From the Enlightenment to Black Lives Matter

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This book is illuminating and groundbreaking in many ways for its examination of how anti-Black racism and the interstices of identities contribute to the legacy of racial trauma in Black communities in Canada, the US, and the UK. Its comparative edge makes the book a must read for all interested in fighting anti-Blackness in Black health, racial trauma and beyond. By tracing perceptions of the Black body in the field of psychiatry, and how these perceptions have informed diagnosis and treatment from the colonial era to the present, readers get new exposures. The book drives home much-needed considerations to be had and actions to be taken to address racial trauma and mental illness in Black communities in Canada, the US and the UK.

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From the Enlightenment to Black Lives Matter: Tracing the Impacts of Racial Trauma in Black Communities from the Colonial Era to the Present

BY

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This book is dedicated to my family.

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About the Author

Ingrid R.G. Waldron was born in Montreal, Quebec, to Trinidadian parents. She is Professor and HOPE Chair in Peace and Health in the Global Peace and Social Justice Program in the Department of History, Faculty of Humanities at McMaster University. She also teaches in the Gender and Social Justice Program in the Faculty of Humanities.

She was a Postdoctoral Fellow at the Centre for Women's Health in the Faculty of Medicine at the University of Toronto. She holds a PhD from the Sociology and Equity Studies in Education Department at the University of Toronto, a Master's degree in Intercultural Education: Race, Ethnicity and Culture from the Institute of Education at the University of London, and a BA in Psychology from McGill University.

She is the Founder and Director of the Environmental Noxiousness, Racial Inequities and Community Health Project, the Co-founder and Co-director of the Canadian Coalition for Environmental and Climate Justice, and the Co-founder of Rural Water Watch.

Her research interests include the impacts of anti-Black racism and other forms of discrimination on the health and mental health of Black, Indigenous and racialised communities, racial trauma, racial disparities in health and mental health related to COVID-19, dementia, and other illnesses, and the social, political, and health and mental health effects of environmental racism and climate change inequities in Black, Indigenous, and racialised communities.

She partners with racialised communities, community-based organisations, health agencies, government, and academics to conduct qualitative and mixed methods research, and to develop legislation, policies, services, programmes, and documentary film and other multimedia tools and resources to address health and mental health disparities and promote health equity and environmental and climate justice. For example, her research and advocacy work led to the creation of several services, legislation, and resources. Her research on Black women's experiences with mental illness in the Halifax Regional Municipality in Nova Scotia, Canada led to the creation of Nova Scotia Health's Sisterhood Initiative, the first health service exclusively for Black women in Nova Scotia. Her research and advocacy on environmental racism in Black and Indigenous communities in Canada led to her co-developing with former politician Lenore Zann the first federal private members environmental racism/justice bill in Canada *An Act Respecting the Development of a National Strategy to Assess, Prevent and Address Environmental Racism and Advance Environmental Justice* (Bill C-226). Ms Zann

introduced the bill in Parliament in February 2020. It was re-introduced in Parliament by Elizabeth May in February 2022, after Ms Zann lost her seat. The bill then moved through Parliament and then to Senate. On 13 June 2024, the bill was approved at Senate, becoming the first environmental racism/justice law in Canada.

She is the author of the 2018 book *There's Something in the Water: Environmental Racism in Indigenous and Black Communities* (Fernwood Publishing), which was turned into a 2020 Netflix documentary of the same name and was co-produced by Waldron, actor Elliot Page, Ian Daniel, and Julia Sanderson, and directed by Page and Daniel.

She has provided expertise on race and gender discrimination, health, and mental illness in prisons, environmental racism, environmental justice, and climate justice for international and national organisations, including the UN High Commissioner in Geneva; the World Health Organization in Geneva; Environment and Climate Change Canada; David Suzuki Foundation; Canadian Climate Institute; Nova Scotia Environment and Climate Change; Ethnocultural Services, Atlantic Region Correctional Service Canada; and Atlantic Region Employment Equity and Diversity Committee, Atlantic Regional Headquarters, Correctional Service Canada. She has also been a board member for several organisations, including Research Canada, Urban Alliance on Race Relations, Across Boundaries – An Ethno-Racial Mental Health Agency, the Health Association of African Canadians, Canadian Association of Physicians for the Environment, and Ecology Action Centre.

She is the recipient of several awards, including the Society for Socialist Studies Errol Sharpe Book Prize and the Atlantic Book Award for Scholarly Writing for her book *There's Something in the Water: Environmental Racism in Indigenous and Black Communities,* as well as Research Canada's Leadership in Advocacy Award (Individual Category), Dalhousie University's President's Research Excellence Award – Research Impact, the Dalhousie Faculty of Health Early Career Research Excellence Award, 100 Accomplished Black Canadian Women Award, Top 25 Women of Influence Award, the Anne Goodman Award for the Promotion of a Culture of Peace and Peace Education from Canadian Voice of Women for Peace, Environmental Defense's Green Champion Award, Clean 50's Clean 50 Award for Education and Thought Leadership, and Springtide Collective's Advocate of the Year Award.

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Abstract

This book uses anti-colonial theory (Fanon, 1963; Memmi, 1965) to examine the structural inequities that have contributed to the legacy of racial trauma in Black communities in Canada, the USA, and the UK. The book also uses an intersectional analysis to pinpoint how the intersections of race, culture, gender identity, sexual orientation, socioeconomic status, age, and citizenship status shape experiences of racial trauma, mental illness, and help-seeking in Black communities. Through existing literature in Canada, the UK, and the USA, as well as the voices of Black Canadians who participated in studies the author conducted over the last several years, the book highlights how anti-Black police violence, employment discrimination, environmental racism, and other forms of structural racism contribute to racial trauma in Black communities.

The book provides a historical analysis of how the discourse of scientific racism during the Age of Enlightenment helped shape negative perceptions of Black people and other 'racial others' within psychiatry, and how those perceptions have influenced diagnosis and treatment. The book also highlights the beliefs and perceptions Black communities in Canada, the USA, and the UK hold about mental health and help-seeking, the diverse approaches they utilise to manage, cope with, and seek help for mental health problems, and the considerations that need to be made and the actions that need to be taken to address racial trauma and mental health problems in Black communities.

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Introduction

Keywords: Black communities; racial trauma; racism; mental illness; psychiatry; health disparities; structural determinants of health; Canada; UK; USA

> It appears that the Negro mind does not dwell upon unpleasant subjects, he is irresponsible, unthinking, easily aroused to happiness, and his unhappiness is transitory, disappearing as a child's when other interests attract his attention …. Depression is rarely encountered even under circumstances where a white person would be overwhelmed. (Fernando, 1991, p. 39)

At the end of the 19th century, a popular topic for debate was the apparent relative absence of 'madness' among African, Asian, and Native American people. As cited by British psychiatrist Suman Fernando in his book *Mental Health, Race and Culture*, the comment above was made by the clinical director of Georgia State Sanitarium about the apparent rarity of depression among Black people in the American South. It was typical of the general views among psychiatrists at the time. But, over the last several decades, studies have been emerging in Canada, the USA, and the UK that challenge misconceptions about Black people's imperviousness to physical and emotional pain. For example, Harriet A. Washington examines pathologising myths about the Black body during the colonial era in her groundbreaking book *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (2007). She observes that scientists made erroneous claims during the colonial era that the primitive nervous systems of Black people made them immune to physical and emotional pain and to mental illness. According to Washington, physicians advanced theories about the greater immunity of Black people to malaria and yellow fever during the colonial era, although there was no evidence to suggest that they had an innate, absolute resistance to these diseases. These and other stereotypes revealed contradictions about the Black body in two main ways during the colonial era: (a) theories about real and perceived physical differences between Black and White people were beginning to take hold, and (b) myths

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about the Black body as inherently stronger, more resilient, or resistant to most illnesses were generated (Washington, 2007).

In an interview with journalist Kristin Moe (2020), clinician Resmaa Menakem, the author of *My Grandmother's Hands: Racialized Trauma and the Pathways to Mending our Hearts and Bodies* (2017), discusses how trauma resulting from the racial violence of the past and present becomes embedded within the body and the approaches that can be used to heal those wounds. Menakem calls attention to how racial violence is intertwined with the collective history, identities, and cultures of Black people, and how emotion, memory, and trauma come to reside in both the mind and the body. Building on the field of epigenetics, which focusses on how trauma gets passed down through generations, Menakem 'contextualizes his clinical work within historical and collective trauma that is passed on from one generation to another through our very DNA' (Moe, 2020), or what is often referred to as intergenerational trauma. When similar traumas are shared by people in this way, as it is for Black people globally, the strategies they use to cope with trauma will also look similar. Menakem refers to this as *traumatic retention.* In his book *My Grandmother's Hands*, Menakem observes that trauma manifests in the body and influences our behaviour, often in ways that have detrimental and harmful effects. It reminds us that racism is not simply an idea but also visceral in the way it is stored as sensation, tension, and pain (Moe, 2020). For Black people, specifically, trauma is rooted in the structural apparatus that imposes a 'White body supremacy' that places an expectation on Black people that they live up to a White European ideal or standard (Moe, 2020). Menakem points out that if these and other conflicts inside the Black body are not resolved, 'racial violence will remain an unhealed wound' (Moe, 2020). He also takes issue with the term post-traumatic stress disorder (PTSD), arguing that 'post' is about trauma in the past. Rather, he suggests that Black people have *persistent*-traumatic stress disorder that remains an ongoing threat (Moe, 2020).

As Cenat (2023) observes, racial trauma can be characterised as experiences related to threats, prejudices, harm, shame, humiliation, and guilt associated with various types of racial discrimination, either for direct victims or witnesses. He notes that a life-course approach captures well how racial trauma is experienced throughout the life course, impacting physical and mental health, behaviour, cognition, relationships with others, self-concept, and social and economic life. And, like Menakem (2017), he acknowledges the complex nature of individual, collective, historical, and intergenerational experiences of racism experienced by racialised communities in Western society, for which the theoretical framework of complex racial trauma (CoRT) is often used to understand, assess, and treat it (Cenat, 2023).

Several authors also characterise racism as trauma (Bryant-Davis & Ocampo, 2005; Carter & Helms, 2002; Carter et al., 2005). Bryant-Davis and Ocampo (2005) define racist incidents as 'cognitive/affective assaults on one's ethnic self-identification' (p. 480). These assaults include verbal attacks, physical attacks, and threats to livelihood that are racially motivated. The authors distinguish between sudden or systematic assaults, intentional or unintentional assaults, and overt or ambiguous assaults, all of which can occur in everyday interactions between people (individual racism), within institutions (institutional racism), or through

cultural dominance (cultural racism). They also conceptualise racist incidents as traumatic and identified several 'daily mini traumas' that racial out-groups are subjected to, including being denied promotions, home mortgages, or business loans; being watched by security guards; and being stopped in traffic. The concept of trauma provides an opportunity to examine how state-sanctioned violence (Alimahomed-Wilson & Williams, 2016; Menjivar, 2016; Pellow, 2016) in the form of colonialism, slavery, and intergenerational structural inequities continue to harm Black communities socially, economically, and politically. For immigrants and refugees from African countries, trauma has also come in the form of war and violence, political instability and persecution, ethnic/religious/sectoral rivalries, territorial disputes, separation from family members, and rape (Yohani & Okeke-Ihejirika, 2018). These harms create an enduring burden on the physical, spiritual, emotional, mental, and psychological well-being of Black communities globally, resulting in depression, suicide, substance abuse, hypertension, cancer, and obesity (McGibbon et al., 2013). It is important at this juncture to define racism. According to Williams and Williams-Morris (2000), racism refers to:

> An organized system that leads to the subjugation of some human population groups relative to others. Fundamental to the development of such a system is an ideology of inferiority in which human population groups are categorized and ranked with some being inferior to others. This often leads to the development of negative attitudes and beliefs towards racial out-groups (prejudice), and differential treatment of members of these groups by both individuals and societal institutions (discrimination). This definition of racism locates it primarily within organizational institutional structures and not in individual attitudes or behaviour. Racial prejudice and discrimination measured at the individual level can often be important indicators of the presence of racism, but it is possible for racism to exist in the absence of racial discrimination and prejudice at the individual level. (p. 244)

It is also important to distinguish between racism and race. Racism is an imposed system of structures, values, and processes that advantage one group over another. Race is a social construction that categorises humans based on physical characteristics, thereby creating a hierarchy of racial groups that suggests some people are inherently inferior or superior, despite there being no scientific validity to these notions. Therefore, racism continues to reinforce the concept of race. These ideas were generated at a time when a strategy to advance imperial, patriarchal, heterosexist, and settler-colonial interests through dispossession, enslavement, genocide, and oppression relied on dehumanisation (CAMH, 2021).

Racial trauma comprises the mental and physical effects and consequences that Black and other racialised people experience after being exposed to racism. It occurs not only when a person experiences racism directly, but it is also a vicarious phenomenon that can be passed down through generations. In other words, experiences of racial trauma are not simply what an individual is exposed

to throughout their lifetime; it is also about the stories shared by family members and colleagues who witness these incidents, are exposed to the images shared on social media, and witness incidents and experiences indirectly. For example, exposure to police brutality or racist encounters on social media and the news forces people to live vicariously through instances of racism and discrimination (Wilson, 2022). Direct or indirect racial trauma can lead to sleep issues like nightmares, night terrors, and insomnia, as well as additional levels of stress and unexpected exposure to triggers. Increased amounts of the hormone cortisol are released by the body when a person is experiencing a considerable amount of stress, which is not healthy and can lead to weight gain; slowed physical healing; muscle weakness; risks associated with cardiovascular disease; and diagnosable mental health concerns like depression, anxiety, and increased hypervigilance (Wilson, 2022). Therefore, it is important to recognise that racial discrimination is cumulative and not a singular experience for racialised people and that while we may survive experiences of racial discrimination, we are constantly triggered by previous experiences that are rarely resolved as our body continues to register new experiences of racial discrimination as stress over time, leading to what we refer to as toxic stress (Wilson, 2022).

Throughout our life course, Black and other racialised people inherit and experience historical, collective, institutional, systemic, interpersonal, and generational forms of racial stress, often before birth for many children who are more sensitive to it because their parents have been exposed to racial trauma (Wilson, 2022). This is often explained by the field of epigenetics, which argues that inheritable changes in gene expression caused by trauma experienced by parents can be passed on to their children, even if their children have not been directly exposed to racial trauma (Wilson, 2022). In the following section, we will take a closer look at the role that racial trauma plays in experiences of mental illness.

Racial Trauma: Implications for Mental Illness

Contributing to the evidence emerging over the years that racism is indeed a legitimate health issue, the Canadian Public Health Association (CPHA, 2018) acknowledged the influence of racism on the health of individuals and populations in a 2018 draft position statement. CPHA also committed in that statement to address and eliminate racist processes within the association, as well as to advocate for the elimination of racist and oppressive systems, laws, regulations, and policies in Canada's public institutions and society generally. The draft statement recognises that systemic racism, although subtle, causes harm in every aspect of life and is correlated to poorer health outcomes for racialised communities, such as negative mental and physical health outcomes and negative health-related behaviours (cigarette smoking, alcohol use, and substance use). CPHA asserts that anti-Black racism is systemically embedded within Canadian institutions and underlies long-standing inequalities experienced by Black people, including unemployment, poverty, racial profiling, law enforcement violence, incarceration, immigration detention, deportation, exploitative migrant labour practices, disproportionate child removal, and low graduation rates. The statement also

acknowledges that the relationship between racism and health is more difficult to assess in Canada than in the USA since care registry data do not regularly record race or ethnicity statistics in Canada. However, CPHA found that significant associations between self-assessed poor or fair health and the experience of racism can be attributed to the following factors: (a) economic and social deprivation; (b) toxic substances and hazardous conditions; (c) socially inflicted trauma (mental, physical, and sexual that are either directly experienced or witnessed, and range from verbal threats to violent acts); (d) targeted marketing of commodities that can be harmful to health; (e) inadequate or degraded medical care; and (f) degradation of ecosystems, including systematic alienation of Indigenous Peoples from their lands and traditional economies.

Structural racism is characterised by the ways societies foster racial discrimination through mutually reinforcing and inequitable interconnected systems that are historically rooted and culturally reinforced over generations. These systems, in turn, reinforce discriminatory beliefs, values, and distribution of resources, which together affect the risk of adverse health outcomes (Bailey et al., 2017). These systems include education, employment, income, health care, and criminal justice, among others.

Until recently, frameworks in medicine and health research attributed racial disparities in illness and disease to biological, genetic, cultural, or lifestyle choice differences between different racial groups. However, it is now acknowledged that an analysis of the social context of inequality (income, poverty, education, criminal justice, etc.) is important for understanding why structural racism and other social factors are important predictors of health status. Over the last several decades, Canadian studies have been emerging that show that the main determinants of health are, in fact, not rooted in medical or behavioural factors but rather stem from several structural determinants, such as Indigenous status, race, immigrant and refugee status, early life experiences, education, employment, unemployment, income security, working conditions, availability of social safety net, food security, quality of the neighbourhood, quality of housing, access to health services, access to transportation, access to formal or informal child care, exposure to violence, criminalisation and racial profiling, educational streaming, racial or cultural stereotyping, unequal access to information, concentration in racially segregated neighbourhoods, and social exclusion (Access Alliance Multicultural Community Health Centre, 2007; Jackson et al., 2013; Kisely et al., 2008; McGibbon et al., 2013; Waldron 2002, 2003, 2018a; Wilkins et al., 2002). Rodney and Copeland (2009) note that several health and mental health problems can be attributed to these structural determinants of health, such as higher rates of chronic disease, accidents, prolonged stress, anxiety, alcoholism, substance dependence, depression, suicide, and homicides. Studies I have conducted over the years (Waldron, 2009, 2013a, 2013b, 2015a, 2016, 2018a, 2019a, 2020a) observe that health outcomes in African Nova Scotian and other Black Nova Scotian communities (stress, high blood pressure, allergies, depression, cancer) can be attributed to long-standing and historically constituted forms of structural racism within labour, employment, immigration, environment, education, and health care. McGibbon et al. (2013) observe that cardiovascular disease

experienced by Black and Indigenous communities is an outcome of racism-related stress and intergenerational forms of trauma, often referred to as historical trauma, even in the absence of other risk factors. The stress of racism results in the body's physiological stress-handling systems becoming overtaxed, leading to cardiovascular disease and several other health problems. Kisley et al. (2008) identified rates of circulatory disease, diabetes, and psychiatric disorders as being significantly higher in the Prestons (East and North Preston are primarily African Nova Scotian communities) than in other Nova Scotian comparison communities. They also found the incidence rates of all three disease groups (circulatory disease, diabetes, and psychiatric disorders) in the Prestons were 13%–43% higher than for Nova Scotia as a whole.

Health disparities between more and less-advantaged groups can be attributed to racial, socioeconomic, and other inequalities that impact negatively on health, deter or prevent individuals from accessing health services, and subject racialised individuals to differential treatment by health professionals (Waldron, 2010, 2018a). Understanding the complex web of inequalities that impacts the health of Black and other racialised communities requires an appreciation for structural or distal determinants of health. An approach that acknowledges the structural determinants of health is better able to capture colonialism and the many other structurally rooted factors impacting health beyond simply the social. Structural determinants are deeply embedded, representing historical, political, ideological, economic, and social foundations from which all other determinants evolve (Reading, 2015; Waldron, 2018a). For example, the legacy of colonialism has had enduring health impacts on African Nova Scotians (the oldest Black population in Canada) and other Black Nova Scotians, contributing to higher rates of heart disease, cancer, high blood pressure, diabetes, and death relative to White Nova Scotians (Saulnier, 2009).

Structural determinants of health interconnect with proximal and intermediate determinants to impact health. Proximal determinants influence health in the most direct ways. They include early child development, income and social status, education and literacy, social support networks, employment, working conditions and occupational health, the physical environment, culture, and gender. Proximal determinants produce various physical, emotional, mental, spiritual, and social challenges. Intermediate determinants facilitate or hinder health through systems that connect proximal and distal determinants. They include health promotion and health care, education and justice, social support, labour markets, government and enterprise, kinship networks, relationship to the land, language, ceremonies, and ways of knowledge sharing. While these determinants may have less of a direct impact on the health of individuals, they have a significant influence on proximal determinants of health (Reading, 2015; Waldron, 2018a).

A report by CAMH (2021) in Toronto examines the link between anti-Black racism and the mental health issues suffered by Black Canadians, observing that Black people experience racism in unique and specific ways, such as through the long history of anti-Black racism in Canada. This includes the dehumanisation and commodification of Black lives during the transatlantic slave trade that

depended on social relations that forced Black people to provide free labour intergenerationally, thereby subsidising racial capitalism and imperialism. Anti-Black racism continues today through the intergenerational wealth and power of White people (CAMH, 2021). Power structures are embedded and reproduced in every facet of society and manifest within explicit and implicit forms of anti-Black racism that operate at individual, community, and system levels. Anti-Black racism increases the risk of mental illness because Black populations are more likely to experience stress resulting from their exposure to negative life circumstances (CAMH, 2021).

According to the report by CAMH, the systemic racial disparities experienced by Black people in Ontario, for example, result from several structural determinants of health, such as income. Almost one in four (24%) Black Ontarians are low income, as compared to 15% of the general racialised Ontario population (Black Health Alliance, 2024). Second-generation Black Canadians earn 10% to 15% less than second-generation White Canadians, even when results are adjusted to reflect educational levels (Black Health Alliance, 2024). Education is another structural determinant of health that has negative impacts on Black people's mental health when Black students underachieve; for example, in the Toronto District School Board, 69% of Black students graduated in 2011, as compared to 87% of racialised students and 84% of White students (Black Health Alliance, 2024). The overrepresentation of Black Canadians in prison is another structural determinant of health. While Black Canadians make up 9.5% of the Canadian prison population, they represent only 2.5% of the overall Canadian population (Black Health Alliance, 2024).

These structural determinants of health result in Black populations in Ontario being more likely to report stress and poorer mental health than others (Environics Institute for Survey Research, 2017). Caribbean immigrants and refugees from East African countries in Ontario have a 60% and a 95% higher risk of psychosis, respectively (Anderson et al., 2015). Increasing rates of mental illness in Black communities due to persistent race-based and other inequalities in education, employment, immigration, housing, and criminal justice have called attention to the need to address the impacts of structural racism and other structural inequities on mental health in Black communities.

While the literature on the impacts of racism on mental health has been emerging in the USA and the UK over the past several decades (Bresnahan et al., 2007; Chakraborty et al., 2009; Copeland, 1982; Fernando, 1991; Garretson, 1993; Gilman, 1985; Williams & Williams-Morris, 2000), this has been a more recent phenomenon in Canada. While this is changing, Canadian research has tended to downplay the mental health impacts of racial trauma, preferring, instead, to focus on how ethnicity, culture, and immigrant status shape access to mental health services and mental health outcomes (Adeponle et al., 2012). The focus on culture at the expense of race in psychiatry not only attributes cultural differences to the perceived deviant behaviours of culturally diverse groups, but it also negates the impacts of structural inequities like racism on mental health. The legacy of subsuming race within the culture in psychiatry will be taken up in the following section.

Charades and Masquerades: Subsuming Race Within Culture in Psychiatry

Over the last several decades, several branches of psychiatry have emerged to inquire into the significance of culture in diagnostic assessments and treatments. Comparative psychiatry has been concerned with comparing Europeans with non-Europeans. In the latter half of the 19th century, scientists began discussing culture, focussing primarily on the temperament, ideas, and beliefs of diverse peoples, which gave impetus to the field of cultural anthropology. Darwinian theory provided the paradigm for discussing the nature of culture, with cultural evolutionism put forth as an ideology that espoused the notion that while 'primitive' people and 'advanced' Westerners possessed the same singular culture, the culture of advanced Westerners was at a higher level of evolutionary development. Cultural Darwinism brought with it discussions on race that espoused ideologies about the psychology of non-White peoples, including views that the psyches of non-White peoples were inferior because they were less evolved. The rise of scientific racism led researchers and clinicians to consider the implications of ethnocultural difference in more serious ways (Kirmayer, 2018).

Cultural evolutionism was replaced in the early 20th century by a new theory advanced by anthropologist Franz Boas, which was pluralist and relativist. For Boas, culture impacts people because it influences their perception of the world and, consequently, their behaviour. By the 1930s, Boasian culture was the most generally accepted concept of culture among biologists, social scientists, and the public. It also resulted in the disciplines of anthropology and psychiatry becoming intellectually closer (Bains, 2005). As Kirmayer (2018) observes, cultural psychiatry arises out of a history of interactions between people of diverse backgrounds and the resultant challenges of trying to make sense of and respond to mental health issues experienced by individuals whose cultural differences confound practitioners. He further notes that cultural psychiatry has been premised on three major sets of concerns historically: (a) questions about the universality or relativity of psychopathology and healing practices, (b) the complexities of providing services to ethnically diverse populations, and (c) the analysis of psychiatric theory and practice as products of a particular cultural history and as vehicles of globalisation. These concerns are linked to three successive development phases of the field from colonialist and comparative psychiatry to the mental health of ethnocultural communities and Indigenous Peoples in settler societies and the post-colonial anthropology of psychiatry.

As Europe approached World War II, anthropologists were calling for the disciplines of anthropology and psychiatry to form a complete science that would explain human behaviour. The migration of refugees and displaced peoples following World War II and later conflicts led to renewed work on trauma-related disorders and the adaptation of migrants. The UN Universal Declaration of Human Rights in 1948 and emerging and global anti-colonialist conflicts challenged the dominance of Western notions of history and opened a space to consider non-Western systems of knowledge (or counter-knowledge; Kirmayer, 2018).

Edward Sapir noted that the psychiatrist's role was to explain how culture and the individual could create culture through interaction with other individuals.