Stigma, racism and power

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Does the biomedical model of mental illness – at least its narrow interpretation – promote racism in mental health services? Suman Fernando explores the connections between stigma and racism and how they impact on the provision of mental health services.

Stigma was described by Goffman (1968) as an attribute of people who are stigmatised – "an attribute that is deeply discrediting" (1968, p.13). Although stigma is generally conceptualised as an attribute of a person, a group of people or a 'thing' such as an illness, Goffman (1968) makes the point that "a language of relationships, not attributes, is really needed" in understanding stigma (1968, p.13). In other words, stigma is a reflection of the way people relate to one another or the way society relates to a person or group of people. Essentially "the process of stigmatisation revolves around exclusion of particular individuals [or groups of people] from certain types of social interactions" (Kurzban and Leary, 2001, p.201). And exclusion implies discrimination through individual (or group) prejudice or institutionally mediated processes.

Racism has a long history in western culture (Fernando, 2002). Sometimes racial designations have become stigmatised and used in order to disempower and oppress people. Thus the designation 'Negro' was such a term. Often racial designations collect baggage to become terms of abuse – or at least ones that imply disparagement of some sort. 'coloured' is such a term in Britain today but possibly not in some other places such as Canada where 'people of color' is an acceptable description of certain groups of people. Being called 'black' used to have a stigma in the US until this was reversed by the Black Power movement of the 1960s.

Of course, racial groups are not all stigmatised but the words used in racial descriptions have implication because of context in which they are used. Thus, when people are referred to as 'white' and 'non-white' the implication is that the latter lacks something that the former have, that the non-white is deficient in some way – the context being one of white supremacy. In similar vein, the state of being 'white' is assumed to be a pure state that is contaminated by genetic mixing with black people – represented in the nineteenth century American definition of black people as people who had (i.e. were contaminated by) at least one drop of 'black blood'. This stigmatisation of racial difference can occur in other contexts too. The word 'Turk' has at least two meanings in the English language according to the Oxford English Reference Dictionary (Pearsall and Trumble, 1995); "a native or national of Turkey" or "a ferocious, wild or unmanageable person" (p.1551). We may not think directly and consciously in terms of dictionary meanings of words, but this double meaning indicates how assumptions are woven into our common sense, how our perceptions of people can be biased, and how, in this case, referring to someone as a 'Turk' implies stigma.

About four years ago, the Royal College of Psychiatrists in the UK embarked on (what it called) an 'anti-stigma campaign' – 'Changing Minds: Every Family in the Land' (Crisp, 2000). The aim was to change public perceptions of mental illness in order to counteract psychiatric stigma by focusing on (what it saw as) the medical reality of 'mental illness' as treatable (by psychiatrists). Not surprisingly – at least

not to me - some users of psychiatric services, especially those from black and Asian communities, objected to the campaign, although of course their voices were not heard in academic or institutional circles. They objected because (they said) the campaign by its very nature (of emphasising biological pathology as causing psychological problems and medical treatment as curing them) promoted stigma. The service users felt that the campaign for change should be directed at the minds of psychiatrists and the psychiatric system in the first place.

A similar argument, the argument that the biomedical model of mental illness – at least its narrow interpretation – promotes racism in mental

because of 'stigma'. However, the social workers, speaking in Sinhala, told me that, once they were told that their relative in the mental hospital was now not showing the 'illness' that doctors had diagnosed, many relatives did not see the patient as 'outcast' or 'alien' as implied in the word 'stigma', but as someone needing care and help – and very often they (the relatives) were unable to provide this care for social and financial reasons.

What I heard ties into my own recollection of how 'mad' people are seen in Sri Lanka, especially in communities that had not been 'westernised'. As Nancy Waxler (1974), writing about her research in Sri Lanka, puts it "The sick person, himself, is not believed to be responsible for the illness; his body or

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health services, has been around for some time although it is not as simple as that. This set me thinking about the connections between stigma and racism in issues in mental health service provision.

Stigma across cultures

While observing that psychiatric stigma seems to occur in many societies both East and West, Fabrega (1991) points out the difficulties in analysing exactly how, and to what extent, psychiatric stigma occurs in very different cultural settings. For example, since most non-western cultural traditions handle illness in an integrated way without differentiating it along the psychiatric vs. non-psychiatric lines (as in the West), the matter of stigma attached to psychiatric illness is difficult to evaluate. Further, there is variety in the way people seen (through western eyes) as 'mentally ill' are handled: "Some are medicalized and stigmatised, some are not, creating a picture that is complex because of true cultural variability and the fact that the Western bias about 'the psychiatric' is not found" (1991, p.548).

I can add a personal note here. When I visited Sri Lanka in 2000, I had the opportunity of speaking with psychiatrists practicing there and also with some of the social workers who have been visiting relatives (living in the villages) of patients institutionalised for many years in a mental hospital near Colombo. The psychiatrists generally believed that many patients had been abandoned in hospital by their relatives

soul may be possessed but his 'self' remains unchanged. If he follows the appropriate prescriptions, then it is believed that his symptoms will disappear and he will quickly and easily return to normal. There is no stigma attached to mental illness; no one believes that the patient is 'different' and should be treated in a new way after his symptoms have gone" (1974, p.380).

Power and discrimination

To designate someone as a 'schizophrenic' or 'psychotic' invalidates everything they do or say – designates them as 'alien' to society, not to be trusted, not to be taken seriously. Some racial designations carry similar baggage for similar reasons: for example 'he's coloured' meaning 'not quite one of us' merges into 'black' tending to carry images of fear and dangerousness - messages as it were coming to us from our history, from stereotypes in the commonsense of the societies we live in, and from our own – sometimes subconscious - fears and prejudices. They all go towards the implementation of so-called 'unwitting prejudice' as given in the now well-known definition of institutional racism (Home Department, 1999):

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and

behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping that disadvantages minority ethnic people (p.28).

Writing from the point of view of people who suffer psychiatric stigma (users of psychiatric services), Crass (2000) argues that the focus should shift away from 'stigma' attached to mental illness or people diagnosed as suffering such illness, replacing its discussion with language of prejudice and discrimination. In similar vein, Liz Sayce (2000) believes that the notion of stigma individualises what is really societal discrimination. Indeed psychiatric stigma is essentially discrimination against people who are given a psychiatric diagnosis.

To say then that if we get rid of diagnosis we get rid of stigma is of course far too simplistic. But, as professionals we have to ask ourselves, is stigma perhaps implicit in some diagnoses? Is it in some way our unwitting intention to stigmatise when we make certain diagnoses. In other words, I suggest that, in a context of what it is like in the real world, psychiatric stigma is inherent in psychiatric practice – *has* to be inherent if psychiatry is to work properly in the way society expects and the way we are used to – especially in the field we call forensic psychiatry, locked ward psychiatry, high dose medication psychiatry, compulsory detention psychiatry. I suggest that increasingly in western societies the main function of most psychiatrists – the unstated job description – is to control people who are seen as deviant or judged to be dangerous (because of their 'illness' or personality), to ensure that they are excluded, rather than included. I believe that this is a challenge practitioners must face up to when talking about stigma.

Racism like psychiatric stigma, involves discrimination – in this case usually on the basis of skin colour, rather than diagnosis. Both discriminations may be expressed overtly in terms of personal prejudice or subtly through institutional processes. When a racial group is stigmatised people perceived as belonging to that group also face problems of social exclusion and in extreme instances they are seen as alien to society in the same way as schizophrenics are.

Both psychiatric stigma and racism are based on certain hypotheses or assumptions. In the case of mental illness, it is assumed that that there is an objective 'thing' called 'mental illness' that affects the person given the diagnosis. We forget that a diagnosis is no more than a 'useful framework' that can be justified only by usefulness (Kendell & Jablensky, 2003, p.5). It is not an objective fact. In the case of 'race', the critical (incorrect) assumption is that the concept 'race' has validity for differentiating one person (or group of people) from another person (or group) on a variety of dimensions. And here I mean the commonsense idea of race, where one or two aspects of physical appearance (most commonly skin colour, shape of eyes or hair-type) are used to define one's 'race'.

The ways in which power is exercised in any society is complicated, but it seems to me that identifying one or more groups that need control is always a feature of the exercise of power. The history of psychiatry shows that the need to diagnose mental illness was intimately tied up with the need to control populations and people. Over the years, the power of psychiatry has become integrated with the power of the 'state', the power of the system that is in control.

Just as diagnosis is a reflection of the exercise of power, so is racism. And within the psychiatric system of many western societies, race-power and psychiatric-power have intertwined. So ways of diagnosis promote racism. For example, when schizophrenia is 'found' to be commonly diagnosed among black people in a particular setting (e.g. inner cities of Britain) being a black person (in that particular setting) becomes a signifier for the diagnosis. (I remember being taught in medicine that in making a diagnosis, common things and common; if an illness is commonly found in a particular group then one gives priority to it in that group).

Essentially, the power of psychiatry operates through the commonsense of ordinary people and the diagnoses of ordinary psychiatrists. In the context of mental health today, schizophrenia is a major player in the exercise of power. And so is racism and the two seem to go together. And in my contacts with many people seen as 'patients', I find that *that* is how the situation looks and feels from black service user's perspective. The impression certainly is that it is the *intention* of the diagnosis to stigmatise, to exclude – although many users may well agree that the intention is unwitting.

Conclusion

Stigma has always been closely associated with the concept of mental illness developed within western psychiatry, and is attached to many of the diagnoses within psychiatry – especially 'psychosis' and 'schizophrenia'. Although the reasons for this may well be complex, the reality for users of mental health services is that psychiatry itself is felt as oppressive in many instances. And for black people racist thinking has become implicit in many diagnostic formulations.

In the UK, it is well recognised that some minority ethnic groups receiving less than adequate mental health care, being subjected to compulsory admission to hospital more often than others and so on (see Fernando, 2003). This situation has, so far, resisted efforts at change through (what is called at different times) cultural sensitivity training, recognition of cultural diversity and improving cultural competence of mental health professionals. I suggest that the persistence of these inequalities is partially explained by the strength of racism in the diagnostic process itself and thence its integration with psychiatric stigma. This is especially so in the case of the diagnosis 'schizophrenia' and the more general 'psychosis'.

All this needs to be seen in a wider context. It seems to me that western society and psychiatry is changing in such a way as to promote – not retard – oppression through psychiatry. Changes in society have predicated emphases on competitiveness and self-interest; a tendency to see the human condition in biological terms; the quick fix; and the need to blame someone when there is some misfortune. All this gets reflected in the psychiatric field by a strengthening of categorisation, a reversion to Kraepelinian concepts of racial degeneracy interpreted as an inherited tendency where the diagnosis of schizophrenia or psychosis becomes a calling to account, and the perpetuation of stigma carrying racial undertones and overtones. Racism and psychiatric stigma have blended together to exercise power over black people. And as society changes and other groups are felt to need control and exclusion, psychiatry will collude, will diagnose, will stigmatise because that it what we do, that is our system. Psychiatrists are caught up in this; mental health services serve as the vehicle for it.

What I am trying to argue is that, as it works out in the real world of western society today, psychiatric stigma, diagnosis of schizophrenia (or psychosis) and racist practice are all integrated and held together by power structures or something like that. One cannot hope to successfully campaign against one in isolation from the others. You may remember that in the 1960s a strong movement grew up in UK and North America protesting at the so-called 'abuse of psychiatry' in the old Soviet Union (Bloch and Reddaway, 1984). In short, some political dissidents were being sent to secure hospitals having been diagnosed as schizophrenic because of their bizarre behaviour, delusional and grandiose ideas, etc. Foucault (1988) has pointed out that during Stalinist times, psychiatry in the Soviet Union had a very low profile. It was with liberalisation of the political system under Khrushchev that so-called 'abuse of psychiatry' occurred. In fact it was more the *use* of psychiatry with diagnoses made within the psychiatric medical model by ordinary psychiatrists living and working within a particular political framework that resulted in that situation. The people who were sent to hospitals were indeed showing (what common sense of the times would have called) bizarre behaviour, irrationality and fantasies that psychiatrists within the Soviet system could well have interpreted as delusional. And it is very likely that they 'improved' (i.e. were controlled) on regular anti-psychotics so that they were able to live in the community without showing their symptoms.

In Britain today, excessive numbers of black people are being diagnosed as 'schizophrenic' and being sent to secure hospitals and units. In a context of racism where the control of aliens is clearly on the political agenda (sometimes stated overtly), the analogy with what happened in the Soviet Union in the 1960s is obvious. As long as 'black' is seen as alien – the indication is that this is changing and it is the brown-skinned, Muslim-looking people who are at risk of being see as alien – as long as the 'other' is not accepted as equal, as long as the 'other' is discriminated against, psychiatrisation as currently practised being informed by an ideology of biological inferiority that is implicit in diagnosis of (say) schizophrenia, as long as we do not change the system radically, current psychiatric practice will to some extent be a stigmatising process integrated with whatever brand of racism there is in society.

In summary then, in the real western world of today, blackness or alienness or brownness or whatever the current fashion may be for discrimination, for exclusion, for stigmatising, this sort of thinking permeates psychiatry and constitute its own institutionalised ideology. For this sort of psychiatry to work properly, stigma is a necessary part of diagnosis. And the glue linking all this, I suggest, is power. The medicalisation of social problems, the drug-peddling of pharmaceutical firms, stereotyping of certain groups via racist perceptions of people, all these and perhaps much else are involved in the power that is exercised over people through the psychiatric system.

This is not to say that all psychiatrists are personally racist or power hungry. Nor am I saying that some parts of the psychiatric system do not help people constructively and I would see the world of cultural psychiatry as being within that helping arena, the exception to the rule. But it is weak and I suggest overwhelmed by the generality. The bulk of psychiatry is very different and increasingly so. In the UK for instance the range of forcible psychiatry is increasing, and the majority of people employed in the mental health services are involved in dealing with them. And for the proper working of this psychiatric system as it is supposed to work, stigma is necessary. So if a campaign against stigma is to work, the campaign has to start at home with moves to change psychiatry itself fairly radically.

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