Union College

The Contemporary Mental Health Crisis:

Empowering Schenectady's BIPOC Community Through Culturally-Competent Interventionism



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INTRODUCTION

My name is Eastwood Yeboah, and at fourteen years old, I was diagnosed with major depressive disorder and anxiety. I reveal this information to you because, at the time, those four words meant little to me. As I have grown, though, there has been time for me to reflect on the experiences which ultimately shaped my childhood, and I can honestly say it was one of the lowest points of my life.

I was quick to reject the labels—actively pushing away at the thought of being considered anything other than normal by my peers. At the time, I could not quite comprehend what those four words meant, but what I knew was that I was someone hurting. I was an individual who needed help, something I now recognize could not have been accomplished on my own. Leading up to my diagnosis, I was suffering from an increasing sense of hopelessness, compounded emotional triggers, and eventually, began spiraling into a much darker place. Falling deeper into my depression, I soon battled with suicidal thoughts that would affect me at the core of who I was.

In hindsight, it is much easier to assume a critical role of myself—to judge, criticize, invalidate, or even demean my own mental health experiences. I often think about my journey, recognizing that as my condition deteriorated, at no point did I assume that I was suffering from a much larger, systemic issue. It was only later, as I learned to become a mental health advocate, that it became clear that mental health disparities are not isolated to specific groups defined by things like race, gender, or class.

Rather, this form of health inequality serves as a universal human problem. Further elaborating, because I grew up underinsured, I struggled to get the proper treatment I needed and then couldn't afford the medication I was prescribed once connected. For much of the journey, I had to navigate the system on my own, and a year or so later, I went onto Medicaid and finally received the help I needed. Since receiving my initial diagnoses, they have come to define my life, shaping how I interact with not only my peers or family, but most importantly, the world around me.

UNDERSTANDING WEST AFRICAN MENTAL HEALTH CULTURE

I am a first-generation college student whose parents immigrated to the United States as teenagers. My upbringing as both a first-generation college student and American has led to a unique blend of values across the cultures influencing my life. I recognize that this combination of values underlies my strengths, yet also exist in complex tension with one another at times. One such value is being community-oriented; my parent’s culture places great importance on family, viewing individual behaviors as a reflection of the broader family unit. This sense of collectivism within my culture is not unique though. For example, in African culture, the importance of etiquette and respect, especially for one's elders, is reinforced clearly and at an early age in the household, as children quickly learn the importance of things like "thank you" and "please" in response to virtually every statement. This emphasis on respect and community extends far beyond mere politeness and is deeply embedded within the social fabric of African cultures. It shapes how individuals interact with their immediate families and also within their broader communities. Elders are revered for wisdom and tradition, and their opinions carry significant weight in decision-making processes, whether in family matters or community affairs.

This reverence ensures that cultural values and knowledge are passed down through generations, fostering social continuity and sense of cohesion.

While this blended cultural foundation has positively defined my character, it has also meant that certain ideas like mental wellness or even the conception of socio-emotional health were not things actively or openly spoken about. Historically, within countries like Ghana, there have been efforts by the government to improve mental healthcare services at all levels of care. However, significant gaps remain, with recent estimates finding that only 2% of Ghana's 2.3 million people living with mental health conditions are receiving the psychiatric treatment or support they need (WHO). Existing gaps in Ghana's mental healthcare infrastructure have had a profound impact on how mental health is received and communicated within Ghanaian communities, both domestically and abroad. For many Ghanaians, mental health remains a topic that is highly stigmatized or straight-up dismissed, often viewed through a lens that conflates psychological struggle with one's own moral weakness, spiritual failure, or social deviance.

When my parents grew up in Ghana, mental health was not a subject of open conversation, nor was it regarded as something that required professional intervention. Instead, community and networks of family support would traditionally take precedence over seeking help from psychiatric professionals, making it challenging to discuss mental health openly or in consideration of Western healthcare modalities like psychotherapy as valid options. This stigma stems from a multitude of areas, from limited access to mental health education, a lack of mental health resources, and the lingering influence of white supremacist beliefs that have historically pathologized African cultural expressions. As immigrants to the United States, my parents brought with them these perspectives shaped by their early lived experiences, ultimately informing my unique understanding of what mental health means as a Black American.

With some efforts to integrate mental health services into general healthcare systems West Africa's mental healthcare system has seen advancements in recent years. Still, the infrastructure is under-resourced and public awareness remains low. This limited exposure has influenced how my parents perceive mental health issues, which at one point they viewed through a practical lens and attitude of overcoming adversity, regardless of what the journey endured. They were more likely to frame struggles as challenges that one should simply work through, oftentimes with the help of family or faith, rather than seeing a problem like mental health as requiring distinct, more specialized resources. For example, seeking therapy, incorporating medication, or openly discussing anxiety and depression may not seem necessary to them, given their cultural background, where mental struggles are often managed within the bounds of family or are left unaddressed due to limited discussion of one's options.

My reality was also compounded by the fact that friends in high school, most of whom were members of marginalized groups, utilized humor as a defense mechanism to insulate themselves from the concept of mental health problems. Without adequate resources or knowledge, people around me considered mental health something to be made fun of rather than talked about with empathy and understanding. With the enduring feeling that I lacked a sense of community, soon, my behaviors translated into shutting away from those closest to me, including those I relied on as my support system. Navigating this cultural tension has been challenging for me, as my identity draws from both my parent's cultural heritage, which emphasizes endurance and family responsibility, and American values, which promote individual wellbeing and open dialogue about mental health. This duality has shaped my resilience, but has also made my journey towards finding acceptance and support in addressing my mental health needs more complicated.

DEFINING WELLNESS THROUGH AGENCY

Understanding certain concepts is essential to contextualize the mental health disparities a specific community faces. For example, agency serves as a vital characteristic shaping our ability to self-advocate and maintain a positive state of mental health. Like many others, you probably picked up a toothbrush and cleaned your teeth this morning. You may wear a favorite outfit or engage in mundane tasks like enjoying a good meal. Regardless of the choices made until this moment, they were yours. Many of these decisions were the product of your own volition, a factor that many individuals sometimes take for granted.

And yet, for marginalized identities around the globe, their idea of agency has a tainted legacy. The complications of this relationship are made especially true when considering how systems of oppression are interconnected to limit the autonomy and freedom experienced by certain groups of communities compared to others. Historically, challenges endured within the Black American experience have exemplified these ideas. Black communities across the country have had their sense of agency severely compromised due to social, political, and historical factors rooted in white supremacy, racial discrimination, and oppressive practices. For a long time, the reality of being Black within the United States has meant not having the same agency as one's White counterpart, exemplified by everything from the institution of slavery to non-consensual medical experimentation. These facts inform the Black American experience, which has been historically riddled with complex barriers attempting to undermine their capacity for self-determination. While agency serves as a vital characteristic shaping our identities and influencing concepts like mental wellbeing, there is sometimes a lack of social awareness or recognition of its importance. Agency informs a multitude of prominent constructs, from social justice issues like environmental racism or mass incarceration, to our daily, rudimentary tasks.

Therefore, for individuals to have adequate mental wellness, they must also have a developed sense of agency, with the two being intrinsically connected. On a day-to-day basis, the ability of an individual to make healthy decisions is a reflection of their agency or capacity to willingly engage in these behaviors.

These ideas are critical to recognize because when individuals face systemic issues like mental health disparities or are simply just victims of an oppressive system, their capacity to act with full agency is compromised. What this means is that regardless of an individual's gender, age, sexual orientation, or other social factors that may comprise their identity, mental health challenges will inevitably hinder a person's ability to function at total capacity—thereby restricting their agency and, ultimately, their right to live as a human being. Within the broader context of the human experience, agency is not merely an internal self-assessment but a nuanced process of exchange happening with the world around us. Agency arises when one can recognize and validate their own most basic human experiences with the people around them. It is a necessary skill in learning to more deeply know oneself, which is then used to relay knowledge and experiences with others to foster a shared sense of meaning (Lysaker). This definition highlights a more social dimension of agency, which relies on collective interpretation and mutual validation. In individualistic societies like the United States, the cultural emphasis on independence and self-reliance defines agency largely as the capacity to act autonomously. While this framework celebrates personal achievement, it also creates environments where failure is sometimes attributed solely to the individual. These types of perceptions fosters a blame culture and promotes dismissive ideologies, disregarding systemic and structural factors influencing one’s behavior or life outcomes.

Such narrow understandings diminish the diversity of the human experience by isolating individuals to a specific script of normative cultural values, invalidating other unique lived experiences in the broader societal context. As a result, the potential for shared understanding and collective support is replaced by narratives of personal responsibility, which can perpetuate inequities and hinder the recognition of systemic disparities that shape human experiences. For those having a difficult time due to psychosocial disabilities, such cultural values ignore other social factors beyond one's control. This type of rhetoric is further reinforced by the language we use regarding disability, and socioeconomic indicators we compare ourselves against, all of which can translate to an ignorance of different perspectives. Research conducted by Humphrey and Bliuc supports these findings, with studies suggesting that "...there are variables inherent in vertical individualism, related to competitiveness and comparing oneself with others that can lead to lower levels of psychological wellbeing in young people, while traits associated with horizontal individualism around self-reliance and autonomy tend to have less of an effect. Such findings are significant in framing our understanding of the relationship between individualism and wellbeing, in that they show us that individualistic traits associated with overt independence and competitiveness may be particularly problematic for one's psychological health" (Humphrey and Bliuc). These findings highlight the importance of reevaluating cultural narratives emphasizing competitiveness and comparison as key drivers of agency and self-worth.

When societal values prioritize traits like independence and overt success, they often obscure the role of relational and systemic factors in shaping individual experiences. This framing not only isolates individuals who struggle to meet strict, binary standards, but also perpetuates the stigmatization of people whose life circumstances or identities do not align with dominant norms. For individuals living with psychosocial disabilities, such cultural paradigms

can be especially damaging. The emphasis on self-reliance and comparison may invalidate their lived experiences, framing their challenges as personal deficiencies rather than the result of intersecting social, economic, and systemic inequities. Moreover, the resulting internalized stigma can further diminish psychological wellbeing, as individuals may struggle to reconcile their circumstances with the cultural ideals imposed upon them. Addressing these issues requires adopting a more holistic understanding of agency's role within mental wellness that integrates systemic influences, validates diverse experiences, and emphasizes mutual support over individual blame. However, the reality of these challenges are compounded when they intersect with other forms of harm and oppression, particularly for the most marginalized of our society.

PECULIAR PROBLEMS FOR PEOPLE OF COLOR

What millions of Americans, including myself, fail to realize is that my story was not something uncommon. In 2022 alone, nearly 50,000 Americans died by suicide—meaning that, unfortunately, one person will lose their life every eleven minutes in the United States alone (CDC). Moreover, during 2021, it was reported that suicide was the second leading cause of death among the age demographics of 10-14, and 25-34 within the U.S., as this trend has continuously risen each year. This public health concern is complicated by the fact that nearly 800,00 lives globally are lost every year due to suicide, despite the outpour of resources and prevention efforts throughout different communities (WHO). Suicidality, or one's risk of suicide, is a social phenomenon that has seen a dramatic rise, making it a devastating reality that plagues not just our nation but the global community as well. From substance use disorders to major depressive episodes, many psychiatric conditions and factors can be attributed to the increased risk of suicidality. This fact is especially true in environments where access to resources is limited, and the stigma surrounding mental health continues to perpetuate a culture of silence and

suffering. Given this backdrop, the inspiration for my senior thesis drew from both my lived experiences and recognizing the contemporary disparities present for BIPOC communities attempting to gain adequate mental health care.

Yet, in attempting to craft the most appropriate intervention methods for marginalized identities, one must understand the history informing their unique experience. For Black and Brown communities, their agency has been disproportionately limited due to systemic and historical injustices rooted in the values of Eurocentrism. Over nearly three centuries, these communities have had their agency repeatedly stripped, seized, and restricted in various conditions. Historically, within the United States, Black bodies have not been seen as fully human, often being compared to objects, animals, or beings with less than human value, and were denied the ability to act on their own volition. In attempting to craft the most appropriate intervention methods for marginalized identities, one also recognizes a peculiar history informing their lived experience. This dehumanization has laid the groundwork for a deep mistrust of medical institutions among Black Americans, with this culture of skepticism still alive today and having significant implications for various domains of healthcare accessibility.

One of the most infamous examples of this unethical treatment was the Tuskegee Syphilis Experiment. Conducted between 1932 and 1972, this United States government sponsored study involved 600 African-American men, the majority of whom were diagnosed with syphilis but were deceptively told they were receiving treatment for bad blood. Even after penicillin was discovered to be an effective treatment in the 1940s, the men were left untreated, suffering severe health complications and transmitting the disease to their partners and families. The Tuskegee experiment was not shut down until the public outrage in 1972 brought it to light, leaving a legacy of profound mistrust in the healthcare system (CDC). For Black Americans, the memory

of Tuskegee and similar injustices exacerbates the barriers to seeking mental health care. This mistrust, compounded by systemic racism and inequities in healthcare access, creates a culture where many feel alienated from and wary of medical professionals—even of those with the best intentions. The stigma surrounding mental illness within the Black community further complicates these issues. Black Americans are less likely than their white counterparts to receive consistent and culturally competent mental health care despite being disproportionately affected by stressors such as systemic racism, economic inequality, and generational trauma (Brandon et al.). This mistrust and lack of access leads to underutilization of mental health services, with many suffering in silence rather than seeking help from systems they view as untrustworthy.

Addressing these disparities requires acknowledging historical failures and creating a commitment to rebuilding trust through culturally sensitive care, robust community engagement, and policies aimed at equity in American mental health services. These challenges are deeply intertwined with the broader societal perceptions of racial inequality and the lingering effects of systemic racism. For example, statistics regarding the social perceptions of slavery's legacy between White and Black Americans exemplifies this information, with data collected by the Pew Research Center finding that "the majority of surveyed adults believed that the legacy of slavery continued to affect the position of African Americans today negatively. 40% of the respondents agreed that not enough racial equality had been made in the country. White respondents were most likely to acknowledge that their race positively impacted their ability to get ahead in life, and over 50% of African American respondents held opposite views and believed their race had negatively impacted them" (Horowitz). Understanding the history informing the Black American experience is essential, as it enables all individuals, regardless of their background, to remain empathetic and informed.

Recognition of the broader social constraints enables healthcare professionals and other community members to intervene in a culturally responsive manner. This allows for systemic efforts to address the persistent societal barriers that have resulted in the underutilization of mental health services by African Americans. Research conducted by Richard Majors supports this evidence, as he cites that people of color "experience mental health differently. These experiences are often situated within and tinged by racist connotations. Given these negative racial ascriptions, people of color are often misdiagnosed, treated differently within mental health services, and consistently experience poorer satisfaction and less productive outcomes" (Majors). Such events have ingrained a deep skepticism towards Western practices within communities of color, especially regarding contemporary interactions between healthcare providers, which have only contributed to the underutilization of mental health services that continue to decline for BIPOC identities.

Our nation's history further reinforces the evidence concluded by Majors. During the 1800s, it was thought that African Americans were incapable of having mental health issues. The medical director at the Eastern Lunatic Asylum in Williamsburg, Virginia, from 1841 to 1862, Dr. John Galt, had "postulated that African Americans were incapable of becoming mentally ill… Thus, the term Immunity Hypothesis was formulated to characterize African Americans since they presumably had no responsibilities that required higher-order thinking, purportedly exempting them from mental distress. The Immunity Hypothesis was maintained from the late 1600s through the mid-1800s when a contrasting notion of African American mental health was fashioned" (Umeh). These practices would transform the medical landscape as Black bodies continued to be stripped of their agency, even after the emancipation proclamation in 1863; for

example, American medical schools continuously exploited enslaved Black individuals for anatomical material, further demeaning the humanity of Black Americans.

The perpetuation of racist, discriminatory, and purely harmful beliefs and practices has contributed to a legacy of mistrust and systemic inequities in mental health care for nearly two hundred years This reality not only denies African Americans the agency over their health to this day, but also reinforces a broader societal structure that devalues Black lives and perpetuates inequality in domains like mental healthcare treatment. In understanding this nuance, individuals must also learn to accept that our nation's history cannot simply be undone overnight. Many of these troubling practices and beliefs are embedded within the very fabric of our society, demonstrating why it is imperative to raise awareness and understand how this social context informs the present day.

Historical contexts have always paved the way for contemporary issues, such as the adultification of Black adolescents, where they are perceived as older and less innocent, leading to biases in healthcare and other systems. The threat mental health disparities pose to one's agency perpetuates a culture that ignores the suffering of its community. Actions that undermine agency affect the psyche of all involved, creating a cycle of oppression and further harm through things like discrimination and stigmatization. These cycles have been informed by a multitude of problems which have compounded the antagonistic relationship Black American communities continue to have with health care in this country.

GAPS IN SCHENECTADY'S MENTAL HEALTH CARE

Given current research on mental health, it was clear that Schenectady County served as just one of many examples demonstrating these growing disparities. Schenectady County has the Capital region's second highest non-White population, at roughly 24%, according to the

2022-2024 Community Health Assessment (CHA) conducted by Ellis Medicine, Schenectady County Public Health Services, and St. Peter's Health Partners Sunnyview Rehabilitation Hospital. While this information provides just a glimpse into the realities of a given community, what the CHA also revealed is that of the six cities making up Schenectady County, the city of Schenectady had a median household income of roughly $48,000; this standard of living only made up about two-thirds of the median income, roughly $66,000, at the county level. While income disparity is evident in the city of Schenectady, a sharp distinction reveals itself when the City of Schenectady is compared to Schenectady County, which includes the towns of Duanesburg, Glenville, Princetown, Niskayuna, and Rotterdam.

When examined at a county level, Schenectady County underperformed compared to the New York State median income of approximately $71,000 (Ellis Medicine). It is important to understand that these are not just numbers, figures, or pieces of statistics. This information translates into real consequences which affect the people of Schenectady, and their everyday capacity to have agency in their health decisions. Literature has long suggested that mental health is shaped by a myriad of environmental, political, economic, and social factors into which an individual is born and later socialized into, with poverty consistently serving as a key determinant in one's development. More specifically, research demonstrates that poverty experienced throughout any stage of life can both inform poor mental health and create the conditions for impoverishment.

Conditions that contribute to poor mental health outcomes, such as inconsistent employment opportunities, a lack of culturally sensitive resources, or the breakdown of social relationships with friends and family, are not merely inconvenient—they deeply worsen mental health struggles. Under this intensified backdrop surrounding mental health disparities, residents

in the City of Schenectady are generally found to have a poorer health status, and are at lower socioeconomic statuses compared to counterparts within neighboring towns like Niskayuna.

A NEW WAY FORWARD: HERE2HELP.SCHENECTADY

The historical and systemic barriers to accessing adequate health services for the Black community cannot be overstated. For generations, Black Americans have faced not only social and economic inequalities but also significant mistrust of medical and mental health institutions due to a legacy of dehumanization, neglect, and abuse. These healthcare disparities have resulted in a widening gap in receiving proper diagnosis and treatment, leaving intervention services either ineffective or inaccessible to large segments of the population. This has compounded the struggles of Black and other communities of color, making it even harder for them to break free from cycles of inequity exacerbated by systemic oppression. The need for culturally competent, accessible, and community-specific mental health resources is more pressing than ever. Building on previous academic research and my personal experiences, this project aimed to address these disparities by adopting a non-traditional approach to mental health intervention.

By combining research into the history of marginalized communities, identifying local solutions tailored to their needs, and creating environments that challenge the stigma surrounding mental health, this project sought to ensure that all people, and especially those from historically oppressed groups, have the right to dignity, respect, and agency over their mental health. The outcome of this effort is *here2help.Schenectady,* a multimedia mental health resource platform specifically designed to meet the needs of BIPOC residents in Schenectady, New York. The creation of *here2help.Schenectady* was driven by my personal experiences. There simply were no local mental health resources that acknowledged the ways in which systemic inequality has uniquely impacted the mental healthcare of Black Americans. While state and federal-level

resources are designed to support all populations, they often overlook the specific needs of the BIPOC community, especially in smaller cities like Schenectady. The absence of localized, culturally aware mental health interventions made it clear that there was a gap in resources, especially for those who may struggle to access these services during a health emergency. By focusing on where the gaps lie, this project provided a critical expansion of mental health resources while being tailored to meet the unique needs of Schenectady's BIPOC residents.

Here2help.Schenectady is a direct response to localized disparities, offering a platform rooted in cultural competence, community engagement, and an understanding of systemic inequities. The project was developed to address the very real barriers that BIPOC populations face when seeking mental health services in Schenectady—barriers often rooted in a history of exploitation and underrepresentation in healthcare systems. *Here2help.Schenectady* bridges current gaps by offering a platform that reflects Schenectady's unique socioeconomic and cultural dynamics. Moreover, the site offers educational materials that cover a wide range of common mental health challenges, such as anxiety, depression, and stress, by breaking down symptoms and contributing factors. *Here2help.Schenectady* offers individuals the tools they need to better understand and manage their mental health in a culturally relevant context, and emphasizes the importance of coping strategies, including problem-focused, emotion-focused, and meaning-focused approaches, to help individuals navigate their emotional and psychological challenges. A key feature of *here2help.Schenectady* is its commitment to demystifying mental health challenges for BIPOC individuals and normalizing the conversation around mental health. The platform utilizes a variety of multimedia tools, such as video content, mental health statistics, and an interactive map feature to help reduce the stigma surrounding mental health and

encourage open dialogue. These resources are designed to foster solidarity within marginalized communities, allowing individuals to see that they are not alone in their struggles.

At its core, *here2help.Schenectady* is more than just a resource hub—it is a call to action. The platform encourages collaboration among local leaders, healthcare providers, and residents to address the structural inequities in mental health care that disproportionately impact marginalized populations. By highlighting the intersection of individual mental health outcomes and systemic barriers, *here2help.Schenectady* advocates for interventions that foster inclusivity and equity in mental health care delivery. This initiative also serves as a potential blueprint for other communities grappling with similar mental health disparities by grounding its approach in community-based solutions, and an unwavering commitment to making knowledge about healthcare more accessible.

This web platform demonstrates the transformative power of acknowledging and addressing the systemic challenges that have long ostracized vulnerable populations, offering a model that can be replicated. Ultimately, *here2help.Schenectady* strives to empower individuals to take control of their mental health by equipping them with the tools, resources, and knowledge they need to navigate the complexities of wellness in a way that is meaningful to their lived experiences. It is a crucial step toward healing, not only for individuals with mental health challenges but also for society as a whole. By working to address the global mental health crisis, it is possible to work toward a future where all systems of interconnected oppression are dismantled and every human being is valued, uplifted, and treated with the dignity they deserve.

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