An Introduction to Anti-Black Sanism

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Abstract

Sanism is an oppression. It makes normal the practice of discrimination, rejection, silencing, exclusion, low expectations, incarceration, and other forms of violence against people who are othered through mental 'illness' diagnosis, history, or even suspicion. Of particular concern for us are the sanist experiences of racialized people who identify as Black, African, or of African descent, for we and others have long noted and experienced an anti-Black crisis in mental health diagnosis and "care." For instance, young Black men are diagnosed with schizophrenia more than any other group, Black children are being psychiatrized at higher rates, and in our experience on the front lines here in Toronto, more Black-identified patients are being held against their will in hospitals. Is what we are seeing here a kind of sanism, a particular form of racism, or something combined that has not yet been named? In 2013, we three authors began to call this place of intersection anti-Black Sanism, starting a historical, theoretical, methodological, personal, and practice conversations in our community work, in our research, and in our classrooms. In this article, we outline our analyses thus far. We also chart the responses we have had to date, responses of the community, research, and pedagogical kinds. We detail how the anti-Black Sanist experience makes itself present in multiple places and spaces complicating "care," critique, and madness.

Keywords: anti-Black Sanism, anti-Black racism, sanism, racism, critical mental health

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> *After the room broke out into chants of "black lives matter," Kiden Jonathan rose from her seat, wailing and screaming. Jonathan was a longtime friend of Andrew Loku, the 45-year-old father of five shot dead by Toronto police Sunday. Both were natives of South Sudan, they spoke the same rare dialect, and came to Canada to escape the violence of their war-torn nation. "Andrew survived war, and then had to be killed here," Jonathan cried, after collapsing on the ground in the middle of a press conference Thursday to decry Loku's death. Kiden and several close friends of Loku's joined a coalition of community groups, including [Across Boundaries], Black Lives Matter Toronto, the African Canadian Legal Clinic and the Canadian Mental Health Association, in calling for*

> *an end to fatal police shootings involving black, emotionally disturbed men. Too many fatal encounters with Toronto police have involved black men with mental health challenges, the groups said. That includes, in the last decade, the shooting deaths of Michael Elgin, Reyal Jardine-Douglas, O'Brien Christopher-Reid, and Ian Pryce. The time has come for an action plan specifically targeted at eliminating fatal encounters with black residents with mental health challenges, the groups said. "Far too often, black and racialized persons lose their lives, are subject to excessive force, have their lives completely disregarded by public institutions, including police services," said Roger Love, with the ACLC. Loku was killed early Sunday inside his Gilbert Ave. apartment complex, in the Eglinton Ave. W. and Caledonia Ave. area. The building's units are leased by the Canadian Mental Health Association to provide affordable housing and services for people suffering from mental illness. Police were called after Loku wielded a hammer during a noise dispute with a neighbour. Robin Hicks, a neighbour who witnessed the shooting, said police were only on scene for a minute or two before one officer fired his gun. According to Jonathan, Loku was still suffering psychological trauma from being a youth soldier while living in South Sudan. "He told me he would sometimes still hear the gunshots," she said.* (Gillis, 2015)

Clearly, there is a crisis on our hands. The crisis is not new, and it is not necessarily surprising. It is a crisis of misdiagnosis, over-diagnosis, incarceration, confinement, silencing, shooting, and physical violence. It is ages old, widespread, every day, and deeply felt in both progressive and conventional spaces. And it is a crisis of the highest degree, often resulting in suffering, violence, and death. It is the crisis and distress visited in their daily lives on individuals who identify as Black, African, or of African descent (Black/African).

The crisis involves all systems such as criminal justice, child welfare, immigration, health, housing, employment, and education. It involves multiple stakeholders, multiple victims, and multiple communities. At its heart is the pathologization of simply being Black.

As the rates of Black/African homicides rise, one of the most concerted responses has been medication, confinement, and the erasure of identity. Black/African individuals make up 20% of the Canadian federal prison population (Crawford, 2011), although Black/African individuals make up 2.5% in the overall population. The school-to-prison pipeline relies on early pathologization and problematization of Black/African children (Contenta & Rankin, 2009), and much has been written about how young Black men are often diagnosed (and most diagnosed) with schizophrenia (Fernando, 2012). According to Metzl (2009), such psychiatric aggressions toward Black bodies have been with us for a long time. He notes that psychiatry—never a neutral, "scientific" exercise—gave us diagnoses such as drapetomania (which we detail later in this paper), 'dementia praecox in the coloured race', and 'dysaethesia aethiopis'. All were attempts to curtail any acts of self-determination or "disrespect" to whites by Black slaves, and all involved "cures" that were brutal and dehumanizing (Metzl, 2009).

What is going on here? Are Black/African people in more distress? Is serious mental 'illness' an inevitable consequence of years of racism, or is the mental health system targeting Black/African bodies in the same way police in the Global North do (Rankin & Winsa, 2015)? Is this racism or colonization again? Is it anti-Black racism (Benjamin, 2003; Pon, Phillips, Clarke, & Abdillahi, in press)? Or is this something tied up with sanism, that oppression long-named (Birnbaum, 1960; Perlin, 1992) but oft ignored and visited on those with psychiatrized issues, diagnoses, and histories?

We believe that the historical and ongoing set of aggressions visited on Black/African people in the Global North is both anti-Black racism *and* a specific kind of sanism, and we have named this suffering, this particularly perilous mix of oppressions, *anti-Black Sanism*[1] (Abdillahi, Meerai, & Poole, in press). In this piece we introduce readers of Mad Studies and other allied fields to what we mean by anti-Black Sanism. We begin by tracing its roots in anti-Black racism and sanism scholarship. We detail its horrifying history. We explicate what we mean by the term *anti-Black Sanism* and how we see it connected to other approaches. Then we share some of the responses we have heard and felt so far. Included are responses to anti-Black Sanism from those who participate with us on a community-based research project at Across Boundaries, a community mental health centre in Toronto, Canada. Included are also the other responses we have personally felt and heard in the community, in our research, and in our classrooms. In short, we explain how we are in a process of identifying, centring, and resisting anti-Black Sanism, a process that has been deeply collective, purposeful, and one that we hope will widen to include multiple people, movements, and communities.

Anti-Black Racism

> First, what we are dealing with, at root, and fundamentally, is anti-Black racism. While it is obviously true that every visible minority community experiences the indignities and wounds of systemic discrimination throughout Southern Ontario, it is the Black community which is the focus. It is Blacks who are being shot, it is Black youth that is unemployed in excessive numbers, it is Black students who are being inappropriately streamed in schools, it is Black kids who are disproportionately dropping out, it is housing communities with large concentrations of Black residents where the sense of vulnerability and disadvantage is most acute, it is Black employees, professional and non-professional, on whom the doors of upward equity slam shut. Just as the soothing balm of 'multiculturalism' cannot mask racism, so racism cannot mask its primary target. (Lewis, 1992, p. 2)

Anti-Black racism is a particular form of oppression and racism visited on Black/African individuals in all aspects of their lives. As explicated above in the Stephen Lewis report of 1992, *anti-Black racism* purposely focuses on Black communities and their experiences of racism. It names this experience in order to

[1] We purposely capitalize Sanism here as we see it as an experience specific and always connected to Blackness.

centre it, to examine it, and to work against it. It has also grown into a particular field of study (Benjamin, 2003; Benjamin et al., 2011), political action, and a theoretical framework that names and addresses the mass killings of Black bodies, overrepresentation in prison systems (Benjamin, 2003), and the school-to-prison pipeline (Contenta & Rankin, 2009). As cited in Abdillahi et al. (in press), anti-Black racism "is entrenched at all levels of Canadian society, functioning to preserve systems of whiteness and power and dominance based on a false perception of white superiority (Henry & Tator, 2010, p. 19)." But it is not the same for all.

Kumsa, Mfoafo-M'Carthy, Oba, & Gaasim (2014) have made clear that there are different kinds of anti-Black racism. Working with research data as well as their own embodied experiences, these Black and African authors "tease out various layers of anti-Black racism, highlighting Anti-Black-African racism (A-B-AR) as the type directed against Africans from the continent" (p. 22).[2] Kumsa et al. reflected on the "inextricable link between A-BR, AB-R and all other forms of oppression" (p. 22) including, and specifically, sanism. The authors write about already knowing that Black/African people "do not go to hospitals for fear of misdiagnosis or for fear of being misunderstood due to lack of English proficiency" (p. 28). They already know "Black folks mistrust the health system" (Bhui & Sashidharan, 2003; Bughra & Bhui, 1999; McKenzie & Bhui, 2007, as cited in Kumsa et al., 2014, p. 29). However, up until this point in their research, they did not fully understand the depth of discrimination visited on Black/African people who are also experiencing challenges to their mental well-being and peace. In the words of one of the authors, Mfoafo-M'Carthy, "Think of Black Africans whose bodies already evoke fear, anxiety and disgust and add sanism to the mix. They are in deep peril" (p. 30).

Sanism

Acknowledging this perilous mix, we have named the co-organization of anti-Black racism and sanism as *anti-Black Sanism* (Abdillahi et al., in press). In this section we outline how we understand sanism.

Not unlike mentalism (Chamberlin, 1990), sanism is an oppression, a belief system, and the pervasive form of violence that makes it possible for psychiatric diagnosis, medication, and other "therapeutics" to strip away dignity and livelihood (Birnbaum, 1960; Perlin, 1992). It makes it possible to sanction and support micro and macro aggressions toward mad people in the name of "health and safety." It makes those aggressions a 'normal' part of clinical practice (Poole, 2013). Poole et al. (2012) detailed sanism as the harm experienced in the mental health system *and* in everyday living. Sanist micro aggressions situate the individual in spaces of silence, conformity, and being "less than." Sanism makes normal name-calling, dismissal, and

[2] We refer to this as *lateralized violence*, and we locate it within and born out of histories of colonialism and white supremacy. This internal or lateral violence is not unique to the Black community or the Black experience. Rather, it is the specificity of an inward deployment of marginalization, exercised and reproduced by the complex relationships embedded in and mitigated by broader systems of power.

the practices that facilitate the erasure of identity (Poole, 2013). Such practices include charting and case notes in which the individual is constructed based on an "expert's" perception. Reviewing such notes, Daley, Costa, & Ross (2012) stated:

> A 19-year old [B]lack woman described as flirting with male co-patients, holding hands with male patients and dancing provocatively for male co-patients … the narrative connected the women's behaviour, way of dressing, etc. to manic like behaviour and the need for psychiatric consult and treatment through medication. (p. 961)

There are many more examples of sanism in action. There are Twitter accounts dedicated to naming and calling out sanism, such as @everydaysanism. There are organizations dedicated to educating around sanism, such as the Coalition Against Sanist Attitudes (CASA), as well as multiple authors and scholars in the mad community, such as Fabris (2011) and LeFrançois (2014). Perlin (1992), a law scholar in the United States, has written prolifically on sanism for 25 years detailing the myths to which many unconsciously adhere as well as the prevalence of sanist rulings in the courts.

However, we want to make very clear that sanism is not the same for all, either. In the same way that Kumsa et al. (2014) have nuanced anti-Black racism, our differently embodied experiences of sanism demand that we acknowledge the interplay of sanism with class, with gender, with sexuality, with religion, and most crucial to us here, with colonization and racism. Sanism exists on a continuum depending on privilege, and it is always and especially compounded when it is visited on racialized bodies. In the next section we make clear what this has looked like for Black/African bodies over the last 150 years.

Detailing Anti-Black Sanism

Tracing History

For us, anti-Black Sanism has its roots in the "rational" turn of the Enlightenment (Starkman, 2013) and the subsequent co-organization of colonizing systems such as slavery and psychiatry. For us, it is anti-Black Sanism that made possible the psychiatric diagnoses of *drapetomania* or the mental "affliction" that "made" Black/African slaves flee their owners in the United States. On this, Jackson (2002) wrote:

> In 1851, Dr. Samuel Cartwright, a prominent Louisiana physician and one of the leading authorities in his time on the medical care of Negroes, identified two mental disorders peculiar to slaves. *Drapetomania*, or the disease causing Negroes to run away, was noted as a condition, "unknown to our medical authorities, although its diagnostic symptom, the absconding from service is well known to our planters and overseers." (Cartwright, 2001, p.1). Dr. Cartwright observed, "The cause in most cases, that induces the Negro to run away from service is such a disease of the mind as in any other species of alienation, and much more curable, as a general rule." (Cartwright, 2001, p.1) Dr. Cartwright was so helpful as to identify preventive measures for dealing with potential cases of

> drapetomania. Slaves showing incipient drapetomania, reflected in sulky and dissatisfied behavior should be whipped—strictly as a therapeutic early intervention … Overall, Cartwright suggested that Negroes should be kept in a submissive state and treated like children, with "care, kindness, attention and humanity, to prevent and cure them from running away (Cartwright, 2001, p. 1)" (p. 4–5).

However, this dehumanizing trend in diagnosis was not just in the United States. A recent discourse analysis reviewed papers about British colonies published in the *British Journal of Psychiatry* between 1865 and 1971 (Jarvis & Young, 2014). One such article from 1880 noted, "Amongst this number it will be seen that there is the great excess in the proportion of the insane found amongst the Africans." Another from 1895 said, "The native [African] brain has its analogue in the European child's cerebrum; in many aspects his mental attributes are similar to those of a child." In 1951, one of these "scientific" documents argued, "Certain facts emerged which forced the writer's attention to a striking resemblance between African thinking and that of leucotomized Europeans." Intriguingly, these articles suggested that African people did not tend to suffer from 'depression' at all. Most important, however, is the finding that many articles suggested issues of 'psychosis' were a result of colonization (Jarvis & Young, 2014). One such article, published in 1960, simply stated, "It is clear that the syndrome is related to 'westernization'" (Jarvis & Young, 2014).

We agree, noting the role that the co-organization of colonization and psychiatry has played in the history and growth of anti-Black Sanism. Like Metzl (2009), Mills (2014), and Fernando (2014), we also think psychiatry has continued to colonize unchecked, gaining ground in particular in the Global South at unparalleled speeds.

Tracing the Present: "Living Mad While Black"

This brings us back to Andrew Loku and how it came to be that he was shot, almost on sight, in the doorway to his home. If we start to dig into why, if we trace the conditions of possibility (Foucault, 1970) that created that moment, what stands out for us is the role of colonization and the more than a hundred years of damning "scientific" reports and diagnoses. What stands out is that not only was Andrew Loku Black but he was also African, and that he lived with few resources in supported housing. He was a survivor of war, no doubt living with a myriad of unseen injuries of the spirit. It is a perfect storm of anti-Black racism and anti-Black-African racism. It is also a storm of sanism. In short, all the conditions of possibility point to anti-Black Sanism.

We argue that anti-Black Sanism provides a framework that names the injustice, the pain, and seeks to address the historic discrimination, continued overrepresentation of Black/African-identified individuals in the mental health system (Fernando, 2012; Fernando, Ndegwa, & Wilson, 1998). Anti-Black Sanism takes into account how identity is negotiated, stripped away, and always up against white supremacy. Anti-Black Sanism also allows us to join with others in de-centering whiteness in mental health as well as in the ex-patient, survivor, disability, and mad movements (Gorman, 2013).

Is living mad while Black the ultimate affront to the supremacy of white rationality? Is it the ultimate threat to the social order "protected" by racist and sanist policing? Does anti-Black Sanism give us something to work with and hold onto when we ask, "Would it all have been different if Andrew Loku had been white? And different in what way?"

Fanon (1952) identified these issues long ago. He paid attention to how Black/African individuals were forced, ordered, and maintained in constant battle within themselves, (between living what we call mad while Black and) striving to be White in society. He knew that the White liberal subject was and still is the dominant identity to achieve. He knew the psychiatric system was and continues to have an instrumental role in this social construction (Fanon, 1952). He might have guessed that it would continue through practices of recovery, evidence-based medicine, and middle-class and decidedly white therapeutic interventions (Poole, 2011).

And because gender changes things as well, in addition to Fanon, we also note that our anti-Black Sanist framework is influenced by Black feminist analysis (Collins, 2000). Collins (2000) noted that "Black women have been assaulted with a variety of negative images [including] stereotypical mammies, matriarchs, welfare recipients, and hot mommas [that] help justify … Black women's oppression" (p. 69) and the scripting of their interactions as hypersexual, 'sick,' unsafe or dangerous, and inappropriate. Such representations of the Black female body effectively "transmit distinctive message[s] about the proper links among female sexuality [and] desired levels" of "wellness" and respectability (Collins, 2000, p. 84).

Additionally, we note once more the influence of scholarship that seeks to more generally decolonize and de-centre whiteness in mental health and mad places (Fabris, 2011; Mills, 2014; Tam, 2013). Haraway (1988) entreated us to consider people's situated knowledges, "establishing the capacity to see from the peripheries and the depths" (p. 583). This perspective requires that we historicize and locate the experience of the non-white bodies and minds, such as the "African Mind" for example (Butchart, 1998) "as an object of psychiatry[,] psychology[, and social work, which is] rooted in colonial space[s] of domination and subordination" (Yen & Wilbraham, 2003, p. 563). Thus we seek to name the contradictions evident in Global North discourses of "holistic" "healing" and resistance practices. These practices are often dismissive of Indigenous and Aboriginal practices (Lavallee & Poole, 2009). They are evidence of what we call the *mental health economy of Indigenizing and Racing*, which celebrates disingenuous attempts at inclusion while refusing to expand the notion of appropriate support and healing for non-white people. In other words, we have long noted the "reinforc[ing of] western psychiatry's power as a bastion of rationality through its professional indignation at extreme practices, i.e., Indigenous healing" (Yen & Wilbraham, 2003, p. 575).

Further, we note how the rise and privileging of what we call a *white rationality* paints those who are Indigenous, local, and non-white as irrational, untrustworthy, and odd. When ancestral spirits are given a "literal, ontological reality," Indigenous healers are seen as "genuinely mentally ill" (Yen & Wilbraham,

2003, p. 578). When Indigenous individuals hear the voices of those spirits, they too are 'ill' and needing correction and cure (Baskin, 2009).

Therefore, in the face of a white rationality, the doing of Blackness and the being Indigenous or African/not white is always "strange," always marginal and subjugated. This occurs in all systems (Benjamin, 2003) as well as at the intuitive and spiritual level. Anti-Black Sanism enables us to see how these systems benefit from the 'mentally ill' Black body, how they create an economy (hospitals, prisons, etc.) and co-opt a knowledge base (holistic, anti-racist) at the expense of lost, murdered, marginalized, and uncared for Black/African lives. Anti-Black Sanism demands white mainstream practitioners and organizations review how they include and engage in "culturally competent" and "ethnic" healing practices (i.e., *Africanized* or *Can-Africanized* treatment practices). It demands that the mad movement and Mad Studies do some considering, too. If, according to Hart (2009), colonialism operates though exclusion, appropriation, and marginalization of Indigenous knowledge, practice, and peoples, both the mental health system and those who seek to change it must decolonize through inclusion, crediting, and centering Black/African experiences, pain, knowledge, scholarship, and experiences of sanism.

Responses to Anti-Black Sanism … So Far

In addition to history and theory, we ground anti-Black sanism in the findings from our community-based research study based in Toronto. In Phase 1, we conducted two focus groups, guided by a set of six semi-structured questions with eight self-identified Black/African participants. The overarching purpose of our study is to address a gap in knowledge within the current understandings of madness, mental health, and racism. Aligned with principles of community-based research, the voices of participants are centred in this project (Minkler, 2005). Specifically, community-based research provides a platform whereby data is interpreted in a meaningful way by directly reflecting the voices of participants throughout the research and dissemination processes (Minkler, 2005). For the purpose of this analysis, all identifying information has been removed and anonymized, and pseudonyms have been assigned to each participant, as directed by the participants of the focus groups and in alignment with the research ethics protocol.

Based at Across Boundaries in Toronto, Canada, participants have been sharing their own experiences of anti-Black Sanism as well as their ideas and suggestions for educating others around the issue. The conversations have been heated, extended, informed and informing. They have also raised two particular issues so far that further nuance anti-Black Sanism. The first is what we call *in the middle*, an experience of anti-Black Sanism perpetuated by both white and Black people.

Benta (pseudonym), a Black African woman writer, explained what this means:

> This is something that's we also have to talk about 'cause it's not just the white people that are discriminating us, it's also your own people. [Group agrees.] Because you'll find probably in a group like this, we don't talk to each other…we don't…trust each other. I would not go out for help because I'll tell you and then you'll look at me and start judging me and

> that's where isolation comes from. 'Cause if I go to the white people and they treat me this way, I go again I go to my own Black people and they treat me this way, then I'm in the middle. I isolate myself. And that's when suicidal thoughts come. So how do we, where we, what can we do about it? One person can do about it? If I come to you [researcher] you say, do you have any community supports? No. Are you in any community here? I tell you yes, and I try to explain to you that this is why I don't want to go to my community. Not because I'm embarrassed of having mental health issues, I just don't want to say anything political that will [put] another member of my family [in danger]… So I will isolate myself to save my family. And then you're sending me back to the same people telling me look for a community that will serve you.

What we are hearing is how deep the experience of sanism is in this participant's community, and how dangerous it is to speak up about it. She risks reprisal and violence from her peers and from whites alike. The result is isolation and "suicidal thoughts." Anti-Black Sanism thus becomes a multi-directional determinant of safety, well-being, social inclusion or exclusion, and overall health.

We also heard stories of how anti-Black Sanism is further nuanced and compounded by gender and, in particular, Black masculinities (Adebimpie, 1981; Baker & Bell, 1999; hooks, 2004; Metzl, 2013). As John (pseudonym), a Black African man and educator, explained:

> I was told by my own mental health care provider … on several occasions, "be careful, don't do that, and don't speak this way." … Because he said you're Black, tall, you have a beard.… Dark skin, beard, and well quickly they will call the police on you. So you know, it makes you actually uncomfortable going there. To me, not only uncomfortable, it slows down the process of my recovery because I feel like I'm not in the right environment. And so … is that racism? [Laughs] … I've been going there for over a year that particular place, and they're all caucasians. I am the only Negro there as a patient. And I'm told you're Black, you're tall, you have a beard, they will call the police on you in a heartbeat.

In this narrative, being Black is problematized. Being tall is, too, talking in a "way" and with a beard, a simple and yet oh so terrifying strip of facial hair, the "caucasians" are more likely to be fearful, to retaliate and act from a place of acute anti-Black Sanism. Ironically, this is what mental health "care" looks and feels like for those in masculine Black bodies, and again, it is a deeply perilous place.

Moving from the focus group participants, we now turn to how each of us authors has experienced responses to the naming and introduction of anti-Black Sanism, first in Black/African communities (as narrated by Idil), in research (as narrated by Sonia) and finally, in the classroom and academy (as narrated by Jennifer). Inspired by Kumsa et al. (2014), we have "voiced" our narratives and claimed our first-person storytellers. We begin with Idil, a Black African-identified scholar and activist.

Part 1—Responses in the Community: Idil

The Blacks are out front and we're all lined up behind.

—Urban Alliance on Race Relations (1992, as cited in Lewis, 1992, p. 3)

The terms *mad* and *madness* are certainly not new to the Black community. Rather these terms are historical, contextual, and deeply personal. These terms are used descriptively and subversively, with caution and with curiosity. In much of our recent community work, the responses to naming anti-Black Sanism, to what lives at the intersection of Blackness and madness, have been profound. For some mad-identified Black people in the community, using this language has been described as "liberating, authentic, much needed and long awaited" (ABS participant). Indeed, previous to our naming this as suffering, the narratives shared with us and the trespasses we have witnessed have all too often been about both the dehumanization and superhumanization of the Black body.

Superhumanization refers to what Trawalter, Hoffman, & Waytz (2012) described as Black people being "less emotive" and more able to endure pain both physically and mentally. Further, it is the positioning of Black people as "supernatural, extrasensory, [with] and magical mental and physical qualities" (Waytz, Hoffman & Trawalter, 2015, p. 353). It is important here to underscore terms like *magical*, *supernatural*, and *extrasensory* in the context of anti-Black Sanism as specifying strangeness and otherness (Thobani, 2007) rather than uniqueness or possessing gifts. In fact, Waytz et al. (2015) stated:

> Superhumanization of Blacks might contribute to medical decisions that involve undertreatment of pain for Black patients (Bonham, 2001; Drwecki, Moore, Ward, & Prkachin, 2011) … Relatedly, superhumanization of Blacks may contribute to Whites' tolerance for police brutality against Blacks (Goff et al., 2008); perhaps people assume that Blacks possess extra (i.e., superhuman) strength enables them to endure violence more easily than other humans. (p. 358)

It is this ongoing "enduring" of and consistent exposure to violence and death specific to Black bodies that has informed and led us to theorize in ways that implicate the plantocracy of the mainstream mental health system, mad Studies, and the mad movement. It is the stories of those who have "braved" these spaces and who bear the battle scars that have first chosen and connected their experience to what we call Anti-Black Sanism.

We have heard from members of the Black/African communities that mad spaces are often inadvertently white spaces. We have experienced the outright silencing and de-centring of Blackness by mad folk wanting less "dissension." I think that despite the best laid plans, Blackness continues to be constructed as "unsafe" and dangerous but potentially a site of commodification or "growth." And there is always a benefactor for this growth, such as the prison industrial complex or a field or discipline. The articulation of a reality that seeks to name sanist practices while simultaneously centring race, and particularly anti-Blackness, has provided for the beginnings of a lengthy and broader space to theorize narratives and scholarly work.

In doing so, while we (re)theorize and (re)name, a brother, father, husband, college graduate, community member, and musician was fatally gunned down in his home. What we know is Andrew Loku was not the first. So, we are responding to the urgency required in how we understand the convergence of Blackness and 'illness'—which seldom leads to "treatment or support" but, for Andrew and many others, leads to their deaths. The excavating of these and other narratives of "living Mad while Black," is not simply the exercise of engaging peripherally in scholarly work. Rather, by way of our writing, it is our expression of resistance, outrage, and our collective community outcry and demand for our survival. We must continue to question whether madness has become a site of privilege like many others that deliberately exclude both the Black body and experience.

By using the term anti-Black Sanism it has allowed us to better understand that while the terms mad and madness are not new terms to Black communities, they carry a pejorative history in relation to Blackness. As we noted, these terms have been used to enslave, incarcerate, castrate, and colonize. To take up mad and madness as an entry point into the broader discourse of sanism allows for several critical opportunities: relocating, disrupting, and inserting Blackness in uncharted spaces while continuing to uncover another language for what it means to be Black and survive the mental health plantocracy. The problematic we highlight regarding Mad studies and madness, Blackness, and mental health extends to all who seek to go beyond "culturally competent" service provision, "multicultural" rhetoric, and neoliberal practices in both mainstream and so-called progressive spaces.

Part 2—Research Responses: Sonia

> *We live in a world in which knowledge is used to maintain oppressive relations.*
>
> —Kirby & McKenna, 2004, p. 67

Working in positions that often require reading and writing for literature reviews, coordinating research studies, conducting interviews, focus groups, data analyses, and supporting knowledge production has been and continues to be problematic. It is difficult to be implicated in research processes that are not always from the margins, a process that Kirby & McKenna (2004) described as being "concerned with how research skills can enable people to create knowledge that will describe, explain, and help change the world in which they live" (p. 68). It is harmful to continue to be implicated in the responses from institutional spaces within higher education, community settings, and online.

This implication we are a part of is dangerous within these spaces because it upholds epistemic violence as defined by Spivak (2003). This is the making of subjects through discourse from knowledge creation. Epistemic violence keeps the door open to sustaining the marginalization and subjugation of Black bodies. Historically and currently, the process of eurocentric research methodologies itself is entrenched in anti-Black Sanism. An example of this is demonstrated through the research process, where the construction of identity is defined, documented, distorted, and used in institutional settings that do not always address the gaps in

practice—such as lack of therapeutic support for Black/African communities and funding for supports outside of the eurocentric ideology of support. Black/African individuals are documented in harmful ways in research that do not centre their voices and do not explicitly name the systemic and everyday violence they experience in their homes, communities, and within institutional settings specific to mental health practices. Research methodologies centred in eurocentric ideology in the past 10 years have been hidden under the guise of inclusivity, but do not embody knowledge creation from the bottom up.

My arguments stated are grounded through my recent experience with research ethics applications that illustrate the mechanisms that continue to allow epistemic violence to flourish among how Black/African communities are written about in research and scholarship. The research process includes an extensive ethics application to ensure that "ethical" practices are considered and implemented for any type of research study involving human participants. Potential participants are defined and documented, which constructs participants as vulnerable and viewed with one and/or multiple issue(s).

With an open heart, I added that refreshments and tokens would be provided for participating in the study. The reason why we do this is that it honours lived experience, the reality of poverty and it also creates access to the research process (Poole et al., 2012). Further, as anti-oppressive researchers (Brown & Strega, 2005), we need to make explicit the commitment to a social justice agenda that recognizes power relations and disrupts ways research is carried out.

With respect to refreshments, we often share food as a way to build community. However, the harmless practice of refreshments was critiqued. The research ethics board questioned whether participants were only interested in receiving the "incentive," and whether this would "affect the validity of the research." However, evidence-based studies with participants often provide gift cards as a thank you. Why was our token of appreciation and exchange questioned?

The process of knowledge production continues throughout the research process and into knowledge dissemination, often known as the transferring of new knowledge to others, where scholarly work is created and published. Abdillahi et al. (in press) has called for the "decentering of whiteness in mental health care and practice and the hierarchy and elitism of white supremacy acknowledged" (p. 19), which can be extended to research practices grounded in eurocentric ideologies that perpetuate anti-Black Sanism.

Part 3—Jennifer's Tales from the Classroom

It has been more than a year since I, a self-identified white and mad woman, started using the term anti-Black Sanism in the classroom. Specifically, it has been just over a year since we started naming it as a pedagogical practice in our School of Social Work. I teach it as part of everything, rather than in a particular course. It has been centred in my approaches to advanced practice in our BSW program, in how I read and support graduate work and create access for students at all levels. It has

also become the heart of how I took up and taught our course, Critical Approaches to Mental Health and Madness.

Our school has long focused on anti-oppressive practice (Baines, 2011), teaching students about what oppressions do, what they look like, and the intersections between them. But until recently, we did not include the oppression known as sanism in our curriculum, our examples, and our conversations. It sat on the sidelines, unknown and unused, relegated by an odd collective loyalty to psychiatric approaches to 'mental illness'; a collective ignorance of the scholarship born out of the ex-patient, consumer, survivor, disability, and mad movements; and more than a smattering of inadvertent sanism. As a mad scholar, this was always painful to experience, difficult to understand; but there has been a mad turn in our school, a consciousness raising around that which had been overlooked, dismissed, and undermined. At the same time, there has been a turn toward what our colleague Akua Benjamin has named as *anti-Black racism*. I am "turned" toward them both.

It would seem our students are, too. In my advanced practice class, one for graduating BSW students ready to work or further their studies, we start the year by talking about colonialism, grappling with Canada as a settler society and the privileging of the white citizen. We come to understand the depth of white supremacy, its effect on social work and the helping professions. We also come to understand that the white settler is always a rational settler, willing and able to correct and cure the mad "other." Mindful of debates around the terms, we nevertheless name this as *sanism*, delving into an oppression of which many have never heard before. We wonder out loud about why this kind of knowledge has been so subjugated, so disqualified. And then, we move into anti-Black Sanism, and when we do that, everything stops.

"This has a name? This has a place," students exclaim. And when we, being Idil and Sonia and I, say *yes*, students start to be able to name and frame their experiences in the field, in the classroom, and in their lives. Last year, a student, working with precariously housed youth, realized that many of the critical incidents taking place at the "home" were because of a powerful form of anti-Black Sanism being directed toward a young Black man diagnosed with schizophrenia. And with a name and a frame and the beginnings of an analysis, they could not only unpack what they were experiencing but start to work against its spread.

Similarly, to name anti-Black Sanism in the school's course on critical mental health and madness is a game changer. For some racialized and Black/African students, it may be exactly what they have been experiencing. It may be exactly why they have not connected with the term *mad* or its movement before. It is why they may have been over-medicated or over-diagnosed or under-resourced and unsupported. It is why they may keep their mouths shut about anything that can lead to more surveillance, including speaking up in class and claiming madness. It is why it takes until we, led by Idil and Sonia, introduce this term in the classroom for them to even imagine a time when they may speak to it, too. And speak they do, in their writing, their projects, and in floods of assignments that identify examples of anti-Black Sanism in everyday life. What we learn is that it is everywhere, it goes unnoticed

and unnamed, and because of that students have had to self-edit or push down their own hurts so deep that they started to think the ache was 'normal'. Teaching it makes it possible for that which has been repressed to return to centre stage.

Conclusions: Why All of This Matters

As we have made clear elsewhere (Abdillahi et al., in press), our work around anti-Black Sanism is new, but the experience is not. Many scholars have already noted an anti-Black/African trend in mental health care and multiple other systems, for racism has always and will always be a part of why many are mad in the first place. For this reason, the responses we have had in the classroom, the community, and in our research work have been both encouraging and dispiriting. Of course it has been a game changer for students who know only too well what anti-Black Sanism looks and feels like in social work practice. Of course it is coming out in narratives in a community purported to be superhuman, and of course there are those who question its legitimacy.

What we have put forth in these pages is an introduction to anti-Black Sanism, a tracing of its roots in anti-Black racism (of various kinds), in sanism, in Black Feminism, and in scholarship that seeks to decolonize mental health. We have centred the history of anti-Black Sanist practices in British colonies and the United States. We have centred the stories of how anti-Black Sanism is being visited on Black/African bodies by white and Black communities and how anti-Black Sanism is compounded by gender.

What we need to say now is that the inspiration for this piece came in our different direct and indirect experiences of sanism. Because of racism, there is a palpable difference in our experiences of sanism, and that difference plays itself out everywhere; in our communities, in our work, and in the classroom. We note that when Jennifer claims her madness publicly and with her students, there is little or no recrimination. But recrimination and sanism are visited on Black/African bodies who are not mad identified and never will be. It is visited on them simply because they are Black/African and therefore "dangerous." In short, this piece was inspired by the double standards in anti-sanist action and the embodied difference we live when it comes to racism. By naming this difference as anti-Black Sanism, we have something to hold onto and fight from.

Most important to us is that we continue this exploration, this excavation and conversation, unearthing experiences, practices, and responses that may change how mental health "care," organizing, research, and pedagogy look and feel. We hope you will join us.

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