Sanity, Madness and the Family: A retrospective, *Journal of Psychosocial Studies*, Special Issue, Volume 11, Issue 1, April 2018

Moving on from Laing: The politicization of schizophrenia

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The paper demonstrates how the use of 'schizophrenia' as a diagnosis has changed in the context of changing racial and cultural demographics of British society – that in effect the diagnosis has become politicized and predominantly attached to racialized groups of people. The situation in other European countries is not clear, but similar change appears to have occurred in the United States in association with the civil rights movements of Black liberation. It is concluded that psychiatry and clinical psychology need fundamental changes if they are to serve a useful purpose; they themselves need to be de-politicized.

In an article in *New Left Review*, R. D. Laing (1964) wrote:

> I do not myself believe that there is any such 'condition' as 'schizophrenia'. Yet the label is a social fact. Indeed this label as a social fact is a *political event*. This political event, occurring in the civic order of society, imposes definitions and consequences on the labelled person (p. 64, italics in original).

The first part of this article is presented in the first person as a story of the journey of a psychiatrist of non-Western cultural background who identifies as racially / ethnically 'black', who trained during the 1960s in the UK as a (medical) psychiatrist at a time when Laing's work was influential, and worked almost entirely in the (British) National Health Service (NHS) during the 1970s until the mid-1990s. The second part is a discussion of the meaning of schizophrenia when this label is attached to Black people – meaning people who are regarded as not 'white' and / or to groups of people who are racialized, the term 'racialization' being used in the sense used by Fanon (1967) as equivalent to dehumanization. And, finally, some conclusions are drawn about the current place of schizophrenia as a

construct in British society, arguing that it should be dropped as a psychiatric diagnosis; and that personal experiences that are currently interpreted as symptoms of the illness 'schizophrenia' should be seen as part of life experience and only made out as requiring interventions – 'treatment' – if they cause problems for the individuals concerned.

Personal journey as a psychiatrist in British society

During my training in psychiatry during the 1960s, the Laingian movement – incorrectly called 'anti-psychiatry', but really a critique of the way psychiatry was seen at the time in the UK – was a major influence on my thinking, mainly through reading *The Divided Self* (Laing, 1965) and the *Politics of Experience* (Laing, 1967) and hearing about the work at Kingsley Hall (Barnes and Berke, 1971). The 1960s saw large numbers of immigrants from the Caribbean enticed by availability of work opportunities and scope for economic improvement. Many settled in London where I lived and worked. The psychiatry I was taught in the 1960s focused on bio-medical explanations of what was identified as 'mental illness', while the social and political context in which psychiatry was practiced was alluded to as 'social factors' which were regarded as secondary influences – the basic cause (of mental illness) being the result of functional (rather than structural) disturbance of brain resulting from biological malfunctioning in the brain. Since I was working in the 1970s in areas in London with culturally and racially mixed populations (later referred to as multicultural settings), my interest was drawn to wider social and cultural aspects of what we designate as 'mental' – wider, that is, than 'family', the importance of which in the dynamics of generating 'mental illness' I learned early in my career mainly by reading the works of Laing.

Prior to the 1970s, the idea of 'transcultural psychiatry' was almost unknown in the UK – the transcultural approach being that (a) all models of illness are predominantly driven by the

culture of the societies in which they develop; and (b) psychiatry itself, derived in a culturally Western context, is inherently at odds with non-Western ways of thinking about the human condition. As immigration into UK from the ex-colonies of the British Empire, especially those in the Indian subcontinent and the Caribbean, increased in the 1970s, it became increasingly evident that these immigrants were generally dissatisfied with the mental health services. Mental health professionals (mainly psychiatrists, psychologists and social workers) with a common interest in studying the problem and in providing suitable mental health services for people of non-Western cultural backgrounds got together, and the (British) Transcultural Society (TCPS) was formed (see Bains, 2005, Fernando, 1988, 2003; Vige, 2008). At first, the main focus of discourse within the TCPS was on issues of 'culture', but that shifted to issues of 'race' (as well as culture), influenced, I think, by what our patients and clients told us about *their* experiences in the 'mental illness' system of the NHS, and also by British cultural studies, for example, of the Birmingham group of sociologists led by Stuart Hall and colleagues. These studies were brought together in sociological classics such as *Policing the Crisis* (Hall et al., 1978) and *The Empire Strikes Back* (Centre for Contemporary Cultural Studies, 1982). Essentially, the Birmingham group proposed that what were called 'cultural' issues resulting from the post-war influx to Britain of migrants from ex-colonies were really about their perceived 'racial' nature. After all, Britain was quite used to accepting migrants from the European mainland, but the immigration between the 1960s and 1980s of the 'racial other' (mainly from former British colonies) was something new. The crisis referred to in *Policing the Crisis* was really about the political state (people in power) dealing with 'race relations', by which was then meant controlling the rising numbers of Black British people seen as a threat to the natural order of British society – its 'whiteness'. It should be noted that in the 1970s, Empire and colonization were only in the recent past. The works of Frantz Fanon, translated from the French as *Black Skin, White*

Masks (Fanon, 1967) played an increasing part in the discussions I had with others in the field of 'race', culture and mental health. Fanon had pointed out that Blacks in (European) colonies were beyond even being recognized as 'the other' (Kapuściński, 2008).

In the field of psychiatry, the socio-political crisis in the UK was manifested in various problems identified by professionals in the mental health services as 'ethnic issues' (Table 1), and often experienced by Black people caught up in the psychiatric system as oppression. At TCPS meetings in Bradford, London, Birmingham, and other places where there were significant numbers of Black people, the discourse among professionals concerning these issues was initially about 'them' – their behaviour, their thinking, their beliefs, and so on – but attention also turned to the nature of psychology and psychiatry, the 'psy disciplines', that underpinned and informed much of mental health practice. Books by members of the TCPS included *Race, Culture and Mental Disorder* (Rack, 1982), *Aliens and Alienists* (Littlewood and Lipsedge, 1982) and *Race and Culture in Psychiatry* (Fernando, 1988). Over the next few years, discussions about the ways in which 'race' and culture had been handled in the disciplines of psychology and psychiatry (the 'psy disciplines') as they developed in post-Enlightenment Europe (see Fernando, 2010, pp. 53-55) gave us an insight into why these disciplines, as practised in the mental health services, lacked sensitivity to cultural differences and failed to allow for the effect (on judgements made using the methods of the psy disciplines) of stereotypes and racist attitudes prevalent in society at large. The limitations of the psy disciplines became evident – the inadequacy of the diagnostic system, their ways of assessment of people presenting as 'patients' and clients, and the failure in many instances of the therapies developed by these disciplines to satisfy the needs and wants of people from many minority ethnic communities. Increasingly, institutional racism was blamed for the excessive sectioning of black people – 'sectioning' being short for compulsory detention by

being placed on a legal 'section' of the Mental Health Act – and generally for the oppressive nature of the 'schizophrenia' label.

The ideas from transcultural psychiatry gradually permeated the field of British psychiatry in the 1970s. But transcultural psychiatrists were not a popular group with the British psychiatric establishment, any more than the Langians had been in the 1960s. The thrust of the changes demanded by them simulated the thrust of anti-racism movements in Britain; and transcultural psychiatry in the UK critiqued the psy disciplines from perspectives of both 'race' *and* culture. The changes in mental health practice that British transcultural psychiatry advocated was both for antiracist *and* culturally sensitive ways of working. In should be noted that later, in the mid-1990s, the term transcultural psychiatry was colonized by the establishment at the Department of Health. Special posts in (nominal) 'transcultural psychiatry' were instituted, but in most instances they were taken up by professionals who turned out to be merely traditional psychiatrists loyal to the culture of racism that pervaded the psychiatric system, on the whole practising a type of cultural sensitivity that merely meant asking clients about their backgrounds, developing so-called 'cultural formulations', consisting too often of stereotypical assumptions. Thus, the thrust of 'transcultural psychiatry', especially its anti-racist thrust, got lost in the late 1990s in actual clinical practice within the psy disciplines, although it continued in discourse and writings.

The main critique of the psy disciplines that the early transcultural psychiatrists in UK had propounded – some of whom were not willing to speak out too loudly – was around (a) the Eurocentric nature of the medical model in psychiatric practice and (Western) psychological theories; (b) institutional racism in mental health services, including the practice of psychiatry and clinical psychology; and (c) the criminalization and psychiatrization of Black

and Asian people whose (largely social and personal) problems were often inappropriately attributed to 'symptoms' of 'mental illness', especially with the diagnosis 'schizophrenia' and / or 'psychosis' (e.g. Bhui and Olajide, 1999; Fernando, 1991, 2003, 2010; Littlewood and Lipsedge, 1997; Bhui, 2002).

In the early 1980s, there were 'race riots' in several major British cities (see Home Office, 1981; Solomos et al. 1982). At that time, 'cannabis psychosis' was a common diagnosis given to Black people (McGovern and Cope, 1987); and the 1985 Silverman inquiry into the cause of the riots in Handsworth (Birmingham) was told by Dr Imlah (1985), a local psychiatrist, that the cause of rioting was cannabis consumption by Black youth. Being *Black, mad, and high on drugs* was emerging then as the image of violence on British streets, that Blackness, violence and madness all go together – a message revived more recently by historian David Starkey (2011), speaking on a television programme on the BBC (Quinn, 2011) about the riots in London between 6 and 11 August, 2011 (Phillips, 2011). By the late 1980s, the discourse – and indeed protest – was, predominantly about the '*over-representation issue'*; that being Black seemed to attract the diagnosis of 'schizophrenia' and / or 'psychosis'. A BBC Horizon programme in 1989 called 'Black Schizophrenia' portrayed 'schizophrenia' as 'largely a disease of black people that is associated with violence' (Shaw and Fernando, 1989). By the 1990s, cannabis psychosis seemed to lose its popularity, but over-representation (as 'schizophrenic') seemed to get worse as 2000 approached, higher in the case of British-born Black people than it was among Black immigrants. And this state of affairs has continued (for latest detailed statistics see Fearon et al., 2006).

Over-representation applies not just at the hard end of psychiatry – places like Broadmoor – but all over the place, in community care, out-patient settings, and so on. The diagnosis

seems to justify locking up and / or medicating (controlling) black 'schizophrenics' – something that has parallels in ethnic statistics in our criminal justice system (Table 2) and education (Table 3). In today's multicultural, multi-racial British society, Laing's ideas still resonate but there is more, *much* more, when looked at from a transcultural perspective, from a social-political perspective, from a racialized perspective.

Sanity, Madness and the Family (Laing and Esterson, 1970) talked about the '*politics of experience*' – how human experience, especially that of young people, was structured by power. Also, the book pointed to the importance of *context* when experiences are socially constructed into symptoms (for example of 'schizophrenia'), such as hearing voices, feelings of passivity and feelings of being controlled by external forces. From a transcultural perspective, much of what psychiatry identifies as 'symptoms' of schizophrenia seemed to me when I was training as not really symptoms at all in non-Western cultures, but as perfectly *natural* experience. And, there is little evidence that such feelings / experiences were seen (at that time) in many non-Western cultural contexts as requiring 'treatment' or 'healing' and not mentioned in non-Western medical systems or non-Western psychological systems of healing – 'understanding', perhaps, in some instances, but not 'treatment'. Incidentally, what slightly alarmed me even in the 1970s (Fernando, 1988) – and alarms an increasing number of people today (Fernando, 2014; Mills, 2014; Watters, 2011) – is the globalization of Eurocentric psychologies and diagnoses across the world, a cultural imperialism driven by neo-liberal policies and the profit-motive of corporations (Fernando, 2011).

The concept of the double-bind and the need to consider the nature of 'family life' in making assessments of people presenting with psycho-social problem runs through *Sanity Madness*

and the Family (Laing and Esterson,1970), and the descriptions in the book provide insight into how powerful family systems can be. For Black people caught up in the psychiatric system, what is experienced as even more powerful is the social-political system – 'the state', 'Babylon', the Rastafarian term for oppressive state power (Cashmore 1979) – coupled with the power of Western psychology and psychiatry (psy disciplines). And 'schizophrenia' is part and parcel of the exercise of power when 'white psychiatry' meets Black identity. In effect, schizophrenia labelling (as in fact Laing once said) 'as a social fact, is a *political event'* (Laing, 1964: 64) – *understandable* in a context of 'race relations' as part of state control, of social exclusion, of oppression that goes beyond 'othering'. The issue for Black people has become a struggle against racism (Fernando, 2003).

Personally, I found in *Sanity Madness and the Family* a most illuminating perspective on the meaning of 'schizophrenia', but the accounts of individuals in families who were, as it were, struggling with and against each other, were perhaps too Eurocentric to be of much relevance to the lives of most people from non-Western cultural backgrounds – Asian, African, African-Caribbean – in our, now multicultural, societies. But of course 'schizophrenia' itself is a Western construction representing a particular view of the human condition that arose in post Enlightenment Europe (see Fernando, 2014). The post-Enlightenment culture that bred the psy disciplines focused on positivism, causality, individuality, and so on (the bedrock of the 'scientific approach'), but also excluded spirituality (in adopting secularism) and embraced racism as an ideology (see Morrison, 1993; Eze, 1997). Furthermore, the absence of spirituality and the racist stereotyping in clinical work are often identified by service users from Black and minority ethnic communities in the UK as problems in their encounters with the psy disciplines. I am not discounting intra-psychic experiences, nor dismissing the importance of pressures in family life on all young people (whatever their cultural

background or racial designation); and certainly the existential approach that Laing and Esterson took – the importance of the here and now – makes sense from a transcultural viewpoint. But when seen through the lens of 'over-representation' post-Laing, post-the 1970s, social judgements about behaviour, concepts of dangerousness and fear we experience about 'the other', these seem more important to the understanding of 'schizophrenia' – at least in the case of racialized people in western society today. As a report (SHSA, 1993) on deaths of three Black men carrying the label 'schizophrenia' in Broadmoor, put it, while drawing attention to what it called 'subtle racism', *the power of the 'big, black and dangerous' stereotype.*

Meaning of schizophrenia in Western multi-ethnic societies

The term 'schizophrenia' as the name of a mental illness was originally used by Bleuler (1911) when he re-named dementia praecox suggested by Kraepelin (1919) as a form on insanity. Schizophrenia was born in the following European context: by the late nineteenth century, the ideas of degeneration formulated by Morel and Lombroso's criminology had reached the wider public through popular writings (Pick, 1989, Weindling 1989), and a type of biology with a strong racist message became part of the public discourse on social reform. Eugenic solutions to psychiatric problems were proposed in Germany in the mid-1880s (Weindling 1989), and the biological control of deviant behaviour impressed Kraepelin so much that he 'accepted that patients with existing mental problems should be advised against marriage' (1989, p. 86); and when he 'discovered' that many people deemed insane suffered from schizophrenia, he identified it as the epitome of degeneration. During the 1890s, Forel (in Germany) began to castrate patients as a means of controlling aggression – even then associated with mental problems. In 1918, Kraepelin set up the German Psychiatric Research Institute in Munich with his pupil, Ernst Rüdin, as the head of its Genealogical Department

(Weindling, 1989, p. 336). As Rüdin led its research with money from the American Rockefeller Foundation, the institute's main research thrust was to investigate the genetic patterns of what were assumed to be inherited diseases, including schizophrenia. Much of the early work of the institute consisted of establishing a data bank of people deemed to suffer from inherited mental illnesses – the institute itself being focused on protecting the public from dangerous and burdensome people with such conditions (Weindling, 1989, p. 384). The end result was the sterilization campaigns of the 1930, and finally the actual medical killing of people diagnosed by psychiatrists as incurably 'schizophrenic'.

The notion of degeneration really took off in England when, combined with the racist eugenics of Francis Galton, 'there was a slide into biological idealism [...] into a conception of degeneration as the imagined subject, cause and force of history' (Pick, 1989: 199). From the 1880s through to 1900, psychologists, psychiatrists, anthropologists and lawyers elaborated the language of degeneration, and eugenically-orientated academics, journalists and doctors were involved in its promotion. The mathematician Karl Pearson (1901), then a professor of London University and a Fellow of the Royal Society, justified the extermination of 'inferior races' as being a way of improving human stock, and founded the journal *Biometrika*, promoting eugenic ideology. Pearson's academic department at University College London supported him fully, and London University hosted the first International Congress of Eugenics, with Lord Darwin as president and Winston Churchill as vice-president (Pick, 1989, p. 199). The German school of psychiatry associated with racist ideology became as much a part of British psychiatry as schizophrenia – the two being closely linked ever since then in British psychiatric thinking.

World War Two (WW2), leading to the breakup of European empires in Asia and Africa, was, in many ways, a watershed in human relations across cultural and national borders. The migrations that followed de-colonization resulted in many Western societies becoming 'multicultural' and multi-racial. But the notion of 'race' and that of 'culture' became very muddled. Increasingly, people from 'other cultures' (often differentiated *racially*) in Western Europe and Euro-America were designated as 'ethnic minorities', but more recently these 'ethnic groups' have become diasporas with multiple national allegiances (Bauman, 2011).

The Laingian movement came into being in the world of the 1960s. Four decades later, the 2000s is a very different place sociologically. The label 'schizophrenia' appears to be well suited for politicization to serve purposes that are far from purely medical. As Foucault (1988) has pointed out, psychiatry had a very low profile in the Soviet Union during Stalinist times; but with liberalization in the 1960s during the time of Kruschev, it was 'schizophrenia' that was used as a tool of oppression – as the diagnosis given to political dissidents who were incarcerated in secure hospitals (see Bloch and Reddaway, 1984). In the United States too, major changes in human relationships took place in the 1960s. In his book *Protest Psychosis: How Schizophrenia became a Black Disease,* Jonathan Metzl (2009) has described how 'schizophrenia' became politicized to become a racist diagnosis in the United States. The author, a psychiatrist and professor of women's studies at Ann Arbour in Michigan, perused over several years the records of Ionia State Hospital for the Criminally Insane, one of many American asylums run down in the 1970s, that closed in 1975 to re-open as a prison – with many of its Black patients, still in situ now as prison inmates. What Metzl (2010) found was (to use his own words in several places) 'dramatic racial and gender shifts in persons diagnosed with schizophrenia at Ionia during the 1960s'. Before the 60s, Ionia doctors viewed schizophrenia as an illness that afflicted nonviolent, white, petty criminals, including

the hospital's considerable population of women from rural Michigan. 'By the mid- to late-1960s, however, schizophrenia was a diagnosis disproportionately applied to the hospital's growing population of African-American men from urban Detroit' (ibid). Hospital charts stressed how hallucinations and delusions rendered these men as threats not only to other patients, but also to clinicians, ward attendants, and to society itself – a situation not very different to that in the UK of the 1980s onwards. The likelihood is that it is similar too in multi-ethnic countries of mainland Europe, although there is little information to go on, mainly because (unlike in the UK), ethnic monitoring of psychiatric institutions, or even mental health services in general, are not available in countries such as Germany and France – the keeping of ethnic statistics of any kind in not allowed in France.

Conclusion

What is now fairly evident is the political role of 'schizophrenia' when Black people are the objects of this diagnosis – and it is far more difficult for Black people (as compared to Whites) to survive the consequences of this event, especially now with community treatment orders and the expanding forensic system. The social imperative to control and (as it were) punish Black people for being 'the other' may now be spreading to encompass other racialized groups (groups of people seen *as if* they are 'races' in the old-fashioned negative sense) – asylum seekers, refugees, undocumented migrants, Muslims.

While the struggles of the 1980s and 1990s in the UK made people aware of the suffering that Black people faced because of the diagnosis of schizophrenia, little attention was paid to de-politicizing 'schizophrenia'. We did not then fully comprehend the power of the psychiatric system, especially when it is supported by clinical psychology – as 'psy disciplines' – to promote a political agenda of controlling the 'other', and hence in supporting

state power. It is becoming increasingly evident that the 'psy disciplines' themselves need to change – to become de-politicized. That means that these disciplines must be structured not just to 'understand' schizophrenia as a diagnosis, a label that stigmatizes, how it may play out in family, and so on, but also to understand and address the *political event* of schizophrenia as oppression.

Table 1. Ethnic issues: British findings

Black / Ethnic Minorities more often:
Diagnosed as schizophrenic
Compulsorily detained under Mental Health Act
Admitted as 'offender Patients'
Held by police under S. 136 of Mental Health Act
Transferred to locked wards
Not referred for 'talking therapies'
(and find these therapies do not 'make sense')

Source: Table in Fernando and Keating (2009: 47)

Table 2: British citizens in prison in England and Wales 2013

	% in prison	% in general population
White	73.8	88.3
Black / Black British	13.2	2.8
Asian / Asian British	7.9	5.8

Note: 13 % of all prisoners are Muslims (4 % in general population)

Source: Berman, G. & Dar, A. (2013) Prison population statistics. London House of Commons.

Table 3: School exclusion 2009-10 ethnic statistics (% of all school-age children in each ethnic group)

	Fixed period	Permanent
White British	5.14	.08
Black Caribbean	10.84	.34
Black African	5.37	.11
Black Other	8.27	.22

Source: Department of Education (2012) *A profile of pupil exclusions in England.* Research Report DFE-RR190. London: DOE.

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