This Month's Special Section

Racism

Dimensions of Institutional Racism in Psychiatry

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Defining institutional racism in terms of self-perpetuating barriers to blacks' participation as equals in all areas of psychiatry, the authors review the influence of white racism on the image of the black patient, neglected problem areas, treatment accessibility, community mental health, research, and the professional functioning of psychiatrists. These analyses lead to specific recommendations for new institutionalized practices to be supported by the white power structure of psychiatry if eradication of racism in psychiatry is to be accomplished.

THIS PAPER is an attempt to examine the dimensions of institutional white racism in psychiatry. Since it is gratuitous to speak to blacks about the presence of institutional racism and since we believe that it is necessary for white psychiatrists to change the racist practices of their organizations and institutions, this paper is intended primarily to affect the thinking and the behavior of white mental health professionals.

Many models of institutional racism have been offered. Our own definition emphasizes the implicit as well as explicit institutionalization of barriers that serve to reduce black people's access to meaningful participation as equals in all aspects of a group's function. Such structuralization leads to a relative diminution of the status of black members as well as to a depreciation of the black community as a whole, circularly providing renewed force and justification for the original barriers. We believe that substantial evidence indicates that psychiatry has such a structuralized pattern of racism.

Our examination of the dimensions of racism in psychiatry does not imply a greater component of racist trends within psychiatry than in other professions; indeed, recent events indicate that psychiatry has begun to come to grips with the problem more than most analogous professions. We believe, however, that it is timely to begin an even more thorough examination of racism in psychiatry. We recognize that some members of the American Psychiatric Association believe that the time for words has ended. Others in the Association react with gross denial of the presence of institutional racism in psychiatry. In our opinion, however, most members of this organization will be receptive to information and objective data regarding institutional racism in psychiatry and will, we hope, commit themselves to its eradication.

When confronted with crises in black-white relations, most white psychiatrists tend to focus on the helping role that they can play in resolving these conflicts for *other* organizations rather than looking closely at the ways that psychiatry has perpetuated myths of black inferiority. In this paper we wish to avoid externalizing; we intend to concentrate upon the existence of institutionalized white racism within psychiatry itself.

Read at the 123rd annual meeting of the American Psychiatric Association, San Francisco, Calif., May 11-15, 1970.

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One way we can attempt to ascertain the structures and practices within psychiatry that bar black participation as equals is by asking "What has been American psychiatry's treatment of the black, and to what extent has this treatment reflected white racism?" We do not pretend to have been exhaustive in our search for the answers, but what is most striking in the mainstream of psychiatric literature has been the lack of *realistic* concern, until recently, for the black American. This has been manifested in stereotypes regarding black character structure, gross discrimination in providing needed clinical care, and overemphasis upon psychological explanations in areas where economic and social factors have been preemptive. Indeed, institutionalized white racism in psychiatry has simultaneously overemphasized psychological processes in areas where psychiatry could not effect change while underemphasizing other areas where significant changes could be effected in delivery of services.

As Pettigrew (1) points out, for years the black American has had to face the charges of white racists that he is supposed to be *innately lazy, unhealthy, unintelligent,* and *criminal.* White American psychiatry has its equivalent racist sterotypes about the black psychiatric patient: *hostile* and *not motivated for treatment, having primitive character structure, not psychologically minded,* and *impulse-ridden.*

The utilization of psychiatric data to defend American racist practices began with the 1840 U. S. Census, which purportedly showed over ten times as much black mental illness in the North as in the South, with no appreciable regional differences for whites. Proslavery spokesmen immediately interpreted these findings, later shown to be erroneous, to mean that slavery was a "benign institution" that protected the "inferior" Negro from the stresses of our competitive society.

Stereotyping of black people by psychiatry is well illustrated in Dollard (2); one example he finds a need to refute is the following quote from Lind (3):

> If we accept unreservedly Freud's dream theory, especially the essence of it, that a dream represents a wish fulfillment and that wherever it is not immediately recognized as such, the activities of the censor are responsible. we must admit that the colored race fails to show distorting activity; consequently their psychological activities are analogous with those of the child, and investigation of them might prove to be of considerable value in studying the genesis of the psychosis.

It is impressive to note how psychiatric observers underemphasize the operation of *institutionalized* racism. For example, Rosen and Frank (4) state that the only two barriers that black psychiatric patients must overcome are, first, their own cultural experiences and attitudes and, second, the biases of the white therapist, who must overcome his cultural blind spots, reactive guilt, and unconscious prejudice. Their focus on guilt and individual prejudice in the white therapist and on resentment, distrust, "self-hatred," and pseudostupidity in the black patient obscures their own point that "Membership in a minority group tends to lead to certain *habitual* ways of relating to a member of the majority. . . ." Membership in a majority group also leads to certain habitual ways of relating to the lower caste member; the white therapist is as affected as the black patient by these institutionalized practices.

How much need do black people have for mental health services? In a 1969 review, Crawford (5) reports a failure to be able to answer questions of prevalence and incidence of mental illness in blacks definitively because professionals have failed to collect the necessary data in the face of numerous opportunities to do so.

The lack of data is in itself a clear manifestation of an institutionalized avoidance of dealing with the mental health needs of blacks. Black-white variations in admission rates also demonstrate institutionalized racist practices. Variations in rates based on admissions clearly reflect accessibility to treatment facilities; our discriminatory policies have limited blacks' access to private care (6, 7) and often constrained and delayed their entry into the psychiatric care system by forcing them into the legal system initially and then on to the state hospital—where they are often stored as untreatable chronic patients (8). These practices complete a racist circle since they perpetuate the myth of black inferiority.

We concur with Crawford (5), who con-

cludes ". . . that Negroes still have less chance of receiving the full range of services utilized by whites, that Negroes are not kept under treatment as long as are white patients, that Negroes do not utilize multiple sources of help as frequently as whites and consequently inequality of care still exists." Our own review also suggests that black males are even more likely than black females to be denied access to treatment, be viewed as sicker, and languish longer in custodial settings.

Institutional Racism and the Neglected Areas of Psychiatry

The subsystems of psychiatry that are most neglected by white professionals often have the greatest significance for the black community. These include the medico-legal aspects of psychiatry, the public health and mental health delivery systems, problems of alcoholism and addiction, and the mental health of children. While each of these underdeveloped areas also involves class discrimination, we wish to reiterate that discrimination against blacks still occurs when class is held constant. To a more significant extent than has been acknowledged by white psychiatrists the blocking of professional and economic support for dealing with these neglected areas is a manifestation of institutional racism.

Blockage may occur at any point. White societal forces have created a network of institutions and gateways that regularly channel the disvalued black away from needed treatment by failing to provide accessible treatment facilities, by defining certain behavior as criminal in blacks but as sickness in whites, and by defining blacks as untreatable.

The pattern of psychiatric services available to American blacks reflects at the same time the blocking of paths to psychiatric care for persons manifesting "disturbed" behavior while simultaneously defining certain behaviors as psychopathological that are more appropriately explained on social or economic levels. Unfortunately, greater attention has been paid by white psychiatrists to extending mythical definitions of black psychopathology than to providing psychiatric services for actual black patients.

This neglect is apparent whether we are talking about the North or the South and whether we are talking about adults or children.

Psychiatric Services Available To Blacks

In criticizing psychiatric services for emotionally disturbed children, Mackler (9) makes the following points: 1) for emotionally disturbed youngsters, in contrast to physically handicapped youngsters, placement is determined not only by personal problems but by ethnic status; and 2) white students are likely to be defined as troubled and placed in treatment schools, while minority groups (Negroes and Puerto Ricans) are likely to be defined as troublesome and placed in custodial situations. As Gordon (10) states: "All too often the intake policies of . . . agencies are geared to meet the needs of maladjusted children from intact, middle class, white families. . . . At the elementary school level, especially in predominantly Negro schools it is usually the case that not a single emotionally disturbed child is in treatment at any clinic or social agency. . . ."

The absence of the private or public psychiatrist from the predominantly black inner city long ago dropped him from the list of potentially available mental health resources for the urban slum school child or working class adult. For example, a 1966 report to the Chicago Board of Health (11) included an examination of the availability of physicians' services to poverty area residents as contrasted with their availability to other residents of the city. Using location of physicians' offices as the index of their availability, it was found that far fewer doctors practice in the poverty areas, which have 88 percent black residents. This discrepancy is especially marked when the availability of psychiatrists and neurologists is examined; psychiatry was the specialty least available to black areas. Churches, not psychiatrists or clinics, are seen as providing needed services to the black psychiatric patient; community leaders seeking to develop local psychiatric resources have had to go outside the medical system and work primarily with these churches and other lay groups.

Few articles have addressed themselves primarily to the question of race in mental health planning for new resources. The most

relevant have been written by members of the National Institute of Mental Health biometry group as part of their efforts to correlate epidemiological findings more directly to mental health planning proposals.

Bahn and associates (7), using case register data, demonstrated that previously noted high black admission rates to state hospitals are not solely a function of the utilization of public facilities by the lower socioeconomic classes. Early intervention or sustained clinic treatment is less likely for the black psychiatric patient, resulting in greater need for hospitalization, longer hospitalizations, and chronicity. Bahn also points out how the sequelae of severe mental illness and *hospitalization* create further family disruption and potential maladjustment in the next generation.

The major means by which psychiatry can realistically expect to aid blacks in need of psychiatric care is to provide "no-barrier" community-based and controlled clinical services to meet specific clinical needs. Nevertheless, institutional racism has become a major problem in community mental health.

Community Mental Health and Institutional Racism

In part, the forces leading to the community mental health movement of the 1960s involved realization that an enormous disparity existed between the psychiatric care provided for poor people and that provided to the more affluent. Correcting this gross imbalance was one of the primary goals of community psychiatry. In accomplishing this task, however, relatively little systematic attention was paid to the fact that an overwhelming majority of black people fell into the category of those receiving the poorest psychiatric care. While energetic efforts have been made to give high priority to mental health services in the urban ghettos, insufficient representation was given to black professionals and black consumer groups in both the early and the continuing planning of community mental health services.

In response to this form of institutional racism, black groups have become much more vociferous in demanding services under their own community auspices. For many white "liberal" mental health workers, a rude awakening occurred when their proposals to *do something for* poor blacks were rejected by blacks who wished to take leadership in program planning and implementation. Rather than examine their paternalism and its racist roots, the whites often engaged in withdrawal, scapegoating, or the assumption of even greater power, thus leading to increased distrust and alienation.

Black communities are sensitive to the "psychiatrization" of social issues. To the extent that community mental health workers imply that militancy indicates psychopathology, blacks will reject this approach as gratuitous at best and malignantly racist at worst. These trends support the black community's wish to define priorities and to indicate areas where they wish to seek help. Not surprisingly, some of the issues rated as high priority by blacks have until quite recently received short shrift by white professionals. And the recent emphasis on these problems can be interpreted as racist in origin: when addiction was viewed primarily as a black problem, it was largely ignored by whites; but now that it has spread to include white youth, funding and attention seem to be more available.

Viewing addiction and alcoholism in blacks only in terms of social pathology, which the psychiatrist must combat through social action at the community level rather than providing clinical services, is also a racist practice when the "sociologizing" of psychiatric problems reinforces our historic neglect of black clinical needs (12). Thus "psychiatrization" of social issues and "sociologizing" of psychiatric needs go hand in hand to maintain institutional racism.

Another example of institutionalized racism can be found in several major assumptions underlying community mental health programs. Many white mental health professionals regard black communities as seething cauldrons of psychopathology. They create stereotypes of absent fathers, primitive rage, psychopathy, self-depreciation, promiscuity, deficits in intellectual capacity, and lack of psychological sensitivity. Gross pathological caricaturization ignores the enormous variation of behavior in black communities. It omits consideration of areas where blacks have adapted in

a fashion superior to whites (13, 14). The obsession with black psychopathology has been so great that it has retarded serious consideration of racism as it pertains to white psychopathology. It is not surprising that many blacks are suspicious of community mental health as further contributing to stereotypes of black inferiority and vulnerability. Not uncommonly, blacks respond to our programs based on these stereotypes by saying, "It's your sickness, whitey. Set up your program where you really need it in your racist communities."

While many blacks have supported the moral and pragmatic concepts inherent in the community mental health movement, recognition of the danger of its racist elements has recently come to the fore. Significant confrontations have taken place across the country and are still in process. Unless practical steps are undertaken to reduce the racist elements, the urban community mental health programs will be sharply circumscribed, and one of our major means of revamping the psychiatric care system to be less racist will be curtailed.

Racism and the Black Psychiatrist

There is a distinct under-representation of blacks in psychiatry. Until quite recently black psychiatrists had few possibilities for leadership roles in psychiatric institutions and societies. Little attention had been given to the recommendations of black psychiatrists in planning, decision making, and implementing significant policy issues. Current efforts to alter this pattern cannot distort the fact that psychiatry has been sluggish in moving toward involvement of blacks; today's efforts are at best meager and at worst tokenism.

Recently efforts have been made to recruit more blacks into psychiatry, but as reported by Wilkerson, Lightfoot, Williams, Jones, and Palmer (15), there are many problems confronting black residents, who most often must train in predominantly white institutions. Their description of the "hallucinatory whitening" of the black trainees by supervisors and fellow residents is a poignant example of avoidance of coming to grips with institutionalized racist practices. If these practices are to be overcome we must re-examine and alter our tendencies to try to indoctrinate blacks into the white psychiatrists' myth about black psychopathology. Rather, we must seek the blacks' help in eradicating our institutional racist vestiges. Unless we are vigorous in these efforts our capacity to recruit blacks into psychiatry will be seriously hampered.

As pointed out by Harrison and Butts (16), the stereotypes of both black patients and black psychiatrists persist throughout career lines and profoundly affect the referral patterns of black psychiatrists. The most salient issue from the Harrison-Butts study for this paper is that the referral patterns do not simply represent individual racist tendencies in white psychiatrists. Rather, they reflect a deeply institutionalized process.

Institutional Racism and Psychiatric Research

Few white psychiatrists have commented upon the multiple effects of institutional racism in psychiatric research, although blacks in recent years have frequently commented upon their exploitation by white mental health workers. In our judgment the days of non-negotiated research by whites in black communities are over.

In addition to overt forms of institutionalized racism, psychiatric research has reflected more subtle racism. Once again a simultaneous tendency to overemphasize and underemphasize race issues is in operation. In many areas where it is important to have race data for epidemiological investigation there is a striking paucity of such information. At the same time, race has been overemphasized in many studies where blacks have been characterized as vulnerable and deviant. With only few exceptions the psychiatric literature is devoid of investigations of *superior* coping by blacks.

There has also been a striking underemphasis on the need for black mental health workers to assume research careers. While this tendency may reflect choices for activist rather than investigatory careers by black psychiatrists, it also reflects our institutionalized underemphasis on the need for black research workers to raise their own questions and develop their own research priorities.

Finally, there has been a significant omission of research on the impact of institu-

tionalized racism on white psychopathology. While a few efforts have been made to correlate institutional practices in the South with special problems of white southerners, research efforts in this area have been meager. More significantly, there has been a striking lack of systematized investigation of the more subtle and yet pervasive impact of institutionalized racism upon psychological development in whites, including white mental health professionals.

Recommendations for Change

Current psychiatric structures do not seem viable for rapidly producing the changes necessary to eradicate institutional racism. New "counterstructures" are required in which black professionals and consumers truly share with whites in the determination of all service practices. Institutional racism is a subtle phenomenon; white psychiatrists functioning as they have in the past can continue to act to reinforce the myth of black inferiority while espousing equality. It is the commitment to change and the implementing of behavior that flows from this commitment that will determine whether American psychiatry will continue to manifest institutional racism. The only means to counter institutional white racism is to create new and powerful antiracism mechanisms that will operate continuously and publicly throughout the country in all aspects of the psychiatric care system.

Therefore we recommend that our heretofore essentially white controlled professional organizations as well as federal and state agencies take the lead in exposing and significantly diminishing institutional racism by working with black psychiatrists to create a special network of task forces on racism with more than token black participation. Their task will be to point out the presence of local racist practices, to suggest means to eliminate them, to provide leadership in the actual task, and to report the success or failures of their efforts to the profession.

We are asking white psychiatrists to become increasingly aware of how their everyday practices continue to perpetuate institutional white racism in psychiatry and to support the search for realistic solutions to providing psychiatric services to black people. We ask white psychiatrists to provide strong sanction and support to these efforts. This means making available the necessary resources of money, manpower, and authority—and not just in the current token amounts. It means not defending the vested white interests in old institutional forms of professionalism when new strategies and roles are suggested; it means a significant reduction in economic barriers to psychiatric care; it means relinquishing negative stereotypes of the black patient; it means truly sharing administrative decision-making with black colleagues and black communities.

One way to begin to focus attention on the institutional white racism of psychiatry is to devote a special section of *The American Journal of Psychiatry* to racism's origins, history, and current status in psychiatry and in our nation as a whole as well as to present strategies for change. Following this visible national focus there should be discussions and analyses of local practices that perpetuate or work to eradicate barriers created by racism; these analyses could be carried out within the structure of district branches of the American Psychiatric Association, in conjunction with other psychiatric organizations and local mental health associations, in dialogue with legislators and health administrators, and in dialogue with the local black community, which includes those most likely to know and to have felt the practices.

Bringing together a composite national picture of local practices, North and South, can thus serve to begin our effort. Rather than merely exhorting other professions to change their racist practices, psychiatry can provide a role model for realistic effort by creating a voluntary mechanism for changing its own functioning. Next, work must be done on those psychiatric problems seen by the black community as being most pressing; for example, hospital accreditation should become more dependent on serving the expressed needs of the black as well as the white community. Progress and/or failure can be regularly communicated to all of us through *The American Journal of Psychiatry* and *Psychiatric News*.

Such an effort would represent the nucleus of a mechanism for continuing self-

examination as well as monitoring our achievements; racism is an erosive process negatively affecting black and white. We can no longer pretend it does not exist in psychiatry; we must counter our earlier denial with a hyperawareness that we hope will be temporary during a period of transition. Our own openness and effort can encourage other professional groups to also bring the efforts to combat white racism out of the shadows to the center stage of everyday life where this struggle belongs—if racism is to be eradicated.

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Benjamin Rush and the Negro

BY BETTY L. PLUMMER

The author describes Rush's interest in the social problems of his day, particularly his concern with relations between blacks and whites. Rush was active in the abolition movement; his tracts and extensive correspondence especially emphasized the detrimental effects of slavery on the mind. He was also frequently involved in such activities of Philadelphia's black community as the securing of funds for the construction of churches.

BENJAMIN RUSH (1745–1813) is best known as a signer of the Declaration of Independence and a prominent Philadelphia

Read at the 123rd annual meeting of the American Psychiatric Association, San Francisco, Calif., May 11–15, 1970. Based on an M.A. thesis, "Benjamin Rush and the Negro," submitted to the department of history, Howard University, Washington, D. C., May 4, 1969.

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