourse to discredit The Black Church as a site of intervention for mental healthcare service provision. Relying on The Black Church's checkered history addressing mental health concerns, the scientific bio-medical model casts a perpetual disdain on The Black Church. I flag the supernatural discourse because its prevalence has shaped how Black parish ministers accept responsibility for mental health service delivery in their congregations. For some of the participants interviewed, the mistreatment and misunderstanding of mental illness led to a restraint in discussing indigenous African healing traditions. There was a deafening silence around ancestral African healing traditions in the data. Interviewees did not discuss indigenous African healing traditions as plausible approaches to nuanced forms of care when asked the pointed questioned: "Do you think Black communities require unique approaches to wellbeing?" While this absence is arguably due in part to the fact that religious leaders are tied to the institution of the church and its corresponding theology, I also contend that the absence is largely the result of the negativity and humiliation that 'the supernatural' discourse has cast on The Black Church. Colonial discourses in counselling psychology characterized religious and spiritual mental health practices as regressive methods of healing spearheaded by "crazed" religious shamans and "demonic" witch doctors (Comaroff & Comaroff, 1992). These stereotypes facilitated the continued negation and conceptual problematization of African indigenous cultures' interpretive frameworks and ways of knowing. The devaluation of indigenous African healing traditions, which were viewed as "backwards" and "barbaric" compared to Eurocentric medicine and methods, functioned as a roadblock to religion and spirituality's inclusion in psychological research and interventions (Comaroff & Comaroff, 1992; Slife & Reber, 2009). Today, the bio-medical model of mental health works to effectively shut

out conversations concerning traditional African forms of healing by attaching a colonial primitiveness to its origins that eclipses the strength of indigenous African spiritual traditions. Unwilling to perpetuate the loss of credibility by associating with traditions that carry stigma, parish ministers have distanced themselves to preserve their reputation and re-establish legitimacy within mainstream contexts. In turn, The Black Church is not a discursive space to explore or recognize alternative spiritual traditions. The exclusion is limiting insofar that it prevents unlocking new scripts for wellness and healing and reaching a broader spiritual audience within Black communities.

Thus, while the discourse of the supernatural has excluded certain considerations on healing, it has also worked to encourage parish ministers' advocacy of mental health and mental health service delivery. The interview data indicates how parish ministers have used the 'supernatural' discourse to reposition themselves as informed healers open to learning and tackling mental health concerns. Unwilling to resign themselves to the mistakes made by their forbearers, for some of the participants actively taking a stance against outdated mental health stereotypes is central to their ministry. Whether it is publicly dismantling stereotypes during sermons, offering greater transparency about mental health concerns via special programming, or privately encouraging individuals to seek external help through referrals, parish ministers have used the supernatural discourse to spur their advocacy. The necessity and imperative of parish ministers performing this work is demonstrated most strongly by Dean II. Dean II recounts an intervention he made where he had to combat stereotypes about mental health which were preventing parents from recognizing that their child had a neurological, development disorder:

> *They have a daughter who was exhibiting a lot of autistic behavior and some of the family members were labeling her as being demon possessed and I'm like, she can get*

help, we can really create an environment in which she can thrive in that state, right? It's just being able to scaffold and give her the right support that the child needs, you know?

PHC engages in mental healthcare advocacy by collaborating with formal mental healthcare service providers to provide educational resources on mental health and coordinate referrals:

*…and I think maybe because we didn't know what it was, we couldn't define it, we couldn't put words to it. And then, as a result, we weren't equipped to deal with it, and so now I'm seeing a trend that's taking place in The Black Church, specifically, where there is much more awareness of it, and so I talked with my contacts as it relates to collaboration. As you mentioned, J*** , I know that she works in that particular field and so she was able to provide myself and some leaders training on dealing with mental health. Also, we have incorporated what we call a "Mental Health and Wellbeing Ministry Department," and it focuses on that particular area because we do have qualified personnel now who are able to operate that.*

Araba passionately declares that mental healthcare advocacy starts with him. He discusses working to educate himself on mental health issues to stop the stigma and promote wellbeing in his ministry:

When I came here [Canada], I also did have that perception [about mental illness]- it's witches. So when I met somebody who was mentally ill, instead of me to welcome that person I tried to turn them away...I've not taken clinical mental health training, but it is something that I'm looking at doing. It's not a requirement, but I want to take my ministry to a different dimension, because as I said, a church is a community of faith where people can find safety and health in times of need. Right? If this is how a church is actually

defined, then I have a role to play. It starts with me, the chief servant. I have to serve them so it is very important for me to get a grip on mental illness and mental wellbeing.

These excerpts capture the tenor of the participants' responses to using their position at the head of their churches, within their local contexts, to change the narrative concerning mental illness in Black communities. Motivated by the poor treatment of mental illness within their respective religious and cultural contexts, and the accompanying dangerous malpractices for treating mental illnesses or leaving them untreated, led to parish ministers' increased efforts to confront the church's role in shaping mental health discourses and mental health service delivery. Relying on 'technologies of the self,' they use their positions of power and privilege to educate themselves, create platforms that advocate for the humanity and dignity of mentally ill persons, and help individuals to access treatment. However, the work remains unfinished, and many parish ministers candidly spoke about acknowledging their shortcomings in addressing mental health concerns, and the need to maintain their momentum promoting mental healthcare advocacy.

The discourses presented interrogate the larger ideologies, cultural histories, social realities, and political contexts structuring Black parish ministers' mental healthcare service delivery. Through an analysis of talk data, I have shown how the discourses of 'credentialism,' 'essential work(er),' 'democratic racism,' and 'the supernatural' work to advance a bio-medical construction of mental health and mental healthcare service delivery. The bio-medical approach, constitutive of a neoliberal and colonial rhetoric informs power- knowledge relations in the field of counselling psychology and emboldens disciplinary powers within the government to undermine, overlook and exclude the work parish ministers perform to foster mental wellbeing in Black communities. However, through the parish ministers' technologies of the self, I have

demonstrated how they work to resist the subjugation and denigration of their labour via alternative approaches to care through their church-sponsored community events, advocacy and activism in the pulpit, and educational training on mental health. The study offers important insights into the ways in which Black Canadian parish ministers engage with and resist hegemonic discourses to advance mental healthcare service provision for Black Canadian faith-based communities. Greater research is required to expand on mental healthcare service provision for Black communities by faith leaders of non-Christian backgrounds (Mattis & Grayman-Simpson, 2013). Further, given the highly interpretative nature of reflexive thematic analysis, and its reliance on the time, place and theoretical framework of the researcher, alternative analyses are encouraged to promote greater reflexivity on barriers preventing holistic and anti-racist mental healthcare for Black Canadians.

A Black Feminist Psychology Framework serves to foreground perspectives excluded from the psychology scholarship, identify power dynamics producing inequities, and prioritize social justice efforts to drive societal change for Black communities. By applying BFP as my theoretical framework, I can rescue the Black Church from the margins of the health promotion literature to include Black parish ministers in the discussion on mental healthcare service delivery. The interview data with the parish ministers offers an important starting point for thinking through decolonized approaches to mental healthcare for Black Canadians. Using BFP, I am able to examine the interactive effects of colonialism, neoliberalism and theism on parish ministers' mental healthcare service provision and attend closely to how these forces work to enable and/or restrict activist forms of care. My aim is to continue to use a BFP framework to think through transformative mental healthcare for Black Canadians that is historically attuned,

politically engaged and culturally responsive. The next chapter presents my interviews with Black therapists and explores how formal mental healthcare service providers can work to integrate religion and spirituality within the normal counselling process to advance more culturally responsive, decolonized care.

Chapter 5- Perspectives from Psychotherapists

Collaborative Partnerships and Clinical Practice

The following section engages Black therapists throughout the Greater Toronto Area (GTA) and looks explicitly at counselling as its primary context. I examine the professional practice of psychology, as "it is the domain in which the interrelationship of psychology and religion is most obvious"[80] (Jones, 1994 p.191). The aim of the investigation is to offer an interrogation of the role of religion and/or spirituality (R/S) in mental healthcare service delivery for Black Canadians *and* explore conditions for creating culturally responsive mental health interventions and outreach programs. Pursuant to conversations with Black parish ministers in the GTA indicating a readiness and willingness to build collaborative partnerships, it is imperative to investigate whether mental health professionals reciprocate these inclinations and to assess their own perspectives for enhancing service delivery for this target population. My examination of therapists' needs and concerns for improving mental health service delivery will help define the contours of a collaborative strategy that balances the strengths and advantages of each actor's capabilities and minimizes the disadvantages of each singular approach.

In the past few decades there has been a substantial growth in the scholarship concerning the necessity of spirituality and religion within the mental healthcare system (Cook, 2013; Moreira-Almeida et al., 2016; Pargament et al., 2013). Despite increased theoretical interest, studies have found that most practicing counselling professionals received minimal formal training to work with religious clients and integrate faith perspectives in their practice (Plumb, 2011). Indeed, a 2001 survey of Canadian psychiatry residents reported that "...almost 72% of

[80] While religion and psychiatry use different vocabularies and methodologies to understand human experiences, their goals overlap and are often congruent (Levin & Chatters, 1998). Religion and psychiatry may both be understood as frameworks used to make sense of "human behaviour and human experiences" (Sullivan et al., 2014, p.1268).

Canadian programs did not offer residents training to prepare them to address the interface of R/S and psychiatry" (Grabovac & Ganesan, 2003, p. 181). The slow integration to address the gap on religion within clinical practice has contributed to the counselling field's decreased multicultural competency (Constantine et al., 2000; Moreira-Almeida et al., 2014; Moreira-Almeida et al., 2016).

The American Psychological Association (APA) has recognized religion as an aspect of diversity that warrants representation and inclusion in clinical work and research (1992), yet has failed to meaningfully address religion and spiritual issues in training curricula and counselling. One of the roadblocks to collaboration with religious leaders revolves around the uncertainty and inability for mental health professionals to incorporate faith perspectives and resources into their treatment programs (Sullivan, 2014). For BIPOC communities, counselling professionals' failure to adequately address theism within the therapy room can potentially lead to erroneous (mis)diagnoses, impact treatment compliance, treatment outcomes, and undermine rapport building (Avent-Harris 2021; Campbell et al., 2012; Cook & Wiley, 2000). Plunkett (2009) reported that lack of spiritual care within treatment planning for Black Americans can also compromise help-seeking behaviours, as they may experience "trepidation" pursuing counselling for fear their religious values and beliefs will be unattended (Cook & Wiley, 2000; Plunkett, 2009 p.121; Plunkett, 2014). In turn, Black therapists that work with primarily Black and/or racialized clientele are deeply impacted by this epistemological violence.

Recent studies have found Black clients seek out and prefer mental health professionals that share the same cultural background[81] (Black Health Alliance, 2015; Cabral & Smith, 2011;

[81] "Clients frequently prefer working with mental health providers of African descent (Cabral& Smith, 2011; Townes et al., 2009), though explanations for this phenomenon vary... Regardless of how one explains the origin or

Goode-Cross & Grim, 2016; Townes et al., 2009;). A Canadian study replicated similar findings, reporting that most African, Caribbean and Black populations (ACB) attributed accessing a provider with similar racial and cultural background as an important factor for improving mental healthcare service delivery (Ottawa Public Health, 2020). Although the reasons for this preference vary throughout the empirical literature (Cabral & Smith, 2011), this reported preference demands that clinicians working with these communities receive training that speaks to salient concerns among this underserved ethno-racial group (Goode-Cross & Grim, 2016). Studies have found that Black therapists report "receiving inadequate training in graduate school about working with Black clients….most of these participants perceived themselves as having not been prepared for the complexities of working in same-race dyads" (Goode-Cross & Grim, 2016, p. 40). These "complexities" are many, and religion and spirituality are just one aspect in which its absence impacts the dynamics of the dyad and the inclusivity of services offered.

The notion that religion or discussing one's religious or spiritual orientation crosses professional boundaries or "is a private matter between the client and their creator" works to negate the importance of theistic considerations in clinical practice, absolve counselling professionals from the responsibility of discussing R/S concerns, and delegates these issues to religious leaders (Chidarikire, 2012, p. 300). A holistic approach to mental healthcare must seek to tackle anti-religious sentiment and increase counsellors' awareness and sensitivity to theological concerns and practices, to strengthen the therapeutic relationship between therapists' and R/S communities. It is important to note that the expectation is not that mental health

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maintenance of this connection, a robust theoretical and empirical literature exists suggesting that Black clients tend to strongly prefer working with Black psychotherapists" (Goode-Cross & Grim, 2016, p.30).

professionals become leading experts in theology (Boyd-Franklin 2010; Constantine et al., 2000). Rather, the acquisition of knowledge about Black religious traditions and beliefs, and the importance of African spirituality and its potential protective and risk factors on wellbeing, may afford therapists the opportunity to offer more culturally competent care within their normal counselling process (Boyd- Franklin 2010; Bryant, 2023, Plunkett, 2014, p. 219).

The historical antagonism between "the couch and the pew" (Sullivan, 2014) warrants a renewed study to create a "respective and productive interrelationship" (Jones, 1994, p.191) of R/S within the profession of therapeutic psychology. As recent studies have shown, and Dr. Thema Bryant's 2023 APA presidency has represented, the mainstream narrative of mistrust, hostility and division between clergy and mental health professionals is beginning to be challenged (Adkinson-Bradley et al. 2005, Avent-Harris, 2015; Sullivan et al. 2014;).

A Black Feminist Psychology Framework values a holistic approach to mental healthcare, which requires closely examining the barriers and challenges of including theistic considerations within formal mental healthcare services. Additionally, BFP foregrounds marginalized voices typically excluded in the counselling and psychology literature to help strengthen mental healthcare service provision for Black communities. As such, the following interviews with Black therapists set out to explore the role of religion and/or spirituality in mental healthcare service delivery for Black Canadians and to think through culturally responsive mental healthcare service provision. The research questions aimed to explore potential strengths, and weaknesses of collaboration with parish ministers, therapists' understandings and application of holistic care, and their perspectives on creating more culturally responsive mental health interventions and outreach for Black Canadians. I generated five themes from the interviews with eight Black therapists: a) Holistic care as contextually situated

and provisional; b) The Great Beyond; c) Lived experiences as the bedrock of culturally responsive interventions; d) Gender variance; e) Religious pluralism. I used these themes to weave together a potential collaborative strategy for parish ministers and psychotherapists to improve mental health promotion, intervention, and outreach for Black Canadian religious communities.

Findings and Discussion. The first set of questions I posed served to elicit whether counselling professionals felt integrating R/S was an important component to providing holistic care. I asked the pointed question, "What does holistic mental healthcare mean to you," followed by the probe, "do you see a relationship between individual wellness, community wellbeing and larger societal living?" The questions prompted respondents to explain a vision of holistic care that is coordinated between formal and community networks, which span across personal, relational and spiritual contexts.[82] The consistency between the answers speaks to the uniform training of counselling professionals offered to the participants within their graduate education. For instance, three interviewees repeat the exact same key words — "interconnectivity," "environmental factors," and "multifaceted" in their definitions. The collective utterance can be summed up in Seer's following response:

> *Well, I think that mental wellbeing has to impact all aspects of who we are as humans. And so I think there is the physical, the environmental, the spiritual. And I think all those realms need to be monitored and connected as part of individuals' foundations… so holistic for me means identifying and recognizing the*

[82] Holistic care was also understood as including but not limited to addressing socio-political and economic inequities.

elements that makes us human. And it also includes, connection and community, and the importance of social participation.

The uniformity in responses indicates a general knowledge of and importance accredited to addressing "all aspects" of an individual, including their religious and spiritual inclinations. In fact, many interviewees commented on the significant role of R/S on their clients' mental health journeys. For CF's clients who were experiencing isolation and loneliness, religious and spiritual traditions served as a lighthouse in their darkest hours:

> *I've seen spirituality and religion being able to provide a sense of hope, security, reassurance and even love. I have a lot of clients experiencing isolation and loneliness, and a belief in a higher being or something for them to connect with, comforts and grounds them.*

For SB, her Black clients in particular value R/S to bring them solace and peace of mind:

> *I do find that my Black clients, more than any other group of clients, will identify with religion as either a part of their identity, or will rely on some religious ritual, like praying or going to church or reading their Bible, to help them cope and bring some sort of comfort to them.*

However, despite the uniform acceptance of R/S within holistic mental healthcare and the necessity of attending to it, when participants were questioned how they integrate R/S within their holistic mental healthcare approach, a less homogenized response was elicited.

a) Holistic care as contextually situated and provisional

Holistic care as contextually situated and provisional encompasses therapists' fluid and diverse approaches to applying holistic mental healthcare in practice. Whether or not R/S perspectives were included in their holistic care was largely contingent on the therapist and their comfort

introducing religion and spirituality into the therapy room. For Avon, holistic care entailed using the client's identified psychosocial resources to help them achieve a state of wellbeing:

> *… I think that we need to take a holistic approach when working with people, particularly in mental health, and you know, wherever people can find solace and comfort be open to go there with them, right? Yeah, that's kind of how I see it.*

This flexible and broad approach to holistic care, was contrasted by respondent CC who felt holistic care more precisely embodied "5 pillars of wellness," the first of which was spiritual:

> *For example, one of the things that I do with my clients, maybe around the third or fourth session, is we do something called a "Soul Care Plan-" where we do the five essentials of soul care from a holistic standpoint. Let's see if I can remember them- so spiritual care, mindfulness, body care, self-love and acceptance, and community.*

The variability in approaches suggests that despite the uniform acceptance of R/S within holistic mental healthcare, execution is less standardized and rehearsed. For some of my participants, creating space to discuss R/S, equated to creating an environment in which the client felt safe to be vulnerable and have their values affirmed. In contrast to CC who foregrounded "spiritual care" in her practice, therapists' integration of R/S perspectives within their holistic mental healthcare approach largely depended on whether the client explicitly introduced the topic during their sessions. This in turn places the onus on the client to bring R/S into the therapy room. Unfortunately, due to the checkered history of religion and science, and the stigma associated with secular help-seeking among religious communities, clients can be operating under the assumption that R/S is not within the realm of formal care (Plunkett, 2014). As Lucky 7 notes:

> *In the beginning, I think a lot of people assume that spirituality and mental health can't fit in the same space-because in a lot of cultures, especially working*

with Black, Indigenous and people of colour- you have people growing up feeling that the two things are mutually exclusive or that one must supersede the other.

Therefore, an individual's reticence to discuss R/S in the therapy room, coupled with a service provider's own apprehension or dismissal of R/S, can serve to dissuade clients from disclosing their R/S status, and ultimately function as a barrier to receiving help. As such, counselling professionals' directly inquiring about R/S can offer a more affirmative approach and create an opening for the individual to either discuss or decline speaking about it (Crisp, 2011).

Avon reported that they openly inquire about a client's religious or spiritual orientation:

The interesting thing is that I don't find that people overtly state it. I have to actually bring it up. So it's not like, "this is what I do for coping." It's one of those things where after more discussion it eventually comes out, so I've started asking at intake. And I've found that if they are religious, they do report that religion and religious practices are a way of kind of getting them through.

RB noticed a palpable relief from her clients when she introduced R/S in the room:

I feel and I've seen a lot of people experience a sense of relief when I'm like "Oh yeah, I'm a Christian!" Or asking, "how are you in touch with your spirit, and what does that mean?" Or even just being open to discussing whatever their religion or spiritual traditions are. They have found it refreshing...I've had some clients ask that we pray, and I'm like, "Yeah!" We open up the room to include that. I believe that we have to identify and target all parts of people.

These counsellors' inquiries of religious and spiritual traditions at intake presents a proactive and assertive approach to address R/S in the therapy room and offers insight into coping methods for the client. It is a strategy that is in line with the scholarship that has found "service users need

opportunities to discuss their religious and spiritual beliefs, and the strengths, difficulties and needs that arise from them in environments where they are free of judgment" (Furness & Gilligan, 2010, p.44). In Canada, Baetz et al. (2004) found 53% of Canadian psychiatric patients would welcome inquiry about their faith perspectives and spiritual needs.

b) The Great Beyond

Interviewees discuss how the *afterlife* of slavery[83] impacts their clients. Clients' experiences of intergenerational trauma and social injustices are recognized by therapists as requiring a holistic approach that moves beyond biomedicine. Participants also recognize healing from systemic racism requires resources and communal support that *extend beyond* their clinical practice. Lucky 7 stated the following:

> *The way that I like to look at it –and an analogy that I always use- is like luggage at an airport. I feel that racialized individuals walk, carrying these bags without being asked to carry them. You never asked to hold on to them, but you have to carry them ...whereas other people might get to pick and choose which bag they want to carry in life. I think that's a huge piece in therapy, because there are things that you have to deal with as a racialized individual that we never asked to deal with. They came from generation to generation, and I think it's so important to recognize that the healing journey for those individuals, the unpacking, is going to look very different from non-racialized people.*

For Lucky 7, while the work may start in the therapy room, it doesn't end there. Addressing intergenerational trauma requires also targeting the systems and exploitive conditions that have started and perpetuated the cycle. CD had this to share:

[83] Saidiya Hartman coined the term the "afterlife of slavery" to refer to the "skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment" that people of African descent are forced to contend with in modern society (Hartman, 2007, p.6).

Holistic to me, especially because I work with many Black and Indigenous folks- considers all the social factors that really contributes to the problem that is at hand. It strays away from 'what have you done to cause this problem? And why aren't you doing more of this' to 'yes, there are a lot of circumstances outside of your control, and there are a lot of systemic issues and barriers that have contributed to this problem, so how might we identify and unpack that'. There're so many different ways that systemic violence is hurting us, and so a holistic approach should consider how can we better understand your circumstances and prepare you for them.

Lucky 7 and CD's responses, like many others interviewed, (including the parish ministers), implies that providing holistic care concerns addressing systemic issues within society that impact a client and often extends beyond the tools and resources available within a therapy room. A benefit of collaboration between therapists and parish ministers can be expanding the range of holistic care and material support to their clients. Although the scope of a mental healthcare service provider is limited, existing external and informal networks can help expand the coverage of care required by a client to improve the efficacy of psychotherapy's practice. For example, church related organizations and religious groups can help provide resources and tools to service the needs of disenfranchised community members (Crips, 2011). Indeed, through collaboration counselling professionals can direct clients to make use of free programs sponsored by faith community leaders and their congregations that aim to relieve systemic disparities encountered by Black communities. Such religious services may include housing and food programs, subsidized legal aid, educational scholarships, etc. Including community specific services to address the exploitation of their clients can help counselling professionals to radicalize the therapy room. Here, holistic care can merge individual change (attitudinal/ personal) with the

social justice initiatives (social, political, and economic) required to improve the overall wellbeing of a client. Collaborative partnerships with faith community leaders can thus strengthen the support needed to address larger social inequities disproportionally impacting Black communities.

Collaboration between parish ministers and mental health professionals may also help counselling professionals to extend interpersonal support within the therapeutic relationship. For instance, counselling professionals can rely on community faith leaders to offer extra collegial support to their clients when they feel a patient may require greater mentorship or communal support. This is particularly useful for Black mental health professionals, as they may not be able to model this more intimate level of support. Goode-Cross and Grim (2016) found Black therapists' experiences in same-race therapeutic dyads can potentially lead to over identification and enmeshment in the relationship. Counselling professionals shared cultural histories and experiences of racial disparity within a same-race therapeutic dyad can contribute to this higher potential for countertransference (Goode-Cross & Grim, 2016). Thus, collaborative efforts between parish ministers and counselling professionals through dual or complimentary treatment plans can help counsellors maintain professional boundaries while still increasing the level of support and solidarity required by a client to feel safe to explore their personal mental health needs and social justice concerns. This in turn may help to improve treatment outcomes (Avent-Harris, 2021; Cook & Wiley, 2000).

c) Lived experiences as the bedrock of culturally responsive care

'Lived experiences as the bedrock of culturally responsive care' captures the knowledge base participants draw from to create and undertake unique approaches to wellbeing for their Black clients. Seer expressed the following:

I definitely work from a trauma informed perspective. And so I think we need to ensure that Black people have access to therapists who have lived experiences. It doesn't mean that they can't go to a therapist who isn't Black, but if they do, those therapists should have some awareness of the nature of what goes on in their communities, in their lives and their environments.

For Seer, lived experiences offer a strong foundation for building a good rapport and adopting a trauma informed approach to therapy that recognizes the systems of oppression that Black communities face. Lived experiences can also help to inform culturally responsive interventions missing in the traditional therapy room. A number of the interviewees discussed that many of the exercises in their training curricula often did not translate into clinical settings with their Black clients. These statements are in line with emerging scholarship reporting the incongruence of therapy modules developed in westernized settings and uniformly applied without regard for cultural worldviews (Cook & Wiley, 2000; Sue & Sue, 2008). Unsurprisingly then, many counselling professionals have shouldered the responsibility of adapting their learning tools and activities to make them more applicable to the clients they serve. The study participants interviewed discussed at length the necessity for this and offered a few examples of adapting their exercises to resonate with Black clients. CC emphasized storytelling as a culturally modified exercise:

For me it's bringing in a lot of analogies and metaphors, and I think those are really huge in a lot of racialized communities and cultures. It's bringing the storytelling aspect of something in, and it's not always about worksheets and filling out homework assignments.

For Avon, it wasn't only about modifying the exercises but also about changing the dynamic in the therapy room:

> *It's funny, I was actually having a conversation with a couple of colleagues and we were talking about how the way that we were taught how to counsel and do therapy sometimes doesn't serve the people who are actually coming to see us. Now, I'm seeing a lot more Black people being open to therapy, but the way that they taught us how to engage isn't necessarily always the way that I would say that I engage. I find that we're taught that "you're the professional" and in some cultures, that's just not how we communicate. Right? It's not very cookie cutter, it's not top down.*

For Lucky 7, this labor is difficult but an expected burden for Black counselling professionals in the field:

> *I think most of them [Black counselling professionals] understand working with racialized individuals that I'm going to have to do more in depth learning because our curriculum that we learn from doesn't always include that... I always feel like it's important for me to be creative in the modalities that are there. The way that they're created is not necessarily created for racialized communities, so it's knowing that you're going to have to tweak things. You're gonna have to learn things on your own, and I think that was one thing that I knew, that I'm going to have to read in between the lines to continue to support the community that I want to work with.*

This trend is noteworthy for collaboration because it further amplifies a need for more culturally appropriate programming within these spaces. Therefore, a strength of collaboration could be capitalizing on Black parish ministers' lived experiences with improving wellbeing in their faith communities, to help create more culturally responsive interventions. An undeniable strength of

parish ministers and their accompanying religious institutions is their charismatic and personable appeal to Black masses. Through parables, songs, laying of hands and oral testimonies, Black religious leaders have found means to connect across class divides and regional differences within their congregations and inspire healing (Cook & Wiley, 2000). Parish ministers can serve an important and unique role in thinking through culturally competent psychotherapy practices that rely on and borrow from traditional styles of worship, cultural legacies and celebrations to help Black-counselling professionals in their efforts to engage and connect with their clients. Dempsey et al. (2018) believes that culturally relevant practices engineered in Black religious institutions can offer insight to counselling professionals seeking to work with this target audience.

Additionally, parish ministers' lived experiences teaching and studying the Bible, can help assist counselling professionals with including faith perspectives into treatment plans. Indeed, a working partnership can help counsellors draw on scripture passages within their clinical practice that can help encourage religious individuals' receptiveness to the counselling process. Plunkett (2014) uncovers several passages in the New King James (NKJ) Bible that emphasizes God provides "indirect intercessors" to assist healing, and may be used to advocate formal mental healthcare as not indicative of lack of faith, but a practice of faith works (Plunkett 2014; Sullivan, 2014). Together, a collaborative effort between parish ministers and counselling professionals can help to widely promote the importance of seeking professional help and prepare counsellors to make space for faith communities in formal care settings.

d) Gender Variance

Gender Variance addresses participants' experiences of the gender gap in caregiving and help-seeking and the necessity of amplifying gender-neutral mental health discourses. When

participants were questioned, “What are the demographics of your clients” seven out of eight declared that their clients were primarily either Black women or women of color. This disparity in help-seeking is likely the result of the historical feminization of mental illness and madness (Chesler, 1972). Unfortunately, this enduring negative trope, coupled with the cultural stigma of mental illness in Black communities, has served to relegate concerns of mental health and wellbeing to the jurisdiction of women. Indeed, the mental health profession itself is largely dominated by women. This fallacy has created a divide in the number of Black men and Black women who seek mental health help (Robinson et al., 2018). While Black individuals are less likely to seek formal mental healthcare than their white counterparts (Ayalon & Young, 2005), Black men are even less likely to pursue professional mental health services than their female counterparts (Avent-Harris, 2021; Robinson et al., 2018). If formal mental healthcare settings are read as a space for women, other institutional settings will need to step in to counter these misconceptions and increase their participatory efforts in mental health advocacy. Collaboration between therapists and parish ministers may offer a more gender inclusive approach to tackling mental health stigma.

Robinson et al. (2018) identified The Black Church as an influential and important site to discuss Black men’s mental health. Within Black churches, men are more likely to hold positions of authority and overt leadership roles (Avent-Harris, 2021; Cook & Wiley, 2000). While the patriarchal structure of religious institutions is not above reproach or critique, it can serve as an important vehicle in disseminating information and leading discussions on mental health. As Avent-Harris (2021) argues, Black parish ministers can represent a powerful and influential role in the lives of Black Church communities and can help serve as a liaison for Black community

members and counselling professionals. Many participants interviewed felt similarly about the influence of parish ministers. As RB states:

> *I think it's [collaboration] very important because then it allows the congregation to recognize that mental health is not taboo, especially if their pastor, their minister, is encouraging them to go to therapy. There is trust and familiarity there.*

Parish ministers' access to Black men, youth and boys in these sacred spaces can open the practice of psychotherapy to a wider audience that does not typically seek formal mental healthcare services. Encouraging Black men to be a part of the conversation about mental health and being intentional in how to diversify and include the perspectives of Black men within formal mental healthcare will benefit counselling professionals and the field of mental health more broadly (Black Mental Health Alliance, 2015). Indeed, enlisting male leadership to engage in and create spaces for discussion about mental health can begin to 1) improve outreach interventions for this target population 2) make formal care settings more inclusive and safer for this underserved group (Robinson et al., 2018).

e) Religious pluralism

Religious Pluralism refers to therapists' attempts to hold space for R/S polarizing nature. It encompasses three sub themes: i) religious trauma, ii) superstition, and iii) variability. Interviewees recognize that integrating religious perspectives exists at the intersections of healing and harm, superstition and the sacred. Additionally, 'religious pluralism' refers to therapists' considerations of integrating R/S in their practice as a multi-faceted undertaking. I use this overarching theme to explicate therapists' specific concerns about collaboration with parish ministers.

i. *Religious Trauma*

When participants were asked, “What do you imagine would be the weaknesses of collaboration?” three main concerns were listed. The first concerned religious trauma. Religious trauma is a broad umbrella term and defined “as pervasive psychological damage resulting from religious messages, beliefs, and experiences… Unlike many forms of trauma that occur through acute incidents, religious trauma generally accrues gradually through long-term exposure to messages that undermine mental health” (Stone, 2013, p.324-325). RB shared the following example:

> *For example, I had a female client, where there was domestic abuse, and at times they would share some of the advice they were given by pastors, which usually were supporting them staying in a situation that was not safe for them. So that's why I think collaboration is so important because you know, they [parish ministers] often may put clients at risk with that advice.*

In this instance the pastor prioritized the sacrament of marriage over the safety and wellbeing of the parishioner. The client’s decision to stay in a violent domestic relationship as a result of the guidance and instruction of the faith leader led to her experience of religious trauma. Religious trauma can also take the form of exclusion and marginalization of certain communities (Stone, 2013). Interviewees raised specific concerns around Christian doctrine shutting down conversations about sexism, gender identity and sexual orientation. Seer had this to share on the matter:

> *I feel like they [parish ministers] also need to be more open to broader gender issues, particularly in the Black community. You know they're not so open to various gender identifications and so that's where a therapist is different... So sometimes they can shut people down in their congregations and it can be very traumatic.*

These concerns, which were shared by many other of the interviewees, are in line with the scholarship that have found "in many Black churches, women and lesbian, gay, bisexual, and transgender (LGBTQ+) members are discriminated against, excluded from leadership positions, and further marginalized" (Avent-Harris, 2021, p.16; Heard et al., 2018; Robertson & Avent, 2016). A parish minister's regressive and violent attitudes on this matter can threaten a working relationship with mental health professionals who adopt more progressive and liberal views on sexuality. These matters cannot be taken lightly and can pose unique challenges for collaboration. One likely solution is for counselling professionals to meet with the assigned pastor to ask them their personal opinions on LGBTQ+ rights and practices of inclusion. Some parish ministers may have adopted less hostile stances of the queer community and encourage love and acceptance of all their members (Robertson & Avent, 2016).

Conversely, for parish ministers that represent more intolerable positions, counselling professionals can limit their collaboration and choose to serve as a point of contact for parishioners who are seeking counselling on this matter. In truth, it is difficult terrain to walk; mental health professionals have the right to decline working with groups or organizations that they feel may compromise individuals' wellbeing. However, to abandon religious institutions that do not recognize or accept gay rights, potentially leads queer church community members without the necessary mental health supports that they so deservedly need (Robertson & Avent, 2016). Greater research is required to determine how navigating these polarizing perspectives may be addressed in a manner that places the client's wellbeing at the forefront and promotes respect, sensitivity and the dignity of all parties involved.

ii. *Superstitious beliefs about mental illness*

A second potential drawback of collaboration as reported by the counselling professionals concerned working with superstitious church leaders. Many of the interviewees felt that working through supernatural beliefs about mental health could create roadblocks to collaboration. SB shared how this stance is manifested in Ministry:

> *What they're experiencing, their distress or various mental health symptoms is viewed as a sort of punishment or worst, that they are somehow possessed and that somehow, they can pray their way through the problem.*

Beliefs about mental health issues as the result of witchcraft, demonic possession or lack of faith sometimes espoused by Black religious institutions and their leaders was presented as a potential barrier to collaboration. Parish ministers who adhere to this logic may believe that help for their parishioners is only possible through divine intervention. Avon discusses the dangerous nature of these beliefs and how these superstitious theories can deter individuals from seeking secular help. She had this to share:

> *I think that if you have someone who has decided that they're not going to attend to their mental health needs because they attributed it to, whether it be religious or supernatural reasons, sometimes people may be less likely to seek support, or it could just be like, "this is just how I was made" or this is how "I'm being punished," and sometimes that can be an excuse for not seeking help.*

Under these circumstances, insistences of witchcraft and religious bypassing can sometimes prevent individuals from being proactive in seeking help for their mental distress. More concerningly, these beliefs may serve to prevent individuals from taking accountability for destructive habits that may be contributing to their poor mental health (Harris et al., 2006; Sullivan, 2014). As such, parish ministers that declare mental illness is the result of evil spirits

and contribute to the stigma surrounding mental illness are likely to conflict with counsellors who are actively working to break down these erroneous stereotypes. As CD states:

> *Within The Black Church, mental health in general has been so heavily stigmatized, and so for so long I've had folks who were like, 'OK, there's something wrong with me, the devil is working within me,' and I try to work through that with them to destigmatize it and have them formulate a better understanding and relationship with their own mental health, and in turn, develop a better understanding and relationship with their own faith and spirituality, and how the two can coexist.*

As shared by CD and reiterated by other study participants, counselling professionals are already engaged in the difficult work of combatting mental illness stigma with their clients. As such, parish ministers who are unwilling to stop spreading superstitious beliefs surrounding mental health issues will pose a significant challenge to collaboration.

iii. *Variability*

A third and final primary concern of collaboration raised by the participants addressed more generally the breadth of incorporating R/S. Many of the counselling professionals emphasized the importance of integrating R/S but spoke candidly about how large of an undertaking collaboration would need to be to attend to the sheer diversity of religious expression and thought. For example, collaboration with faith leaders outside of Christian contexts, such as Imams and Rabbis would also need to be prioritized to achieve inclusivity. Moreover, one counselling professional in particular voiced concern of how to address spirituality and faith outside an organized system of religion. CD states:

> *Even working with my clients though, it's how they want to define religion and spirituality, right? Because the reality is we all understand faith in such different ways.*

Regardless of if we're members from the same religion, our approach, our understanding, our experiences are so different. There is so much religious diversity and different ways of relating to the sacred.

As CD indicates, R/S is a widely expansive field. Additionally, given the diversity of Black communities, intra-cultural differences would also need to be accounted for when addressing spiritual and religious issues (Boyd-Franklin 2010; Constantine et al., 2000). Although the intention of collaboration is not for counselling professionals to become leading experts in theology, the weight of the responsibility to engage religion in a well-informed and genuine manner was reported as feeling daunting. Moreover, increasing trends towards secularity in contemporary society may result in clients pursuing new measures for meaning-making outside established religious traditions (Cook, 2013). Thus, greater consideration is required for how counselling professionals can increase their competence to tackle spirituality outside religious observance.

Although the research on integrating R/S remains extant, and additional controlled trials are required to inform the design of religious and spiritual interventions in counselling (Koening et al. 2012; Sullivan et al., 2014), the qualitative interviews help explicate the complex relationship between R/S and the therapy room. The interviews offer valuable information on how collaboration between parish ministers and counselling professionals may improve Black Canadians' mental health treatment interventions, outcomes, and outreach. As informed by the counselling professions interviewed, a collaborative partnership was understood as offering: a) holistic care that is inclusive of spirituality and religious perspectives; b) an expanded network of support to address personal and social justice issues; c) culturally relevant therapeutic interventions that transition into clinical settings and d) larger platforms to stage conversations

tackling stigma about mental illness. These benefits will serve to improve overall service delivery for Black Canadians by creating more historically attuned, politically engaged and culturally responsive mental healthcare. The advantages presented by the therapists do not significantly depart from the benefits enumerated by the parish ministers. Despite the differences in trade and training, their responses indicate an awareness of the limitations of their singular approaches to wellbeing and the necessity for joint efforts to achieve comprehensive mental healthcare for Black Canadians.

Important distinctions present in the interviews with parish ministers and the therapists are the concerns listed as obstacles to collaboration: a) the potential for creating or perpetuating religious trauma b) navigating parish ministers' superstitious beliefs regarding mental illness and c) accounting for the sheer breadth of religious expression and diversity that exists within the heterogeneity of Black communities. Further investigation into these concerns is required to develop "meaningful counselling interventions" that account for the nuance and complexity of Black Canadians, and their varied relationships to R/S (Adkinson-Bradley et al., 2005, p. 153).

Overall, the apprehensions voiced serve as reminders of the work that lies ahead; creating a solid foundation for collaboration will not unfold overnight. As summarized in the interviews with the parish ministers and the therapists, some of the changes that need to be undertaken include: increasing the capacity of counselling professionals and community agencies to deliver mental health literacy to community faith-based leaders; dedicating financial resources towards increasing knowledge transfer of best practices of R/S in the therapy room, and developing comprehensive training materials that encompass religious values and spiritual beliefs that meet the ethical standards and practices of the profession. While these changes are not insurmountable, collaboration between parish ministers and counselling professionals remains an

area for continued exploration. My application of a Black Feminist Psychology Framework allows me to foreground Black therapists' perspectives on strengthening mental healthcare service provision for Black Canadians. Their insights, combined with the parish ministers' offers new strategies for strengthening outreach efforts and treatment interventions for Black Canadians, which can significantly improve mental healthcare service delivery for this target population. Indeed, psychotherapists and parish ministers' collaboration can honour Black communities' historical relationship with the spirit and mind (Nobles, 2015); assist in advancing a social justice mental health praxis by creating larger networks for solidarity and support; and combine cultural practices of healing that uplift and empower Black communities against psychosocial stressors they may encounter.

Chapter 6- Prescribing New Scripts

This chapter engages Black feminist literary works on mental wellbeing to examine what models they may present for thinking through culturally responsive mental healthcare interventions for Black communities in the African Diaspora. I begin by outlining the necessity for the inclusion of novels within an empirical study on Black Canadians' mental health. I discuss the origins of storytelling for Black communities for sharing and transmitting knowledge and contend that its exclusion from western epistemologies is a colonial erasure. I argue that including novels within the mental health field can offer innovative ways forward for improving mental healthcare service delivery for Black communities. Lastly, I perform a thematic literary analysis of three novels: *The Book of Emma* (2006) by Marie Célie Agnant, *Transcendent Kingdom* (2020) by Yaa Gyasi and *Possessing the Secret of Joy* (1992) by Alice Walker. I carefully attend to how these creative texts position decolonized mental healthcare as a mode of resistance to the historical, and socio-political conditions that impact one's wellbeing. I use these creative texts as a model for considering the implications of a new ethics of care that inspires innovative healing and recovery for Black Canadians, and unpack the texts' implications for reimagining collaboration between informal and formal mental healthcare service providers.

Thematic Literary Analysis

> All social research, regardless of design, is a story. All evidence of social phenomena, regardless of method, is story-telling. All social learning derives from stories. Theory itself can be considered another form of story: a story of ideas (Labonte, 2011, p. 154-p.155).

The oral tradition of storytelling is an ancient form of knowledge mobilization and translation among African peoples from time immemorial.[84] It is not unsurprising or unexpected then that stories continue to function as an important means of knowledge construction, validation and mobilization for Black writers and audiences. Despite the efforts of the Natural Sciences to disregard that which cannot be measured or deemed objectively true, or mainstream psychological science's tendency to undermine and overlook qualitative data and non-western epistemologies, stories have traditionally undergirded social science research. The study of the mind and human consciousness as a purely scientific pursuit was itself a fabrication recanted and reinforced by Enlightenment thinkers. Yet, even on a less abstract and historical level, stories are involved at every point in a social research experiment design: Beginning with the story one tells themselves as to why they are pursuing a specific question, to theorizing a hypothesis for how X influences Y (a fictional assumption of causality), all the way through to the story they choose to draw out from their findings (Jones, 2015; Labonte, 2011). If theorizing is fiction, then fiction, too, can theorize (Jones, 2015). Therefore, in line with my methodological framework, I pull back the veil on the dismissiveness and omission of fiction in social science research and encourage the utility of novels for my investigation.

My Black Feminist Psychology Framework values stories as an important epistemological paradigm. Black Feminist Psychology takes as its premise that decolonizing knowledge on Black Canadians' mental healthcare service delivery and treatment preferences requires extending knowledge producers on the subject matter and centering their unique forms

[84] For African-descended people in the Americas, cultural traditions, and practices, such as storytelling, were carried across the Middle Passage in place of material artefacts.

of theorizing, such as storytelling (Hooks, 2006; Jones & Harris, 2019; Phillips, 2006). Within an "afrocentric cultural ethos" it is understood that "knowledge can be obtained through the use of symbolic imagery" (metaphors, parables); however, this has been undercut in Western social science research (Phillips & McCaskill, 2006, p.89). Moreover, the role of Black women as "healing agents in their personal lives and communities" is underplayed and undervalued in psychology scholarship (hooks, 1993; Jones, 2015, p. 33; Oliphant et al. 2022). This remains true, despite Black women's continued attention and activism towards addressing the plights of their communities. Black women as the primary caregivers of their communities is overlooked in discussions on empirical mental health interventions, service provision and outreach programs (Brown & Keith, 2003; Jones & Harris, 2019). Thus, my methodological approach is to position Black women's creative works alongside Black feminist political theorists, and Black womanists to rearticulate and reimagine new scripts on wellness. My examination will make the case for the integration of Black feminist novels in the study on psychological wellbeing for Black communities to help transform mental health service delivery and expand on the treatment interventions available.

Indeed, this chapter presents alternative healing discourses, rooted in Afrocentric worldviews and Black feminist values around emancipation, spirituality, and communal solidarity. The creative texts I examine present tactics of resistance to racist and sexist oppression and insist on survival against pathogenic socio-political conditions. Ultimately, these creative works promote mental healthcare strategies that recommit to traditional systems of knowing, reimagine the bounds of communal support, and transcend the logics of neoliberal care. Questions of healing and mental wellbeing in a climate of anti-Blackness are explored in the three novels presented here for investigation. Through a thematic literary analysis, I examine

authors' portrayal of conditions contributing to poor mental wellbeing for Black folks, how healing from mental illnesses is presented, and whether the reoccurring role of spirituality in these texts might suggest an alternative point of access to achieve culturally relevant, historically attuned, and politically engaged mental healthcare for Africans in the Diaspora. Below, are the detailed findings of my investigation.

The Book of Emma

Many Black feminist creative writers have challenged the limitations of a western episteme of mental healthcare (Wilentz, 2000). Indeed, mental illness in the context of imperialism, white supremacy and the encumbering legacies of the Trans-Atlantic slave trade is a central preoccupation of many Black feminist cultural productions (Collins, 2000). Authors' ruminations of 'wellness' and 'illness' afford them the power to create new discourses on healing that acknowledge historical traumas and articulate new measures of survival in the wake of slavery. In turn, authors can serve the dual function of both world-making architects and healing agents. Marie Célie Agnant, Haitian-born (Port-au-Prince, Haiti), Montreal-based writer, tackles madness and mental wellbeing powerfully in *The Book of Emma* (2006). Her novel serves as an important springboard for my investigation exploring mental healthcare service delivery for Black Canadians. *The Book of Emma* discursively points to the shortcomings of mental healthcare for African diasporic peoples and highlights the very stakes of my project. The novel illustrates that working and thinking through a more ethical model of mental healthcare service delivery for Black communities requires deeper consideration of the broader historical, political and socio-cultural conditions that interweave to marginalize Black life. *The Book of Emma* demonstrates the ethical impetus to reframe mental healthcare to account for the historical,

political, and social contexts of Black injustices to achieve transformative decolonized mental healthcare service delivery.

Agnant's novel shapes the contours of my investigation by examining the very pertinent issue in her work: What are the shortcomings of mental healthcare service delivery for Africans in the diaspora? By narrating the patterns of violence structured by slavery and its attendant neocolonial forces (psychiatric care and policing), Agnant offers her readers compelling insights about living in the afterlife of slavery. *The Book of Emma* begins with the protagonist, Emma Bratte, confined to a psychiatric hospital for allegedly committing the murder of her three-year-old daughter, Lola. An interpreter by the name of Flore is assigned to Emma to help translate her Haitian-Creole testimony, and to assist the leading psychologist, Dr. Ian MacLeod, in determining her fitness to stand trial. Emma recounts a provocative narrative of both her own troubled childhood and her ancestors' struggles against slavery. Her story transcends time and space, as she recounts a cultural memory, passed down from seven generations of women in her family, of colonial occupation and the slave trade, and its enduring ramifications. The novel concludes with Emma's suicide, which she refers to as her return to the "route of the big boats," in a poignant reference to the Middle Passage (Agnant, 2006, p.201). In the novel, Emma is unable to receive appropriate care within a westernized mental healthcare system. Confined to her hospital room, Emma faces a mental healthcare system that actively participates in the erasure of Black suffering.

Agnant represents traditional biomedical approaches to mental healthcare as profoundly limited in their ability to address historical wounds, which then bleed and fester into present day injustices. Dr. Ian MacLeod is unable to grasp the intergenerational trauma impacting Emma's wellbeing, and thus constructs her as incomprehensible: "This is all I've been able to observe" he

murmured, waving the pages in the air. “It's only about blueness: the blue of the sky, the blue of the sea, the blue of Black people's skin, and about the madness which is supposed to have come over in the holds of the slave ships” (Agnant, 2001, p. 10). Dr. MacLeod's inability to understand the trauma of the trans-Atlantic slave trade and his Eurocentric mental healthcare service provision falls short in the face of Emma’s embodied history of trauma. Emma is keenly aware that Dr. MacLeod does not have the knowledge or the political consciousness to truly attend to her and make her well. As Emma critically remarks to Flore: “With their big words, they now claim to be studying the signs of madness in Black women, while they refuse to understand what happened on the slave ships and on the plantations” (Agnant, 2006, p.35). Her suspicions are confirmed by Flore, who observes that for Dr. MacLeod, Emma is “no longer a human being, but a case, a file, perhaps, even an object in room 122” (Agnant, 2006, p.197). Within the mental healthcare system, Emma is dehumanized and dismissed. Even Emma's assigned social worker is not equipped to make sense of her suffering: “If you want my opinion on Emma, I don’t have one. It's too complex, too weird. I don’t have the keys to unlock it” (Agnant, 2006, p.16). *The Book of Emma* depicts a mental healthcare system that “refuse[s]” to grapple with the weight of history, and by extension, map a way forward for those of African descent (Agnant, 2006, p. 35). This shortcoming prevents Emma from experiencing healing under the supervision of Dr. MacLeod and exacerbates her existing feelings of alienation, which only perpetuates further harm to her. In fact, under his care she is rendered incorrigible and intransigent. Yet, it is through Agnant's juxtaposition between Dr. Ian MacLeod, and the relationship that develops between Emma and Flore that the novel gestures towards a path of decolonized mental healthcare service delivery that may help serve the mental health needs of Black people living in the African Diaspora.

Dr. Ian MacLeod is unable to deliver Emma historically attuned, politically responsible or socially engaged mental healthcare. Conversely, Emma and Flore are able to model an ethics of care in which, and through which, those conditions are met. Indeed, through freedom-making practices and wake work, the two heroines present what Michel de Certeau coins “condition(s) of possibility” for mental healthcare service delivery (de Certeau, 1993, p.158). Freedom-making practices may be understood as a manifestation of Robin Kelley’s “freedom dreams,” which entails a steadfast commitment to envisioning freedom outside one’s immediate “circumstances/constrictions” (Kelley, 2022, p. xi). Freedom dreams, through a politics of hope and love, can enable new liberatory possibilities and social movements (Kelley, 2022). As such, freedom-making practices speak more concretely to the *actions* one can take in service of freedom dreams. Decolonized mental healthcare must be invested in helping to co-author and sponsor freedom-making practices for Black communities to achieve self-determination. These freedom-making practices can occur both at a broader political level or within the quotidian. Moreover, Christina Sharpe’s “wake work” refers to “...a mode of inhibiting *and* rupturing” the afterlife of slavery (2016, p. 11). Despite the variations of wake work, at its core, it demands processing and unpacking the conditions that produce anti-Blackness, and insisting on Black peoples’ survival and resistance in the wake of slavery: “while the wake produces Black death and trauma [...] we, Black people everywhere and anywhere we are, still produce in, into, and through the wake an insistence on existing: we insist Black being into the wake” (Sharpe, 2016, p.11). Together, freedom-making practices and wake work can help target and uncover colonial processes that continue to compromise wellbeing for Black communities and help to promote Black liberation against systemic and institutional oppression. Thus, the objective of decolonized mental healthcare must not end at ensuring an individual is well enough to return to the damning

conditions of society, but rather, when the individual is well enough to help transform pathogenic social conditions, and empower others similarly burdened by the structural legacies of slavery and colonialism. In this way, mental healthcare adopts a historical and socio-political orientation. In the novel, a united alliance between Emma and Flore serves as a freedom-making practice against the historical legacies of colonial systems.

Freedom-Making Practices: Political and Ethical Alliances

At the start of the novel, Flore is assigned to help translate and interpret Emma's testimony. Dr. MacLeod has been attempting unsuccessfully for two months to communicate with Emma and retrieve her testimony for the trial. Emma staunchly refuses to work with Dr. MacLeod, and although she is initially resistant to working with Flore, she eventually begins to confide in her: "When you have finished your work with the little doctor, you will perhaps be on the path to becoming a true Black woman, a stand tall Black woman. And to stay standing tall, you will have to be cunning...and hang on to your dreams" (Agnant, 2006, p. 74). This invocation to "dream" and become a "true Black woman" serves as the start of their coalitional partnership; an alliance committed to dreaming of different conditions of freedom for all Black women. It is this motive that ultimately attracts Flore to commit herself to Emma and her mission. Therefore, although translating Emma's testimony begins as a mere job opportunity for Flore, it quickly turns into an ethical and political endeavor. Writing in her notebook, Flore records the following: "I am writing to tell of all that burns in my body and in my blood... so that your voice may live forever, you whose voice no one has ever listened to. I will write to your last drop of your hate, and your voice, like a bell, will sound until the end of time" (Agnant, 2006, p. 42). Flore continues to transcribe Emma's testimony driven by a profound sense of personal obligation and

political responsibility to protect her and others from the continued assaults perpetuated by the continuities of the trans-Atlantic slave trade.

Emma's personal recounting of her family's history permits Flore to confront the historical injustices of the slave trade and the enduring ramifications that have driven her to the brink of insanity. As Flore recounts to the reader:

> Emma projects me into that opaque ocean of a denied identity. With her, I've undertaken a long hard journey in the hold of a ship; in the hell of the plantations, I am suffocating; I am a runaway slave, I have packs of starved dogs at my heels… I'm travelling along the banks of the Mississippi; I discover Blacks hanged from the branches of sycamore trees (Agnant, 2006, p. 79).

Through Emma's shared testimony, Flore is transported back in time, and confronts the historical injustices endured by Emma's forbearers: stories of captivity, displacement, harrowing abuse and death. Emma's impassioned retellings of her ancestral history allow Flore to begin to piece together Emma's fragmented life. Emma's present-day life is marked by stunted intellectual pursuits, painful intergenerational trauma, and an inability to form strong emotional bonds with her lover, Nickolas, or her child, Lola. To disrupt these structural legacies of slavery as experienced by Emma, Agnant presents her readers with an ethics of care, founded on radical solidarity. Flore states: "… for nothing living or moving on the earth is important anymore; the only thing that exists for me is a woman called Emma, and her madness. She is already a part of me" (Agnant, 2006, p. 41). Flore's alliance with Emma is intensified by a depth of embodiment and empathy that seeks to lay bare the historical, political and social conditions that produce anti-Blackness. Her social justice orientation lays in stark contrast to Dr. Ian MacLeod's apolitical provision of care. Flore's role now is to work together with Emma to understand the origins of

her madness and help Black women to liberate themselves from matrixes of oppression: "Little by little, I abandon my role; I become a part of Emma; I embrace Emma's destiny" (Agnant, 2006, p. 21). Indeed, alliances committed to the liberation of Black women and Black people more generally, are represented to the reader as a means of surviving in the wake of slavery and healing from the vestiges of colonialism.

It is through Emma and Flore's alliance that Emma is able to process her historical trauma and arrive at "freedom" as her treatment plan. Agnant's work suggests that by understanding Black history, those living in the African Diaspora, can recognize freedom as the ultimate goal to living 'well.' Indeed, prioritizing freedom can serve as an aperture of possibility for wellness and survival strategies. For the protagonist, freedom is eventually achieved by rejoining her ancestors. As Emma solemnly confides to Flore a few weeks before her suicide: "I don't dream anymore, I don't dream anymore at all. By confining me here, they have really managed to steal my soul" (Agnant, 2006, p.190). Dreaming, which has sustained Emma's ability to imagine endless liberatory possibilities and remain connected to her ancestors (Agnant, 2006, p. 37; Agnant, 2006, p.147) is thwarted in the hospital, along with any hope of imagining freedom on terms other than those offered by the existing penal order. As such, her suicide is the only path to freedom. This act of self-sacrifice aligns with the historical tradition of enslaved peoples choosing death over servitude. Here, Emma chooses death over life imprisonment. Her suicide is an act of defiance that registers intelligible in the wake of "the immanence and imminence" of abjection, suffering, loss and death that accompanies Black life in an anti-Black society (Sharpe, 2016, p. 13). Although Emma chooses this path to freedom, it is not presented as the only path for emancipation. Agnant depicts alternative measures to achieve freedom. Notably, Flore finds renewed purpose in her work after collaborating with Emma and decides to end her collusion

with Dr. McLeod and the hospital to instead pursue alliances that align more deeply with her and Emma's mission: Black liberation from systems of exclusion and domination.

Flore's united alliance with Emma strengthens her own political consciousness and allows her to become increasingly attentive of the intersections between policing and psychiatric care. Despite Dr. MacLeod's confession to Flore that Emma has not admitted to killing her daughter, he is adamant in determining her guilt. As he announces in a thinly veiled threat to Flore: "My goal is to understand what motivated Emma to kill her daughter, and you, you are supposed to help me to do this" (Agnant, 2006, p.45). Rather than his primary goal to be that of healing Emma and ensuring her wellbeing, his true intentions are revealed. Dr. MacLeod's investment in Emma's welfare is strictly perfunctory and reflects a sterile neutrality that mirrors the structural dynamics of the counselling field. Thus, it becomes evident to Flore that working for Dr. MacLeod will result in her complacency and compliance with a neo-colonial system committed to persecuting Black people. As such, Flore refrains from helping Dr. MacLeod and his Interdisciplinary Committee determine Emma's fitness to stand trial. She muses: "Does he know that I have chosen sides? I hear them already: 'What is your interpretation of everything she is saying? ... And that way she has of expressing herself, that violence in her remarks. Can that be attributed to her culture? Could it be an atavism?'" (Agnant, 2006, p. 43). As Flore reckons, a legal system that exclusively condemns individual acts of violence to the exclusion of state-sanctioned violence should not be able to determine Emma's culpability or serve as the arbiter of absolution. Flore's working relationship with Dr. MacLeod is not an alliance that serves her or her ambitions, and she redirects her efforts to creating alliances committed to educating, empowering, and freeing Black women.

Flore's distancing from Dr. MacLeod and the court proceedings allows her to take up the mantle of her newly formed alliance with Emma and continue to advocate for Emma outside of the ward. Flore shares Emma's story with other Black women, including her own mother and sister, to raise their consciousness to fight for liberation against systems of oppression: "All I talk about is Emma, and I talk to them endlessly about the ways devised to avoid the suffering, the continuity of the suffering that is so evident in the existence of blue-skinned Black women" (Agnant, 2006, p. 80). Through her concentrated efforts to attend to the historical and contemporary contexts of Emma's suffering, Flore is able to commit to Emma's freedom, and by extension, help others learn to resist against society's oppressive forces. Her new purpose is clear: it is not enough that she just interprets anymore; Flore must uncover, understand and unite alliances to continue the work, and "defend the Emmas" in all of us (Agnant, 2006). *The Book of Emma,* in revealing the existing flaws of mental health service delivery, calls for a decolonized mental healthcare system that can mirror Flore's ethics of care for those of African descent. Mental healthcare service providers must provide an interrogation of the historical, political conditions and social institutions that impair Black peoples' self-determination and assist in advocating and securing their freedoms.

Wake Work: Black Annotations and Black Redactions

> All this past is past in name only, Flore, it continues to remain there, lying in wait for us, behind the obscure fog of forgetfulness. That's where my decision to study the history of slavery comes from. But you already know what they did to me. They refused to hear my voice. All I wanted was to write this book, that whenever it was opened, would never ever be closed (Agnant, 2006, p.192).

The necessity for mental healthcare service delivery to account for the historical, political and social contexts of Black life is evidenced through Emma's narration of Black suffering and the broader contextual factors that contribute to it. Christina Sharpe's ideas of "Black annotation" and "Black redaction," serve as a useful theoretical framework to make sense of Emma's insistence on making intelligible the nuances of Black life and the violence visited on Black communities. For Sharpe, Black annotation and redaction offer "ethical viewing and reading practices" that can disrupt and counter the colonial project of violence (Sharpe, 2016, p.116-117). As such, she declares that these two practices of wake work can function "to provide a corrective for the erasure of Black experience and the appropriation of Black suffering" (Sharpe, 2016, p.116). In the novel, Emma makes intelligible the nuances of Black life and the violences visited on Black communities through her own epistemological frames of reference. For example, while completing her doctoral research, Emma includes her ancestors' stories in her work to fight against the ruling academic elite who aim to silence histories of colonization and slavery. Emma deploys personal family stories to help author and authenticate the topics she writes about, performing her own Black annotation. Indeed, rather than adhering to Western academic standards of 'credible' scholars to cite, Emma instead enlists the insights of her female forebears. By insisting on Black women's standpoint, she works to negate the zone of non-being to which institutional structures and dominant forces work to relegate Black women: "that's why they trampled on my thesis. So that they alone will continue to write for us, so that people will not know that already on the slave ships they stole both our bodies and our souls" (Agnant, 2006, p. 29). Emma's manner of theorizing provides "new modes of making sensible" Black women's lives and counters institutionalized ways of knowing and interpreting Black social life (Sharpe, 2006, p. 113). Emma's annotation is essential to an ethics of care committed to Black peoples'

survival, an ethics of care marked by cultural literacy, rather than an 'objective set of best practices' that overlook power and race. By tackling the archival erasures and elisions imposed on Black suffering, Emma's annotations capture the longstanding pain and trauma of those of African descent and insists on making them visible to be effectively treated and cured for her successors.

Emma's practice of Black annotation also extends to her psychiatric diagnosis. In the novel, Emma must challenge the diagnosis of a "mad woman" which seeks to misrepresent and distort her own understandings of self and her lived experiences. Emma declares herself 'mad,' but for Emma, this does not carry the negative connotations endorsed in medical discourses. According to Emma, madness is not merely a "disease or mental impairment;" but a "psychic testimony to trauma" (Brown & Garvey, 2017, p. 12). Indeed, madness is a tactic to survive ongoing assaults of cultural and historical alienation and "the often horrendous quotidian realities of life" (Brown & Garvey, 2017, p. 12). More importantly for Emma, this state of being is not the "worst possible fate" for a Black woman (Agnant, 2006, p. 30). Acknowledgement of one's past and the historical injustices inflicted on one's ancestors is valued more than indifference or complacency with oppressive forces, which seek to silence, erase and trivialize histories of racism. Emma's annotation reimagines another interpretation of her diagnosis that instead seeks to validate her critical consciousness for living in the diaspora: "When Black women define ourselves, we clearly reject the assumption that those in positions granting them the authority to interpret our reality are entitled to do so" (Collins, 2000, p. 114). Emma refuses to play the game of the "Little Doctor," and subject herself to a psychiatric framework that fails to account for the full range of expression of Black women's diverse plights (Agnant, 2006, p.9). Emma's annotations in her thesis and on her psychiatric evaluation are generative, as they each offer

alternative ways to reclaim her power and declare the violences her community disproportionally experiences (Collins, 2000, p. 268). An ethics of care for Black people living in the afterlife of slavery requires Black annotations that make legible Black suffering, so that its intricate complexities may be adequately accounted for in mental healthcare service delivery.

It is also through Black redaction that Emma authors and authorizes her suffering**.** Emma performs sonic redaction by refusing to converse in "standard" French with the medical healthcare professionals. Emma's careful use of language—exclusively communicating in her mother tongue of Haitian Creole with Flore or alternating between shrieks and howls with the other "few true Black women in this wing" (Agnant, 2006, p. 78)—violently ruptures the semantic field that has been used against her to misrepresent, misname and misdiagnose her. Her redaction allows her to find an alternative means of resisting and rewriting her narrative. As Flore becomes a co-conspirator in Emma's sonic redactions, she cunningly declares: "With Emma, I have learned to use other codes. I have discovered other clues. The doctor can't follow me" (Agnant, 2006, p. 81). Emma chooses Flore to share her story and enlist in the fight against the oppressive forces she faces, as she is gravely aware of what will happen to her if her testimony is left in the hands of Dr. MacLeod: "You will be the expert, and you, Little Doctor, will be believed by everybody because your word is gold, even though you know nothing, absolutely nothing, of what is hidden under my skin" (Agnant, 2006, p. 39). Resisting Dr. MacLeod allows her to maintain ownership of her story and share it in a manner that rings authentic to her and will be useful for her intended audience.

Emma's refusal to provide a comprehensive account of her life events functions as another act of auditory redaction. As Christina Sharpe argues, redaction is an ethical practice of care that resists continued exploitation and violence:

> …the repetition of the visual, discursive, state, and other quotidian and extraordinary cruel and unusual violence enacted on Black people does not lead to a cessation of violence, nor does it, across or within communities, lead primarily to sympathy or something like empathy. Such repetitions often work to solidify and make continuous the project of violence. With that knowledge in mind, what kind of ethical viewing and reading practices must we employ, now, in the face of these onslaughts? What might practices of Black annotation and redaction offer? (Sharpe, 2016, p. 117).

Emma disrupts totalizing discourses on Black suffering through a fragmented account of her testimony, by performing an auditory redaction that forecloses the "continuous project of violence" (Sharpe, 2016, p. 117). Emma's testimony consists of digressions, metaphors, abrupt pauses, and emotional breaks. The patchwork storytelling challenges an all-encompassing, totalizing interpretation of the gratuitous violence she once endured and is continuing to experience in the mental hospital. As a result, Emma is able to transmit her story to Flore, without providing Dr. MacLeod with the information he needs to capitalize on and repeat the violence she recounts for his manuscript. Flore muses: "I realize that the doctor will never be able to find the keys that would let him unlock the evidence of the unconscious in his patient's narrative framework" (Agnant, 2006, p. 81). Emma's unique storytelling ensures that her experiences cannot be forced into master narratives that aim to clumsily interpret and organize her life in neat, little boxes. Flore and Emma's forged alliance allows them to continue working together to undermine the schemes of Dr. MacLeod, and Flore's political and ethical responsibility to Emma's testimony emboldens her to maintain the encryption. As such, through Emma's annotation and redaction she creates her own forms of storytelling as an act of defiance against others authoring her tale. Emma chooses who has the authority to repeat her story, whom

it may be shared with, and insists on its validation. Thus, Emma uses Black annotation and Black redaction to render visible the violences of the state and its accompanying threats to Black peoples' freedoms. Agnant's juxtaposition between Dr. MacLeod's provision of care and Emma and Flore's healing work, asks us to resist the substandard care Dr. MacLeod offers to Emma under the guise of concern and judiciary process, and instead, lobby support for the unique ways Emma and Flore make legible colonial histories of abuse and displacement that eclipse Black futures. To achieve transformative mental healthcare for those of African descent, Flore and Emma's freedom-making practices, and Emma's wake work, reinforce the notion that mental healthcare service delivery must be decolonized.

If *The Book of Emma* stages the question: what are the shortcomings of traditional mental healthcare services for Black men and women living in the African Diaspora? Then, the novel's incisive response is that mental healthcare fails to account for the haunting persistence of colonial systems on Black life and the nuances of Black suffering. A decolonized model of mental healthcare, as indicated by Agnant's formidable work, suggests that accounting for historical and sociopolitical factors that produce injustices for Black communities can allow for generative ways of reframing mental healthcare service delivery. I have argued that through freedom-making practices, such as political and ethical alliances, and wake work, such as Black annotations and Black redactions, that Emma's embodied intergenerational trauma is made legible. As such, Agnant's novel models treatment measures that center liberation and self-determination, which can be identified as key healing approaches to be prioritized and pursued within mental health practice and theory. The novels under discussion in the following section, *Transcendent Kingdom* (2020) by Yaa Gyasi and *Possessing the Secret of Joy* (1992) by Alice

Walker, usefully extend the conversation by helping to meditate on a new ethics of care within mental healthcare service delivery for Black diasporic peoples, that centers on spirituality.

Sacred Healing Scripts: A Generative theory of Spirituality

While Chapters four and five of the dissertation explore the role of collaboration between parish ministers and psychotherapists to advance a more holistic model of mental healthcare, missing from the conversation was an explicit discussion on spirituality. Spirituality, which is not tied to organized religion, can help to think through and articulate new wellness narratives that adopt new liberatory and affective orientations. Although religion and psychiatric care are constituted by a set of social and political relations, and parish ministers and therapists are tethered to their practicing institutions, spirituality can create space to think through wellbeing practices that exist beyond these constraints. Therefore, the following section transitions from earlier discussions on the role of *religion* within mental healthcare service delivery, which was a pragmatic and generative starting point; to direct our attention to the role of *spirituality* on mental healthcare service delivery for Black Canadians, which is a necessary and crucial next step for proposing unorthodox healing interventions.

My departure is in line with the scholarship within psychology of religion, and the Black feminist tradition, which refrains from treating religion and spirituality interchangeably. The former is understood as relating to religious institutions and dogmatic practices and instructions: "an institutionalized set of beliefs and practices by which groups and individuals relate to the ultimate" (Burke et al., 1999, p. 252), while the latter is represented as a more informal and expansive approach that supersedes denominational affiliations:

> spirituality is defined as a connectedness to God or a Supreme Being (that may be religion-based but without dependence upon an institutional context or participation in formal religious practices) which serves as a personal or communal source of liberation, solace, hope, meaning of one's life purpose, centering, strength, willingness to cope, as well as an understanding and acceptance of self (Heath, 2006, p.159).

A study on improving mental healthcare service delivery for Black communities must consider the value systems historically prioritized by its members, and seek to unpack the ways in which these sociocultural beliefs may be mobilized to transform mental health efforts and interventions: "Spirituality has been long recognized as a key component of emotional and psychological well-being and has maintained its place as essential to the overall health of individuals and communities of non-European descent" (Dudley-Grant, 2003, p. 341 as cited in Heath, 2006, p.165). In fact, the importance of spirituality and mental wellbeing has gained increased consideration and importance within the mental health field, but its subjective and multidimensional nature requires a unique lens to understand how it may be integrated within the normal counselling process. Indeed, for psychologists there is a necessity for spirituality to be interrogated by researchers outside of the field to better understand its multifaceted relationship to wellbeing (Heath, 2006; Miller & Thoresen, 2003; Thomas, 2004).

The study of spirituality and its therapeutic functions is best undertaken as an interdisciplinary endeavor due to its incommensurability as a "measurable concept"[85] (Heath,

[85] The scholarship reports there are significant challenges to studying spirituality. One reason concerns the difficulty and inconsistency of defining the construct due to its epistemological nature (Speck, 2005). The other primary reason concerns one's inability to measure spirituality; quantitative measures are not able to fully capture the subjective nature of spirituality, and many assessment tools created to study spirituality are only developed from a Judeo-Christian perspective (Moberg, 2002). Miller and Thoresen (2003) posited that spirituality is best described as a "latent construct, which are complex and multidimensional variables. Therefore, such complexity in a construct implies that no single assessment instrument can adequately capture its meaning" (Brown et al., 2013, p.109).

2006, p. 157). Although this may serve to dissuade some, for others, including myself, who work within interdisciplinary frameworks, spirituality's complexity offers rich ground to explore and document healing beyond the limits of western science. By applying BFP, I can investigate how spirituality may serve as a key element in the delivery of holistic mental healthcare, a query which eludes health and scientific research (Heath, 2006; Oliphant et al., 2022). This is why my turn to analyzing creative texts becomes important. Many Black feminist literary writers have discussed and conceptualized spirituality as a healing mode with such animation, creativity, expertise, and nuance since the beginning of their output (Collins, 2002; hooks, 1989; Wilentz, 2000). Toni Morrison's *Beloved* presents a spiritual sermon by Baby Suggs, a Black elder who revives her community through her spiritual preaching:

> In this here place, we flesh; flesh that weeps, laughs; flesh that dances on bare feet in grass. Love it. Love it hard. Yonder they do not love your flesh. They despise it. They don't love your eyes; they'd just as soon pick em out. No more do they love the skin on your back. Yonder they flay it. And O my people they do not love your hands. Those they only use, tie, bind, chop off and leave empty. Love your hands! Love them. Raise them up and kiss them. Touch others with them, pat them together, stroke them on your face 'cause they don't love that either. You got to love it, you! And no, they ain't in love with your mouth. Yonder, out there, they will see it broken and break it again. What you say out of it they will not heed. What you scream from it they do not hear. What you put into it to nourish your body they will snatch away and give you leavins instead. No, they don't love your mouth. You got to love it. This is flesh I'm talking about here. Flesh that needs to be loved (1987, p. 88).

In a clearing in the woods, Baby Suggs gathers formally enslaved community members and zealously preaches to them to love themselves as a form of active resistance. Suggs' spiritual ceremony ushers a powerful revival that awakens her community to heal the parts of themselves most deeply wounded by the dehumanizing institution of slavery. Laying her outstretched hands over the band of people congregated, Suggs' spirituality unlocks a therapeutic force that strengthens and empowers her community against the psychosocial stressors and injustices of the antebellum South. Although this captivating scene is fictional, Toni Morrison's work speaks to a rich tradition of Black healers and spiritual leaders inspiring wellness during captivity and torture. Black feminist writers' recognition and celebration of spirituality warrants careful examination of the ways in which it may function to facilitate positive wellbeing. Thus, my pivot towards spirituality is in line with my Black Feminist Psychology Framework and presents a way forward in my interdisciplinary interrogation of researching culturally responsive, historically attuned, and politically engaged mental healthcare for Black communities.

A Spiritual Praxis of Healing

In *Talking Back: Thinking Feminist, Thinking Black* (1989) bell hooks firmly states:

> Throughout our history in this country, Black women have relied on spirituality to sustain us, to renew our hope, to strengthen our faith. This spirituality has often had a narrow dimension wherein we have internalized without question dogmatic views of religious life informed by intense participation in patriarchal religious institutions. My intent is to share the insight that cultivating spiritual life can enhance the self-recovery process and enable the healing of wounds (184).

My engagement is invested in following this line of inquiry and exploring *how* spirituality "enable[s] the healing of wounds" (hooks, 1989, p.184). By applying my BFP framework, I can

examine examples presented by Black literary writers whose works model a spiritual praxis for healing. A Black feminist conceptualization of spirituality may be understood as manifesting three overarching characteristics that underscore its healing praxis: a) Offers a cartography of the African Diaspora; b) Community based-model of support; and c) Presents holistic ontological systems of wellness.

Cartography of the African Diaspora. Throughout the African Diaspora, various historical and cultural ruptures have negatively impacted the wellbeing of those of African descent:

> Those have included the African, Atlantic, and Arab slave trades; The colonization of Africa and the Americas by European powers; the establishing of apartheid regimes and neo-colonial nation states; And current patterns of global migration based on the often gendered transfer of human capital from poorer nations to wealthy ones. Blacks have been subjected to social domination, economic exploitation, and political marginalization, both from without and within (Brown, 2003, p. 8).

These events have fostered resistance among Black peoples, including sacred practices of wellbeing that have been cultivated across time and space. Black women's spirituality is historically "grounded in an ancestral source of African traditions" (Heath, 2006, p. 161; Jones, 2016). It drives the learning of one's history through its emphasis on connecting with one's ancestral homelands, and ancestors to acquire traditional knowledges[86] (Heath, 2006). While it is commonplace to call on one's ancestors to solve personal and communal problems, one may also rely on this practice to receive tools of resistance to ensure everyday survival. These modes of

[86] There is a longstanding spiritual tradition of people calling on ancestors to help solve their personal and interpersonal problems (Heath, 2006).

resistance, passed down from one generation to the next, can be wielded to face contemporary challenges, conflicts, and crises. As a site of psychic return to one's ancestral roots, one may use spirituality to unlock a diasporic consciousness that forces individuals to "draw personal strength from their cultural traditions and religious practices" to re-evaluate how one perceives mental illness, how we conceptualize wellbeing and most importantly, how we engage in healing (Comas-Diaz & Greene, 1994; Heath, 2006, p162; Wilentz, 2000). Indeed, spirituality's transcendent cartography of cultural traditions and its corresponding healing practices maps a symbolic and cultural path towards renewal and recovery (Wilentz, 2000, p. 3).

Community based-model of support. A community-based model of healing is similarly promoted through spirituality's emphasis on interconnectedness among all "living things" and its promotion of commonweal.[87] Spirituality is an interdependent force that seeks balance in the metaphysical and physical planes to generate ideal conditions of wellbeing and belonging among people and nature. Spirituality is premised on creating unity among all aspects of life, in all areas of life, which renders it an ideal forum to develop communal relations and new ethical ways of relating to one another. Spirituality "honors the fundamental relationships among all life" and seeks to counter the isolation that contributes to individuals' poor wellbeing (Heath, 2006, p. 159). Spirituality emphasizes the necessity of working against a culture of alienation and dispossession through its trope of harmonic relationships (Heath, 2006). Indeed, it models itself on an afro-centric understanding of community that values genuine connection over competition and domination (Collins, 2016). In doing so, spirituality carries a liberatory potential by

[87] "Commonweal is the state of collective well-being; it is the optimization of well-being for all members of a community... included in this conception of community is what Taliba Sikudhani Olugbala has called "livingkind" (all living things—from humans, to animals, to plants, to microorganisms) as well as the "inanimate" components of Earth, the universe(s) beyond Earth, the spiritual world(s) and transcendental realm(s) encompassing the universe(s), and, ultimately, all of creation" (Phillips, 2006, p. xxvi).

encouraging collective political resistance and mobilization against the sociopathic conditions that are fostered through an increasing neoliberal governance. As a mode of resistance to individualism, spirituality demands social support and communal solidarity as an adaptive coping strategy to bring upon personal and communal healing.

Holistic Ontological System of Wellness. This characteristic is useful for a healing praxis for Black communities because it challenges conventional, western notions of wellbeing, while advocating for non-western ontological systems of wellness. For example, Black feminist spirituality resists linear constructions of healing, expands networks of caregivers to include informal healers accepted as cultural agents of knowledge, and it presents a different epistemological starting point for sacred healing practices. Indeed, spirituality's holistic ontological system makes space for oral traditions, dreams, intuition, apocalyptic visions, and folklore to serve as a guide for the Healing Arts. It encompasses indigenous spiritual ties, folk medicine (herbs), music, dance and various alternative medical treatments to achieve wellbeing. Modes of healing that have been historically dismissed by scientific rationalism and empiricism are re-centered through spirituality's holistic approach to wellness (Wilentz, 2000). Binaries, such as the mind-body dualism that are commonplace in western medical scholarship, are challenged in a holistic ontological system that values multiplicity and polyvocal pedagogies in its efforts to create and maintain a curative domain.

Each of the listed characteristics of a Black feminist spirituality, work in their own unique ways to address historical trauma, center Afro-indigenous knowledges, worldviews and practices, and cultivate community connectedness and self-awareness. In doing so, a healing praxis is created that offers a pathway towards stronger mental wellbeing for individuals and their communities. I will examine how the novels uniquely present spirituality as functioning in

this manner to facilitate healing and health promotion for their protagonists. Additionally, I will explicate how this spiritual praxis may inform how we structure clinical and community interventions to enhance mental healthcare service delivery for Black communities.

My subsequent thematic literary analysis explores two novels by two renowned Black writers, Yaa Gyasi (1989-) and Alice Walker (1944-). Limitations of space and time constrained my efforts to study Black feminist writers across the African diaspora; however, the authors presented are representative of the Black feminist literary tradition's approach to mental health and healing. Moreover, while my investigation could not address the complete spectrum of mental health disorders that Black communities experience, I focus on mood disorders, particularly depression, as presented in the novels. My analysis is informed by the texts' literary format, themes, and characterizations. Drawing on my Black Feminist Psychology Framework, I analyze the socio-political conditions represented in these texts to consider the ways they contribute to the poor mental wellbeing of the characters. I also examine *how* the authors devise what I have termed a "spiritual praxis" in their stories. Lastly, I highlight how this praxis serves as a mode of resistance and facilitates healing journeys for the characters. Both novels speak across different cultural contexts, geographic boundaries, and temporal divisions; yet, despite these differences, the works constitute a meditation on the role of spirituality as a mode of healing. Indeed, in each novel, the authors evoke a spiritual praxis, which transitions the protagonist from a state of distress to wellbeing.

Transcendent Kingdom

The second novel under investigation is *Transcendent Kingdom* by Yaa Gyasi. The novel was published September 1st, 2020 by Alfred A. Knopf Publishers. It is the second novel by the Ghanaian-American author. Her first release, *Homegoing,* was well acclaimed and led to Gyasi's

notoriety as a spellbinding literary artist[88]. Gyasi's highly anticipated *Transcendent Kingdom* offers a smaller scope compared to her previous odyssey, yet, with no less complexity or intrigue. Indeed, while the two novels are quite different in scale, a Ghanaian protagonist and the tropes of familial ties and race remain an enduring feature of her work. In *Transcendent Kingdom*, Gyasi unpacks the infamous binary of religion versus science through her two leading characters, a mother-daughter duo. The mother turns to faith, and her daughter to "fact," as they each try to make sense of and heal their mental distress. By foregrounding this debate, Gyasi showcases the limitations of each dogmatic approach, and instead poses an alternative: Yaa Gyasi models a spiritual praxis that transcends the constraints of both medical science and religious codes, staging an important intervention in healing discourses.

The novel opens with our protagonist Gifty, who is an intelligent and inquisitive doctoral candidate pursuing her PhD in neuroscience at Stanford University School of Medicine. In accordance with her namesake, she is incredibly talented and her aptitude for studying and working hard is unparalleled. Her colleagues, while arguably also academically astute, do not share Gifty's passionate intensity for their research. Indeed, her graduate work on "the neural circuits of reward-seeking behavior" (Gyasi, 2020, p. 21) is motivated by a dark and grim secret. Her older brother, Nana, has died from a crippling heroin overdose. The story reveals in flashbacks Gifty's intimate relationship to her thesis project, while slowly disclosing the existential battle she is grappling with that places her at odds with her religious upbringing.

"The line of those drug-addled years of Nana's life is not so easy to draw, so direct. It zigs and it zags and it slashes" (Gyasi, 2020, p. 153). The format of the story switches between

[88] Yaa Gyasi's accolades include: The National Book Critics Circle's John Lenoard Award for best first book, the PEN/Heminway Award, and the 2016 National Book Foundation's "5 under 35".

the past and present, as the novel tackles depression, grief and addiction. Readers are introduced through flashbacks to Gifty's older brother, Nana, a towering, animated young boy who is easily impressionable as he is loveable. Understood to be the crowning jewel of the household, Gifty's parents are in awe of their eldest male child: “He was the darling of their compound. Neighbours used to request him at parties. ‘Would you bring Nana by?’ They'd say, wanting to fill their apartment with his smile, his bowlegged baby dancing” (Gyasi, 2020, p. 15). A younger, more inquisitive and pious Gifty is introduced to us as well. Readers are able to gauge the likeness between the siblings as well as discern their differences. Nana is rambunctious and eager, while Gifty is methodical and reflective. As a child, Gifty writes in her journal, beginning her entries with “Dear God,” as she dutifully reports on the day-to-day occurrences in her life. Her letters betray her child-like innocence and wonder: “Dear God, if you're in space, how can you see me, and what do I look like to you? And what do you look like, if you look like anything at all?” (Gyasi, 2020, p. 13). As time progresses, these journal entries mature with age and angst and Gifty begins to record dark passages of racist micro-aggressions endured by herself and her family members (p. 59); tales of her father's abandonment (p. 75); details of her brother's painkiller addiction (p. 170); and notes documenting her mother's increasingly concerning despondency and eventual descent into depression. Gifty's letters begin to give way to desperate pleadings with the all-knowing omniscient Creator to intervene on her family's behalf, but the failure of divine intervention weakens her relationship with God. When we meet Gifty in adulthood, she is a practicing atheist, who desires an empirical answer to make sense of her brother's addiction and her mother's suffering. Gifty wonders:

> Could optogenetics be used to identify the neural mechanisms involved in psychiatric illnesses where there are issues with reward seeking, like in depression, where there is too

> much restraint in seeking pleasure, or drug addiction, where there is not enough?....Could it get a brother to set down a needle? Could it get a mother out of bed? (Gyasi, 2020, p. 44).

While Gifty portrays this search for answers, and by extension, healing, as a battle between rationality and religiosity, Gyasi stages another intervention. Indeed, right in between the pages, or perhaps more fittingly, right in between the sheets, is the answer: “Her suicidal mother is living in her bed” (Gyasi, 2020). Gyasi offers the matriarch of the family as not only a compelling case for exploration on depression, but also a representation of a potential healing agent as well. Gifty's mother, who is never referred to by her first name in the novel, is first introduced to us in the present. She is travelling to stay with Gifty in California while she struggles to recover from another debilitating mental health episode. Upon entering Gifty's house, a business-as-usual banter is assumed between the two of them. The encounter is revealing. Despite the incredible burden and weight of depression experienced by the mother, it remains something to be relegated to the margins of a conversation, only observed through innocuous questionings “Are you hungry?” (Gyasi, 2020, p.7). Explicit conversations of the decline of her mother's state of mind are not openly tackled by Gifty, who is used to treating conversations on mental illness as taboo. For Gifty’s mother, mental illness is a western invention: “She was distrustful of psychiatrists and she didn’t believe in mental illness. That’s how she put it. ‘I don’t believe in mental illness.’ She claimed that it, along with everything else she disapproved of, was an invention of the West” (Gyasi, 2020, p.35). Gifty tries to convince her mother of this erroneous logic by drawing on Ama Ata Aidoo's *Changes* (1991), in which one of the central characters of the novel challenges the oversimplification of African vs. Western origins of concepts.

The reference to this text opens an intertextual dialogue with the Ghanaian born author, Aidoo. This nod to her work suggests that Gyasi is working within and across the African diaspora, to position her novel in conversation with other Black writers who have grappled with themes of mother-daughter relations, anticolonialism, and mental illness within the tradition of postcolonial and continental African texts. In Marie Célie Agnant's T*he Book of Emma* (2006), mental illness is framed as the result of psychic trauma caused by the trans-Atlantic slave trade, and yields fatal consequences for the protagonist and her daughter, Lola. Similarly, Edwidge Danticat's *Breath, Eyes, Memory* (1993) follows a mother-daughter relationship haunted by the violent acts of colonialism, and culminates in the mother's suicide, and the daughter's healing journey. As in these texts, there is a similar reticence from the characters in Gyasi's novel to address mental illness despite its very prominent role in their lives, which deeply impacts their mother-daughter relationship. While the reasons for the dismissal of mental health issues vary between texts, the trope of the Strong Black Woman, and the African attribution of mental illness as a "Western invention" underscores these works. Trudier Harris' "This Disease Called Strength: Some Observations on the Compensating Construction of Black Female Character" (1995) discusses how societal constructions of Black women's strength are perpetuated across African-American literature written by both men and women, and the ways these images have become internalized by Black women more broadly (Harris, 1995). This trope, in conjunction with Africans, particularly religious Africans' cultural mistrust of formal mental healthcare services (Black Health Alliance, 2015; Campbell & Long, 2014; Njiwaji, 2012), contributes to the devaluation of mental health in Black

communities. Thus, Gyasi paints us a very convincing portrait of an African mother[89] in denial of the very serious, and dangerous, threat her mental illness poses to her life.

Readers learn that this is not the mother's first mental health episode. Shortly after the death of her son, Gifty's grief-stricken mother attempts suicide. Gifty finds her in the bathroom: "I found her, sinking in the bathtub, the faucet running, the floor flooded..." (Gyasi, 2020, p.36). Born and raised in Ghana, Gifty's mother, and her father, who she refers to as the Chin-Chin man, lived a comfortable and uncomplicated life in their hometown, Kumasi. However, lures of the "American Dream" grew stronger for Gifty's mother with the birth of their son: "Nana, beloved and loving, deserved the best. But what was the best the world had to offer?" (Gyasi, 2020, p. 15). As for many immigrants from the global South, the draw of more lucrative opportunities 'in the land of the free' is an attractive impetus. Gifty's mother is able to convince her husband to travel with her to America in hopes of achieving this dream. Her proposal is meant with reluctance, but eventually he agrees, and they settle in Southeast Huntsville, Northern Alabama. Unfortunately, the integration process is difficult for the family: adjusting to new social norms, acquiring gainful employment, raising children within a different cultural context, and suffering subtle microaggressions and blatant racism. All these conditions prove too much to bear for the husband, particularly the racial discrimination:

> But walking around with my father, she'd seen how America changed around big Black men. She saw him trying to shrink to size, his long, proud Black hunched as he walked with my mother through Walmart, where he was accused of stealing three times in four months. Each time, they took him to a little room off the exit of the store. They leaned

[89] In fact, Gifty's mother is never named— her anonymity lending a universal nature to her character's disposition.

> him against the wall and patted him down, their hands drifting up one pant leg and down the other. Homesick, humiliated, he stopped leaving the house (Gyasi, 2020, p. 27).

Within the small, racially homogenous town of Huntsville, the Chin-Chin man's Blackness becomes a target. Unable to live under the racist assaults of the community, the Chin-Chin man packs his bags, and returns to Ghana indefinitely. This decision renders Gifty’s mother a single parent. The emotional toll and financial burden it places on her forces her to withdraw from her home and children. She attempts to hide her disappointment and anger by burying herself in work. Consequently, the emotional safety and security once present in the home for her children, begins to disintegrate, hardening both Gifty and her brother who are deeply impacted by the rift: “I could feel that something had changed among the three of us and I was trying to learn what my role in this new configuration of my family might be” (Gyasi, 2020, p. 79). While Gifty turns inward, excelling in her studies and daydreaming of a brighter future, her brother finds his outlet in basketball: “It was clear right away that this was the sport that he was intended to play. It was like something, in his body, in his mind, clicked into place once he held that basketball in his hands” (Gyasi, 2020, p. 109-110).

Nana's participation in basketball offers a short reprieve for the family who enjoy a new-found celebrity status as the household name responsible for Huntsville Alabama's most prominent basketball player:

> When Nana was king, Pastor John would sometimes call him up onto the stage on Sundays, and the congregation would stretch out our hands and pray for his upcoming week, for victory in all the games that he was about to play. Up there, with his head bowed, our hands outstretched in coronation, Nana received every blessing (Gyasi, 2020, p. 176).

As the “best basketball player in the city” (Gyasi, 2020, p. 229), some of the blatant racism experienced by the family is temporarily halted as church members, coaches, teachers and peers rally together to uplift and protect their most valuable asset. Carl James’ “Why is the School Basketball Team Predominantly Black? And What That Says About Educators' Role in ‘Leveling the Playing Field’” (2011) discusses how basketball becomes one of the few avenues Black men achieve social acceptance and can counter the racist and isolating environments they interact within. James argues, much of the acceptance young Black basketball players acquire is largely predicated on their ability to meet and exceed the expectations of their coaches and teammates (James, 2011). Unsurprisingly then, when Nana suffers a painful ankle injury that threatens his basketball season, the comradeship and belonging he was once treated to, vanishes. Nana is prescribed OxyContin for the ankle injury, which spirals into a harrowing heroin addiction that eventually leads to his fateful overdose: “Nana had overdosed on heroin and died in the parking lot of a Starbucks” (Gyasi, 2020, p. 180). The irony of his death in the parking lot of a Starbucks, a lucrative colonial enterprise that has benefited from racialized labour on coffee plantations, (much like Huntsville's reputation from Nana's basketball success) is un-mistakable. Moreover, the very public setting of his death raises important questions concerning culpability: with the exception of his family, why did no one help him? Where were the “outstretched” hands (p.76) that once fervently prayed over him? Why was Nana neglected? The purpose of Gifty’s doctoral research introduced to us at the beginning of the novel moves into sharp, painful focus: she is searching for answers to make sense of the suffering Nana faced with his addiction. However, her scientific quest does not address the socio-political conditions that contributed to Nana's addiction, and it is an important and large oversight in her research.

The social and political climate of anti-Blackness in their community creates a hostile environment that makes it difficult for the characters to thrive and achieve complete self-actualization. Although Nana is hailed for his performance on the court, his full humanity is denied to him, as he becomes acknowledged and praised exclusively for his basketball skills:

> It insulted her, I think, that people were so keen to talk about Nana's basketball prowess as the key to his future, as though he didn't have anything else to offer. His athleticism was a God-given talent, and my mother knew better than to question what God gives, but she hated the idea that anyone might believe that this was Nana's only gift (Gyasi, 2020, p. 111).

The denial of his full humanity leaves Nana very little room to find authentic ways to express himself wholly, as his self-esteem and self-worth become largely tied to his basketball prowess. The limited Black representation and acceptance within a white supremacist, hetero-patriarchal capitalist context (James 2011), pigeonholes Nana, and reinforces his belief that basketball is his only path towards belonging. Thus, when he is unable to continue playing, and the support and favour he was once treated to is pulled from under him, very little hope or enthusiasm remains for Nana about what might become of him. The memory of his father, the only Black male role model in his life, cast down and demoralized by racial discrimination and abuse, serves only to confirm his fate. These factors are presented as increasing the brother's susceptibility to developing an addiction. But these things are hard for Gifty to process. How does one measure lost hope? Dehumanization? Loss of faith? And its causality with addiction? Gifty reflects:

> I am not a psychologist or a historian or a social scientist. I can examine the brain of a depressed animal, but I am not given to thinking about what circumstances, if any, led up

> to that depression. Like everyone else, I get a part of the story, a single line to study and recite, to memorize (Gyasi, 2020, p. 173).

Gifty's rigid scientific study of addiction is limited in its scope. Gyasi paints Gifty as emblematic of the biomedical, empiricist tradition to draw attention to the limitations of this line of inquiry. Gifty's strictly scientific method of studying addiction is inadequate because her quest will not yield the answers she is after. It is a conclusion Gifty intuitively knows, but has difficulty accepting (Gyasi, 2020, p. 21). The representation of Gifty as a caricature of the scientific model is starkly contrasted with the portrayal of her mother, who is represented as fundamentally religious, a position which carries its own unique set of limitations.

Religiosity's Rigidness. Gyasi demonstrates the limitations of a strictly religious framework for ushering healing, particularly within a hostile, exclusionary social environment. Her family's difficult transition to Alabama encourages Gifty's mother to seek out a church. Mensah (2009) states that for recently arrived Ghanaian immigrants in Toronto, locating a church, and by extension, a religious community, helps to maintain one's sense of cultural roots and grounding, and build social connections. Gifty's mother tries to find a church that will foster a sense of security, familiarity and belonging, but as the only Black patrons at a white suburban Methodist congregation, her family's experiences of cultural alienation and isolation are instead exacerbated. Gifty, in particular, feels the sharp stares and judgements of the church members who are quick to summon and cast stereotypes towards her family (Gyasi, 2020, p. 172). Rumours of her father's abandonment and brother's addiction only further ostracize Gifty and her mother from the church community:

> We were the only Black people at the First Assemblies of God Church; my mother didn't know any better....not all churches in America are created equal, not in practice and not in

> politics. And, for me, the damage of going to a church where people whispered disparaging words about “my kind” was itself a spiritual wound- so deep and so hidden that it has taken me years to find and address it (Gyasi, 2020, p. 174).

Although the mother is able to develop a relationship with Pastor John, and build a small support system with him and his wife, the church is unable to adequately help her with her depression nor bring her the peace she is longing for. And for Gifty, the religious trauma she endures in her church community is too great to receive healing from this outlet. Notwithstanding the abuse and alienation perpetuated by the church's community members, Gyasi demonstrates how religious institutions can also fail to be politically liberating. The proselytizing at First Assemblies of God Church, mirrors the white, conservative culture it belongs to, as the Sunday teachings proclaim a conservative and exclusionary God: “And the part that bothered me the most was that I couldn’t shake the feeling that the people P.T believed deserved Hell were people who looked like Nana and me” (Gyasi, 2020, p. 99). The teachings of the youth pastor, Pastor Tom (P.T), promote a vision of God that awards the powerful and privileged private entry into Heaven's gates. P.T’s preaching to the youth group suggest only an elite few, who ‘work hard’ and are ‘deserving’ have a place in God's kingdom. Kerri Day's *Religious Resistance to Neoliberalism: Womanist and Black Feminist Perspectives* (2016) discusses how “religious conservative groups offer a religious template of personal responsibility that aligns with neoliberalism's larger cultural project of producing and regulating good subjects who are industrious and therefore economically successful” (p.122). This rhetoric, which implies an individual’s hard work reaps fair and just rewards, serves only to negate structural injustices, and dissuade people from engaging in compassionate and collaborative ways of caring for one another.

Gyasi presents the implications of religious institutions that do not seek to reimagine nor articulate new ways of relating to one another that extend past the classist social hierarchies, gender and power dynamics of its environment. A neoliberal religious logic that negates the role of systemic and institutionalized racism, considers poverty an individual failing, and encourages the notion of meritocracy above radical changes to systems of domination, will continue to serve as a barrier for Black and racialized communities who face unique matrixes of oppression. Indeed, this praise song for individualism and "just desserts" only forces Gifty and her mother to feel more estranged from their religious community. The pulpit and the parishioners become another source of alienation and anguish for the family. Thus, in the novel, neither science nor religion is presented as offering the respite and healing necessary for Gifty or her mother. Instead, Gyasi offers us a spiritual praxis that is evoked by Gifty's mother, and helps to facilitate Gifty's healing from her unfathomable grief.

Motherhood and the Black Feminist Tradition: Re(birthing) New Healing Practices

The restorative and healing powers of motherhood are well documented within the Black feminist tradition.[90] Indeed, it has a long history within the African Diaspora canon. The emphasis on motherhood can be traced to the earliest writings of slave narratives. Harriet Jacobs' *Incidents in the Life of a Slave Girl* (1861) chronicles the extreme risks Black mothers have undertaken to secure the livelihood and the futurity of their children. Jacobs spends seven years in a garret watching over her children and fighting for their freedom. Mary Prince's *The History of Mary Prince, A West Indian Slave* (1831) discusses the critical necessity of maternal

[90] Although Black motherhood is widely celebrated in the Black feminist tradition, outside of Black Studies, Black motherhood was historically negatively appraised. "In Killing the Black Body, law professor and Black feminist scholar Dorothy Roberts contends that American definitions of womanhood, and by consequence, motherhood were never permitted to enslaved Black women. Seen and thought of as abject and nothing more than property, Black women were exiled from the institutional and vernacular praxis of mothering and womanhood…Treated as laborers and eventual incubators for prospective enslaved beings" (Story, 2018, p. 878).

relations, both biological and outer biological, which helped ensure her survival under the institution of slavery. Covert lessons passed down from one mother to the next that centered on informal and formal measures of resistance, such as rejecting advances from enslavers, ensuring one's infertility, sharing workloads, and other useful skills and operations for navigating life as an enslaved woman. These stories served as a springboard for the scholarship dedicated to "Black mothering." Black mothering is an expansive term that extends past the role of a biological, gendered mother, to include "all kinds of Black bodies" engaged in practices of caregiving for Black life (Nash, 2019, p.558). This labour of non-biological Black mothers speaks to what Black feminist writers have celebrated as "community mothering," or what Patricia Collins has explicitly coined as "other mothers;" mothers who extend care and are accountable to not only their own children, but to their "fictive kin" as well (Nash, 2019, p. 558). Practices of Black mothering can include but are not limited to: "caretaking, management, nurturance, education, spiritual mediation, and dispute resolution" (Phillips, 2006, p. xxix). Within the African context, motherhood similarly encompasses "a number of meanings not generally recognized in the Euroamerican context"[91] (Phillips, 2006, p.xxix). Black mothering not only transcends biological categories, but it also cuts across the domestic sphere. Black motherhood's adamant insistence on Black humanity and its investment in Black life has made it a unique socio-political category. Indeed, Black motherhood represents a "site of resistance and contestation to state violence" and is emblematic of a form of "politicized care" (Story, 2018, p. 877; p. 893).

[91] "As Ogunyemi explains, using examples from West African cultures, most germane here are the notions of spiritual mother (Osun or Chi/Ori), mother as oracle (Odu), childless mother (Mammywata), and community mother (Omunwa/Iyalode)" (Phillips, 2006, p.xxix).

"Politicized care" is a practice of "radical anti-state-care-work," as it aims to "reveal and rupture the parasitic relationship between the state and Black people" (Nash, 2019, p. 558). Examples of this work include contemporary campaigns by organizations such as Black Lives Matter (BLM). Black Lives Matter is largely spearheaded by Black women's leadership and tackles social and political issues disproportionately impacting Black communities, such as police brutality and gun violence. Jennifer Nash's (2019) "Black Maternal Aesthetics," states that Black motherhood powerfully stands in against the dismissal and disposal of Black life performed and perpetuated by the state. Black motherhood's commitment to protecting those most vulnerable to an anti-Black social order, marks Black mothers as pillars of the Black community and catalysts for social transformation. In this way, Black mothering is inextricably tied to Black wellbeing, as their maternal practices of resistance against anti-Blackness contribute to Black communities' preservation and actualization (Nash, 2019, p. 558). I wish to extend the literature on Black motherhood serving as a mode of resistance and survivalist ethic, by establishing how Gyasi uses the matriarch figure in her novel to model a spiritual praxis. As previously stated, a spiritual praxis constitutes three overarching characteristics: cartography of the African Diaspora, community-based model of healing and a holistic ontological system. I will demonstrate how Gifty's mother evokes each of these conditions, ultimately ushering Gifty's healing journey.

The Mother, Daughter, and the Holy Spiritual Praxis

> Were there places in the world where neighbours would have greeted us instead of turning away? Places where my classmates wouldn't have made fun of my name-called me charcoal, called me monkey, called me worse? I couldn't imagine it. I couldn't let

myself imagine it, because if I did, if I saw it-that other world- I would have wanted to go (Gyasi, 2020, p. 69).

Cartography of the African Diaspora. During one of her mother's bouts of depression, Gifty travels to Kumasi to stay with her Aunt Joyce. Up until this point, the Ghanaian motherland exists purely in Gifty's imagination, fashioned from a few anecdotes shared by her father. Her connection to Ghana is weak as she has no strong cultural, familial or ancestral ties to her mother's homeland. Her relations with her Ghanaian relatives are either estranged or nonexistent, and she is largely alienated from Ghanaian customs and traditions. The decision for Gifty to travel 'back home' is made by her mother who feels Gifty will not only be carefully looked after, but also strategically positioned to aid her wellbeing: "You can go to church in Ghana. I need spiritual warfare. You'll be my warrior, won't you?" (Gyasi, 2020, p. 203). It is the mother's belief that back home, on the continent, Gifty can find a way to induce her mother's healing. This charge is met reluctantly by Gifty who desires to stay with her mother in the US, and who has since become skeptical of the power of prayer. Although Gifty finds it difficult to initially adapt to her new setting, she is able to quickly pick up her mother tongue, re-familiarize herself with the traditions and everyday habits of her people, and slowly begin to integrate herself within the Ghanaian community: "That summer in Ghana, I learned to pound fufu. I learned to haggle at the market, to get used to cold- water bucket baths, to shake coconuts down from their trees..." (Gyasi, 2020, p. 207). Her adaptation to her new environment emboldens Gifty, who will later rely on her skills of settlement and integration during her time away at graduate school. However, her most profound lesson unfolds during a marketplace encounter. While in Kejetia, she encounters "a crazy person" (Gyasi, 2020, p. 3). The episode is alarming for Gifty, who is fearful of the man, but is more strongly concerned with the backlash and gossip

the man's open display of madness may incur: “I was mortified. My aunt was speaking so loudly, and the man, tall with dust caked into his dreadlocks, was within earshot. ‘I see. I see,’ I answered in a low hiss. The man continued past us, mumbling to himself as he waved his hands about in gestures that only he could understand” (Gyasi, 2020, p. 3). It is in the opening pages of the novel that Gifty recounts this childhood memory. The public display of the “crazy man” causes her to reckon with her personal taboos surrounding mental illness. As she watches this man, she draws comparisons to her sick mother: “I'm not sure what crazy looks like, but even today when I hear the word I picture a split screen, the dreadlock man in Kejetia on one side, my mother lying in the bed on the other” (Gyasi, 2020, p. 4). Gifty’s exposure to this man's mental illness, which recalls that of her own mother’s, allows her to start considering what it might mean to approach mental illness differently and the importance of doing so. The knowledge that mental illnesses can afflict anyone; that it does not need to be treated under a shroud of secrecy and embarrassment; and that someone suffering from mental health issues can still be a part of the social fabric of society, rewards Gifty with new insights into mental health from a different cultural context.

Gifty also witnesses the collective acceptance of the man's malady modeled by the Ghanaian community: “I think about how no one at all reacted to that man in the market, not in fear or disgust, nothing, save my aunt, who wanted me to look. He was, it seemed to me, at perfect peace, even as he gesticulated widely, even as he mumbled” (Gyasi, 2020, p. 4). In seeing the response of her community, Gifty begins to think about mental illness less negatively, and it inspires a flickering hope that her mother might similarly attain this man's “perfect peace” amidst her mental health struggles. Here, mental illness is not viewed as a personal failing, personal weakness, or even a spectacle: “The sea of people in Kejetia didn’t part for him, didn’t back

away in fear. If his presence was weather, it was a cloud on an otherwise clear day. It wasn't a tornado; it wasn't even a storm" (Gyasi, 2020, p. 122). The non-reaction from the crowd suggests that although the man is visibly unwell, he is still regarded as member of the community, and by extension, is still deserving to take up space, even in an overcrowded market. A study by Neil Quinn (2007) found there is "greater acceptance of and less stigma towards people with mental health problems" in Ghana, especially within rural areas (p.187). This is likely because traditional beliefs about mental illness in Ghana are attributed to factors outside an individual's control and requiring societal interventions (Quinn, 2007). This reframing of mental illness cuts through the neoliberal logic of care prioritized in the West that demands individuals pull themselves up by the bootstraps to be well and treats mental health issues as private as their market relations. Thus, her visit to Ghana, among her culture and kin, brings her new, albeit traditional, insights concerning mental illness, and opens her eyes to the ways in which dealing with her mother's mental health struggles and her own needs to change.

Community based model of healing.

> I should have said all of this to Katherine. She was a great doctor, an empathetic person, but when I tried to broach the topic of my mother, my words turned to ashes in my mouth (Gyasi, 2020, p. 84).

The novel suggests that Gifty's and her mother's mental health journeys are tied to each other. In order for one to be well, both characters must take the necessary steps to begin healing. It is the mother's continued decline that eventually motivates Gifty to open up to her colleagues and accept their help. Although Gifty desires to heal her mother independently, she is unable to, and struggles with the next steps to take: "What was the ethical thing to do? Was it right of me to let her stay in that bed courting death, practicing for it, even? I turned this question over in my head

every day, playing out the possible scenarios, the things I could do, should do...” (Gyasi, 2020, p. 84). Eventually, her mother's worsening condition forces her to rely on communal support and aid. By accepting external help, Gifty is able to prioritize her own wellbeing and cultivate other areas of her life that she had neglected by assuming the role of sole caregiver for her mother. By expressing her vulnerability to those from whom she requires help, she is able to develop stronger and healthier bonds with her colleagues and feel a sense of personal relief and freedom by disclosing her suffering (Gyasi, 2020, p. 184). Her relationships — platonic and budding romances —help her socialize and restore some optimism and hope to her life. In addition to offering emotional support and encouraging Gifty to prioritize her own mental wellbeing, her peers assist her materially. They help by cooking and baking meals, notetaking to help her stay on top of her studies and offering other instrumental forms of help. These various forms of emotional and tangible support from those around her speak to the importance of not only healing in community but the necessity for community to aid in healing. This community-based model of healing serves as a particularly helpful counter-attack to the exclusion and isolation Gifty originally experienced in Alabama, within and beyond her church community. By creating her own networks of support that are loving, empathetic and helpful Gifty takes a stronger and more confident step forward on her healing journey.

Holistic Ontological System of Wellness. Gifty's mother values the Spirit and takes her inspiration, wisdom and devotion from her faith. Even in her depressive state, she adamantly believes the Bible/Word of God are tools for salvation (Gyasi, 2020, p. 20). While Gifty's mother does not have a scientific rationale for the loss of her child, she is aware that knowledge about what happened will not be answered with a scientific explanation of the problem. Instead, it is through her faith that she intends to make sense of what is happening to her. Knowledge about

her pain and suffering is taught in the bible passages she reads, the parables she recites and the psalms she sings and laments. By turning to these sources, she slowly works through the unspeakable grief of burying her son. While this alone does not facilitate her healing, it does serve as a useful adaptive strategy to help her cope. Spiritual outlets are not typically consulted or included in psychiatric care, and often are positioned as antithetical to healing. However, for Gifty's mother, and other religious patrons, these measures provide other ways of learning how to be well.

In addition to spiritual tools serving as one way to arrive at healing, Gyasi presents personal testimony as the other vehicle. In the novel, it is ultimately the mother's testimony of the unspeakable grief she carries with her that functions as a means of knowledge construction, translation and validation for Gifty: "We had been trying something new in our relationship. It involved my mother not evading my questions; it involved telling me the truth. She hated it, but I held more cards than I had in childhood, and so she shared things with me that she never would have back then" (Gyasi, 2020, p. 214). As she begins to openly discuss her son's passing with her daughter and her struggle with depression, she is able to begin dressing the wound suffered all those years ago. It is through these intimate shared details of her mother's pain, guilt and disappointment that Gifty can start to face her grief. This recognition allows her to realize that despite her best efforts, she too has been struggling with the passing of her brother, and that she has been mentally, emotionally and spiritually stunted by his death. Testimony becomes the platform of truth and reconciliation for Gifty, who has buried her feelings and emotions while striving for an empirically sound and objective reasoning of her brother's overdose. It is through her mother's personal testimony that she is able to absolve herself from the shame of not being able to stop the tide of events and it is through her mother's testimony that she is able to undergo

a process of self recovery: “I felt so little continuity between who I was as a child and who I was now…” (Gyasi, 2020, p. 18). The grief she experienced forced her to abandon the little girl from childhood, who she perceived as weak, and naïve. On her healing journey she is able to reckon with her ‘inner child,’ and value the incredible strength and perseverance she demonstrated. The self-discovery enabled through the shared testimonies marks an important step forward for Gifty. This other way of knowing, other means of making sense of one's life, and alternative approach to gaining clarity and understanding, is empowered by a holistic ontological system that values and embraces Black women's lived experiences, shared trauma and broken dreams. In turn, Gifty no longer needs to run from her past, but can confront it with the knowledge that she is emotionally equipped to address her trauma and affirm who she is in relation to it, rather than losing herself within it. In the end of the novel, Gifty is able to complete her dissertation. While the completion of her project offers her some satisfaction, it is the understanding of her mother that finally ushers in her spiritual renewal and redemption.

The novel concludes a few months after Gifty completes her doctoral degree. The readers are informed that Gifty's mother has passed. The shock is cushioned by the knowledge of Gifty’s transformation and growth. Gifty, now a doctor of neuroscience, has discovered a balance between scientism and spirituality; love and work; tradition and change; healing and grieving. No longer caught between binaries, Gifty embraces a holistic, multivalent outlook on life that transcends western dichotomies and dictum:

> But this tension, this idea that one must necessarily choose between science and religion, is false. I used to see the world through a God lens, and when that lens clouded, I turned to science. Both became, for me, valuable ways of seeing, but ultimately both have failed to fully satisfy their aim: to make clear, to make meaning (Gyasi, 2020, p. 198).

Instead, our protagonist opts for a spiritual openness that values and makes space for intellectual curiosity and faithfulness. A spirituality that values the interconnectivity of all things living and dead and judges the grey areas of life as invitations rather than provocations. While the novel refrains from presenting Gifty as completely healed, the spiritual praxis evoked by her mother will continue to help her on her healing journey as she mourns the loss of her family and begins her own. However, what is evidently clear is that Gifty has the internal resources and emotional capacity to prioritize her wellbeing. No longer searching for healing in divine interventions or in scientific experimentations, Gifty has learned that two things can be true at once: healing exists in the quotidian, and that in itself can be transcendent.

In line with A Black Feminist Psychology Framework, Yaa Gyasi's *Transcendent Kingdom* (2020) models a way forward for improving mental healthcare service delivery for Black communities. The novel espouses what I have defined as a "spiritual praxis of healing," which presents innovative ways of thinking about how informal and formal mental healthcare service providers can structure their community and clinical interventions for Black communities. Centering ancestral knowledges and worldviews, emphasizing communal support for addressing emotional and material needs, and prioritizing nuanced ways of defining one's pain are presented as important building blocks for fostering Black peoples' wellbeing.
While Gyasi represents a spiritual praxis through her matriarch figure, Alice Walker in *Possessing the Secret of Joy* (1992), represents a spiritual praxis through the *format* of her novel. Her experimental literary format offers important insights into how we might move from a place of psychic trauma, grief and depression towards an emancipatory wellness.

Possessing the Secret of Joy

The final book under investigation is *Possessing the Secret of Joy* (1992) by internationally celebrated author Alice Walker (1944-). Alice Walker is perhaps most famously known for her Pulitzer award winning novel, *The Color Purple,* which debuted in 1982 and marked her as the first African American woman to win the Pulitzer Prize in fiction and the National Book Award. Since then, her impressive literary outputs include collections of short stories, essays, penned poems, and children's books. She is largely regarded for her creative sensitivity which captures intimate portraits of the devastating effects of racial violence and interlocking oppressions of white racism, patriarchy and classism that impact Black life. Walker offers spiritual ruminations that inspire political activism whilst thinking through novel ways to relate to one another and nature. Although Walker's contributions to the canon as an essayist, novelist and storyteller are substantial, even greater is her influence on the Womanist tradition. In *Search of our Mothers' Gardens: Womanist Prose* (1983), Walker explores a womanist framework that inherently values the gift of spirituality as a means and method of survival. She aligns womanism with the overarching tradition of Black feminism(s): "womanist is to feminist as purple is to lavender," but emphasizes Womanism's specific orientation towards humans' spirituality and intersectionality (Walker, 1982). Womanism celebrates the interior spiritual resources of Black and racialized women and promotes a spiritual practice of community building and political mobilization for effecting change and targeting interlocking oppressions. This philosophical stance frames much of Alice Walker's writings. Thus, Walker's work is uniquely positioned to think through a spiritual praxis of healing and can help to achieve the objectives of A Black Feminist Psychology Framework, which is similarly invested in spirituality's radical liberatory potential.

Possessing the Secret of Joy was written in 1992 at the height of Walker's political activism against female genital mutilation (FGM).[92] Walker's public condemnation of the traditional practice in “African, Far Eastern and Middle Eastern countries” helped to raise global awareness on the pressing health emergency (Walker, 1992, p. 281). Her advocacy includes fundraisers for African organizations working to end FGM, a documentary with filmmaker Pratibha Parmar, titled *Warrior Marks: Female Genital Mutilation and the Sexual Blinding of Women,* accompanied by a companion book by the same title, which traces the socio-political complexities of the practice and its harrowing effects on its victims, and of course, a fictional novel exploring the subject matter as well. Through her engagement with different mediums, her work serves to democratically bring visibility and understanding among the masses, so others may enter the conversation and add their voices to the campaign. Alice Walker's meditation on FGM in *Possessing the Secret of Joy* places her among other fellow Black feminist literary writers who have used their artistic platforms to address social injustices facing Black women across the Diaspora.[93] Writing across seas and oceans, she grounds her interrogations within and beyond feminist scholarship to extend to political realms and public health discourses. Walker leverages her novel as a fictional sustained study on the practice of FGM and as a clarion call to end the violent practice, which yields interminable physical and psychological consequences on its victims. The novel presents a protagonist who undergoes the controversial procedure and

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[92] “There are three types of female circumcision: sunna circumcision, referring to the removal of the prepuce or vaginal foreskin; clitoridectomy, referring to the detachment of the clitoris; and infibulation, referring to an excision of both sides of the vulva, which is then scraped raw and sewn together, often in less-than-sanitary conditions. Infibulation leaves only a small opening for the vagina, which can give heightened sexual pleasure to a man during intercourse, but makes urination, menstruation, intercourse, especially the birth process, not only painful but life threatening" (Moore, 2000, p. 113).

[93] Walker donated royalties from the novel to help educate men and women about the "hazardous effects of genital mutilation” (Walker, 1992, p. 266).

details the resultant struggle with her mental health. Walker offers the readers an in-depth look into the pain and suffering that haunts the protagonist in the aftermath of her FGM; yet, she also presents a path towards recovery and healing for her protagonist. Cemented into the foundation of the novel's structure is a spiritual praxis for healing that inspires resistance for the characters and the wider audience.

Possessing the Secret of Joy follows Tashi-Evelyn, a young African woman who partakes in the FGM ritual of her ancestors in a misguided anti-colonial effort to reclaim and assert her cultural legacy. The ravaging effects of colonialism in her birthplace, Olinka, inspired a rise in nationalism in its wake. Tashi-Evelyn believes the Olinkans' sacred "bath," a euphemism for FGM, is a means of maintaining cultural purity and aligning herself with the liberation fighters that are engaged in an armed struggle for the independence of their country and people: "The operation she'd had done to herself joined her, she felt, to these women, whom she envisioned as strong, invincible. Completely woman. Completely African. Completely Olinka. In her imagination, on her long journey to the camp, they had seemed terribly bold, terribly revolutionary, and free" (Walker, 1992, p. 63). Although the procedure is traditionally conducted in childhood, the death of Tashi-Evelyn's sister, Dura, from complications of FGM, prompted the family's discontinuation of the practice and their conversion to Christianity. Years later, in the United States living with her Christian missionary American husband, Adam, Tashi-Evelyn begins to feel estranged from her homeland and her people. Her feelings of cultural alienation prompt Tashi to make a fateful decision to return to Olinka and have the procedure. She states that she wants:

> To be accepted as a real woman by the Olinka people; to stop the jeering. Otherwise I was a thing. Worse, because of my friendship with Adam's family and my special relationship to him, I was never trusted, considered a potential traitor, even. Besides, Our Leader, our Jesus Christ, said we must keep all our old ways and that no Olinka man–in this he echoed the great liberator Kenyatta– would even think of marrying a woman who was not circumcised (Walker, 1992, p.120-121).

Tashi-Evelyn's blind allegiance to tribal traditions and societal expectations of femininity result in her voluntary submission to have the female initiation ceremony. The physical healing process is painful and arduous,[94] yet, the mental consequences of the procedure yields even more substantial consequences: "It was heartbreaking to see, on their return, how passive Tashi had become...That her soul had been dealt a mortal blow was plain to anyone who dared to look into her eyes" (Walker, 1992, p.65). Her mental health deteriorates as she faces the emotional costs of her decision, which impacts her relationships, wellbeing and cultural acceptance. Tashi-Evelyn is presented as experiencing depression, evidenced through her anhedonia, and while we as readers don't receive explicit diagnoses, post-traumatic stress disorder (PTSD) and mania are alluded to as potential psychiatric diagnoses. Her psychotic episodes are triggered by repressed memories from her past that conflate with her contemporaneous feelings of anguish, anger and cultural alienation. Thus, Walker characterizes Tashi-Evelyn as unwell and unable to be treated by

[94] "It now took a quarter of an hour for her to pee. Her menstrual periods lasted ten days. She was incapacitated by cramps nearly half the month. There were premenstrual cramps: cramps caused by the near impossibility of flow passing through so tiny an aperture as M'Lissa had left, after fastening together the raw sides of Tashi's vagina with a couple of thorns and inserting a straw so that in healing, the traumatized flesh might not grow together, shutting the opening completely; cramps caused by the residual flow that could not find its way out, was not reabsorbed into her body, and had nowhere to go. There was the odor, too, of soured blood, which no amount of scrubbing, until we got to America, ever washed off" (Walker, 1992, p.64).

Western forms of therapy or within psychiatric institutions. Therefore, instead of rooting Tashi-Evelyn's wellness journey exclusively in western medicine or approaches to care, Walker instead models a spiritual praxis of healing that celebrates a holistic ontological system, community-based model of healing and cartography of the African diaspora for Tashi-Evelyn's wellbeing.

Formatting a Spiritual Praxis of Healing

Holistic Ontological System of Wellness. Throughout the novel, parables, myths and dreams are deployed to capture the intensity and breadth of Tashi-Evelyn's experiences. The audience is informed early in the novel that Tashi-Evelyn is an avid storyteller, and often speaks through fables to make sense of her circumstances. Reflecting on a conversation she had with her therapist, Raye, Tashi states:

> I told Raye about my lifelong tendency to escape from reality into the realm of fantasy and storytelling. Without this habit, I said, it would be impossible for me to guess anything out of the ordinary had happened to me...I mean, if I find myself way off into an improbable tale, imagining it or telling it, then I can guess something horrible has happened to me and that I can't bear to think about it (Walker, 1992, p.130).

By expressing herself in this manner, Tashi-Evelyn relies on other means of communicating her truth. Walker uses these forms of storytelling in her novel as a means of truth telling. Here, the inclusion of tales that range from fantasy, the supernatural and ominous to horror offers another means to voice and translate experiences that are beyond articulating. Tashi-Evelyn’s experiences of pain are unfathomable through ordinary conversations and so she relies on alternative means of expressing her emotions of rage and sadness. The story of her birth, her sister's death, and her FGM ceremony are recounted to us through either fanciful stories, artistic

paintings or vivid dreams. Her refrain from relying on everyday language to capture her experiences, and her preference to opt for metaphors and symbols to convey meaning, suggests that generic forms of theorizing one's experiences are not always sufficient: “she dreams they have imprisoned her and broken her wings” (Walker, 1992, p. 27). Tashi-Evelyn's reoccurring dream of being locked in a dark tower with clipped angel wings, speaks to her experiences of feeling caged in by Olinkan “tribalism and sexism,” which demands the loss of her innocence and womanhood (Moore, 2000, p. 113). Walker presents us with a protagonist who draws on her own meaning making systems and epistemologies to unpack her trauma and move towards healing. Indeed, Tashi-Evelyn’s reliance on these forms of storytelling challenges her to understand on her own terms the trauma she has faced and allows her to progress on her healing journey.

Walker demonstrates for readers that a holistic ontological system can serve as an important vehicle for knowledge production and knowledge affirmation. Further, Walker speaks to the liberatory potential of choosing *how* one decides to arrive at their truth, even if it extends beyond conventional knowledge systems and practices. The backdrop of the story is Tashi-Evelyn's court case, in which she is on trial for murdering her female circumcizer (T*sunga*). Similarly to *The Book of Emma*, the setting of truth telling is one that is overwrought with surveillance, patriarchal authority, and state-sanctioned violence. Ironically, all of these factors are also largely responsible for Tashi-Evelyn's circumcision, ensuing madness, and ultimate decision to murder. Thus, the setting of the courtroom for establishing truth and culpability for Tashi-Evelyn is contradictory from the outset. Hence, Walker represents Tashi-Evelyn as experimenting with her own forms of truth-making. Walker is suggesting that some truths defy how we are trained to recognize validity and deem its importance, and therefore, new measures

must be uncovered. Standing on trial in the court room, Tashi-Evelyn begins to artfully weave a tale concerning her decision to purchase razors, the suspected murder weapon:

> Once upon a time there was a man with a very long and tough beard.... I began without thinking. Stopping only when it dawned on me that the entire courtroom had burst into laughter. Even Olivia, when I cast a glance at her, was smiling. Oh, Tashi, her look seemed to say, even here, on trial for your life, you are still making things up! If you would be so kind as to answer the question, says the dapper young attorney, and not attempt to indulge and distract the court with your fantasy life. My fantasy life. Without it I'm afraid to exist (Walker, 1992, p.35).

In an effort to contest traditionally accepted, top-down approaches of validity and objectivity (as modeled in a court of law), Walker has Tashi-Evelyn impose her own meaning systems for how she processes, arrives and stands in her truth. Therefore, through storytelling, dreams, artistic paintings, metaphors, symbolic imagery and visions, Tashi-Evelyn relies on non-conventional and abstract methods to communicate her traumatic realities and express her personal convictions. These nuanced approaches of meaning-making are integrated into the structure of the overarching narrative of the novel. Thus, Walker affirms a holistic ontological system as central to a spiritual praxis that promotes healing.

Community Model of Healing. The importance of community for one's wellness journey is emphasized through Walker's format and contributes to a spiritual praxis of healing. Walker employs several characters to help carry the narrative. In addition to Tashi-Evelyn, our main narrator, several secondary characters take up the torch. Tashi-Evelyn's husband Adam, her son Benny, her childhood best friend Oliva, Adam's mistress Lisette, M'lissa the circumcizer*,* and many others add their perspectives and reactions to Tashi's narrative. Together, their voices create a collective utterance of the tragic tale and unspeakable violence that Tashi-Evelyn endures. Each character helps to move the narrative along and fill in gaps where Tashi-Evelyn herself has failed to close. The number of frames through which we hear the story emphasizes the significance of interconnectivity for the reader. Each character plays an instrumental role in Tashi-Evelyn's life, either as supporters, instigators, perpetrators, or witnesses of Tashi-Evelyn's pain. Their lives are interconnected with Tashi-Evelyn's and Tashi-Evelyn's healing is bound to them. Through these multiple perspectives we learn that Tashi-Evelyn's madness has impacted all of them in unique ways, and that everyone must participate in (re)dressing the wounds if they are to free themselves and Tashi-Evelyn from the grips of madness. M'lissa, the *Tsunga,* must accept accountability for circumcising young women in the village under the pretense of cultural humility and purity. Adam, Tashi-Evelyn's husband, must recognize that his negation and embarrassment of the traditional rite prevented him from understanding Tashi-Evelyn's intense cultural alienation. Lisette, Adam's European mistress, must recognize her consent to an affair with Adam augmented the loss and dispossession Tashi-Evelyn experienced at the hands of colonizers, and later, her own people. The list of accountabilities is extensive. In the novel's epigraph, Walker cites: "when the axe came into the forest, the trees said the handle is one of us" (Walker, 1992, p. xi). The quotation speaks to the relationship between responsibility,

accountability and interconnectivity and frames the proceeding story; each character must unpack how they have contributed to Tashi-Evelyn's misfortune to assist Tashi-Evelyn on her wellness journey and save themselves too. Writing this story through a multivocal narration, then, works not only to emphasize the necessity for a community model of healing, but it also speaks to Walker's political impetus to break the collective silence that enshrouds FGM to achieve wellbeing for all future victims.

Healing through community is also emphasized in the novel's structure through the division of chapters. Walker refers to each chapter as a "Part." This subtle renaming speaks to the importance of individual segments joining together to create a cohesive whole, a message that echoes the author's own imperative to corral people to work together to address FGM on a wider and international front. In the same way that each "part" is useful for offering readers understanding of the plot's complete storyline, so too does transformative policy change require the involvement of all parties— health units, grassroots organizations, political leaders, and community stakeholders—to generate change. If attempted, small individual efforts can make significant communal changes. At the end of the novel, Tashi-Evelyn's trial has brought together a formidable community of supporters committed to fighting in the resistance: "Professional women visit the president to ask for an appeal of Tashi's death sentence while other women stand vigil outside the jail in solidarity with Tashi-Evelyn, even as they are faced with men physically and verbally abusing them" (Buckman, 1995, p.93). Their activism is ignited by Tashi-Evelyn's act of resistance against the patriarchy, which is marked by her murder of the *Tsunga*, "a national monument," and her vocal protests of the cultural taboo (Walker, 1992, p.147). Moreover, "part" signals to the reader that each piece is not only inchoate on its own but incomplete. Arguably, this may be read as a caution against non-comprehensive approaches to

care. Mainstream healing interventions that only address one vector of oppression but overlook or dismiss others, will similarly be fragmentary and faulty. Healing must target personal issues in tandem with larger social justice issues, an approach affirmed by parish ministers and psychotherapists in my study. Tashi-Evelyn's madness may be the result of her personal decision to undergo the female initiation ceremony, but larger structural factors such as colonialism and patriarchy created the conditions for this fateful event. Thus, healing must target structural forces operating outside of one's immediate social network and idiosyncratic choices to address underlying systemic issues influencing one's livelihood and existence. These changes require communal support and collective mobilization. Walker's own activism on this issue has mirrored this all-encompassing form of political organizing.

The blurring of boundaries between literary genres also serves to emphasize the importance of community for healing and activism. Walker seamlessly combines epistolary writing, folktales, myths, and dream allegories in her novel's format to draw on the collective strengths of each literary and cultural tradition. One literary form bleeds into the next, with little regard for formalities, transitions or explanations. I argue this exercise of genre blending speaks to the symbolic importance of uniting across fabricated "marked" differences to collaboratively address important issues. Walker relies on various literary genres to convey her story and the result is a comprehensive and critical engagement of FGM and its colossal impact. Walker's approach speaks volumes concerning the fluidity of genres, which are often policed by literary conventions. Her "transgression" teaches us that nuanced work requires defying these strictly held canonized directives. Indeed, Walker may be suggesting through this literary maneuver that large important issues such as FGM warrant innovative and collaborative approaches. Through Walker's personal activism on this issue, she has engaged various mediums to reach wider

audiences. Perhaps the sliding of boundaries between literary genres speaks to this very impulse. Walker may be insinuating that multiple approaches can help target and tackle misconceptions about FGM to spread greater global awareness. By employing different genres, she meticulously explores the complexities of FGM and its effects. Dream sequences convey the haunting persistence of FGM's effects that disturb not only one's waking-physical life but their psychic state as well. The letters penned by Tashi-Evelyn and her loved ones humanize the pain and emotional weight FGM carries for all recipients explicitly named and unnamed in the novel's address, compelling audiences to consider their own collusion in social injustices. The myths offer a meta-narration on the hegemony of cultural taboos and customs that demand individuals' blind obedience and loyalties (Cogeanu, 2011). Together, Walker uses the different literary genres to collaboratively engage the topic of FGM and help make sense of it through a combined style of written literary and oral storytelling traditions. Thus, composing her novel in this way may be read as Walker gesturing once again towards the importance of communal efforts to promote and inspire healing. Healing as a communal-activist undertaking echoes the findings from my interviews, which affirm the need for multi-level collaboration.[95]

Cartography of the African Diaspora. Lastly, Walker's structure of the novel emphasizes the significance of mapping a cartography of the African Diaspora to usher healing. Walker's literary format achieves this through three main practices: name-changes, intertextuality, and a fabricated African language. Throughout the course of the novel there are at

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[95] Although the focus was on collaboration between parish ministers and psychotherapists, the novels show us that other collaborative partnerships can and should be pursued as well.

least six variations[96] of Tashi-Evelyn's name: Tashi, Evelyn, Tashi-Evelyn, Evelyn-Tashi, Tashi-Evelyn-Mrs. Johnson, Tashi-Evelyn Johnson Soul. Some monikers center her western, American identity, others rely explicitly on her African heritage, and a few formations combine two or three of her namesakes. The aesthetic name changing practice speaks to the African Diaspora and its pretense of hybridity. Due to the trans-Atlantic slave trade and forceful migration of Black peoples from their native lands, the African Diaspora captures the heterogeneity and diversity of identity which is reproduced through an individuals' encounter with different lands, cultures, and peoples (Hall, 1990). Each of Tashi's names symbolize her different relationships to the places she has visited and the time she has spent in each location, including, but not limited to Olinka, the United States, and even her travels in Europe to Switzerland. Her cultural identity is constantly in motion; shaping and reproducing itself as she adopts new habits, worldviews and traditions. As Stuart Hall states in "Cultural Identity and Diaspora:" "cultural identity is not a fixed essence at all, lying unchanged outside history and culture. It is not some universal and transcendental spirit inside us on which history has made no fundamental mark. It is not once-and-for-all. It is not a fixed origin to which we can make some final and absolute Return" (Hall, 1990, p.226). Indeed, this conceptualization of cultural identity is favoured by Walker, who presents fluidity in African identity as a means of achieving a viable sense of belonging, community and overall, strong wellbeing. Thus, her depiction of Tashi-Evelyn's

[96] "Walker creates six personas: Tashi, the troubled African child who submits to the tribal rites of scarification and circumcision and upon whom silence is imposed; Evelyn, the scarred adult Tashi who becomes an American citizen; Tashi-Evelyn, the African American whose cultural duality is dominated by the nightmarish remembrance of her African past; Evelyn-Tashi, the Americanized African whose cultural selves coalesce into a picture of herself as a Wounded American (Walker, 1992, p.167); and Tashi-Evelyn-Mrs. Johnson, the aging matriarchal composite of selves who confesses to killing M'Lissa, the mutilator or tsunga (a Walker neologism), who reconciles herself with Lisette, Adam's mistress, and Pierre, Lisette's son by Adam. And, finally, there is Tashi Evelyn Johnson Soul, who achieves the Self upon her reconciliation of opposites, resistance to lies, and acceptance of death for her "crime" of alerting other women to her conviction that resistance to lies (imposed through silence upon suffering women in a patriarchal social order) is the real secret of joy" (Moore, 2000, p.114).

pursuit of a fixed and frozen Olinkan cultural identity is represented as a ‘mad’ desire that precipitates her dangerous mental decline.

Tashi-Evelyn’s adamant refusal to understand or articulate her diasporic identity in more fluid and mutable terms results in her decision to return to her homeland as a means of preserving her presumed cultural 'purity' and maintaining cultural fidelity to Olinka. Tashi-Evelyn’s belief that she is not ‘true Olinkan’ without the physical markings and scarring of her people, speaks to her limited understanding of identity as one that is easily corrupted and defiled by migration and difference rather than empowered by it. Her inability to embrace, adapt and reconceptualize her cultural identity results in an over-romanticization of the circumcision procedure and blinds her to its patriarchal and nationalistic underpinnings: “We had been stripped of everything but our Black skins. Here and there a defiant cheek bore the mark of our withered tribe. These marks gave me courage. I wanted such a mark for myself” (Walker, 1992, p. 24). Tashi-Evelyn believes honoring her people and her culture is only possible through physical acts (mutilation, infibulation, face scarring). This fantasy deludes her into thinking her African traditions can be recovered and reasserted, countering the impact of colonization and Christian missionaries. As Stuart Hall warns, attempts at a ‘return’ to a homeland untouched by the events of history is not possible (Hall, 1990, p.235). Indeed, one’s yearning to “return to the beginning,” is a vain pursuit (Hall, 1990, p.236) Unsurprisingly then, Tashi-Evelyn's attempt to ‘return’ home to reconcile with her ‘lost’ origins is futile. Therefore, through name changes Walker presents what Tashi-Evelyn is unable to do, which is recognize her diasporic identity as one “which lives with and through, not despite difference” (Hall, 1990, p.236). If Tashi-Evelyn was able to embrace the notion of a diasporic identity, and not seek to restore a ‘pure’ or fixed Olinkan identity, she would have been able to consider other measures to reconnect to her culture

and support her people that did not require her mutilation. In the end of the novel, Tashi-Evelyn signs off her letter to Lisette using each of her names; “Tashi Evelyn Johnson” (Walker, 1992, p. 277). Unfortunately, it is only at the end of her life that Tashi-Evelyn can reconcile her hybrid cultural identity and feel “satisfied” (Walker, 1992, p. 279).

The necessity for mapping a cartography of the African diaspora for one's wellness journey is also modeled through the novel's intertextuality. Throughout the novel, several influential Black theorists are heralded through Pierre's readings (Langston Hughes, James Baldwin, Richard Wright), as he tries to work through his stepmother's depression, or, what Tashi-Evelyn refers to as her “dark tower” (Walker, 1992, p.175). Pierre's father remarks: “Since the moment, as a small boy, Pierre heard of Tashi-Evelyn’s dark tower and her terror of it, he has never put her suffering out of his mind. Everything he learns, no matter how trivial or in what context or with whom, he brings to bear on her dilemma” (Walker, 1992, p.175). His readings speak across different disciplines as he unpacks how they theorize freedom, heterosexual relationships, queer sexuality, and other central concerns that structure his life and the lives of those around him. These intertextual references frame Walker’s novel within the context of a Black diaspora literary tradition, which takes the experiences of Black lives, past and present, and helps to reimagine new potentialities and freedom-making practices for Black lives in the future. These works create a time continuum between theorists, activists and artists to present new ways of knowing, in addition to, recovering age old insights that can be re-applied to contemporary concerns. Pierre learns much from these thinkers, and his quest for knowledge serves as a meta-narrative. Pierre demonstrates that there is great emancipatory power in acquiring knowledge in this manner to help improve individuals' wellbeing. Indeed, Pierre’s wealth of knowledge, particularly of Indigenous African practices and histories, inspires his

commitment to help others who are struggling with their mental health. Tashi-Evelyn finds great solace in Pierre's work and writes to Pierre's mother praising his dedication to helping heal others: "This, Lisette is your son. I still find him absurdly small for a man, but he is big in mind. On the day of my execution, he says, he will rededicate himself to his life's work: destroying for other women-and their men- the terrors of the dark tower. A tower you told him about" (Walker, 1992, p. 276). Relying on the insights and resources of our forebears throughout time and space can serve as an educational tool in helping to effect change and bring healing. In addition to these references, famous western psychologists are alluded to as well, most notably, Carl Jung.[97] These intertextual examples across time, geographic borders, fiction and reality represent the African Diaspora and our ability to mobilize knowledge, theorists and interventions across it to inform our understanding about our lived realities. This form of knowledge transfer carries the potential to equip all individuals with the resources and understanding they need to be well. In the end of the novel, Tashi-Evelyn's band of followers deem resistance 'the secret of joy,' a conclusion derived after their careful consideration of the ways in which Africans throughout the Diaspora, have theorized their survival and enacted it.

The final practice Walker employs to emphasize the importance of mapping the African Diaspora for one's wellness journey is through her neologisms. Walker states this of her fictionally constructed language and setting of the novel:

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[97] The allusion to Carl Jung is made through the character Mzee, the "doctor of the soul" (Walker, 1992, p. 49). "Possessing the Secret of Joy is most clearly Jungian, for even in the afterword of the book, Walker acknowledges reading Jung in her own "self-therapy" (Moore, 2000, p.112). However, despite Walker's inclusion of Carl Jung and her favorable portrayal of him, Walker still presents traditional western psychoanalytic models as insufficient for healing her protagonist.

> Tsunga, like many of my “African” words, is made up. Perhaps it, and the other words I use, are from an African language I used to know, now tossed up by my unconscious. I do not know from what part of Africa my African ancestors came, and so I claim the continent. I suppose I have created Olinka as my village and the Olinkas as one of my ancient, ancestral tribal peoples. Certainly, I recognize Tashi as my sister (Walker, 1992, p.283).

I understand these fictional expressions as Walker speaking to the self-creation and mythical nature of the Black Diaspora,[98] and how one must map their own relationship to it to improve not only their wellbeing, but the wellbeing of others. By creating a symbolic relationship with her African ancestors, Walker can take on the plights of African people as her own, “Certainly, I recognize Tashi as my sister,” and use her resources and platforms to help address the injustices Africans experience (Walker, 1992, p.283). By inventing a location and tribe where FGM is practiced, Walker creates a psychic partnership with those on the continent to draw attention to the hazardous practice of FGM among the people there and throughout the Diaspora. Walker's inclusion of the character Amy Maxwell in her novel, who is subjected to FGM in New Orleans at the tender age of eight, suggests Walker is keenly aware that the practice extends beyond the borders of the Global South. Walker reports “on the growing practice of female circumcision in the United States and Europe, among immigrants from countries where it is part of the culture” (Walker, 1992, p. 281). Creating her own setting thereby allows her work on FGM to speak to

[98] “….and yet, this ‘return to the beginning’ is like the imaginary in Lacan - it can neither be fulfilled nor requited, and hence [cultural identity and diaspora] is the beginning of the symbolic, of representation, the infinitely renewable source of desire, memory, myth, search, discovery - in short, the reservoir of our cinematic narratives” (Hall, 1990, p. 236).

anywhere in the world in which FGM is practiced and to anyone on whom it is practiced (Cogeanu, 2011). Indeed, the lack of specificity attributes a particular kind of universality. Thus, by mapping a psychic and symbolic cartography of the African Diaspora through her novel's fictional world, she arrives at coalition and partnership to advocate against FGM throughout the diaspora. For Walker, the African Diaspora exists physically and psychically, and through her fictional formulations she works to cultivate healing and offer refuge to all those who suffered “under the shards of unwashed glass, tin-can tops, rusty razors and dull knives of traditional circumcisers” (Walker, 1992, p.282). Walker demonstrates how tracing the Diaspora through a symbolic act of solidarity can help to physically translate into activism against this practice.

Alice Walker's *Possessing the Secret of Joy* has received acclaim and criticism in equal measure.[99] The criticism for the novel largely centers around its conclusion, which closes with Tashi-Evelyn’s execution. For some critics, Walker’s decision to have the protagonist executed by the courts renders Tashi-Evelyn an archetypal martyr, resigned to a cycle of victimization.[100] For these critics, Tashi-Eveyln has failed her mission: her decision to kill one *Tsunga,* is viewed as ineffective for dismantling the larger oppressive forces that sanction FGM, and her death, is deemed largely inconsequential to the overarching efforts of resistance (Bass, 1994). Walker is condemned for creating a novel that is too “didactic” in its preaching against FGM, which some critics argue fails to think through a more radical response to abolishing the practice and cultivating one's wellbeing in the face of psychic struggle (Kirkus Reviews, 1992). However,

[99] Some critiques argue Walker’s campaign against FGM is largely Westernized, superficial and self-indulgent (See Obiora et al., 1996).
[100] See Stephen's Souris’ “Multiperspectival Consensus: Alice Walker’s *Possessing The Secret of Joy*, The Multiple Narrator Novel and The Practice Of “Female Circumcision” (1997) for a condensed summary of critical reviews on Alice Walker’s *Possessing the Secret of Joy.*

leaving the novel's format unexamined in relation to its content, sets one up for an incomplete analysis. Woven tightly into the form of the novel is a spiritual praxis of healing that captures the subtleties of Walker's activism and educational strategies to tackle FGM, and most notably, her approach to fostering mental wellbeing. Walker's tapestry draws attention to the many oppressive forces that interlock and seek to impede one's psychological wellbeing (such as patriarchy's collusion with colonialism), and the format of her novel takes careful steps to animate strategies one may use to safeguard one's mental health against these forces (Buckman, 1995). A holistic ontological system, community-based model of healing and a cartography of the African Diaspora offers a model of resistance for the audience and healing balm for our protagonist. Therefore, while some of Walker's detractors may view the novel unconcerned with dismantling systems of domination or Tashi-Evelyn's welfare, others, who are familiar with Walker's womanist activism and have carefully traced the evolution of Tashi-Evelyn on her mental health journey, will arrive at a different conclusion. Indeed, within the pages they might recognize Walker's blueprint for political mobilizing, and read Tashi-Evelyn's death as spiritual transcendence made possible through a powerful spiritual praxis of healing.

Black Feminist Psychology (BFP) represents a decolonial pursuit to consider the historical and socio-cultural factors impacting Black Canadians' mental health service delivery, and it aims to dismantle neoliberal mental health efforts that fail to address political injustices as part of a totalizing mental health strategy. I was prompted by this theoretical mode of inquiry to enlist Black feminist writings to (re) write new wellness scripts that may speak to these objectives. Historically, Black women's creative writings have simultaneously engaged the question of resistance and healing, articulating new ways of wellbeing that have yet to be theorized in political or health discourses. Marie-Celie Agnant's *The Book of* Emma (2006), Yaa

Gyasi's *Transcendent Kingdom* (2020) and Alice Walker's *Possessing the Secret of Joy (1992)* make an invaluable contribution to this effort. *The Book of Emma* advances a social justice mental health praxis that addresses the legacies of colonial violence and anti-Black racism through freedom-making practices and wake work. Additionally, *Transcendent Kingdom* and *Possessing the Secret of Joy* model what I have coined a "spiritual praxis of healing." A spiritual praxis of healing supports my BFP framework by offering an alternative viable point of access to think through historically attuned, politically engaged and culturally responsive mental healthcare for Black Canadians. Particularly given its emphasis on holistic ontological ways of processing trauma, community model of healing, and unique charting of African Diasporan connections, traditions and ways of knowing. Moreover, a spiritual praxis of healing yields important implications for thinking through collaboration between formal and informal institutions of care, which can serve as a guiding framework for coalition and capacity building. Indeed, a spiritual praxis of healing may help service providers, such as psychotherapists and parish ministers, to develop culturally relevant programming in clinical and community interventions grounded in afro-centric values and knowledge systems and promote expanded social networks of support that target wider- socio-political injustices. Reimagined mental healthcare service delivery for Black Canadians requires a full-fledged commitment to these priorities for the safety and protection of Black communities' mental health. Hence, the final chapter will consider how advancing A Black Feminist Psychology Framework that recognizes Black mental health at the intersections of self, community, historical consciousness, spirituality and political activism can be mobilized to address the unmet sociopolitical needs and concerns of Black Canadians. The concluding chapter of the dissertation will consider how BFP forcefully swings the pendulum from palliative to transformative mental healthcare for Black Canadians.

Chapter 7- Potentialities

From Palliative Practice to Transformative Praxis

This dissertation aims to think through improving mental healthcare service delivery for Black Canadians through an interdisciplinary lens. My objective is to contribute to the scholarship on wellbeing by changing the questions we ask and the places and people we look to for answers. My engagement with Black parish ministers, Black counselling professionals and Black creative fiction is my attempt to weave together an untold story about mental healthcare service delivery for Black Canadians and the larger forces that impact it. In doing so, I also wanted to think through culturally informed therapeutic interventions that could help address deep historical wounds and target socio-political ills negatively impacting Black communities. This final section turns to a brief discussion of some of the largest obstacles I perceive as preventing the actualization of my findings and I offer future directions for continuing this work. I contend that neoliberalism and the carceral state pose significant limitations to Black Canadians' mental wellbeing, and I propose "critical dreaming" and political organizing as necessary starting points for transitioning from palliative to transformative mental healthcare.

The term "palliative" is most commonly used within the context of medical caregiving; particularly, among people suffering from chronic, degenerative, life limiting, or terminal diseases (World Health Organization, 2020). The aim of palliative care is merely to assuage suffering and provide as much pain relief from the symptoms as possible as the patient awaits their inevitable end. My use of the term "palliative mental healthcare" takes its roots in afropessimism's school of thought and is a conceptual departure from community psychology's notion of 'ameliorative' approaches to mental healthcare. Within community

psychology, “ameliorative efforts" in mental healthcare refers to “person-centered interventions that only contribute marginally to social change” (Prilleltensky, 2008, p.131). Ameliorative efforts are invested in altering the individual rather than transforming societal structures (Prilleltensky, 2008). By extension, “palliative efforts” in mental healthcare encompass not only the systemic negation of the role of power in Black peoples’ lives, but it also foregrounds mental healthcare service delivery’s active facilitation of Black social death. I contend Eurocentric mental healthcare systems position Black communities living in the afterlife of slavery as the “living dead” by limiting their self-actualization and self-determination (Hartman, 2006; Wilderson, 2003). While a research project on mental wellness does not share the same deficit and defeatist orientation as afropessimism,[101] which refutes futurity, wellbeing and humanity in Blackness (Wilderson, 2003); it usefully draws on how the tradition captures conditions of “non-being” through the denial of subjectivity and humanity. Under this operative logic, mental healthcare creates *conditions* of nonbeing/living dead by seeking only to offer end-of-life support, to allay suffering, rather than heal its root causes. Thus, my use of the term “palliative” seeks to explicitly foreground ‘death’ as both the starting and end point of how Black Canadians’ mental healthcare is currently conceptualized. As previously discussed in Chapter Four, the government endorses mental health initiatives that equip people with resources to address their idiosyncratic mental health concerns, rather than targeting systems of oppression that inflict deleterious mental health outcomes (Sugarman, 2015). Through my

[101] My thinking departs from the afropessimist belief that Black people are perpetually marked as the ‘living dead,’ ontologically slaves, or exclusively exist in the conditions of social death (Fanon, 2008; Wilderson, 2003). My project staunchly negates this line of essentialist thinking. I aim merely to draw attention to how particular structural, disciplinary, hegemonic, and interpersonal contexts work to create and reproduce conditions of nonbeing/living dead. The living dead are marked by a history of abject suffering, violence, and disenfranchisement, and are denied subjectivity and humanity (Wilderson, 2003).

analysis, I found that the biomedical model and neoliberalism work together to promote an individualistic approach to wellbeing that undermines the necessity for politicized mental health efforts. To disrupt society's provision of palliative mental healthcare services, it requires that we unsettle the performative act of 'care' committed by public health units and the government and identify and critique structural oppressions negatively impacting wellbeing. The veil must be lifted.

Christina Sharpe's *In the Wake: On Blackness and Being,* posits Black life "must resist, rupture and disrupt the immanence and imminence" of death (2016; p.13). This proclamation would suggest two things. The first is that we must counter the forces that create conditions of immanent and imminent death for Black communities. The conditions that structure our existence can be widely attributed to the neoliberal society in which we live, work and play. Neoliberalism's emphasis on one's own interiority, "maximisation of the self" and competitiveness, prevents individuals from thinking about the greater good for the greatest number of people (Hilgers, 2013). Freedom under this logic is framed as entrepreneurial freedoms or "consumer choice," as opposed to true self determination and liberation (Joseph 2013). As such, neoliberalism fails to inspire collective efforts to build solidarity around social injustices (Teo, 2018). Housing, food insecurity, disparities in the educational and health system, poverty, and asylum seeking are all societal ills that are also grave mental health concerns (Kendall, 2021). The precarious nature of these social issues yields interminable consequences on an individual's wellbeing. Yet, as neoliberal agents we are expected to accept sole responsibility for these circumstances, effectively absolving government institutions of responsibility for structuring our lives in ways that are antithetical to our wellbeing (Fine, 2012). The systemic failure of the government to address the uneven distribution of inequities and social

exclusions for racialized communities prevents Black communities from experiencing unadulterated mental wellbeing. There is an urgent need to reallocate government funding and redirect its resources to targeting systemic disparities disproportionally impacting Black Canadians living in the "afterlife of slavery" (Hartman, 2006, p.123).

Future work will benefit from the consideration of how neoliberalism's market rationality precludes discussions of dreaming new alternatives, outside of capitalism, that permit the full expression of Black humanity and wellness. Due to the instrumental nature of neoliberalism, individuals who work in educational disciplines or career fields that do not neatly feed corporate interests, are discouraged, or deterred from imagining new possibilities for how we can live well, relate and care for one another (Fine, 2012; Teo, 2018). Indeed, a threat to the "scholarly imagination" serves as neoliberalism's second attack on freedom (Giroux, 2015; Gershon, 2011, p. 538). The liberty to dream, to imagine realities and life worlds that organize differently than what currently exists or is available, is necessary work for building more robust community-based projects to support Black mental health and ensure its longevity (Kelley, 2002). The infringement on one's abilities to engage in this labor of critical thinking and political resistance carries important implications for those invested in continuing this work. Mental health researchers and practitioners alike must be committed to this undertaking of reimaginings or confront their complicity in contributing to palliative measures of redress. Researching mental wellbeing for Black communities is always at once a project of disillusion and dreaming.

The final provocation implied by Sharpe's directive to disrupt the immanence and imminence of death is "to live well." To live well would mean society must actively target institutions that perpetuate racial terror and obstruct Black communities' safety and

freedoms. While outside the scope of this immediate work, future research examining the irresponsible response to the number of Black Canadians and more vulnerably, mentally ill Black Canadians, killed, arrested or wrongfully detained by the police, warrants careful examination of its impact on mental healthcare service delivery and mental wellbeing (Meerai et al., 2016). Between 2000-2017, there have been over 19 Black Canadians killed in encounters with Toronto police forces (Dunn, 2018). On a national scale, the numbers grow exponentially with Black Canadians outnumbering other racial groups in fatal encounters with the police (Dunn, 2018). The threat of police violence also gravely impacts Black communities,' particularly Black youths' willingness to seek help during mental health crises (Butler, 2020; Fante-Coleman et al., 2023; Wiktorowicz, 2020). There is an urgent need for greater support and resources for individuals to pursue these lines of inquiry. A disruption to palliative mental healthcare would require mental health practitioners advocating for a totalizing mental healthcare strategy that encapsulates police reform, defunding the police, and reimagining alternatives to police services that center community driven solutions to safety concerns and endorse community-based service interventions. If we are to move beyond the proximate causes of mental health issues and challenge the fundamental causes of poor mental health outcomes, then it must begin with a serious interrogation of our carceral state. We live within a penal order rooted in histories of colonization and the trans-Atlantic slave trade that is nurtured through present-day anti-Black racism.

Perhaps what is becoming increasingly evident at this point in the project is the necessity to move from intellectual pursuits of theorizing how to improve mental healthcare delivery for Black Canadians, to more explicitly enacting changes to improve Black Canadians' overall mental health. There exists a rich tradition of Black psychologists, mental health

researchers and counselling professionals adopting scholarly-activist roles in their commitment to improving wellness for Black communities. These endeavors traverse the boundaries of academia and the private therapy room. Frantz Fanon (1925-1961) left his posting as a psychiatrist at Hôpital Psychiatrique de Blida-Joinville to join the FLN in the fight against French colonialism.[102] He became an avid supporter and spokesperson for the Algerian revolution (Bulhan, 1985). E. Kitch Childs (1937-1993) remained a dedicated practicing therapist while advocating for LGBTQ+ rights. She was a founding member of Chicago's Gay Liberation Front. Many other pioneering Black psychologists such as Mamie Clark (1917-1983), Kenneth Clark (1914-2005), Jennifer Lynn Eberhardt (1965), Beverly Greene (1950) and Herman George Candy (1901-1970), participated in ongoing advocacy efforts while simultaneously maintaining private practice, teaching and/or conducting research. Their work for greater equality, justice and by extension wellbeing for Black populations reverberates loudly within educational, health and legal arenas. Achieving transformative mental healthcare requires the ability to extend conversations of wellness outside the exclusive jurisdiction of psychology and the counselling sciences, to create new collaborations and political organizing around social justice issues across all public domains. The future of mental healthcare for Black communities' rests in researchers' ability to continue to evoke changes that extend beyond the boundaries of the ivory tower and ivory painted walls of the therapy room.

The interdisciplinary nature of my Black Feminist Psychology Framework offers an important step forward for thinking about how we assess Black Canadians' participation in the mental health field and improve service delivery. Moreover, it presents parish ministers, Black

[102] Although Fanon left his posting and was critical of the racist underpinnings of the practice, he did not "abandon psychiatry for politics" (Bulhan, 1985; Mills, 2017, p.101).

counselling professionals and novels as repositories for mental healthcare knowledge acquisition and treatment interventions. Although my efforts attempt a comprehensive endeavor to study and improve service delivery for Black Canadians, my findings are limited. While my interviews present thoughtful and incisive details on creating culturally informed-holistic mental healthcare, my interviews were held exclusively in English and explore only Christian faith traditions and counsellor collaborations with clergy. Albeit, most religious Black Canadians report Christian denominations (Statistics Canada, 2022), future iterations of the work will include other religious and spiritual traditions to enrich my findings. Further, I will aim to include a larger selection of Black literary novels across the African Diaspora to more firmly ground my conclusions on Black resistance and spiritual healing. Lastly, a noticeable absence in my work is Black Canadian mental healthcare service users. Empirical data from Black Canadians would have allowed me to intimately explore the nuances of individuals' reticence to use formal mental healthcare services and their recommendations for its improvement. Although this has been widely studied in the scholarship and tackled more recently by larger Canadian organizations such as the Black Health Alliance and Ottawa's Black Mental Health Coalition, it remains a growing area of research. Direct questions regarding decolonized mental healthcare to Black Canadian participants would have been particularly useful for my analysis. Future research will benefit from including Black Canadians in the chorus of voices contributing to the discussion on mental healthcare service delivery.

Pursuing this project as a dissertation placed considerable time and financial constraints on myself and my work that prevented me from exploring my research questions in the scope and scale that these queries require. Nonetheless, the insights that were gleaned through my scholarly pursuits provide a solid foundation for future research. The application of my

framework reinforces the necessity of creating politically and culturally responsive mental healthcare to help cultivate resistance to systems of domination that seek to dispose and dispel of Black life. My findings represent the potentiality of my framework to dream nuanced alternatives to service delivery and begin to define the contours of an emancipatory wellness. Although the focus of my dissertation is on Black Canadians, it would run counter to the spirit of my Black feminist project to not encourage its adoption and adaptability for other disenfranchised groups who may similarly be invested in transforming mental healthcare for their respective communities. Future research will benefit from exploring how an interactive historical, political and socio-cultural framework of mental healthcare service delivery may illuminate new findings on treatment interventions and collective liberation for other racialized populations.

Conclusion

The following engagement proposes A Black Feminist Psychology Framework that examines historical, political and socio-cultural forces impacting Black Canadians' mental healthcare service delivery. Through different methodological approaches, my project offers a survey of the intersections of colonialism, neoliberalism and theism on Black Canadians' mental healthcare service use patterns and service delivery. I first interrogated how the field of psychology colluded with the West's agenda of colonial imperialism and expansion to pathologize Black lives within the discipline and practice. In doing so, I illuminated how the constructed historical nature of the 'Black subject' impacted diagnoses and treatment outcomes for Black clients. My analysis demonstrated how this formal exclusion and by extension, epistemological violence against Black persons, resulted in Black communities' turn to indigenous practices of healing. I presented religion and spirituality as one of these distinctive coping practices that Black communities across the African Diaspora relied on as a medium to engage in therapeutic rest and

resistance safely and freely. Tracing the role of The Black Church in the Global North, I explored the relationship between Black Canadians and religion. This served as a useful point of departure for thinking through how to create historically and culturally responsive mental healthcare service delivery for Black communities.

Black Canadians' waning mental health in the contemporary moment demanded new considerations for improving mental healthcare. As such, I explored the role of religion and spirituality in mental healthcare service delivery to bridge the divide between R/S and mental healthcare service provision. The aim was to uncover how both formal and informal institutions of care could benefit from the other and work to facilitate mental health promotion and stronger mental health outcomes for Black community members. I contended parish ministers awarded cultural trust, celebrated styles of worship and penchant for community building, paired with psychotherapists' trauma informed mental health counselling could strengthen the provision of mental healthcare for Black Canadians and improve outreach and treatment interventions for this underserved population. During my interviews, several benefits were enumerated by both parties that defined the contours of a collaborative holistic mental healthcare strategy. As expressed by the interviewees, collaboration held the potential to privilege both personal and social justice issues whilst tackling structural and ideological barriers that impacted Black communities' help-seeking patterns. However, important limitations of collaboration were also raised by the participants.

One primary concern centered on the necessity for interrogating exclusionary practices embedded in the foundation of psychotherapists and parish ministers' respective institutions of care. The field of psychology's histories of anti-Black racism and surveillance, and religious institutions' historical homophobic and superstitious orientation, were shared by the participants

as potential obstacles to working together. Both parties felt the other must work to implement accountability and transparency measures within their practice to ensure the safety and wellbeing of the referred client to the other's care. Moreover, a successful partnership was understood as requiring continued learning on behalf of both parties to strengthen understandings of what each actor brings to a client's wellness' journey. Additionally, through a constructionist analysis of the interviews, I identified neoliberalism as serving as a roadblock for establishing more community-based interventions of care. Neoliberalism's market rationality advocates for wellbeing that is premised on individual problems and solutions. As such, it conveniently forecloses discussions on socio-political issues that impact one's wellbeing and circumvents conversations surrounding social responsibility and social welfare. This reigning economic philosophy pervades the mental healthcare system and obstructs parish ministers' efforts to pursue social justice projects that work towards the collective good.

Resultingly, my turn to fiction served as a means of imagining approaches to wellness outside the constraints of our current existing order. The novels under study offered nuanced ways of thinking about healing that challenged contemporary frameworks and presented valuable insights on how wellness must overlap with freedom-making practices. Indeed, the links between wellbeing and freedom were foregrounded as the novels unsettled the capitalist-biomedical-patriarchal- world order that contributed to adverse mental health outcomes for all, particularly, Black communities. Rewritings of care premised on liberation were articulated in the novels and revealed through my analysis, which powerfully reinforced novels as an important conceptual and discursive tool for thinking with and against the grain. A "spiritual praxis of healing" that constitutes African indigenous knowledge and worldviews, makes legible historical trauma and grief, and cultivates communal care, was also brought forward as a potential response to the grey

area left in the wake of preceding collaboration discussions. Therefore, a concerted effort to balance freedom-making practices, wake work and a spiritual praxis of healing can help inform how we structure clinical and community interventions to enhance mental healthcare service delivery for Black communities and present new modes of resistance against systems of oppression.

Thus, arriving at the end of my research project, I return to the beginning of my inquiry: "What is transformative mental healthcare service delivery for Black Canadians?" Each chapter aimed in its own unique way to unpack this question, and each offered different responses to this quandary. Chapter one affirmed the need to expand understandings of service use disparities and curate culturally responsive mental healthcare to eradicate anti-Blackness from psychology. Chapter two introduced A Black Feminist Psychology Framework that considers the interactive effects of colonialism, neoliberalism and theism to improve mental healthcare. Chapter three advanced an interdisciplinary methodological approach to investigate service delivery for Black Canadians. Chapters four and five presented a holistic model of care that could bridge secular and faith traditions and work to target personal and societal ills. Chapter six proposed new forms of healing and recovery that exist outside of traditional biomedical frameworks and center emancipation and social justice. In sum, historically attuned, culturally responsive, and politically engaged mental healthcare was identified as an important step forward for transformative mental healthcare. My investigative journey revealed through historical accounts of the origins of psychology, contemporary lived experiences of mental healthcare service providers, and perennial Black cultural literary productions, that many paths towards wellness exist for Black Canadians; some of which have been tried, others of which can prove true, and many more that lie in wait for a world not yet born.

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Appendix

Interview Questions for Parish Ministers

1. What does mental wellbeing mean to you? Do you see a relationship between individual wellness and community wellbeing?

2. How do you understand your role as supporting and maintaining mental wellness in Black communities?

3. Have you experienced moments when you felt ill equipped to address a mental health concern or illness?

4. Have you ever undertaken specialized clinical training in mental health? Why or why not? (Specialized training can include mental health first aid, mental health rehabilitation courses, crisis and trauma training programs, suicide and crisis training programs, etc.).

5. Do you think there is space for collaboration between the Church and and professional mental healthcare service providers? If so, what would collaboration look like? What do you imagine would be the strengths and weaknesses of collaboration?

6. How could the government and/or public health researchers assist you in your mental health efforts for the community? What resources do you require?

7. Do you think traditional approaches to mental healthcare are capable of addressing the needs of Black community members? Or, do Black communities require unique approaches to wellbeing?

8. How do you counsel community members who are not religious? For example, a religious mother brings her agnostic son who is experiencing depression to see you.

9. Is there anything you would like to add or circle back to regarding the topics we have discussed today?

Interview Questions for Psychotherapists

1. What does holistic mental healthcare mean to you? Do you see a relationship between individual wellness, community wellbeing and larger societal living?

2. Do you have clients that report religion or spirituality as a means of coping with their mental health?

3. How does religion and/or spirituality function as an obstacle to mental health for your clients? How does religion and/or spirituality enable positive coping outcomes for your clients?

4. Have you experienced moments when you felt ill equipped to address the religious concerns of your clients?

5. Have you ever undertaken specialized training in religious education? Why or why not? Was religious education introduced in your curriculum?

6. Do you think there is space for collaboration between parish ministers and professional mental healthcare service providers? If so, what would collaboration look like?

7. What do you imagine would be the strengths and weaknesses of collaboration?

8. Do you think Black communities require unique approaches to wellbeing?

9. Have you found that recent socio-political conditions warrant greater consideration in your sessions with racialized clients? For example, the BLM protests against police brutality?

10. Is there anything you would like to add or circle back to regarding the topics we have discussed today?