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Racism in Psychiatry and Psychology

Psychology and psychiatry complement each other, the former as the study of the 'normal' human mind and the latter as a medical specialism concerned with the 'disordered' human mind. Thus both disciplines are concerned with identification of normality and pathology – *psychopathology* – interpreted as 'symptoms' and/or dysfunction in mental processes, recognised on the basis of theoretical conceptions of, and about, the (human) 'mind'. When 'mental health' is identified under the influence of these disciplines it is seen inevitably as dependent on the lack of a significant degree of psychopathology denoting 'mental illness'. Psychology and psychiatry developed within European culture (including its extension across the Atlantic). Thus the ideologies represented in theories of mind and in concepts of illness and health represent worldviews prevalent in European society; and European thinking about race and culture has been naturally incorporated into psychology and psychiatry (see Chapter 1). Psychiatrists and psychologists, like others around them, had very definite ideas on which races were civilised and which were not. A paper published in the mid-nineteenth century, in the *Journal of Mental Science*, by a former physician superintendent of Norfolk County Asylum who was working in Turkey, referred to that land as 'a country which forms the link between civilization and barbarism' (Foote, 1858); in the same journal, another British psychiatrist, Daniel H. Tuke (1858), denoted Eskimos, Chinese, Egyptians and American blacks as 'uncivilised' people, contrasting them with Europeans and American whites referred to as 'civilised' people, but with a grudging reference to China as 'in some respects decidedly civilized'. The description of Africans as 'child-like savages' by Arrah B. Evarts (1913), a physician at the Government Hospital

for the Insane in Washington, DC, was typical of American opinion of his time – views that persisted in that country until recently.

The history of racism in psychology and psychiatry is as old as the disciplines themselves. Both disciplines developed together in relation to each other and, from the very start the disciplines took on the then prevalent racist ideologies in European thinking. In the nineteenth century Darwin's theory of evolution was used as a model for theories of psychological and social development: races were held to exist at different stages of development on a biological ladder of human evolution. An important proponent of this phylogenetic concept of race, or 'evolutionary racism', Herbert Spencer saw 'primitive' races as having minds like those of the children of 'civilized' races (Fryer, 1984) and social practices, such as monogamy, as characteristic of 'higher races' (Thomas and Sillen, 1972). Nineteenth-century anthropologists were strongly influenced by this type of thinking (Harris, 1968); and sociologists saw European civilisation associated with white skin as 'the culmination of the evolutionary process' (Fryer, 1984). Francis Galton (1869), a cousin of Charles Darwin and the founder of eugenics, claimed that the 'Negro race' included a large number 'of those whom we should call half-witted' (1869: 339). The main thrust of the pseudo-science of eugenics was to identify 'inferior' races; and eminent people, such as Karl Pearson (1901), saw the extermination of such races as an inevitable part of the evolutionary process. The view that black people had inferior brains and/or defective personalities were commonplace in the nineteenth century and early part of the twentieth; and these ideas were taken by psychiatry and psychology. Although overt racism has been less obvious since the Second World War, racism persists into the present in the common sense of traditional European thinking. Thus in British society today, pairs of words such as 'culture' and 'race', 'primitive' and 'underdeveloped', 'advanced' and 'Western', 'alien' and 'inferior', 'immigrant' and 'black', etc. are often confounded or used purposefully to obscure racist contentions. Further, racial images are raised in references to 'muggers', 'inner-city decay', 'alien cultures', etc.

Mind and mental illness

Three distinct views about the mind of non-Western peoples, usually identified in racial terms, were discernible during the development

of psychiatry. In the mid-eighteenth century, Rousseau's concept of the 'Noble Savage' proposed the view that 'savages' who lacked the civilising influence of Western culture were free of mental disorder; later, in the late eighteenth and nineteenth centuries, Daniel Tuke (1858) and Maudsley (1867, 1879) in England, Esquirol (cited by Jarvis, 1852) in France and Rush (cited by Rosen, 1968) in the United States voiced similar views, expressed most firmly by J. C. Prichard (1835) in his *Treatise on Insanity*: 'In savage countries, I mean among such tribes as the negroes of Africa and the native Americans, insanity is stated by all . . . to be extremely rare.' But Aubrey Lewis (1965) has pointed out that a second, somewhat different, stance was also evident in Europe about that time, namely, the view that non-Europeans were mentally degenerate because they lacked Western culture. A third viewpoint was voiced in the United States by psychiatrists arguing for the retention of slavery: epidemiological studies based on the Sixth US Census of 1840 (Anon, 1851) were used to justify a claim that the black person was relatively free of madness in a state of slavery, 'but becomes prey to mental disturbance when he is set free' (Thomas and Sillen, 1972). The underlying supposition was that inherent mental inferiority of the African justified slavery. However, Benjamin Rush, the father of American psychiatry, refuted such arguments and maintained that the mental capacity of black people could not be evaluated while they were slaves because of the effect on the mind of the condition of slavery (Plummer, 1970).

Although the 'Noble Savage' viewpoint idealised non-European culture in some ways and the 'degenerate primitive' attitude vilified it, both approaches sprang from the same source – a racist perception of culture which supposed that European culture alone, associated with white races, was 'civilised'; the culture of black people being 'primitive', rendered them either free of mental disorder or inherently degenerate. American views determined by a warped perception of the lives of black Americans – or more correctly, determined by a need to justify slavery – had no room for cultural considerations at all; in fact an assumption that black Americans lacked a culture was implicit in the way these ideas developed. Almost into the twentieth century, Babcock (1895), a psychiatrist from South Carolina, was to use pro-slavery arguments to develop the theme that Africans were inherently incapable of coping with civilised life. In a paper, 'The Colored Insane', Babcock juxtaposed the idea that mental disease was 'almost unknown among savage tribes of Africa' with the alleged

observations in the United States on the 'increase of insanity [among African Americans] since emancipation'; he quoted such causes for this increase as the deleterious effect of freedom on 'sluggish and uncultivated brains' and 'the removal [during emancipation] of all healthy restraints', and forecast 'a constant accumulation of [black] lunatics' in the years to come.

The underlying theoretical question that was being addressed in the discussions about 'civilisation' and mental disorder (noted above) was akin to the current discussion about the universality of schizophrenia – reviewed by Richard Warner (1985) and Fuller Torrey (1987). As then, the matter is currently confused by racism. It is less easy to discern the racism inherent in the methodology of studies than it is to appreciate the racist influences in the way they are perceived and interpreted. Most cross-cultural studies in the first 40 years of this century designated or perceived – and reported – non-Western cultures as 'primitive' cultures. Demerath (1942), reviewing a spate of such studies, observed that some of the non-Western societies that had been studied 'were not truly primitive, but on the contrary were either traditionally literate, or had been exposed to Euro-American culture', i.e. suggesting that not *all* non-Europeans were 'primitive' since some had languages of their own or had become civilised by contact with Europeans! An important review by Benedict and Jacks (1954) of studies on Maoris of New Zealand, indigenous Fijians, Hawaiians of the United States and people of so-called 'Negro Africa', was entitled *Mental Illness in Primitive Societies* – a review which, according to Torrey (1973), was largely responsible for the acceptance by mainstream psychiatry of the universality of 'schizophrenia' as an illness.

One of the earliest observations reported by a psychiatrist about mental illness among Asian people was the claim by the German psychiatrist, Kraepelin (1913), that people of Java, now a part of Indonesia, seldom became depressed and that when they were depressed they rarely felt sinful. Kraepelin (1920) perceived the differences in terms of genetic and physical influences rather than cultural ones – a reflection, not only of the biological orientation in German psychiatry at the time, but also of the acceptance of racial explanations for cultural difference. In fact, Kraepelin (1921) saw the Javanese as 'a psychically underdeveloped population' akin to 'immature European youth', and looked to ways of racial–cultural comparison as a method of scientific study. Sashidharan (1986) believes that Kraepelin's notion 'became detached from main-stream

psychiatry over the next few decades and gradually reorientated itself around emerging ideas from anthropology and psychoanalysis'. Since both these disciplines also carried racist ideas about culture, the 'transcultural psychiatry' that arose continued a racist tradition. Theories have emerged in modern psychiatry about culturally determined brain function, emotional differentiation, personality defects, family life, etc., all of which harbour racist doctrines (Fernando, 1988).

From the mid-nineteenth century onwards, racist ideas were evident in many scientific theories. For example, in the seminal paper describing the syndrome that became known as 'Mongolism', John Langdon Down (1866) proposed that many so-called idiots and imbeciles were racial throwbacks to 'the great divisions of the human family', namely races. He claimed that physical characteristics of Ethiopian, Malay, American and Mongolian racial types were present among patients in asylums housing 'idiots and imbeciles', and estimated that more than 10 per cent of all patients were 'typical Mongols' – a condition that he postulated as 'an instance of degeneracy arising from tuberculosis in the parents'.

Psychological and intellectual differences

The nineteenth-century anthropological and medical tradition that the brains of black people were inferior to those of white people was supported by dubious research. For example, even as late as early in the twentieth century Robert Bean (1906) claimed that in 103 brains from American Negroes and 49 white Americans he found that: '[The] Negro is more objective and the Caucasian more subjective. The Negro has lower mental faculties (smell, sight, handcraftmanship, body-sense, melody) well developed, the Caucasian the higher (self-control, will-power, ethical and aesthetic senses and reason)' (1906: 412). Significantly, reports that did not support the ethos of white superiority, such as the report that brains of Eskimos were larger than those of the average white person (Connolly, 1950), were ignored.

A racist ideology was evident very early in the development of modern psychology. Nineteenth-century study of facial expression and the emotions attached great importance to blushing as a particularly human characteristic; in his classic *The Expression of the Emotions in Man and Animals*, Charles Darwin (1872) devoted a whole chapter to it. Blushing and conscience were thought to be related; the debate

that ensued about the capacity of Negroes to blush was 'not so much a physiological one, as one about moral development' (Skultans, 1979: 63). Francis Galton (1865) claimed that European 'civilised races' alone possessed the 'instinct of continuous steady labour' while non-European 'savages' showed an innate 'wild untameable restlessness' (1865: 157). A classic text on adolescence written by Stanley Hall, the founder of the *American Journal of Psychology*, was published in 1904; in a chapter on 'Adolescent Races' Indians, Africans and North American 'Aborigines' were likened to immature children who 'live a life of feeling, emotion and impulse' (Hall, 1904: 80). The author of a standard textbook on social psychology, McDougall (1921), formulated the concept that different races produced different 'group minds', Nordics showing a propensity for scientific work, Mediterraneans for architecture and oratory and Negroes an 'instinct for submission' (1921: 119).

Carl Jung fancied himself as a specialist on black people since he had actually visited Asia and Africa. Following his travels in India, he observed a 'very characteristic defect in the Indian character', i.e. 'deception' (Jung, 1939a). British psychologist Dalal (1988) sees this theory as 'the Jungian version of "original sin" , in that deception is seen as a 'defect' as well as a 'natural' characteristic of the Indian mind. On visiting the United States, Jung (1930) felt dissatisfied at being unable to 'size them up' – referring to the white population; he could not, at first, understand 'how the Americans descending from European stock have arrived at their striking peculiarities' (1930: 195). He focused on 'the Negro' as the cause. In postulating a psychological danger to white people of living in close proximity to blacks, Jung (1930) deduced the theory of 'racial infection' as 'a very serious mental and moral problem wherever a primitive race outnumbers the white man' (1930: 196):

> Now what is more contagious than to live side by side with a rather primitive people? Go to Africa and see what happens. When the effect is so very obvious that you stumble over it, then you call it 'going black'. . . . The inferior man exercises a tremendous pull upon civilized beings who are forced to live with him, because he fascinates the inferior layers of our psyche, which has lived through untold ages of similar conditions.

Although Jung clearly attributed the 'peculiarities' that he saw in the behaviour of (white) Americans to this 'racial infection', it was not clear from his writings whether the 'infection' spread via socio-psychological influences or through genetic means. But, either way,

the infection was seen by Jung as detrimental to white society and white individuals.

Jung's model for the mind of the infant was very similar in many ways to that of 'primitive' humans: both were not conscious of self as opposed to 'other', had no sense of individuality, related to the world as a collective, confused the objective with the subjective and had no will or volition (Dalal, 1988). Jung (1921), quoting an observation that the experience of a 'savage' during a dream was just as real to him as what he saw when he was awake, stated: 'What I have seen of the psychology of the negro completely endorses these findings.' Clearly, Jung identified the modern African as 'primitive' in every sense of the word; according to Dalal (1988), Jung then went on to see all non-Europeans – the (politically) black – in similar terms, as people who cannot separate out as individuals, in whose minds object and subject were not differentiated and whose feelings were concreistic, i.e. 'the antithesis of abstraction' (Jung, 1921). In developing his theories of the mind, Jung saw the mechanism of 'projection' as being different for the 'primitive' when compared to the European. In describing 'primitive projection' of the Buddhist person, Jung (1939b) stated: 'To the oriental, therefore, the world must appear different to the occidental who animates it with his empathy.' In analysing Jung's writings, Dalal (1988) concludes that Jung equated the white unconscious with the black conscious, and then assumed that what he could discern of his own unconscious life represented the symbolism used by black people: 'It is certain that Jung feared the black man.... His error was in assuming that because the blacks symbolised the primitive to himself, therefore they were primitive.' Such an explanation for the racism of Jung sees it as an abnormal event due to a personal quirk or psychopathology. A more realistic approach is to accept that racism is inevitable and normal in any theory within a framework of Western thinking – and psychology is very much so – that addresses any aspect of culture or race unless specific efforts are made to exclude racism from it. Jung is one of the very few psychologists who attempted to devise theories incorporating race and culture – and clearly did not recognise the extent to which his thinking was fashioned by racist notions. Freud, on the other hand, did not venture into theorising about race and culture. However, when he did, racist notions were not far from the surface.

Freud (1913) saw similarities between 'the mental lives of savages and [European] neurotics' in his *Totem and Taboo*; and Devereux

(1939), an anthropologist, viewed non-Western healers (generally referred to as 'shamans') as neurotics or psychotics. Freud (1930) envisaged the development of civilisation being dependent on suppressing instinctual behaviour under the guidance of the superego, elaborated into a 'cultural superego'; it was natural for him that the 'leadership of the human species' should be taken up by 'white nations' (Freud, 1915, 1930), and that 'primitives' have a lower form of culture. According to Hodge and Struckmann (1975), Freud's primitives included Melanesian, Polynesian and Malayan peoples, the native people of Australia, indigenous people ('Indians') of North and South America and 'the negro races of Africa'.

The study of intelligence is another field in which racism has a long history. Army data on cognitive test results gathered during the 1914–18 war led to a discussion of the reasons for racial differences in scores on intelligence tests (IQs) done in the United States; a 'racist IQ movement' that envisaged genetic inferiority of blacks in comparison to whites (Thomas and Sillen, 1972) developed, but died down after the horrors perpetrated by the Nazis in the name of race. But Arthur Jensen (1969), professor of educational psychology at the University of California, revived the argument with a paper in the *Harvard Educational Review*. Jensen proposed that differences between blacks and whites on scores on IQ tests were genetically determined. Further, he postulated two categories of mental ability – abstract reasoning ability characteristic of white people and rote learning among blacks. Eysenck (1971, 1973) supported Jensen's views while he was professor of psychology at the Institute of Psychiatry, but other psychologists (Kamin, 1974; Stott, 1983) opposed them as scientifically invalid. The racist tradition in studies of intelligence carried into the 1990s in books such as *The Bell Curve* (Herrnstein and Murray, 1994) and numerous publications by Rushton quoted by Richards (1997).

Post-war psychiatry and psychology

A British colonial psychiatrist who achieved the distinction of producing a monograph for the World Health Organisation (WHO), *The African Mind in Health and Disease*, was J. C. Carothers (1953). His first paper (Carothers, 1947) was an analysis of Africans admitted to a mental hospital in Kenya between 1939 and 1943. He proposed several explanations for the 'peculiarities' he observed: first, he

deduced that 'the rarity of insanity in primitive life is due to the absence of problems in the social, sexual and economic spheres', while contending that the 'African may be less heavily loaded with deleterious genes than the European' because 'natural selection might be expected to eliminate the genes concerned more rapidly in a primitive community'. After commenting upon the lack of pressure on Africans because they (allegedly) had no long-term 'aims' in life, he commented on the apparent lack of depression among Africans: 'Perhaps the most striking difference between the European and African cultures is that the former demands self-reliance, personal responsibility, and initiative, whereas there is no place in the latter for such an attitude.' Carothers did suggest that the differences were cultural, because of the 'primitive' nature of African society, rather than intrinsically 'racial', but clearly he had a racist view of African culture as inferior in terms of its influence on mental health.

Four years later, Carothers (1951) took his 'studies' much further. On following up 'a request by the Kenya Director of Laboratory Services for tests of character which would help him to select *reliable* Africans for work in the Laboratory', Carothers apparently noted a 'striking resemblance between African thinking and that of leucotomized Europeans'. After analysing his clinical experience with patients and the experiences of colonial European employers dealing with 'domestic servants, mental hospital attendants, laboratory employees and various other persons', apparently 'without bias and selection' (!), Carothers (1951) concluded:

> The African attitude implies that, apart from certain swift and almost automatic responses and inhibitions, he can do what he likes from moment to moment and feels little need to think of the future or indeed of any other than the immediately presenting aspect of the situation. So he feels free to exercise his most egotistic and emotional impulses (within well defined limits) and such mental organisation as he evinces is imposed from without and not self-developed. He is hardly in fact an individual in our sense of the word, but a series of reactions.

It is hardly surprising that Carothers 'found' what he suspected: 'Except in so far as the African's ritual training mitigates some of the more socially flagrant symptoms (e.g. rudeness and tactlessness), and except that the African shows no lack of verbal ability or of phantasy, the resemblance of the leucotomized European patient to the primitive African is, in many cases, *complete*.'

In his monograph for the World Health Organisation, Carothers (1953) reiterated the racist views propounded earlier and quoted,

with approval, claims that the brains of African and American blacks were inferior to those of Europeans. This monograph was presented and widely quoted as an authoritative treatise on the psychology of Africans. It was, in effect, a compendium of racist stereotypes of black people, referring to their (alleged) failure in psychological development after puberty with a 'total absorption ... in the pleasures of sex', impulsiveness of behaviour, inability to sustain personal relationships, lack of 'personal integration' as an adult, etc. Although Carothers referred frequently to 'culture' as the basis of all their (alleged) peculiarities, the discussion and presentation in his treatise, with references to blacks in both Africa and America as equivalent, clearly indicates the racial nature of his assumptions.

Apart from the publications by Carothers, overt expression of racism has been rare in post-war psychiatric and psychological literature. In fact, a contemporary psychiatrist and researcher, Torrey (1973), has referred to Carothers' work as being 'more appropriate as classroom works on racism'. However, there is little doubt that racism continues to manifest itself in the writings of eminent researchers in subtle ways which are no less damaging to black people.

A theory that has been propagated over several years and now even in psychiatric textbooks is concerned with the 'differentiation of emotions'. The original study (Leff, 1973) reported the alleged emotional expression of subjects in various countries obtained from data collected for the International Pilot Study of Schizophrenia (IPSS); Leff equated 'emotional expression' (based on deductions from measures of anxiety and depression made by psychiatrists) with the ability of the subjects actually to experience emotions, and then added on supplementary data from the US–UK study (Cooper *et al*., 1972) on black Americans and white Americans. The conclusion arrived at was that people from 'developed countries showed a greater differentiation of emotions' than did people from 'developing' countries, with American blacks resembling the latter in this respect. The racial undertones in Leff's initial presentations of the studies become less subtle when the theory is presented later (Leff, 1977) as representing an 'evolutionary process', whereby the state of being industrially underdeveloped or being an American black is seen as culturally inferior to being industrially developed or being an American white. The racial nature of the theory and the racism in its conclusions are obvious; and, as with the writings of Jung and Carothers several years earlier, the theories represent the racist ethos of psychiatry and psychology.

The basic fallacies of Leff's theory, when viewed in a global, multicultural context, are described by, among others, Lutz (1985) and O'Nell (1989): Leff derives his data from ethnocentric methods of assessment, mainly the psychiatric tool devised in Britain called the 'present state examination' (Wing *et al.*, 1974); he uses culturally constructed concepts of emotional expression *cross-culturally*; and he takes a 'paternalistic and judgemental view of non-Western idioms for emotional distress' (O'Nell, 1989: 54). A similar way of thinking to that of Leff is shown by Bebbington (1978), also from the British Institute of Psychiatry, in a review of depression: Bebbington uses the term 'primitive cultures' as meaning non-Western cultures and, more significantly, argues for 'a provisional syndromal definition of depression as used by a consensus of Western psychiatrists against which cross-cultural anomalies can be tested'. In other words, the 'depression' of non-Western peoples is hailed as an 'anomaly' and the paper indicates that these so-called anomalies are found among black Americans, Africans, Asians and 'American Indians'. It is not necessarily the racial prejudices of individual research workers, but the pervasive influence of a racist ideology within which they carry out their work, that is expressed in these theories and ideas.

Diagnosis

The identification of mental illness in terms of diagnosis is a sine qua non of psychiatry; and diagnosis is based on a medical model of illness that has developed in Europe over the past 300 years. But this has not occurred in a vacuum or as an objective process uninfluenced by social milieu. 'On the one hand, it [psychiatry] deals with mental phenomena (actions, beliefs, motives, feelings) which look very much like the sort of things that societies regulate; on the other hand, its roots in objective, physical knowledge of how the brain works are extremely shallow' (Ingleby, 1982). The social construction of mental illness is shown up dramatically in the political abuses of psychiatry in the Soviet Union (Bloch and Reddaway, 1984) and the decision of the American Psychiatric Association in 1973 that homosexuality should cease to be an 'illness' (Bayer, 1981). In both instances, political forces determine the nature of what constitutes illness. Similarly, racist considerations are evident in the construction of two diagnostic categories reported in the United States at the

time of slavery and described by Cartwright (1851) as peculiar to black people.

Dysaesthesia Aethiopis was described as a disease affecting both mind and body, with 'insensibility' of the skin and 'hebetude' of mind, commoner 'among 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.' Cartwright claimed that nearly all 'free negroes' were afflicted by this condition 'if they had not got some white person to direct and take care of them'. Consequently, he saw the 'disease' as 'the natural offspring of negro liberty – the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks'. Stating his lack of interest in treating the 'disease' among 'free negroes', he described the symptoms that he observed among slaves:

> they break, waste, and destroy everything they handle – abuse horses and cattle, – tear, burn, or rend their clothing, and paying no attention to the rights of property, they steal from others to replace what they have destroyed. . . . They raise disturbances with their overseers and fellow servants without cause or motive, and seem to be insensible to pain when subject to punishment.

He argued against the alleged view of overseers that this was 'rascality' and suggested a regime of 'treatment' consisting of hard work in the open air with rest periods and 'good wholesome food'. The second disease described by Cartwright was more straightforward – '*Drapetomania* or the disease causing slaves to run away'. After attributing the condition to 'treating them as equal' or frightening them by cruelty, Cartwright advocated a mixture of 'care, kindness, attention and humanity', with punishment 'if any one or more of them, at any time, are inclined to raise their heads to a level with their master or overseer . . . until they fall into that submissive state which was intended for them to occupy'. Daniel Tuke (1858), referring to Cartwright's accounts of these diseases, approved of *Dysaesthesia Aethiopis* but even he ridiculed the attribution of a diagnosis to the propensity of slaves to run away: 'In our judgement, the absence of such a propensity would be a melancholy proof of imbecility or incipient dementia.'

The influence of ideological and political forces in determining diagnosis, and sometimes treatment, is not usually as obvious as it is in the four examples given above, namely, the illness contained in dissenting politically in the Soviet Union, the demedicalisation of homosexuality in the United States, the illness induced by freedom

given to black slaves, and the disease of running away that affected black slaves. The ways in which the racist ideology inherent in Western culture permeates the construction of illness categories must take note of the diagnostic process itself. Ingleby (1982) makes three observations about the diagnosis of mental illness: first, although it is not usually made on the basis of observed pathology, the existence of such pathology is implied when a diagnosis is made; secondly, criteria for mental illness refer to intelligibility of feelings and behaviour which in turn refer usually to common sense and clinical experience; finally, some types of irrationality are designated as illness for various pragmatic and traditional reasons. The influence of racism in the social construction of commonly diagnosed categories of mental disorder is not always easy to discern. Political, social and ideological pressures current in society always impinge on the diagnostic process by influencing questions of intelligibility, common sense, clinical opinion, pragmatism and tradition. And racism acts through these pressures. It is in this light that observations about racial differences in 'rates' of 'mental illness' and diagnostic patterns, especially those of 'schizophrenia', should be seen – a matter explored in Chapter 6.

Psychiatric diagnoses carry their own special images which may connect up with other images derived from (say) common sense. Thus, alienness is linked to schizophrenia (as a diagnosis) and to racial inferiority (as a human type). The result may be an overdiagnosis of schizophrenia among black people who are seen as both 'alien' and 'inferior'. Similarly, if psychiatry is called upon to 'diagnose' dangerousness, common-sense images of dangerous people are taken on – and black people seen as excessively dangerous. In some situations, pragmatic considerations may promote the denial of illness if political influences encourage some types of behaviour to be ignored or punished. Racist images of the 'lazy black' may lead to the ignoring of self-neglect as indicative of illness among black people; the idea that blacks should not smoke cannabis, but do so, enters into the construction of the disease of 'cannabis psychosis' – a British diagnosis that is given almost exclusively to blacks (McGovern and Cope, 1987). In a context in Britain where public images, fostered by the media and police, associate race with drug abuse and attribute the anger of black youth to their use of cannabis, value judgements attached to drug abuse and the need to 'pathologise' the anger of black people seem to come together in this diagnosis. Also, perhaps a pragmatic need to avoid the diagnosis of schizophrenia because of

public criticism of its overuse among blacks may play a part. Diagnoses specific to groups of people identified racially may carry racism within them, when they are derived in a racist context. Thus, many of the so-called 'culture-bound' syndromes are seen as conditions that are alien to mainstream psychiatry and so diagnosed among people considered to have 'alien' cultures – a matter usually seen in racial terms. (Culture-bound syndromes are discussed in some detail in Chapter 2.)

Depression is a diagnosis of increasing popularity; Brown and Harris (1978) refer to it as an illness with a 'pivotal position in the explanation of what is wrong with our society'. The history of its diagnosis may reflect wider issues. The following comment by the clinical director of Georgia State Sanatorium (Green, 1914) about the apparent rarity of depression among blacks in the American South in the early part of the twentieth century is typical of the general views among psychiatrists at the time:

> It appears that the negro mind does not dwell upon unpleasant subjects; he is irresponsible, unthinking, easily aroused to happiness, and his unhappiness is transitory, disappearing as a child's when other interests attract his attention.... Depression is rarely encountered even under circumstances in which a white person would be overwhelmed by it.

Carothers (1953) (referred to above) is among many white psychiatrists who have claimed that depression is rare among black Africans, attributing his alleged observation to 'the absence of a sense of responsibility' among blacks. In reviewing the reports on depression from Africa, Raymond Prince (1968) notes that, although this condition was reported as uncommon among Africans well into the 1950s, since 1957 – the year of Ghana's independence – papers have appeared reporting that depression is not rare but common among Africans. Prince refers to 'the climate of opinion' about Africans having determined observations made by psychiatrists; another form of words would designate racism. It seems likely that depression is found to be rare among Africans when they are seen as lacking a sense of responsibility, rather than vice versa. Since that particular racist stereotype has lessened in popularity, the syndrome of depression is now as recognisable in Africa as it is in Europe. (The questionable validity of designating the syndrome of 'depression' as an illness in the African cultural context is referred to elsewhere.)

In addition to the (racist) pressures arising from the context in which diagnoses are made, the diagnostic process is affected by racism at various points – during the recognition and evaluation of symptoms or psychopathology, in their assessment for the purpose of illness recognition, and in making the decision on the propriety of designating illness. For example, the failure to acknowledge racism as a real threat to black people may result in the designation of anger and fear as 'paranoia'; the dismissal of culturally determined ways of emotional expression by a black person as an 'inferior' mode of expression may negate the value of 'symptoms' that are identified. Also, racism may play a role in diagnosis by its effect on the context in which the diagnostic interview itself takes place. For example, in transactions between a black patient and a white professional, the former may be unwilling to divulge information because of the racist misperceptions (held by the latter) of his/her family life and culture, while the white professional may have very little knowledge of, or 'feeling' for, black lifestyles and attitudes. Indeed, the rapport between the participants of an interracial psychiatric interview may be totally disjointed in a racist context. What happens after diagnosis – the 'management' of the patient – is also affected by racism. American stereotypes of the patient who is perceived as 'non-Western', usually on the basis of colour, are described by Sabshin *et al.* (1970): 'Hostile and not motivated for treatment, having primitive character structure, not psychologically minded, and impulse-ridden.' Similar myths prevail in Britain, with additional stereotypes (for example, the passive Asian) derived from Britain's colonial past. The images of black people as lacking the capacity for insight or 'somatising' their psychological feelings (reinforced perhaps by their reluctance to divulge these very easily to white therapists), may influence the decision of psychotherapists to accept them for treatment and/or the referral of blacks for behaviour modification therapy. The emphasis on the perceived dangerousness of black people may lead to the excessive use of seclusion or high levels of medication.

Thus, it is in diverse ways, often peculiar to the particular society or situation concerned, that racism affects the way that mental disorder is conceptualised and so-called mentally disordered people managed. The extent of its influence is not just determined by tradition and history but also by current political and economic forces that promote the ethos of white supremacy.

Post-war social and cultural studies

Although sociology had shown little interest in issues around racism in the early part of the twentieth century, social science studies after the Second World War appeared to recognise the importance of doing so. A renowned study that focused on the effects of discrimination and social conditions on the personalities of black people was the book *The Mark of Oppression* by Kardiner and Ovesey (1951). The book is based on a psychodynamic assessment of 25 case records of black people considered against a background of the history of African-Americans in American society. The authors argued that the original (African) culture of black people in America had been 'smashed, be it by design or accident' (1951: 39); African-Americans were seen as people living in a sort of cultural vacuum, their family life as disorganised and the dominance of African-American women as disturbing family cohesion. The authors concluded that racial discrimination had resulted in a low self-esteem and self-hatred within the black personality, partly dealt with by being 'projected' as aggression and anxiety. 'There is not one personality trait of the Negro the source of which cannot be traced to his difficult living conditions. There are no exceptions to this rule.... The final result is a wretched internal life' (1951: 81).

Later studies of black families and culture were gathered together in a report by Moynihan (1965) which informed American social policy and also influenced the thinking of psychologists and sociologists. Moynihan argued that the experience and deprivations of slavery had resulted in a matriarchal structure in African-American families that is out of keeping with 'American society'. Although the book by Kardiner and Ovesey and Moynihan's report highlight racial discrimination as the main problem, their lines of argument were often flawed, and the conclusions drawn on black family life, and indeed on personalities of black people, were generally as racist as earlier views focusing on (alleged) inferiority of black brains. The arguments themselves were based on a naive view of human development where negative experiences were assumed to lead to personality defects. Judgements about family cohesion, the role of women, etc. were deductions made from a white perspective assuming that white families and white people were the norm. A major failure was not to recognise that oppression might uplift as well as depress self-worth and may promote as well as destroy communal cohesion. A sociological approach that transfers the focus of emphasis from the

oppression – racist oppression in this case – to the oppressed, inevitably has the effect of pathologising and stigmatising the oppressed.

American ideas about black families were taken as fact in crossing the Atlantic to become evident in British research; negative images developed about African-Caribbean and Asian families. According to Lawrence (1982) the former were seen as having a family life that was weak and unstable, with a lack of a sense of paternal responsibility towards children; and Asian families were seen as strong 'but the very strength of Asian culture . . . [was seen as] . . . a source of both actual and potential weaknesses' (1982: 118). The American 'Moynihan Report' (Moynihan, 1965) called the black American family 'a tangle of pathology'; in the UK, a Select Committee on Race Relations (1977) reported a connection between the problems of African-Caribbean British families and family life in the Caribbean which was seen as unsuited to British society.

Fortunately, the decade beginning in the 1980s saw a shift away from the racist notions of the earlier years. This change resulted not from academic studies using scientific (*sic*) methods but from black people themselves striving for equality by political action – for example in challenging police brutality and psychiatric racism – supplemented by writings of black and Asian authors on both sides of the Atlantic – such as (to mention a few) Toni Morrison (1987), Paul Gilroy (1993), homi bhabha (1994), Edward Said (1994), bell hooks (1994) and Cornel West (1994). A review of their work and other relevant literature is beyond the scope of this section. The main lessons for the mental health field that come through are about the positive results of the struggles of black people during the many years of slavery; about the richness and variety of black and Asian cultures that have developed in the UK and USA; about the interaction and melding together of cultures; about the changing nature of racism; about the forging of new identities and ethnicities; and about the struggles against racism. Unfortunately mainstream psychiatry and psychology have so far failed on the whole to take on board the insights available in the progressive thinking that has flooded the British and American scene at the end of the twentieth century.

Conclusions

Although it is important to recognise and oppose racism in psychiatric and psychological literature and in the literature that is likely

to inform these disciplines, it is the racism of everyday psychiatry and psychology that is really dangerous, not just to the future of the disciplines but to the social fabric of Western society as a whole. And, of course it is this grass-roots racism that creates problems for people who come into contact with mental health services. The (racist) attribution of primitiveness to non-Europeans, i.e. peoples seen as originating in Africa, Asia and the Americas, and their cultures is an ideology that continues to inform much psychiatric and psychological practice. The racist IQ movement within clinical psychology remains strong. The universalist psychiatric/psychological doctrine, i.e. that Western concepts of the mind, of illness models and of treatment have global relevance, subsumes within it a distinct racist judgement of cultures and peoples – often only partially concealed. And psychiatric diagnoses continue to carry racist undertones. Current practitioners tend to ignore the racist dimension of their disciplines and therefore little, if any, action is usually taken to counteract the effects of racism in practice. Consequently, not only are racist traditions perpetuated, but also, racism in Western culture continues to permeate the disciplines of psychology and psychiatry in research, theory and practice.

Black professionals in the USA have come together to devise a strategy known as 'black psychology'. According to Watson (1973), who, incidentally, regrets the need for a 'black psychology', this movement addresses three areas of concern: first, black psychologists provide a picture of black family life that is different from that presented by conventional white wisdom, emphasising the strengths within it and its ways of making out in the world that blacks live in. Secondly, in highlighting the excessive numbers of black people being diagnosed as mentally ill, the movement tends to concentrate on white racism as the cause for black mental illness. Watson believes that 'Blacks have chosen this because in so doing they have been able to caricature white racism itself as a sickness.' Thirdly, in questioning the validity for black people of established IQ tests, black psychologists have devised new tests geared to the black experience. 'These tests . . . can be seen as a response to what was viewed as a growing racism not just in society at large but in the psychology profession itself.' In the field of psychiatry too, black professionals have formed an association – the Black Psychiatrists of America (Pierce, 1973). Attempts by black and Asian psychologists and psychiatrists to oppose racism within their professional practices have been few and far between. In practice, any individual

who does this becomes marginalised within his or her respective profession and there is little in the way of supportive organisations among these professional groups that they can have recourse to. Similarly, the situation in the UK is that, although white service users have formed bodies to press their case – mainly one of 'anti-psychiatry' – black users of psychiatric services have yet to get together in an effective way.

Although there is some concern in Britain about racism in psychiatry, this has not led to the adoption of any particular strategies to counteract it – although the author suggested some in a book (Fernando, 1988) published over 12 years ago. The Transcultural Psychiatry Society (UK) changed its constitution in 1985 to specify its opposition to racism as a primary object (Transcultural Psychiatry Society, 1985). In 1987, the Royal College of Psychiatrists established a committee to consider 'problems of discrimination against trainees, other doctors in psychiatry and patients on the grounds of race' (Royal College of Psychiatrists, 1989); but the report of the committee was ignored by the governing body. Successive biennial reports of the Mental Health Act Commission, a sort of inspectorate established by the British government, have identified the needs of black and ethnic minorities as a priority, quoting the disadvantages that are being suffered by black people in Britain because of racism (Mental Health Act Commission, 1991, 1993, 1995). And in 1993, a report of a inquiry into three deaths of young black men in Broadmoor Hospital (SHSA, 1993) found that 'subtle racism' (akin to 'institutional racism') was a significant problem that should be addressed as a matter of urgency; but the (then) governing authorities of the hospital rejected this contention and took no action on it.

Thus purely from the point of view of an insider within the psychiatric system, the future looks bleak. However, the challenges to both psychiatry and psychology are increasing, particularly from users of psychiatric services and from voluntary (not-for-profit) organisations run by black and Asian people (see Fernando, 1995). The struggle against racism in the British scene is particularly hopeful in the aftermath of an inquiry into police practices following the racist murder of a black teenager (Home Department, 1999); although the report of the inquiry highlighted institutional racism within the police, the reaction of the government has been to intensify examination of institutional racism in all public bodies, including its own Department of Health, and in services such as the mental health

services. A further reason for optimism is the increasing willingness of black and Asian people, including professionals and academics working within mental health services, to speak out about racism within mental health services and develop alternative, culturally sensitive approaches in the voluntary sector which may demonstrate ways forward. In such a context, it is inconceivable that mainstream psychiatry and psychology could carry on much longer without undergoing radical changes and survive as disciplines that address human problems – mental health problems.