Is spirituality the answer to mental illness in Black patients?

Introduction

The historic journey between psychiatry and spirituality is complex, with ever-changing perspectives on the effect of spirituality on mental illness. Similarly, the relationship between the Black community and spirituality is multi-faceted and cultural influences are tightly interwoven into this narrative. Yet one thing appears pervasive: a racial bias seemingly colouring interactions between Black patients and mental health service provision. As people have more transparent conversations regarding race in the wake of the 'Black Lives Matter' movement along with ongoing racial tensions between institutions such as the police force and the Black community, it seems prudent to include race in an essay exploring the impact of spirituality on psychiatric outcomes. Similarly, it is necessary to explore the interplay of spirituality and race to uncover strategies that can be incorporated into psychiatric practice to improve the approach of psychiatrists to Black patients and hence improve psychiatric outcomes. This essay explores the intersection of spirituality, its presence within the Black community and the psychiatric outcomes of the Black community.

Minority stress and access to mental health in the Black community

Despite London being shown to be the most diverse city in the United Kingdom (UK), only 13.3% of the population identify as Black (*Regional ethnic diversity*, no date). This objectively highlights the fact that being Black in London makes you part of a minority group and hence vulnerable to minority stress. Meyer (2003) highlights, in the context of gender non-conformity, the psychological impact being part of a minority group has on a person's mental health, both in creating psychological distress and also in forming resiliency. There also seems to be a prevailing dogma that Black patients are at high risk of developing schizophrenia, yet these studies and their methodology have been challenged, suggesting that there is not an appreciable risk associated with mental illness and race (Alvarez *et al.*, 2019). This suggests that, though Black people do face risk factors to mental illness such as minority stress and the psychological risk this poses, Black people are not automatically more mentally unwell. However, they are more likely to be diagnosed as such, especially with schizophrenia rather than mood disorders, and this unfortunately seeps into the experience Black people have when experiencing psychiatric services (Bignall *et al.*, no date).

There is a wealth of information suggesting that Black patients are over diagnosed, misdiagnosed, detained more often, and have poorer health outcomes (Raleigh *et al.*, 2011; Kendrick, 2003). Interestingly, overdiagnosis is seen with both White and Black clinicians. However, there are differences in the symptoms used to inform diagnosis, with White clinicians relying more heavily on negative symptoms to inform a schizophrenia diagnosis and Black clinicians on psychotic symptoms like hallucinations (Trierweiler *et al.*, 2006). This raises an interesting point- the extent to which ethnicity influences both history taking and the unmasking of symptoms. Perhaps Black clinicians are better able to elicit positive symptoms in Black patients, or are misattributing normal sensory phenomena to hallucinatory experience? Are White clinicians less able to differentiate between patient apprehension and negative symptoms and thus are using apparent negative symptoms to inform diagnosis when

positive symptoms cannot be elicited? It is crucial to understand the way in which clinicians of different races approach patients of different races as clinician belief and culture affects the eventual management patients are offered (Galanter, Larson and Rubenstone, 1991). A more detailed understanding of this phenomenon may also help tailor psychiatric reasoning. Since psychiatrists of different races use different mechanisms to illuminate patient symptoms, perhaps these mechanisms could be elucidated and detailed to allow psychiatric trainees to choose which strategies work best for them to uncover patient symptoms? Despite relying on different symptoms for diagnosis, both Black and White clinicians gave comparable schizophrenia diagnoses to Black and White patients. Since clinicians of different races are reaching the same conclusion via different methods, perhaps it is necessary for diversity training to address how clinicians of different ethnicities approach diagnosis of patients of different ethnicities. This could present learning opportunities for clinicians to master different diagnostic tools- this is especially useful within psychiatry where objective tests for diagnosis are somewhat limited and having a diverse arsenal of subjective tools, including precise history taking, is incredibly advantageous.

There has been a long-standing history of mistrust between the Black community and healthcare, particularly mental health services (Schwartz and Blankenship, 2014). This may be mediated by the disproportionate rates of Mental Health Act sectioning used for Black patients (Bhui *et al.*, 2003) and the difference in treatment strategies Black people tend to experience, notably the disproportionate use of seclusion and, more significantly, restraint as management options (Sainsbury Centre for Mental Health, 2006). Moreover, this distrust is also fostered by clinicians- psychiatrists are more likely to perceive Black patients as dishonest and this dishonesty mediates some of the relationship between race and schizophrenia overdiagnosis (Eack *et al.*, 2012). Interestingly, this large study shows an inconsistent relationship between socioeconomic status (SES) and the racial disparity in schizophrenia diagnosis. This suggests that psychiatrists, of all ethnicities, need to actively monitor their examination process when evaluating Black patients, as their perceptions can significantly influence diagnosis and subsequent treatment and prognosis for these patients. SES, though an important factor mediating clinical outcome, seems to be less impactful than a meaningful relationship between patient and psychiatrist, especially cross-racially. Even when using a more objective method of diagnosis, this race difference in diagnosis, though somewhat reduced, remains (Neighbors *et al.*, 1999; Neighbors *et al.*, 2003).

The beauty of psychiatry is having the freedom to take long and detailed histories which are not confined to 'SOCRATES' and symptom elicitation. Psychiatry requires a detailed understanding of the patient- intrusive questions are encouraged to allow psychiatrists to develop a full understanding of the patient and truly identify pathological symptoms requiring diagnosis and treatment. Yet studies seem to suggest that this method is adversely affecting Black patients- such unstructured history taking allows racial biases to infiltrate the process and fails to eliminate reciprocal distrust between Black patients and their psychiatrists. Conversely, structured history taking simultaneously strips psychiatric examination of the 'je ne sais quoi' that allows detailed and organic examination and is still not completely effective in removing racial bias.

The situation seems somewhat irreconcilable. Even with the inclusion of cultural formulation, fewer Black patients had their psychiatric diagnosis changed (Adeponle *et al.*, 2012) despite epidemiological studies suggesting schizophrenia is equally prevalent across ethnic groups (Chien and Bell, 2008). Spirituality may play a role in bridging this gap.

The role of spirituality in psychiatric illness

Spirituality is defined as belief and obedience to an all-powerful force, usually called God, who controls the universe and the destiny of humans. More specifically, spirituality involves belief in a force beyond that of human nature and hence does not necessarily have to be confined to a deity or organised religion. Religion on the other hand constitutes organised and institutionalised spirituality (Verghese, 2008).

Historically, spirituality has been viewed as an addition to the 'normal' human experience, with the DSM-III classifying spirituality and the feeling of connectedness to a deity as an example of mood-congruent psychotic features. Whilst a perceived special relationship with a famous person can be considered psychotic, the very nature of spirituality breeds feelings of closeness to a force greater than oneself. This experience necessarily includes a special relationship with this force which constitutes part of a 'normal' experience for the patient (Post, 1992).

There has since been a shift in the interpretation of religious beliefs within the literature, with the DSM-IV incorporating a religious or spiritual problem diagnostic category, enabling a distinction between psychological problems of a spiritual basis and true mental health disturbance (Turner *et al.*, 1995). DSM-5 elaborates on this further, incorporating spirituality and religion into a cultural context, empowering psychiatrists to adopt a more personalised and cultural approach to spirituality and presentations primarily concerning spirituality (Prusak, 2016).

With the shift in terminology and interpretations of spirituality came a new wave of research forming a foundation for that shift. Numerous studies have been conducted highlighting the positive effects of spirituality and religion on psychiatric outcomes (Verghese, 2008). Religiosity (defined as the variables related to belief) in mothers is demonstrated to be protective against depression- this relationship is not dependent on attendance to religious services (Miller *et al.*, 1997). This highlights the fact that spirituality and a connectedness to faith seems to be the foundation for the protective mechanism of religion, rather than attending organised religious services. No relationship was found between offspring religiosity and offspring depression, suggesting that spirituality develops over time; as a person's faith develops the protective factors attendant with that faith can also begin to manifest. Furthermore, these findings are independent of other social factors such as SES, maternal bonding and functioning and other factors. Again, this emphasises the role of spirituality as an independent factor regulating mental health for some patients.

Not only is spirituality protective, but for some patients the complex nature of spirituality and existentialism results in their existential needs not being adequately communicated to their carers. This is confounded by carers believing that the existential needs of the patient are secondary to other needs such as the need for work or health. This dissonance means that, although patients report their existential needs as being the most important, these needs are insufficiently addressed and can be mistaken as part of the disease process of psychosis (D'Souza, 2002; Wagner and King, 2005).

Given the growing body of evidence suggesting that not only is spirituality an important component in improving mental health, but it is also considered important by patients, it is essential psychiatrists recognise the value of including spirituality as a component of psychiatric assessment. Furthermore, it is imperative for psychiatrists to be taught about incorporating a spiritual enquiry into their psychiatric history. Many psychiatrists understand the importance of including spirituality in psychiatric assessment (Baetz *et al.*, 2004), however, psychiatrists themselves have low levels of spiritual belief and this colours the willingness of psychiatrists to broach a topic which they may consider inappropriate. Additionally, psychiatrists believe that religious belief is an important part of psychiatric assessment for different reasons- some believe religion may lead to psychiatric illness, others that psychiatric conditions intensify religious belief and others that religion may protect from psychiatric illness. Hence, a psychiatrist may be hesitant to address a patient's spiritual beliefs if they themselves are not spiritual and are concerned regarding the role of spirituality in psychiatric illness (Neeleman and King, 1993). For psychiatrists in training, this is compounded by the fact that an assessment of spirituality is not included when they are taught psychiatric history taking as medical students- even when students are taught how to conduct a spirituality assessment, they are unlikely to include this in their clinical history taking (Musick *et al.*, 2003).

Harnessing the beneficial effects of spirituality for patients is in its infancy but shows promise. The novel spiritually augmented cognitive behavioural therapy (SACBT) highlights the role of spirituality in maintaining remission for schizophrenic patients and improving patient adherence to treatment (D'Souza and Rodrigo, 2004). Importantly, SACBT also improves patient function, which is tantamount to cementing the recovery of a patient by facilitating their social functioning (D'Souza, 2013). SACBT is founded on four principles, namely acceptance, hope, forgiveness and achieving meaning and purpose. This treatment option was developed with Australian indigenous elders, highlighting the non-denominational nature of spirituality incorporated into this treatment option. Moreover, SACBT is personalised to the patient to allow them to confront their own existential queries and allow them to follow their own faith beliefs- this means that the patient is encouraged to pray or meditate as is appropriate for them. As medicine shifts towards a more personalised approach to patient treatment, SACBT could be used as a vehicle towards even more personalised therapy options within psychiatry: what is more personal to a patient than their spirituality!

Moreover, there has been a shift in psychiatric practices. Psychiatrists are encouraged to take a spiritual history and fully understand any religious or spiritual ideas or delusions a patient may harbour (Koenig, 2008). This is crucial, as a significant proportion of delusions and hallucinations feature religious and spiritual content (Krzystanek *et al.*, 2012) and thus fully understanding the spirituality of a patient is

paramount; particularly because patients with religious delusions take longer to establish service contact and generally have poorer outcomes (Grover, Davuluri and Chakrabarti, 2014). There have also been suggestions that patients could be referred to religious leaders such as the clergy (Huguelet and Koenig, 2009) and even a possibility of psychiatrists praying with the patient in appropriate circumstances (Koenig, 2008). As psychiatrists shift their perception, perhaps this will be reflected in psychiatric teaching.

Notwithstanding, it is important to recognise the limitations of this new body of research. Firstly, the focus is largely on organised religions, particularly Christianity, as opposed to spirituality. It is simply easier to recruit people self-identifying as Christian rather than spiritual or agnostic which is more difficult to self-report. This means that it is difficult to separate the benefits or negative impacts of spirituality from other religious factors impacting on mental health such as the sense of community religious organisations offer or the pressure to conform to a collective (Cornah, 2006). There are some studies showing the negative effects of religion and spirituality especially as it relates to guilt: guilt is a symptom of depression, suggesting that religion and potentially spirituality may also contribute to mental ill health (Albertsen, O'Connor and Berry, 2006). The new research regarding spirituality and mental health seems to be overwhelmingly positive (Cornah, 2006). Though religion can have a negative impact on mental health (religious delusions are held with more conviction and so may be harder to challenge) there are also benefits that come with religious beliefs such as lower rates of substance abuse and suicide and increased social functioning (Grover, Davuluri and Chakrabarti, 2014). Taken together, these studies suggest that religion, and spirituality by proxy, is a complex mediating factor for good mental health.

The Black community and spirituality

It has been consistently shown that the Black community is heavily involved in religion, prayer and spirituality (Krause, 2003b; 2004; Krause and Chatters, 2005; Taylor, Chatters and Jackson, 2007). As organised institutions, religions have historical importance and benefit within the Black community (Taylor, Chatters and Levin, 2004; Taylor, Chatters and Jackson, 2007). This allows cohesion within the Black community and serves as a base to help challenge the social issues Black people face such as social injustices, health inequalities and disenfranchisement. Additionally, independent of the more secular role the Black church plays within the Black community, Black people get a sense of religious meaning from private prayer and regular church attendance (Krause, 2003b). Similarly, African Americans also sought Islam as a method of activism and community engagement as well as self-empowerment whilst also rejecting Eurocentric Christianity (Chande, 2008).

Though the aforementioned studies focus on the African American community, many of the stresses Black people in the UK face are similar. Feelings of disenfranchisement and injustice, poorer health outcomes, lack of access to or knowledge of health services, overarching societal racism, microaggressions and importantly a societal ambivalence towards these inequalities are all daily experiences of Black people in the UK (Raleigh *et al.*, 2011; Salway *et al.*, 2016). Hence, though the

Church and its relationship with the Black community in the UK may have different historical roots to the Black Church in America, it serves a similar purpose for Black people in the UK (Kalilombe, 1997). Similarly, young Black converts to Islam seem to be drawn to the sanctuary offered by faith in comparison to the harsh realities of disproportionate stop and searches and knife crime targeting young Black individuals (Reddie, 2009).

Though the British religion in numbers survey suggests that Black Africans and Caribbeans are almost exclusively Christian or Muslim with regards to religious affiliation (Sobolewska, 2011), there are also non-religious cultural influences on Black patients- the spiritual experience of Black patients is not limited to religious experience alone. Among Black communities, as part of an overarching spiritual and cultural belief, regardless of spiritual or religious position, some Afro-Caribbean people believe in witchcraft. This belief extends to the idea of witchdoctors who practice herbal medicine and historically have been central members of Afro-Caribbean societies (Mesaki, 1995; Pierre, 1977). There is a paucity of accurate research on the topic, with many early works coloured by colonial and racist overtones, yet ethnographic studies have suggested that witchcraft and the acknowledgement of spirituality is conserved among many African communities (Mbiti, 1990) and extends beyond the continent to the diaspora via the slave trade (Pierre, 1977; Paton, 2015). Across Afro-Caribbean nations, the idea of witchcraft is pervasive and this spirituality is interwoven with the spiritualty accompanying organised religion such as Christianity, where African Christians amalgamate the gospel with the idea of spiritual warfare via witchcraft (Asamoah-Gyadu, 2015). As such, understanding spirituality in the Black community is much more complex than simply studying organised religions such as Islam or Christianity, especially concerning Black people who are not religious but are still affected by cultural influences of spirituality.

The complex nature of spirituality among Africans is illustrated by the case report which describes the trial of an accused witch for child abduction- she had had a relapse of her schizophrenia (Dhadphale, 2015). This case highlights the importance of working with local spiritual leaders (in the UK this tends to be local religious leaders) and having an in-depth understanding of the culture of the patient to ensure appropriate treatment. This also provides a strong foundation to begin to understand and challenge delusions as well as to liaise with the community that will ultimately be instrumental in the recovery of said patient. Carrzana et al (1999) also depict, through a series of case studies, the importance of cultural understanding among Caribbean patients and their families to allow for adequate medical treatment. How much more important is it for psychiatrists to be culturally sensitive? Spirituality and culture form large parts of a person's sense of self and the functioning of the mind- psychiatric disorders are disorders of the mind, sense of self and functioning. Simply understanding that culture impacts treatment does not equate to taking a cultural and spiritual history and approaching the beliefs of patients in a culturally sensitive manner. Perhaps, if patients believe you are willing to consider their own differential diagnoses for their illness they will be more willing to accept the differential diagnosis given, and most importantly adhere to the treatment plan, improving patient compliance and overall outcomes. At the very least, attempting a spiritual and cultural history will likely improve rapport between psychiatrists and patients which is vital for healthy therapeutic relationships.

The Black community and access to mental health services

Black patients are more likely to be referred via the justice system than primary care (Sainsbury Centre for Mental Health, 2006). Perhaps spiritual community leaders such as Pastors or Imams could play a role facilitating less daunting routes to mental health services. Furthermore, Black social workers and psychiatrists involved in their local Churches or Mosques could galvanise and prepare culturally and spiritually sensitive materials to improve awareness and education within the Black community concerning mental health (Robinson *et al.*, 2018). Many African American Churches have an established health program and health ministry (Rowland and Isaac-Savage, 2014). This ministry was overwhelmingly coordinated by health professionals- this could be within the Church or external to it. This highlights the importance of psychiatrists, especially community psychiatrists, reaching out to local faith-based organisations to improve mental health education and referral in marginalised communities, namely Black communities. Perhaps if Black people began their treatment via community referral rather than detention or police referral their prognosis would improve. Health education is key in improving mental health outcomes in Black communities. Many mental health issues are not recognised as pathological and so Black patients may not seek professional help, resulting in compulsory detention as their condition deteriorates. Illustrating this, Black participants thought of dementia as a 'White person's illness' and so did not seek medical attention when forgetfulness became a presenting problem (Berwald *et al.*, 2016). If these types of programs were established, it could also be an opportunity for psychiatric trainees to observe first-hand the importance of community psychiatry in an informal non clinic-based manner.

Given the central role faith organisations play in the lives of many spiritual Black people, with many turning to their priest for personal support rather than psychiatrists and other health professionals (Robinson *et al.*, 2018), incorporating mental health education and referral to existing faith-based health programmes could be key in improving psychiatric outcomes for Black patients. When coordinating this response with faith leaders, it is essential to deliver sufficient training to those involved, including when, how and who to refer to, allowing appropriate care to be delivered to the Black community involved. If priests are the first point of contact for many Black people in a mental health crisis then it is essential that these priests have sufficient training to recognise what a mental health crisis looks like (Taylor *et al.*, 2000). Hankerson et al (2015) demonstrate the feasibility for the medical community to partner with faith communities and identify mental health problems such as depression. This is key, as it has been argued that depression is often misdiagnosed as schizophrenia in Black patients (Barnes, 2008). Acquiring a timely depression diagnosis, particularly before it becomes severe depression with psychotic features which can be difficult to distinguish from schizophrenia (Adeponle *et al.*, 2012), may help improve prognosis in Black patients by ensuring the correct treatment is provided. Many Black people rely on God, faith and spirituality to 'fight' mental illness (Black, Gitlin and Burke, 2011). Consequently, it is imperative that faith leaders are able to both support the spiritual needs and beliefs of the patient whilst also recognising mental illness and referring their community to mental health professionals for appropriate treatment. Faith-based interventions with appropriate cultural adaptations improve mental health outcomes and can have enduring effects (Hays and Aranda, 2016).

A local initiative with South West London and St george's mental health and surrounding faith groups encapsulates perfectly how community and more importantly spiritual engagement could be used to improve the outcomes for Black patients as patients encounter healthcare through a less coercive route. As such mental illness can be addressed in a non threatening manner at the infancies of disease rather than once a patient has deteriorated further (*Ethnicity Mental Health Improvement Project*, no date).

Does being part of the Black community render the protective effects of spirituality void?

Why is this so important? Given the data suggesting that Black people are overwhelmingly spiritual both in a religious context and culturally, one would hope that this enhanced spirituality would lead to improved psychiatric health outcomes in the Black community, yet this is not the experience of Black patients.

Many of the studies highlighting the use of religion and spirituality as a gateway for improved mental health diagnosis and treatment have focussed mainly on America and the Church. There is significant paucity of research pertaining to Islam, another dominant religion within the Black community. Muslims face a unique experience: mental health issues may be interpreted as a test from God. Furthermore, Black Muslims face the dual challenge of Islamophobia and racism which both contribute as stressors to good mental health. A lack of counsellors able to underpin mental health service provision to the affected community, specifically Islamic but also the Black community more generally, may be contributing to poor service provision for these marginalised communities (Haque, 2004).

Though much of the research is based in America, this is also highlighted in UK based research. Churches in particular, which have large Black congregations, are an invaluable resource in disseminating health education and resources (Codjoe, Barber and Thornicroft, 2019). There is a recurring belief that admitting to mental ill-health is a sign of lack of faith, or conversely that praying and having faith is sufficient to heal any mental ill-health (Haque, 2004; Black, Gitlin and Burke, 2011; Codjoe, Barber and Thornicroft, 2019). A focus group highlights this succinctly; the combination of both faith and culture means that Black participants may attribute mental ill health to possession, by the devil or by other spiritual forces shaped by their cultural norms (Mantovani, Pizzolati and Edge, 2017).

It is also noteworthy that Black people have a legitimate fear of admitting to mental health problems- namely of being detained when admitting to facing mental health difficulties (Codjoe, Barber and Thornicroft, 2019). Black people are more likely to enter mental health services via criminal or coercive routes, they are also more likely to be involuntarily re-admitted (Barnett *et al.*, 2019). The human need for freedom of choice and freedom of space is deep-seated and as such it is understandable that, given the outcome many Black people expect, they may be wary of voluntarily entering mental health services. Local initiatives such as the ON TRAC project can help educate Black communities to recognise signs of mental illness sooner, as well as demystify ideas of mental health treatment (https://ontracproject.com). Moreover, work done by religious organisations in a top-down fashion is also extremely promising, as Black Christians do not just attend Black majority Churches- this allows Black people of faith to access resources regardless of denomination (*UK Minority Ethnic mental health toolkit*, no date).

Whilst not the only factor involved in poor psychiatric outcomes for Black people, SES is still an important factor to consider. Black people tend to pray for others more than their White counterparts, yet the deleterious effects of economic difficulty outweigh the benefits of prayer for good health. As such, it follows that spirituality alone cannot ensure a patient remains mentally healthy- other social factors are crucially important such as financial stability (Krause, 2003a). Since not all Black people are religious, though they may be affected by cultural spirituality, it is particularly necessary to carefully consider other factors impacting mental ill health in this subset of Black patients.

Psychiatrists operate on the basis of a social agreement of the norm- it stands to reason that psychiatrists that are not Black may not fully understand the cultural norms of their Black patients and may over-medicalise experiences which are culturally normal to their Black patients. Similarly, legitimate pathological processes in Black patients may be missed and misdiagnosed by psychiatrists who are unfamiliar with their cultural and spiritual experiences. It is important to recognise the heterogeneity of the Black community, across different continents and with different cultures. Again, it is also crucial to acknowledge that not all Black people are religious and so strategies beyond faith community engagement are necessary to improve mental health outcomes for these patients. Therefore, psychiatrists of all ethnicities, including Black psychiatrists, must make a sincere effort to fully understand the cultural perspective of the patient, then infer what the cultural norms of the patient are and consequently diagnose deviations from those cultural norms. This may simply take the form of a collateral history from relatives or friends to understand cultural practices- as psychiatrists do take collateral histories, this is a feasible way to attempt a better cultural understanding of Black patients. Though this essay focuses on spirituality and its role within the Black community, reflecting on my own experience has made me yearn for greater access to resources for medical students and junior doctors to begin to approach spiritual and cultural assessment of patients of all ethnicities. This could empower trainees to have meaningful conversations with patients who do not share the same cultural beliefs. Hopefully, as medical students are increasingly taught to appreciate the importance of spiritual and cultural consideration when taking histories from patients, as well as considering the role race plays in healthcare more generally (Cherfils, 2021), they can propel an impactful shift in psychiatric practice, and medical practice more generally, when interacting with Black patients and patients of different ethnicities more broadly.

Conclusion

There is a growing body of research generally suggesting that spirituality proffers a good prognosis for mental health. Yet Black people, who tend to be more spiritual in their culture and in a religious setting, face poorer mental health outcomes, namely seclusion, detention, compulsory treatment orders and readmission. It seems that at the intersection between spirituality, Blackness and mental health outcomes, Blackness seems to prevail- spirituality alone cannot provide overarching protection for Black people to facilitate good mental health outcomes. Though bleak, advances such as SACBT and initiatives within revolutionary trusts offer hope that cultural and spiritual inclusion could be used to aid treatment

of patients from the Black community and other marginalised groups. In light of racially motivated deaths and retaliatory protests, with ministers proclaiming 'Black Lives Matter' on television, perhaps this is the era to propel meaningful change and allow Black people to experience fairer treatment and improved mental health outcomes. Rather than explaining away institutionalised racial bias (Singh and Burns, 2006; Gajwani *et al.*, 2016) and deeming all involuntarily detained Black people as mentally unwell, perhaps society can move towards a more open discourse (McKenzie and Bhui, 2007) including training and hiring more Black psychiatrists, working more closely with Black communities, including Black faith communities, and employing more cultural sensitivity training to allow Black people to experience appropriate management. Spirituality may be the saving grace for the Black community- I look forward to a future where spirituality can truly bestow its full benefits upon the Black community.

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