An Exploratory Note on Discrimination and "Race" in Relation to Mental Health in the West

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The history of psychiatry shows that "race" has long been an influential concept in determining human behavior, problems with living and their management and treatment. More recently, this history shows how systems of mental health provision and policy affect racialised[1] communities living in the west. For example, as late as 2003, an inquiry into the death of a 40-year old African Caribbean man, David Rocky Bennett led to an in-depth examination of mental health care in the UK. The report found the National Health Service to be "institutionally racist".[2] Institutional racism was defined in an earlier inquiry into the murder of a young black man, Steven Lawrence as "a feature of institutions where there are pervasive racist attitudes and practices, assumptions based on racial differences, practices and procedures which are discriminatory in outcome, if not in intent, and a tolerance or acceptance of such differences."[3]

In Western countries where there are substantial populations of people from communities and backgrounds other than indigenous/occupying white populations, racial discrimination interacts with structural (social, cultural) discrimination against people deemed mad or "mentally ill". This multiple discrimination happens in several contexts affecting the practice and theory of psychiatry and mental health. We attempt to examine some of these contexts below in six sections a) the racist underpinnings of the history and development of psychiatry; b) racialised

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theories of the psyche, emotions and mental health/ill-health; c) racism as cause and context for mental and emotional distress; d) Racial discrimination in relation to access of health and healing systems; e) discrimination against alternative meanings and contexts of healing and health; and f) multiple discrimination based on notions of "race" and "madness" within societies and communities.

Racist Underpinnings of the History and Development of Psychiatry

On that day, completely dislocated, unable to be abroad with the other, the white man, who unmercifully imprisoned me, I took myself far off from my own presence, far indeed, and made myself an object. What else could it be for me but an amputation, an excision, a haemorrhage that splattered my whole body with black blood . . . My body was given back to me sprawled out, distorted, recoloured, clad in mourning . . . I was battered down with tom-toms, cannibalism, intellectual deficiency, fetishism, racial defects . . .

- Franz Fanon, *Black Skin, White Masks*[4]

Psychiatry and allied disciplines and their categories and practices have, throughout their history, been heavily influenced by social constructions of "race" – the supremacy of the white races and the inferiority of other races – and by philosophical ideas of Eugenics. Psychiatric disease classifications and explanations of human behaviours were an aspect of colonial forms of knowledge. They were used to justify practices of subjugating populations and for instituting power structures. We examine just two of these contexts:

1)   Diagnostic and explanatory "disease" categories

In the mid- to late 19thcentury, Samuel L Cartwright coined two diagnostic categories specifically relating to slaves who tried to challenge or escape from slavery.

Dysaesthesia Aethiopis was a condition described by Cartwright in 1851 as afflicting the body and mind of slaves, especially "free slaves living in clusters by themselves than among slaves in our plantations, and attacks only such slaves as live like free negroes in regard to diet, drinks, exercise etc."[5] A perceived *"insensibility to pain when subject to punishment"* was one of the symptoms [emphasis added].

Drapetomania was another "disease" defined as a condition "that induces the negro to run away from services", a condition perpetrated either by "treating them as equal" or by "frightening them by cruelty." The treatment proposed included, along with care and attention, *punishment "until they fall into that submissive state* which was intended for them to occupy in all after-time…" [emphasis added].[6]

2)   In more recent times, in the 1980s, a very British psychiatric diagnosis emerged specific to African Caribbean migrant communities living in the UK. The popularity of this diagnosis, records show, coincided with the race riots. The diagnosis confirmed public images of the riots, nurtured both by the media and by the state that associated African Caribbean communities with drug abuse in general. More insidiously it interpreted the anger expressed by young black men against racism as associated with cannabis use. It has been argued that this diagnosis neatly

packaged the moral indignation against drug abuse and violence and the political need to invalidate a people's struggle into a pathology of anger and discontent.[7]

But perhaps most telling of all is the controversial diagnosis of "schizophrenia". From the time "schizophrenia" was constructed as an explanatory model and diagnostic category to understand certain human experiences and behaviours its validity has been in question.[8] In almost all Westerncountries, more black[9] people, especially young men of African and Caribbean backgrounds, are given a "schizophrenia" diagnosis than other (especially white) people. This disproportionate overrepresentation is a phenomenon not common in black countries. In a study[10] enquiring how "schizophrenia" became a black diagnosis, Jonathan Metzl presents historical evidence showing that the concept of "schizophrenia" went through significant revisions – first from a change (splitting/transformation) in personality into one of "masculine belligerence". Later in the context of the mid-1970s civil rights movements in the USA, "schizophrenia" became a diagnosis disproportionately given to black men. This pathologisation of the continuing anger and disaffection among black communities is coupled with the racialised stereotype "big, black and dangerous". It continues to colour psychiatric diagnosis in contemporary Britain, US, Canada and other Westerncountries with large populations of immigrant communities.[11]

A.   Racialised Theories of the Psyche, Emotions and Mental Health/Ill-Health

Several studies over the decades have found less incidence of mental "illness" among non-white populations in non-Western environments. This has led to several racialised theories about their

mental and emotional capacities and, consequently, their ability to feel distressed. For example, in a 1947 analysis of Africans in a Kenyan mental hospital, J.C. Carothers[12] justified the "rarity of insanity in primitive life" as reflecting the absence of problems in the social, sexual and economic spheres". This apparently resulted in a process of natural selection: "the African may be less heavily loaded with the deleterious genes than the European… [because]… natural selection might be expected to eliminate the genes concerned more rapidly in a primitive community." Carothers made further analyses that went on to influence psychiatric practice worldwide. These include a) the idea that a lack of qualities such as self-reliance, personal responsibility and initiative is the reason for reduced rates of depression among Africans when compared to Europeans; b) the idea that there was a "striking resemblance between African thinking and that of leucotomised Europeans" – meaning that Africans underused their frontal lobes;[13] and c) that the Kikuyu who participated in the Mau Mau uprising were suffering a form of "mass psychosis" arising from "a crisis of transition between primitive and modern worlds."[14]

Racialised theories of "differentiation of emotions" have been used more recently to justify the different outcomes found in the International Pilot Study of Schizophrenia. People in "developed" countries showed higher ratings for anxiety and depression measures in these studies when compared to people in "developing" countries. This has been justified by the idea that people in "developed" countries showed a "greater differentiation of emotions" when compared to people in developing countries; the only exception was African Americans.[15] This theory was further developed as representing an evolutionary process.[16]

This racial prejudice persists in the practice of psychiatry today: a quick example is the recent call for "social engineering" to combat a perceived "epidemic of schizophrenia" among the African Caribbean populations in the UK.[17] The racism and discriminatory attitudes involved in the assumption that Western cultural constructions of mental "illness" and disease can be easily transplanted across the globe have also been highlighted in the critique of the Global Mental Health programme.[18]

B.   Racism as Cause and Context for Mental and Emotional Distress

When I was a child we lived on an all-white road. Nobody was friendly to us and, as luck would have it, our next door neighbour was a member of the National Front and he kept throwing abuse over the garden wall at us… It was really horrible, horrible stuff. And when you were growing up as a child, you think that's how the outside world sees you. You are not going to have pride in yourself and you actually fear the world around you. I can see where that has had a knock-on effect on my experience or "paranoia" but then all you are told is "schizophrenia"…
- *Kalathil, Recovery and Resilience[19]*

The history of racism has a tremendous impact on how mental health and ill-health/distress is perceived and categorized in relation to different racial groupings. Racism has been the broad ground on which different aspects including statistics, diagnosis, treatment, legal determinations and popular cultural myths have thrived. This ground includes the migration of ex-colonial populations into North America and Europe, bringing with them the history of being subject to colonialism and slavery. These continuing prejudices co-exist with prejudices against "new"

migrants (including other white communities from an expanding European Union, for example), and the refugee and asylum seeker population. Such prejudices are fuelled by public imaginings of a dangerous and parasitic "other", defined variedly from "the benefit scrounger" (i.e. feeding on a wealthy and benevolent state) to "the terrorist". Racist discrimination in all these contexts leads to external oppression and in addition the internalization of oppression (leading to issues of self esteem, sense of self, confidence). In turn, low self worth can and has led in many cases to a tragic inability to succeed in an immensely hostile environment, leading to profound distress that is most often categorized as "mental illness".

C.   Racial Discrimination in Relation Access of Health and Healing Systems

The concept "high-risk" was associated with mental health service users who represented a "close fit" with the archetypal risk figure of the young male with a diagnosis of schizophrenia or personality disorder, where the focus was on the potential for violence to other people rather than for self-harm by these individuals. [It] was associated even more strongly with young black men from this category… In this instance, the location of risk was therefore closely related to the social location of the individual in terms of their age, "race" and "gender."

-       Warner, "Community care and the location and governance of risk in mental health"

Research over the years in the West has shown that "pathways to care", i.e., the way in which a person seeking help for mental or emotional distress comes in contact with the mental health system, differ radically between white and non-white populations. Some key facts from the UK illustrate this disparity:

- Rates of involuntary admissions are 2-6 times higher than average for some minority ethnic groups, especially black groups

- Detention under the Mental Health Act is 2-13 times higher than average for some black groups

- Rates of supervised community treatment orders (CTOs) show that people from black communities are 5-7 times higher than those given out to white people

- The category "high risk" is most likely to be attributed to young black (African Caribbean) men with a diagnosis of "schizophrenia"

- Women from black communities are four times more likely to be under compulsory admission, less likely to be referred to crisis houses or to therapeutic interventions such as IAPT (Improving Access to Psychological Therapy, a government policy initiative), and most likely to have their children taken away by social services.

In many Western countries, evidence shows that rates of voluntary admissions into mental health institutions are going down while involuntary admissions and compulsory treatment in the community are increasing. This situation is even more dire for people from minority ethnic communities, including migrant, asylum seeking and refugee communities. Despite "multiculturalism", stereotypical views of the behaviour and motivations of people from racialised communities combined with the stigma and anxiety associated with mental "illness" affect the way in which mental health services assess and respond to communities seen as "alien", resulting often in more and more coercive and controlling treatment. Consequently, people approach mental health and other support services with caution, even fear. This situation

is well explicated by a study that analysed the relationship between mental health services and the black communities in the UK.

When [racial] prejudice and the fear of violence influence risk assessments and decisions on treatment, responses are likely to be dominated by a heavy reliance on medication and restriction. Service users become reluctant to ask for help or to comply with treatment, increasing the likelihood of a personal crisis, leading in some cases to self-harm or harm to others. In turn, prejudices are reinforced and provoke even more coercive responses, resulting in a downward spiral, which we call "circles of fear", in which staff see service users as potentially dangerous and service users perceive services as harmful.[20]

D.   Discrimination Against Alternative Meanings and Contexts of Healing and Health

"I left home with just the clothes I was wearing and no money and seven months pregnant. And from there to where I am now – working, I have a car, I'm earning money, I don't take benefits... People say, oh you have done well, but what's the criteria? Who's grading? Who's the judge to say I have done well? What will they say if they know I still hear voices?"

-        Kalathil, *Recovery and Resilience*

The dominant model of mental health is the medical model, which treats 'illness' as degeneration of or fall from mental health and "cure" as facilitating the return to some norm of mental health. In the last few decades, the concept of recovery has been developed from a service user/survivor point of view with meanings beyond definitions of illness and cure. The

concept of recovery embraces a journey of resilience, discovery and hope, self-determination, agency and empowerment. In this mode of thinking, recovery is not a return to a former state of normality, but a process of negotiating strategies and contexts from which to lead a meaningful life. Sometimes these strategies include ways to live with ongoing realities of voice hearing, self-harm and other aspects that are often diagnosed as "illness behaviours". Recovery, in effect, is a process of meaning making. It is intrinsically linked with the ways in which people make sense of their own distress, its socio-cultural, familial and personal, and bio-medical causes and contexts.[21]. Narrative research exploring the experiences of mental health service users and survivors has shown that social justice is as much a root to recovery as is medication or psychological therapy. This is especially true for people who have been subjugated by systems of oppression.[22]

However, mental health systems and psychiatric knowledge have been in many cases slow (if not entirely resistant) to accept the experiential narratives and theories of distress. The healing and recovery that arise from these positions have also not easily been accepted as part of valid scholarship and evidence. Personal narratives and survivor theorisation become part of the knowledge base of psychiatry only to strengthen the "technological" or "ameliorative" aspects of an authoritarian paradigm of mental health, that is, to provide experiential views about the effect of a certain medication or as part of an anti-stigma campaign or news story.[23] More recently however, there is some hope for Reason in the processes of "re-balancing" psychiatric scholarship that are underway with survivor research gaining momentum in many parts of the world.

Some recovery processes and their implications in the Indian context are discussed in Shubha Ranganathan's paper on healing shrines in this volume.[24]

F.   Multiple Discrimination Based on Notions of "Race" and "Madness" within Societies and Communities

There is evidence from all over the world that people diagnosed as "mentally ill" or perceived as mad face stigma and discrimination in all walks of life, including education, employment, marriage and relationships, housing, property ownership, citizenship and voting rights and so on. Evidence also shows that this discrimination is multiplied when the person perceived as mentally ill belongs to a racialised community. For example, a national study of six major employment services for people with mental health problems and disabilities in the UK found that people from racialised communities were significantly less likely to find work (even when severity of mental health problem was not a debilitating factor).[25] In a survey assessing attitudes to mental illness, while 29 per cent of participants said that they would not like to live next door to a person with mental health problems, this increased to 47 per cent if that neighbor was a Muslim with mental health problems.[26]

As discussed at the beginning of this note, there are parallels between "institutional racism" and the discrimination imposed on people with mental health problems within society and culture (structural discrimination). The multiple effect of this may explain the situations described above; and the answer to address these issues may not lie only in health and social care contexts but in social justice contexts.

Endnotes

1 The language used to refer to ethnic minority communities in the west is rife with controversies. In the UK, the preferred term is BME (Black and Minority Ethnic) communities. In this note, we use the term "racialised communities" to foreground not just the possession of identities that are different (in terms of "race", ethnicity, nationality, culture, religion, skin colour etc.) but the processes and power structures that perpetuate differentiation and "othering".

2 Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003)*Independent Inquiry into the Death of David Bennett*. Cambridge: NSCSHA.

3 Macpherson, W (1999). The Stephen Lawrence Inquiry: Report of an Inquiry. London: The Stationery Office.

4 Fanon, Franz (1952/1988). *Black Skin, White Mask*. London: Pluto Press. p 85

5 Cartwright (1793-1863) was a Louisiana physician, member of the Confederate States of America during the civil war and a contributor to the development of "scientific proof" of the inferiority of the negro race. The report has been republished in Caplan, Engelhardt and McCartney (eds) *Concepts of Health and Disease*. Reading: Addison-Wesley, 1981. Also see for an extract: http://www.pbs.org/wgbh/aia/part4/4h3106t.html. According to Cartwright, the symptoms of included "insensitivity of skin", "hebetude" of mind and lesions on the body, along with raising disturbances and destroying private property. Cartwright advised the application of oil to the skin "and to slap the oil in with a broad leather strap, and then put the patient to some hard kind of work in the open air."

6 This idea of pain and punishment as curative is extremely important in later development of coercive psychiatry in general and how it affects black communities living in the West in particular: several justifications for the increased rates of black people in compulsory care, including compulsory admissions often involving the police, in control and restraint rates, seclusion and isolation etc. continue to be made by mental health services based on this idea.

7 See, for example, Hickling, FW and Hutchinson, G (1999). "Roast breadfruit psychosis: disturbed racial identification in African-Caribbeans." *Psychiatric Bulletin* 23.3, 132-134 and Fernando, S (2010)*Mental Health, Race and Culture*. Basingstoke: Palgrave Macmillan (Revised edition).

8 See, for example, the review of arguments by Bentall, R (2013) "Would a rose, by any other name, smell sweeter?" *Psychological Medicine*, 43.7: 1560-1562 and for testimonies of people affected by the diagnosis: Inquiry into the "Schizophrenia" Label, www.schizophreniainquiry.org.

9 The term "black" is used in this document to refer to people of African, Caribbean and Asian origin. It acknowledges the political use of the term to refer to people who have been historically discriminated against on the basis of their skin colour and "race".

10 Metzl, J (2010) The Protest Psychosis: How Schizophrenia became a Black Disease. Beacon Press.

11There are other examples of political and social unrest/questioning leading to psychiatric diagnoses in the annals of the history of psychiatry. For example, see the development of "Borderline Personality Disorder" as a uniquely female diagnosis in the context of feminist movements. Wirth-Cauchon, J (2001)*Women and Borderline Personality Disorder: Symptoms and Stories,* Rutgers University Press.

12 J.C. Carothers is the author of the 1953 monograph *The African Mind in Health and Disease* written for the WHO in which several of his racist ideas are explicated. This monograph still features on the WHO website: http://apps.who.int/iris/handle/10665/41138

13 Carothers, J.C. (1951) "Frontal lobe function and the African". *Journal of Mental Science*, 97, 12-48

14 Elkins, C (2005) *Imperial Reckonings: The Untold Story of Britain''s Gulag in Kenya*. Henry Holt. Carothers theorized that the only "cure" for this psychosis was confessing their role in the uprising and helped the British government organize a programme of recovery that resulted in years of torture and forced confessions.

15 Leff, J (1973). "Culture and the differentiation of emotional states" *British Journal of Psychiatry*, 123: 2990306

16 Leff, J (1981.) *Psychiatry around the Globe: A Transcultural View*. New York: Marcel Dekker

17 Lewin, M. "Schizophrenia "epidemic" among African Caribbeans spur policy change." *Society Guardian*, 9th December 2009. http://www.guardian.co.uk/society/2009/dec/09/african-caribbean-schizophrenia-policy. For a critical response, see "Poor research or an attack on black people?" *Society Guardian*, 3rd February 2010. http://www.guardian.co.uk/society/2010/feb/03/mental-health-bme-schizophrenia-letter

18 See letter to editor *EPW* (October 20, 2013 47:42, pp 4,5) signed by representatives of MFC, Anveshi, CAMH, Surivivor Research and ICPN critiquing the research priorities proposed in an essay in the journal *Nature* titled "Grand Challenges to Global Mental Health".

19 Kalathil, J (2011) *Recovery and Resilience: African, African Caribbean and South Asian Women's Stories of Recovering from Mental Distress*. London: Survivor Research and Mental Health Foundation.

20 Keating, F, Robertson D, McCulloch A & Francis E (2002) *Breaking the Circles of Fear: A Review of the Relationship between Mental Health Services and African and Caribbean Communities*. London: The Sainsbury Centre for Mental Health.

21 See note 19 preceding.

22 Also see, for Mauri and African American experiences and views on recovery: *Lapsley H, Nikora LW & Black R(2002) "Kia Mauri Tau!" Narratives of Recovery from Disabling Mental Health Problems*. Wellington: Mental Health Commission; Jackson, V (2001) *In Our Own Voice: African-American Stories of Oppression, Survival and Recovery in Mental Health Systems*. Massachusetts: National Empowerment Center.

23 Kalathil, J and Crepaz-Keay, D *(2013)."Introduction" to the web resource on Personal Narratives of Madness accompanying the Oxford Handbook of Philosophy, Psychiatry and Psychology*.http://global.oup.com/booksites/content/9780199579563/narratives/

24 Shubha Ranganathan, "Discrimination, Mental Health, and Subaltern Healing Practices" *MFC Bulletin* (forthcoming July 2013-February 2014).

25 SESAMI (2006) *SESAMI: Social inclusion through Employment Support for Adults with Mental Illness: Final Report.*

26 You Gov PLC (2007) *Mental Health and Religion*. London: Rethink