

Institutionalised racism lies at the heart of the conceptual systems we use in psychiatry

A lead clinician for a child and family service serving a large ethnic minority community once told me: 'You cannot work with these Asian families. The best you can hope is to save a few of their youngsters if you can get access to them.' This is not an isolated incident. I have come across many similar sentiments from well-meaning professionals who hold stereotypes that will have enormous impact on clinical practice. Institutional racism is generally unconscious and the result of broader racist beliefs and stereotyping becoming deeply embedded in institutional practices. Since the Stephen Lawrence case we have become more aware that institutional racism exists, not just in the police forces, but also in many other institutions, including the health services. Mental health services are no exception.

In a recent editorial in the *British Journal of Psychiatry*,¹ Professor Peter Tyrer discussed the impact of institutional racism on academic psychiatry. He pointed out the serious inequality in the number of articles accepted for publication by leading psychiatric journals (including the *British Journal of Psychiatry*) by authors from the non-industrialised world, with around 90% of published articles coming from authors in the richest ten per cent of countries.

His acknowledgement of this institutionalised bias is very welcome; what he didn't discuss is the more deeply embedded problem of the institutionalised racism that lies at the heart of the conceptual systems we use in psychiatry. This is, of course, a harder and more painful issue for we doctors to face. Such an analysis would reveal that the core assumptions of psychiatry's theory base, and consequently its practice, are more or less unchanged from those used 100 years ago, which developed during an era where racism was the accepted norm and where the intellectual and psychological superiority of the European over the colonised 'primitive' went unquestioned.

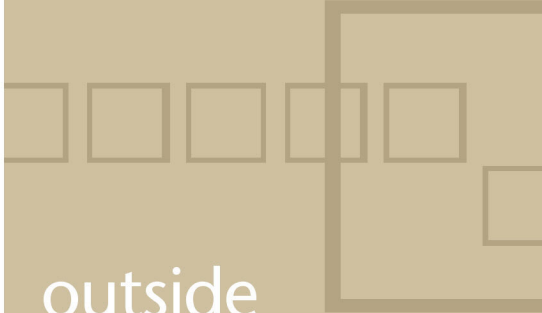
For example, is the consistently higher rate of diagnosis of schizophrenia in second generation British-Caribbean people due to the racist stereotyping of the diagnosing doctor? Or is it because diagnoses like schizophrenia have the potential to paint whole communities as

biologically inferior, thereby stigmatising these communities (and, of course, obscuring through use of the biomedical template the impact of social issues such as immigration and racism)?

Many key western psychiatric symptoms refer to concepts that developed out of western philosophy, and are meaningless in other cultures. For example, depression is built around a Judeo-Christian conception of guilt and hopelessness. These are looked for in depression rating questionnaires and by clinicians diagnosing depression. Yet guilt is rarely encountered as a description for emotional suffering in many communities (for example, in the Muslim world), and hopelessness is positively valued by some eastern psychologies (for many Buddhists a deliberate rejection of pleasure accompanied by a sense of hopelessness can be the first step on the road to salvation). A colleague of mine who trained and started her psychiatric practice in India before coming to the UK told me: 'The difference is amazing. Here in the UK the patients tell me the diagnosis, they say they are depressed. None of my patients in India ever came complaining of depression.' What impact does imposing a meaningless diagnosis have on someone's willingness and motivation to engage with services, let alone our ability to help them?

We should not be surprised that there are inherently racist concepts embedded in our institutionalised ways of thinking about mental health problems, how we conceptualise them, what we do about them, and the value system we apply in our daily practice. Mental health ideology and technology developed in the western world not through the study of physical pathology, which can be tested, but through a system of consensus whereby the most influential psychiatrists agreed on an interpretation of the available evidence. From the beginnings of the current diagnostic systems used in psychiatry, these psychiatrists have all been western, so inevitably they developed a system based on their own western cultural beliefs and ideals.

Sadly, I'm not sure how ready the psychiatric profession is to engage in honest self-reflection on this issue. It may be just too painful. However, if we don't, we will not get rid of the scourge of institutional racism from our mental health services. ■



outside
the box

¹ Tyrer P. Longstanding editorial racism in psychiatry. *British Journal of Psychiatry* 2005; 186: 1-3.

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