ROOTS OF RACISM IN

Psychiatric practice is often experienced by black people as racist. Suman Fernando, who speaks at MIND’s annual conference in November, describes the historical background of psychiatry, concluding that psychiatry is as racist as any other social system within European culture and has developed its own racist traditions.

An exact science or Western ideology?
Psychiatry depends on identifying ‘illness’, but has neither an objective means of measuring, nor a precise culture-free classification, of illness. At best, psychiatry is a body of knowledge about people built on a framework of hypotheses and information. It has always been ‘permeable to the social and political norms of the times’ (Castel, 1985). And these norms – the values, ideologies and assumptions that have fashioned psychiatry and continue to permeate it – come from the culture within which psychiatry lives and grows. This has been, and still is, broadly Western culture – or perhaps West European culture.

So psychiatry, by its very nature, is ethnocentric to European culture (i.e. Eurocentric). The fact that it has been applied – or rather imposed — all over the world says something about power and status rather than about usefulness or validity.

Colonization, slavery and evolution
Psychiatry developed at the time of colonialism and slavery when myths of racism were being integrated into European culture. Darwin (1872) saw the domination of white races as a natural result of evolution, and ‘Social Darwinism’ placed races, like animal species, on an evolutionary hierarchy, the ‘white race’ being top.

The resulting eugenic movement aimed to improve the racial composition of humankind by social manipulation of inter-racial breeding – an ideology taken to its logical conclusion by the Nazis and revived in our times as ‘ethnic cleansing’.

Small brains, primitive instincts
As psychiatry and psychology developed theories and practices, racism was integrated into their traditions. By the end of the last century, the myth was accepted that brains of black people were smaller than those of whites (as discussed by Thomas and Sillen, 1972, and Fernando, 1988).

A well-known psychologist of the turn of the century, Stanley Hall (1904), described Asians, Chinese, Africans and indigenous Americans as psychologically ‘adolescent races’. Professor Bean (1906) of Johns Hopkins University concluded that black people’s lower mental faculties (for example, smell, sight, body-sense) were well developed in contrast to whites who were inherently better at self-control, will-power and reasoning.

Blacks were described by Francis Galton (1865), the most eminent British psychologist of his time, as having the instinct of ‘continuous steady labour’ and by William McDougall, a foremost social psychologist, as having an ‘instinct for submission’ (McDougall, 1920).

Noble savages
At the turn of the century, a popular question for debate was the apparent relative absence of madness among Africans, Asians and indigenous Americans. Henry Maudsley, a prominent British psychiatrist, and Sigmund Freud espoused the ‘noble savage’ idea of Rousseau, believing that black people were relatively immune to mental illness because they lacked civilization. Aubrey Lewis (1965) has pointed out that others argued that non-Europeans were mentally degenerate anyway – and mentally ill in that sense.

A variation on both themes (discussed by Thomas and Sillen, 1972) was voiced by American psychiatrists who claimed the black person was relatively free of madness in a state of slavery but ‘becomes a prey to mental illness when set free’. The collusion of psychiatry with racist slavery was evident clinically when the illness ‘Drapetomania’ was constructed by a Dr Carwright (1851) to explain what he called ‘an irrepressible propensities to run away’ among black slaves.

Low IQ, racial infection
When Freud wrote about primitives, meaning black people, he assumed that ‘white nations’ would dominate the human race culturally (as discussed by Hodge and Struckmann, 1975). In the 1930s, Jung (1930) postulated his theory of ‘racial infection’, warning white people of the psychological dangers of living in close proximity to blacks.

The racist IQ movement started with Lewis Terman’s (1916) influential They Measurement of Intelligence, which claimed that intelligence was linked to race. The movement lost favour following the Nazis’ holocaust but was revived in the seventies by Jensen (1969) in the US and Eysenck (1971) in Britain. It has reappeared in the nineties in (for example) an article by Rushton (1990) in the Bulletin of the British Psychological Society.

Immaturity and black genetics
The application of Western psychiatry across cultural boundaries, now referred to as ‘transcultural psychiatry’, emerged early this century. But this too was permeated by racism from the start.

The earliest transcultural observation is attributed to Kraepelin (1904), who observed that guilt was not seen in Javanese people who became depressed. But to Kraepelin (1921), the Javanese were ‘a psychically underdeveloped population’ akin to ‘immature European youth’.
The apparent rarity of depression among Africans and black people in America was also noted at that time and promptly attributed to their 'irresponsible' nature (Green, 1914). It was also attributed to 'the absence of a sense of responsibility' by Dr Carothers (1953), a British psychiatrist who worked in Kenya for many years. Earlier, Dr Carothers (1951) had claimed that Africans did not show Western-type illnesses because their brains resembled those of 'lucemonized Europeans'. This view was revived recently in a theory developed by Dr Julian Leff (1973) which claimed that people from underdeveloped countries and black Americans (the politically 'black') are less able to differentiate emotions compared to Europeans and white Americans. And when researchers in Nottingham in the eighties reported that schizophrenia was diagnosed much more frequently among black people, they discussed the differences in terms of black genetics.

**Stereotypes**

Modern social science studies tend to look at black experience from the outside, in terms of theories and concepts based on white European norms and practices. Although seldom explicitly racist, they often have racist undertones, the usual approach being a matter of 'dissecting the culturally bizzare' (Britten and Merryweather, 1984).

The concepts about family life and cultural patterns that psychiatrists, social workers and psychologists seem to work with in Britain are often little more than stereotypes - about lack of culture, paternal irresponsibility, maternal domination, female passivity, male aggressiveness and so on.

**Subjectivity and bias**

Western psychiatry promotes ways of thinking about mental health generally and guides the practice of professionals working in the mental health field.

When we do not understand people, we fit them into categories we think we understand. When we fail to establish rapport, we judge our 'patients' as beyond rapport, diagnosing inappropriate emotions or disordered thought processes - for this is the way we have of making sense of puzzling situations.

Our systems of analysing mental health problems do not allow for racial bias nor give credence to ideologies about life, approaches to life's problems, beliefs and feelings that come from non-Western cultures. This attitude applies to many professionals from Asia and Africa working in our mental health services in the UK, it is related to questions of power, status and training.

**Medicalizing social problems**

In British society today, the importance of racism is denied, and in a sense the victim is blamed for social problems. This is where psychiatry comes into the picture - letting society off the hook by medicalizing social problems.

When the African Caribbean says 'we are not mad, we are angry', the response of psychiatry is the diagnosis of schizophrenia. When the Asian says 'we need help', psychiatry responds with a diagnosis of, say, atypical depression - not even real depression.

Black people in Britain do not trust psychiatry; communication and rapport between the two sides has broken down. In such a situation, racism runs rampant and power dictates. The black experience in society that generates anger or despair is not appreciated, and health professionals have nothing but a disease or criminal model to fall back on. And so diagnoses based on stereotypical assumptions emerge - for example, of black violence leading to judgements about dangerousness. It is significant that the ethnic breakdown for the prison population is very similar to that for secure hospitals.

**Multicultural awareness**

In emphasizing racism, I am not denying the cultural issues that need to be taken on board by psychiatry. The importance of cultural differences in the expression of distress, concepts of illness, expectations from the helping agencies and linguistic needs in a multicultural society have to be addressed.

The trouble is that often racist perceptions result in non-Western cultures being seen as curiosities that would and should be superseded as black people adopt 'white' cultural patterns. So sometimes the implementation of 'multicultural awareness' by British institutions with the best of intentions obscures the real problem of racism faced by black users of services.

Again, we are back to racism as the most important issue to be tackled. But it is not just psychiatry that has to change. A will to tackle racism must be instilled into all parts of the health service and voluntary and user organizations involved in mental health. In a future issue of OPENMIND, I will look at ways of combatting racism in the mental health services.

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**Advertisement for runaway slave, North Carolina, 1827.** The mental illness 'Droptomatia' was constructed by Dr Cartwright (1851) to explain 'an irrestrainable propensity to run away'.

**$50 Reward.**

**RANAWAY from the Subscriber, living in the county of Edgecombe, N. C. about eight miles north of Tarborough, on the 24th of August last, a negro fellow named WASHINGTON, about 24 years of age, 5 feet 8 or 10 inches high, dark complexion, stout built, and an excellent field hand — no particular marks about him recollected. The said fellow was formerly owned by Mr J. Jas. Taylor, of Martin county, and I think it more than probable that he is now lurking in the neighborhood of Taylor's Ferry. The above reward of Fifty Dollars, will be given to any person who will apprehend said negro and deliver him to me, or lodge him in jail so that I get him again. All persons are hereby forbid harboring or employing said fellow under penalty of the law.**

**JOHN LAWRENCE.**

Oct. 4, 1827.