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Chapter

Perspective Chapter: Cultivating Environments of Belonging in Psychiatry, Clinical Psychology and the Allied Mental Health Fields

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Abstract

Mental health science as a field of research, education and care practices has a fundamental role to play in mitigating the costs of racism for affected communities. The development and the implementation of solutions, such as *gaining perspective*, *encouraging mentorship* and *finding empowerment,* can only meaningfully occur through the involvement of lived experience expertise. Notably, as a first step, the inclusion of such expertise at a structural level would require the cultivation of environments of belonging in psychiatry, clinical psychology and the allied mental health fields for students racialised as Black and Of Colour. Black Lives Matter, as a specific political movement, articulates a critique of how certain subjectivities and identities belong more naturally in spaces of knowledge and power such as universities. This chapter reflects on belonging as a 'feeling of mattering' and a contemporary politics. It is argued that the possibility to facilitate the effective elimination of structural racism in mental health science requires the cultivation of environments of belonging at an institutional level causing greater inclusivity and enjoyment for Black students and students Of Colour in 'liberated learning spaces'. A clear, actionable path to create environments of belonging to help resolve structural racism is outlined.

Keywords: racism, mental health science, decoloniality, interculturalism, belonging

1. Introduction

As people struggle with the social instabilities and stress-filled emotions necessitated by COVID-19, the pandemic has produced a significant need for mental health care [1]. Racism and the pandemic are a double burden of stress for racialised groups [2]. On the one hand, racism-induced distress and fear can increase the risk of negative mental health outcomes for those affected by COVID-19 [3]. Distress and fear over COVID-19, on the other hand, can additionally increase the risk of negative mental health outcomes for persons who are affected by racism [4]. The murder of George Floyd at the start of the pandemic heightened public awareness of racialised people's experiences with racism [5]. Meanwhile, George Floyd's murder also heightened racialised people's anxiety and fear of racism. Moreover, keep in

mind that George Floyd was only the catalyst. Police brutality, as one format of structural racism, has been and continues to be a problem. Several social campaigns, including #SayHisName, #SayHerName, and #SayTheirNames, have attempted to raise awareness of the issue's scope [6, 7].

In Germany, the pandemic began at a time when there was an exceptional public interest in the problem of racism, following the murders at the Halle synagogue and the Hanau shisha bars, in which Jewish and Muslim persons were the victims of violent anti-Semitic and racist attacks [8]. Vicarious racism is a term used to describe when people are indirectly exposed to violently racist incidents, such as in the media [9]. Although vicarious racism does not pose a direct threat, evidence suggests that the anguish and terror induced by it are associated with unfavourable mental health outcomes [10, 11]. Throughout the pandemic, racism has been a societal stressor. Not to mention that the pandemic is associated with increased instances of interpersonal racism for many racialised groups, particularly against people of Asian descent [12]. For people from India, the United Kingdom, South Africa, and Brazil, the pandemic has also become linked to a higher risk of interpersonal discrimination because of unintended public stigma caused by the identification of various variations. In an attempt to eliminate discrimination, the World Health Organisation has altered the naming system to remove associations with the regions where they originated and has replaced them with Greek alphabet letters. The Indian variant (B.1.617.2) is now called Delta. The UK variant (B1.1.7) is now called Alpha. The South African variant (B.1.351) is now called Beta. And the Brazilian variant (P.1) is now called Gamma [13].

The COVID-19 pandemic has brought to light several issues relating to structural racism and mental health, including the impact of pre-existing racism-induced disparities in rates of diagnosable mental illness as well as shortages in mental health care allocations [14]. These disparities are becoming exacerbated by infection containment strategies [15]. The fact that the pandemic is amplifying racism-induced disparities, rather than causing them in and of itself, emphasises the importance of reflecting upon how structural racism in society and in the mental health system perpetuates disparities**.** We recommend implementing decolonial intercultural competency into culture and migration mental health and prioritising the provision of emotional safety in services focused on (a) the ability to recognise social identities, socio-cultural formations, and essential humanity, as well as the ability to engage a decolonial approach when it comes to over-pathologising/under-pathologising variances in racism-induced difficulties, (b) the ability to strengthen the capacity of Black people and People of Colour to achieve the greatest possible gains at the lowest possible cost in terms of social efficacy and quality of life and well-being, and (c) the ability to respect each human being's intrinsic human dignity as a person, including his or her social and cultural history, regardless of developmental stage, existential state, or other extrinsic circumstances.

2. The racism-induced reactive negative emotionality cycle

The mental health of Black people and People of Colour is negatively impacted by a double exposure to vicarious racism and interpersonal racism, which is occurring in the context of ongoing societal pandemic stress and instability. Racism is a set of harmful events that occur due to racist attackers ascribing derogatory views to racialised aspects of the victims' personhood, such as their name and skin colour [16]. Racism sends the message to victims that their racialised characteristics prevent them from fully participating in the microcosm. A microcosm is a group

of people, an area, or a situation. Racism on the streets sends the message that they and their racialised attributes do not belong in the district or city, but racism at schools or universities sends the message that they and their racialised attributes do not belong in the classroom, for example. Sociologists have defined the emotionality of social and political belonging as an overarching positive feeling of affinity to the microcosm [17]. Similarly, and in contrast, the sense of not belonging is the conclusion of a slew of destructive emotions triggered by racism.

These reactive emotions can evolve into proactive emotions in the future. However, victims may become engulfed in a racism-induced reactive negative emotionality cycle in the first instance (see **Figure 1**). The psychological strains experienced by people within various intersecting systems of oppression and inequity increase their susceptibility to poor mental health outcomes that accumulate over time, according to social stress process models like the Immigrant Risk Model [18] and the Minority Stress Model [19]. Racism is one of the most pressing societal phenomena for mental health practitioners to increase knowledge about in the context of migration and culture. Racialised people's vulnerabilities to various injustices in their daily lives and the unresolved anger and bitter disappointment surrounding these racist experiences may act as precipitating factors for emotional alienation and further perpetuating factors for poor mental health [1, 20]. Through an intersectionality lens, understanding the emotional impact of racism allows us to realise the complexity of dynamic lived experiences under changing situations. For example, in mental health counselling, it is not about who has more or less racism in their lived experiences, but rather how racism is experienced qualitatively due to the junction of other ascribed social identities and the differential allocation of/access to resources that may make racism easier to handle [21].

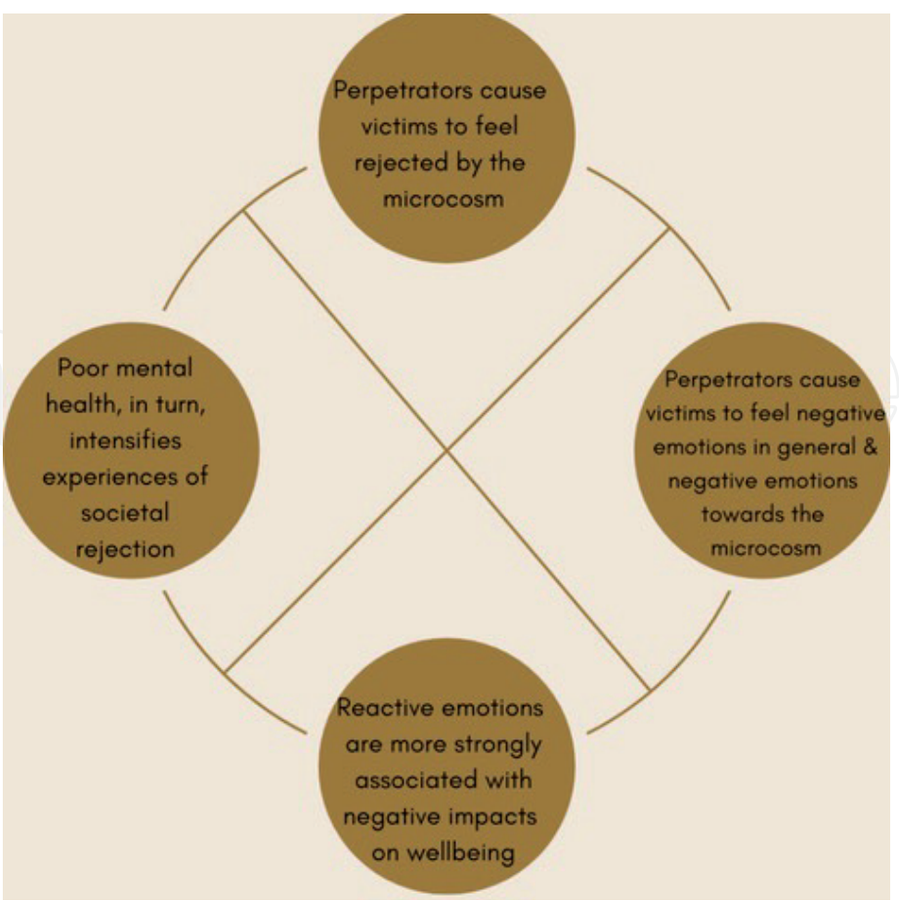


Figure 1.
The racism-induced reactive negative emotionality cycle.

In recent years, the usefulness of intercultural competency in overcoming racism in patient-professional communication and treatment provision has received some attention in the transcultural mental health discourse [22]. The phrase 'intercultural competency' is sometimes used interchangeably in the literature with terms like 'multicultural competency', 'cross-cultural competency' and 'transcultural competency'. In so doing, interculturalists may draw upon philosophical tenets of interculturalism to provide a standard that aims to concretely centre the intrinsic human dignity of each human being as a complete person, including his or her background, regardless of developmental stage, existential condition, or other extrinsic considerations in patient-professional interactions [23]. Bhiku Parekh [24] describes interculturalism as,

> *"[the]cultural embeddedness of human beings, the inescapability and desirability of cultural diversity and intercultural dialogue, and the internal plurality of each culture...to illuminate the insights and expose the limitations of others and create...a vital in-between space, a kind of immanent transcendentalism, from which to arrive at a less culture-bound vision of human life and a radically critical perspective".*
>
> *(p 338–339).*

Interculturalists have developed a plethora of best-practice guidelines for practical intercultural competency (e.g., [25–32]). Decolonial interculturalists conceptualise intercultural competence as two broad steps, notwithstanding the intricacy of many of these frameworks. On a structural level, the first step is to recognise the underlying fact of ethnocentrism in terms of the values and patterns of behaviour embedded throughout the depth and breadth of Western mental health science, including institutionalised practices and governance [33]. The second is a greater engagement with Black Lives Matter's 'embodied feeling' to integrate non-Western worldviews, thereby facilitating the successful elimination of structural racism throughout Western mental health science [34].

3. Structural racism is structural exclusion from the priorities of intercultural concern.

Racism and other forms of stigmatisation in Western mental health systems creates delays and failures in access via self-stigmatisation [11, 35]. Actual and perceived structural racism exists throughout the depth and breadth of national political-cultural traditions and institutions, so racialised people do not necessarily expect to be humanised by mental health practitioners who are, for the most part, seen as one separable dimension in a *white* matrix of domination [36]. Research suggests that racism is associated with a lack of trust and satisfaction with services provided, as well as a lack of willingness to engage in the first instance and reduced adherence to recommended prescriptions [37, 38]. This *white* matrix of domination, according to Bell Hooks (quoted in Hill-Collins [39], p. 222), refers to.

> *"the ideological ground that they share, which is a belief in domination, and a belief in the notions of superior and inferior, which are components of all of those systems. For me it's like a house, they share the foundation, but the foundation is the ideological beliefs around which notions of domination are constructed."*

The mental health system is just one system of many in which we live, all of whom have become constructed over time within a *white* politics of domination, which *white* society established, sustains, and condones [40]. As such, our systems

have been formed and continue to be maintained by an ethnocentric dominance structure that makes *whiteness* the default standard against which all racialised groups are contrasted [41]. It is in this juxtaposition that *whiteness* dismisses decolonial equality, diversity, and inclusion [42]. Black mental health professionals speak about an 'unspoken level of comfort' when it comes to connecting with the "anger of exclusion, of unquestioned privilege, of racialised distortions, of silence, ill-use, stereotyping, defensiveness, misnaming, betrayal and co-option" [43] that their Black patients bring to therapy sessions [44]. Black patients and Of Colour patients speak about how *white* privilege overrides good intentions in theory with *white* mental professionals and creates a lack of willingness to engage further about the topic of racism [45].

When it comes to clinical care, racialised patients want to be seen and treated by therapists who recognise their humanity, presence, and spirituality in all their diversity. Mental health professionals racialised Black and Of Colour make up a disproportionately small percentage of the workforce [32]. With the current emphasis on the value of lived experience expertise and the potential for including it throughout the research process, it should be clear that therapists who are racialised as Black and Of Colour are, to some extent, lived experience experts when it comes to the topic of racism. Many mental health professionals are positioning Black Lives Matter as a framework for supporting Black and Brown patients by focusing on reversing the impact of traumatic historical and current racism on mental health [22, 46, 47]. However, often this position is met with benevolent racism [48]. Such as the assertion that care provided by professionally competent *white* practitioners in racism-insensitive, non-diverse teams should be good enough to treat the kaleidoscopic origins, episodes, and expressions induced by racism, as well as the needs of racialised patients despite gaps that patients themselves have voiced. Recognition of socio-cultural formations - fundamental humanity - alongside an ability to give voice to patients is a crucial tenet of decolonial intercultural competency [49]. Kivel [50] describes a critical approach to intercultural competency as.

> *"...realizing the limits of your understanding. It should make you less arrogant and more humble. It should provide you with skills for promoting the leadership of those from the cultures in which you are competent. As we become more multiculturally competent, we increase our effectiveness in working with diverse populations, but we cannot substitute for people who are experts in their own culture".*

A decolonial framework of workplace belonging tries to comprehend group identification negotiations and how racism on various levels links with broader discriminatory experiences in the workplace [51]. Furthermore, more specifically, these cumulative experiences function as conditions of saturated disadvantage, negatively affecting workplace relationships, productivity, and mental health [52]. Romero's [53] Rubik's cube metaphor can help further to understand the relationship between several layers of racist encounters and compounded risk of having unfavourable mental health effects (**Figure 2**). In its entirety, the Rubik's cube depicts the macrocosm of belonging (e.g., to Germany). Each of the Rubik's cube's 21 separable cubes represents a microcosm of belonging (e.g., to the city, to work, to a generation, to community and to family). Each face of a microcosm of belonging is assigned a colour representing an ascribed social identity (for example, orange represents racialised identity, blue represents gender identity, *white* represents socioeconomic status, yellow represents national identity, green represents age identity, and red represents sexual identity). A privilege-disadvantage continuum and a superiority-inferiority hierarchy exist inside each ascribed social identity (**Figure 2**). The privilege-disadvantage

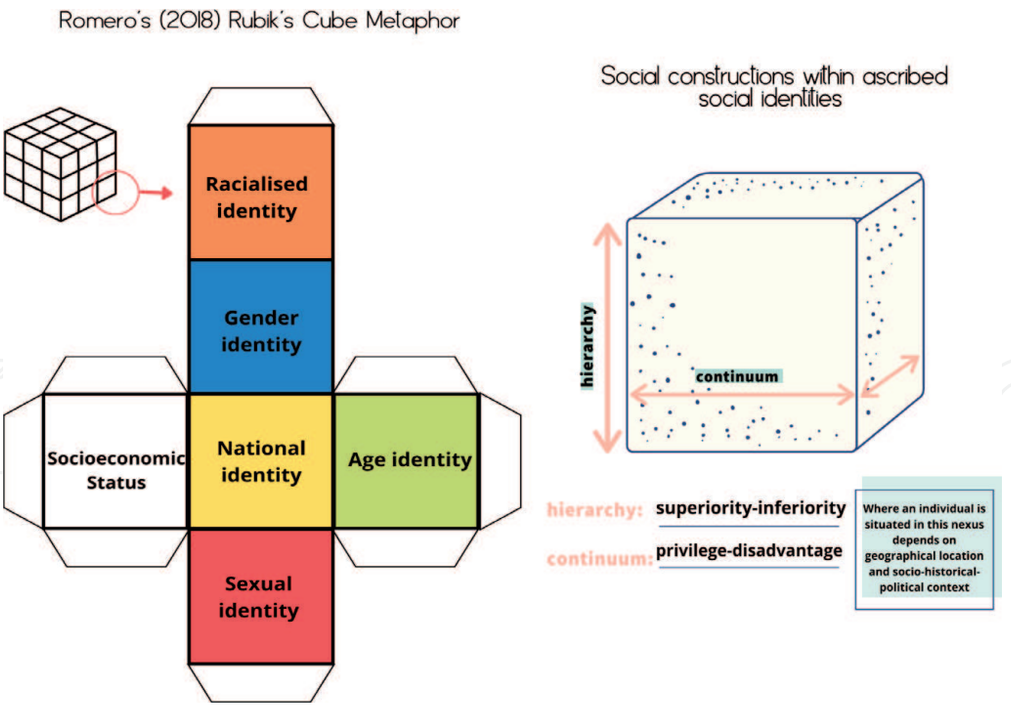


Figure 2.
One microcosm of belonging situated with the macrocosm.

continuum refers to the structural advantage that one group gains over another by systemic exploitation, which one group continues to benefit from to the exclusion of another group who is structurally disadvantaged due to a lack of access to the same possibilities [54]. The inferiority-superiority hierarchy describes how one group is treated by another group in terms of importance, as well as the dominant group's control over the subordinate group [55]. The geographical location and socio-historical-political context determine where an individual fits inside this nexus (**Figure 2**).

The meaning and expression of privileges and penalties intersecting across and within networks of probable social inequalities have sparked increased intellectual understanding among political allies who have chosen to stand together in solidarity in new geopolitical settings [56]. These profound forms of solidarity are not, however, indestructible: these relationships of compassion and understanding need constant care and attention to be maintained [57]. Racialised immigrants and refugees in European cultures have expressed frustrations surrounding the 'potential space' between embodied phenomenological experiences of racism and theoretical comprehension of racism [58, 59].

Many interculturalists (also known as '*white* political allies') are embarking on self-reflection journeys to find ways to bridge the socially constructed 'us vs them potential space', thereby contributing to unity rather than antagonising tensions [60, 61]. However, there is a growing sense of dissatisfaction among racialised people who become burdened with teaching would-be interculturalists about racism without the appropriate infrastructure to support the duty [62]. Racialised patients describe having to teach their intercultural therapists in mental health services about their lived experiences of racism, with little assurance that their testimonies will be deemed reliable [63]. They describe how exhausting it is to explain one's existence at a first point, especially to those who cannot connect fully with the lived body of knowledge, suffering, and struggle [36].

An emerging generation of racialised Black and Of Colour young people have begun to articulate why it is far less stressful to communicate about racism among

people who share the lived essence of these experiences [64]. Patients who need to talk about racism often prefer to talk to racialised mental health providers because they have genuine, on-the-ground information [65]. Having a preference is not to suggest that *white* mental health practitioners cannot learn to work sensitively with people for whom racism has caused them harm [66, 67]. Many *white* practitioners, particularly those working from an intersectional perspective, are learning that the success of an intercultural competency movement in mental health related to racism relies upon their willingness and ability to embark on a journey of self-reflexivity [68]. Amid all these consciousness-building processes, however, it is argued by the decoloniality movement that intercultural competency as a tool for disrupting systemic violence and eliminating racism lost its utility because interculturalists have not gone far enough to question mental health sciences' dominant epistemology, ethnocentrism.

4. Ethnocentrism: western mental health science's dominant epistemology

The international resonance of the Black Lives Matter movement, and in Germany, the racist attacks in Halle and Hanau, have revived longstanding arguments concerning the negotiation of solidarities and the diversity of racist definitions [69]. For some, racism is a worldwide phenomenon in the sense that identical patterns of institutionalised racism are found around the world; others would, on the other hand, say that specific forms of racism are the result of historical disparities and political forces in the context of racism [70, 71]. The need for contextualisation is one of the reasons why some prefer to use the term racisms rather than racism to imply diversity rather than uniformity [72–75]. In an era of digitalisation in media, communication, and information technology, one of the consequences of the COVID-19 pandemic is that our world and societies are becoming even more rapidly submerged in a level of interconnectedness that we have never been accustomed to, and for which there is no precedent [76, 77]. As history unfolds before us, for some, it is clear that the dominant ideology of the Western World monopolises the context of geopolitical power dynamics, including the cultural fluidity of lifestyles, health and well-being pursuits, ethics and spirituality in the non-Western World [78]. Because history is time in motion, culture is in flux. Within this monopoly, socio-political systems conceived in the Western World form a Euro-American macro-culture that continues to invalidate indigenous epistemologies in non-Western World countries. The history and continuing system of mental health theory and care is one example of one such monopolisation.

With the mental health of African heritage patients as an example, African psychology matters in the examination and reconciliation of the time, space, and body - of lived knowledge in the African Lifeworld - to achieve psychological equilibrium [79]. African colonial education transports socio-political systems of thinking conceived in Europe and Europeanised America to communities in the Majority World, where they may have little relevance [80]. Elements of such Western approaches became invented for a more efficient teamwork approach to exploiting landscapes, agricultural harvests, and precious resources in other parts of the world to benefit the 'elite' Minority against the well-being of the 'second-class' Majority. As such, "the blood that has dried in its codes" legacy refers to the history of racism and colonial brutality that Western mental health science is rooted in ([81], p. 56). The erasure of socio-political systems of African thinking such as indigenous repertoires including preparationism, functionalism, communalism, perennialism and holiticism is contributing to a sizeable gap between actual economic growth, human development

trajectories and the predictions made by human capital theory (cited in [82], p. 25; [83]). The canonisation of only *white* (political)intellectual achievements and the curating of reading lists containing only *white* knowledge and knowers, which can make the study of Western mental health science seem irrelevant for many racialised students, does not happen by chance: it is a deliberate move by those who benefit from this epistemological injustice [84].

In Western mental health science, ethnocentrism contributes racialised, gendered, and classed binaries of between-group cultural difference such as "native/migrant", which are used to measure and explain harmful "us/them" comparisons of the human psyche, self-concept, and personhood (e.g., [33, 85–90]). Structural racism persists due to mental health service's failure to recognise and confront its existence and causes through policy, example, and leadership openly and sufficiently. Racism can become entrenched in a mental health service's ethos or culture if it is not recognised and addressed [33]. Thus, structural racism in Western mental health science reflects the occupational culture historically delineating the geopolitical "zone-of-being" bestowed upon the subjectivities, epistemologies, and identities emanating from Europeans and Europeanised Americans that these disciplines are built around (see [91]). In contrast to the geopolitical "zone-of-non-being" ascribed to all racialised Others "born with less" - if any at all - access to environmental resources and quality, material capabilities, and domestic/international socio-political power; thus, their subjectivities, epistemologies, and identities dubbed "primitive", "inferior" and "uncivilised" are erased [92–95]. Furthermore, eliminating structural racism is to eliminate *white* societal investment in sustaining power disparities, both individually and collectively [96–99].

Influenced by the discourse of postcolonial scholars such as Frantz Fanon (1925–1961) [100–104], Edward Said (1935–2003) [98], and Gayatri Chakravorty Spivak, Ake [105] argues, like Fernando [33], that the dominant European epistemology underpinning social science - that is, the ethnocentrism of scientific knowledge - is the most pernicious form of structural racism [106–108]. According to Ake [105], the Western social sciences comprise a bourgeois ideology meant to serve capitalism principles and institutions, resulting in the capitalistic underdevelopment of non-Western communities [107]. Theorising decoloniality as an antidote to ethnocentrism, Bulhan [109], in a similar vein, argues that the dominant European epistemology of Western mental health science is a neo-colonial strategy that ignores the diversity of social and cultural variants, as well as their local meanings. In contrast to decolonial perspectives on the human psyche, self-concept and personhood, Western mental health science implants Eurocentric 'universal' scientific truths onto judgements of postcolonial people, postcolonial land and postcolonial states and societies [110]. It was, moreover, colonising non-Western people and penalising them for not fulfilling Western master narrative expectations [111]. International diagnostic criteria developed in the Western model of mental health are the epitome of stated Western master narrative [109–112]. In the current systems of diagnostic classifications, it is vital to know what constitutes 'normal' social behaviour and moral philosophical consciousness in each community context when using diagnostic criteria, as even supposedly objective disease criteria are defined with respect to social norms (for a criticism see Heinz [113]).

As Mfutso-Bengo [114] puts it, the continual 'push-and-pull' or finding an ethical balance between moral absolutism and moral relativism, presents awareness of social constructionism as a duty of care in therapists' virtuous decision-making processes. Ethical balance orchestrates bridging capital for inclusive and intersectional links across approaches to 'normality' and 'abnormality', 'health' and 'sicknesses', and the sanctity of decolonial humanism and human rights [115–123]. The Azibo Nosology II (ANII) is an example of a classification scheme for the mental

health of people of African heritage that is based on African cultural knowledge and traditions, as well as and on the understanding that the curriculum and pedagogy of Western diagnostic manuals are hegemonic. Moreover, that the learned helplessness that results in the internalisation of epistemological injustice has harmful mental health consequences [124]. Some writers argue that Azibo [124], rather than DSM or ICD, provides a more culturally suitable diagnostic system for people of African heritage [125]. Local non-Western knowledge should be appreciated, but relativists should be wary of assuming that all local values must be honoured. Azibo's [124] nosology includes some misogynistic terms for women who have multiple lovers, as well as many other problematic categories including sexual misorientation and unwillingness to procreate.

When practitioners see mental health problems as arising from local socio-political contexts rather than from individual intrapsychic malfunctions, ethical balance is achieved [126]. For people of African heritage, these local contexts contain regional versions of systems of dominance such as racism, sexism, homophobia, ableism, and transphobia, as a reading of Azibo [124] would clearly point out. However, such approaches are rarely reflected upon in the currently dominant classification systems. Although the globalised Western nomenclature's science of praxis clearly has its origins in Europe and Europeanised America, European ethnocentric concepts have been widely and uncritically adopted in intercultural therapy with non-Western patients because they are believed to have universal applicability and philosophical value [85]. Improving diagnostic accuracy requires an ethical-political framework within which socio-cultural formations of moralised reasonings are deliberated upon to reach a consensus on what constitutes a clinically relevant mental illness for a patient and what are sickness-related social consequences within his/her/their system of community values as part of efforts to strive for more beneficence, nonmaleficence, and justice [127, 128].

5. Attending to Western mental health sciences' existential crisis

Even many interculturalists are concerned about the influx of non-Western migrants into Western civilisation. In 2015, the media began to report on a significant surge of migration throughout Europe because of, to quote Crastathis and colleagues, "...the accelerated conditions of war and state violence, which are inextricable from globalised capitalism, histories of colonialism, and contemporary imperialism" (p. 4) [34]. This particular influx of migrants and refugees was dubbed 'The Refugee Crisis' by the media. In Germany, Chancellor Angela Merkel's decision to extend an open-door policy was praiseworthy. Many people in many sections of German society exhibited welcoming, altruistic behaviour and attitudes. Meanwhile, *white* nationalist groups like The National Socialist Underground have already carried a series of racist murders of Persons of Colour, the Islamophobic Pegida movement gained popularity, and the rightist party Alternative für Deutschland (AfD) gained political ground in parliament [129, 130]. The emotive term 'crisis' in forced migration is not peculiar to this migration trend. Robinson questioned the term's use already in his 1995 article *The Changing Nature and European Perceptions of Europe's Refugee Crisis*. He believes that framing the concept of 'crisis' in the context of migration builds Europe up as the 'centre' of an imagined sanctuary, allowing European governments to enact draconian political control techniques under the guise of 'required security' [131, 132].

With this critique in mind, the declarative language of 'crisis' used in the context of migration is symptomatic of a political and existential crisis of privileged European citizenship [133]. In fact, the origins of the 'race' idea and the socially

constructed meaning of racism [134], as well as how ethnocentric theories have established methodological barriers to the care of racialised minorities [32], are at the heart of Western mental health sciences' existential crisis. The hegemony crisis is that the Western mental health sciences are openly biased. They favour quantification methodologies in a scientific paradigm that values positivism, causality, objectivism, and rationality. It fails to address that, in their attempts to distance themselves from philosophy and theology to be seen as a 'legitimate science', these disciplines neglect their own origin and have become positioned to produce and reproduce ethnocentric knowledge [91]. The crisis of legitimacy is the prevalent belief that these disciplines generate the most valid knowledge, with extended intercultural legitimacy and corresponding intercultural clinical utility, for all of humanity in their unadapted Western, academic, scientific formulations.

This existential crisis of ethnocentrism in the European-Europeanised American macro-culture of *whiteness*, that is, the Western mental health sciences, is a pervasive issue because: (1) for many people, *whiteness* is imperceptible, (2) the growth of capitalism required a *white*-racialised curriculum., (3) its cross-cutting nature lends itself too much to power, (4) we do not have to think since the *white* curriculum has already done it for us, (5) the academy's physical environment is based on *white* dominance, (6) *white* people are not the only ones 'included' in the *white* curriculum, (7) the *white* curriculum rests on a widely held belief, and (8) the *white* curriculum indoctrinates people into the belief that it is not proper if it is not *white* ([135], p. 643). The intercultural competency movement opposes the status quo by harnessing its conceptual nature, but it also needs a decolonial positionality in constructing an academic revolution against that *white* European and Europeanised American geopolitical milieu and its dominance. Western mental health science's existential crisis of conceptual problems impedes the cultivation of environments of belonging, for racialised students and employees, necessitating a resurgent and insurgent decolonisation of epistemological ethnocentrism [33].

The 'successes' or 'failures' of interculturalism lies outside the reach of sociodemographic methods to civic involvement without integrating a more deeply critical consciousness into a more socially engaged intercultural paradigm [136, 137]. As Bhattacharyya [138] reiterates, the problematic neglect of racism is embedded in many 'multicultural' approaches.

> *"... is not about multiculturalism [...] what this really is, is an attack on the claim that racism exists and shapes social outcomes, and as other (contributors) point out, this is a long-standing point of political debate and struggle. The most effective method of silencing a critique of racism is to argue that racism no longer exists. Those claiming to suffer from its consequences must be pursuing their own selfish agendas".*
>
> *(cited in [136], p. 4).*

This statement alludes to the problem of colour-blindness among a majority of interculturalists positioned in normative *whiteness*, many of whom can understand and deal with concerns of gender and socioeconomic status outside of the topic of racism but cannot deal with the issue of racism. Colour-blindness refers to *white* people's denial, distortion, and minimisation of racism's reality and its negative impact on many aspects of neo-colonial/neoliberal democracy [139]. Colour-blindness is a prevalent form of aversive racism that is part of "an epistemology of *white* ignorance" ([140], p. 37) [59, 141–145]. Aversive racism is a type of racism that is minor yet persistent and is often known as 'microaggressions'. The literature shows that microaggressions may have serious mental health repercussions for affected people [146]. Microaggressions such as colour blindness prevent persons

who are racialised Black and Of Colour from being heard. The erasure of Black and Brown knowledge and knowers in *white* institutional spaces is an epistemic injustice that excludes, represses, censors, abstracts, masks and conceals, which is why Gayatri C. Spivak posed the question "Can the Subaltern Speak?" [99]. People socially ascribed the subaltern position, that is, the racialised phenomenology of Black and Of Colour bodily experience, in other words, have long since struggled to have their voices heard, to have their experiences of racist injustices heard, all to no avail [99].

Feeling respected and treated correctly is fundamental to developing a sense of belonging in situations [147]. A sense of belonging and happiness are linked, and, unlike emotional alienation, belonging functions as a protective factor against mental health issues, including depression and anxiety [148]. Part of the efforts to eliminate structural racism is cultivating belonging settings on a structural level [149]. Workplace climate, which refers to a climate that encourages involvement with positive relationships, social connectedness, and mattering, is one of the most important aspects determining the ability of workplaces to cultivate settings of belonging on a structural level [150]. To this end, a decolonised workplace climate is a liberated space for ongoing learning, and it seeks a greater understanding of racialised employees' 'embodied feelings' [151]. In a decolonial framework, gaining a better understanding of racialised employees' 'embodied feelings' entails listening to their perspectives on ethnocentric mental health philosophy [152]. In epistemology, decoloniality is a fundamental questioning of a 'naturalised' and 'normalising' coloniality of knowledge/power/being/truth/freedom [153]. As concerns mount that evidence-based approaches established without proper embodied representation of those from the 'periphery' merely serves to reinforce structural racism. Belonging and inclusion are vital for performance-related outcomes at the service level:

> *"...if there are no Black academics moving up, then you end up with a lot of precarious Black labour in universities, with no power and no ability to set an agenda or to even check an agenda that is being set" (Prof. Robbie Shilliams, cited in Richards [154]).*

On the one hand, decoloniality clarifies a shift in how coloniality is perceived: "from [the] occupation of land to [the] occupation of being", as Bulhan [109] puts it, but it also clarifies that the contemporary implications of structural racism from a historical point of view transcend time and place [155, 156]. As a result, recognising the impact of racism directed at the group to which people belong is at the heart of a decolonial framework of workplace belonging in mental health services. The most common unintended residue of modest but powerful political anti-racism advances in recent decades is the popularised, habitual dismissal of institutional racism as simply 'unconscious bias' [157–159]. In contrast, the phrase '(un)conscious bias' emphasises the fact that Western discourse frequently attempts to exploit the assumption that racism is a result of unconscious negative attitudes and behaviours. That in doing so it is hoped not to be held accountable through an "epistemology of *white* ignorance" ([140], p. 37). Thus, the term '(un)conscious bias' challenges the symbolic racism embedded in the language of non-responsibility [160]. Kilomba [161], in her book *Plantation Memories: Episodes of Everyday Racism*, explains how Western mental health science is a *white* space corrupted with deeply rooted and pervasive racism, all too often dismissed as simply '(un)conscious biases', and how this structural racism impacts the emotional safety of People of African heritage in a variety of everyday settings including in mental health services. Who gets published, gets funded, and sits on funding approval panels is influenced by these supposedly unintended '(un)conscious biases' [161].

Because mental health practices are evidence-based, '(un)conscious biases' in the generation of evidence result in '(un)conscious biases' persisting in the provision of mental health services [162]. Furthermore, it results in the diffusion of '(un)conscious biases' into the mainstream culture milieu. Because of the current popularity of political correctness, racist 'social imagination significations' psychically necessitate neglect of racism as epistemic and ontological '(un)conscious biases' which nevertheless still serves to oppress, control, and assimilate Black people and People of Colour [163]. It is not by chance that inappropriate and culturally insensitive instructions and curricula are developed, designed, and delivered; instead, the beneficiaries prescribe them [140]. The raison d'être of continued colonial pedagogical strategies is to socially engineer future generations of scholars and practitioners into a collective consciousness of '(un)conscious bias' to maintain the harmful effects of racist ontological order on structurally excluded, marginalised, and oppressed groups [164]. On the other hand, the eradication of imposed European ethnocentric identification of itself as the (political)intellectual, ideological standard defining global mental health is part of eliminating structural racism in Western mental health science [84, 165].

The mental health system is one structure within a network of national-level political institutions and political-cultural traditions that racialised individuals experience as sources of emotional suffering, humiliation, and intra-psychic conflict [166]. Structures they report that fails to recognise their worth regularly [167]. All too often, *white* mental health providers have rejected racialised patients' problems with racism as excessively sensitive impressions of events, rather than seeing these issues as a sign that something is wrong with the system [168]. At its core, colour-blindness is an epistemological weapon that obscures the connections between systemic racism, life chances, and mental health [169]. Aversive racism exists in a spectrum of structural racisms. However, it is less severe than more extreme racisms, such as ethnocentrism and biological racism [163, 170]. There is still a lot of mistrust, scepticism, resentment, and unhappiness among many racialised populations about mental health practitioner's ability to provide emotional safety in therapy. Threads of these emotions bind together to form significant hurdles to voluntary participation and early intervention for mental health problems [45].

6. Conclusions

Decoloniality is a framework for a more socially engaged intercultural paradigm that lays the groundwork for solidarity among postcolonial, indigenous, and decolonial alternatives to hegemonic Western epistemology in order to achieve a common purpose [171]. Makhubela [172] uses Zizek's Lacanian theory of ideology to apply European philosophy to South African scholarship to create culturally diversified intellectual capital in a powerful counter-hegemonic narrative. He warns against the complacency that comes with 'intellectual rebranding' in the name of decolonisation [173]. According to Makhubela [172], genuine decolonisation requires us to delve deeply into its many theorisations to understand how we can channel an 'embodied feeling for culture' to operationalise it as a long-term goal requiring more extensive, coordinated, and sustained political support. Because as Ratele et al. ([173], p. 5) has said,

> *"...to paraphrase Audre Lorde [174], the coloniser's psychology cannot be used to decolonise the coloniser's psychology".*

In order to allow racialised people to have their voices heard in narratives about them, the quest for a genuinely global decolonial stance in mental health science must incorporate ideas presented by racialised people [84]. In what ways might interculturalist collaborators assist without adopting a saviour mentality or its trappings?

1. Increase the voices of thinkers in the Western canon of psychological work who are not heavily representative of the key texts that maintain the ethnocentric epistemology, while amplifying the voices of thinkers from various cultural, religious, and politico-economic contexts and regions (Global South, Majority World, Non-Western, African, Asian, Latin American, women), to enable truly intercultural dialogue.

2. Encourage students to become aware of structural racism by including teachings about empires' particularly destructive role in shaping narrow ways of thinking in mental health science, which is responsible for a low opinion of even very sophisticated psychological ideas, thought, and concepts solely because they emanate from specific cultural, religious, and politico-economic contexts and regions.

The dearth of decolonial intercultural competency, an issue connected to the provision of emotionally safe environments in mental health care for racialised people, is exacerbated by the underrepresentation of racialised professionals and the pervasive ethnocentric epistemology at all levels of academia. As many Black people and People of Colour perceive or experience, going into counselling and psychotherapy often entails relying on an ethnocentric culture for profound recognition of the most intimate components of the human situation. Decolonial interculturalism-informed orientations, theories, training practices and methodologies acknowledge the daily occurrences of racism at many levels, as well as the intersection of additional societal injustices, which forces Black people and People of Colour into a constant stressful state of "I am therefore I resist" in order to survive ([175], p. 208). When Black patients and Patients of Colour are supported to "discover, uncover and recover" their sense of humanity in counselling and psychotherapy, they find dignity ([176], p. 496). With decolonial intercultural competency and cultural humility, recognition entails seeing and understanding and strengthening positive connotations associated with positive racialised persons' identity consciousness [177, 178]. The effective elimination of structural racism is a moralised imperative within this decolonial intercultural perspective. Requiring a devotion to authenticity, humility and reflexivity.

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