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Decolonising the medical curriculum: psychiatry faces particular challenges

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ABSTRACT

Colonial thinking runs deep in psychiatry. Recent anti-racist statements from the APA and RCPsych are to be welcomed. However, we argue that if it is to really tackle deep-seated racism and decolonise its curriculum, the discipline will need to critically interrogate the origins of some of its fundamental assumptions, values and priorities. This will not be an easy task. By its very nature, the quest to decolonise is fraught with contradictions and difficulties. However, we make the case that this moment presents an opportunity for psychiatry to engage positively with other forms of critical reflection on structures of power/knowledge in the field of mental health. We propose a number of paths along which progress might be made.

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Introduction

In recent years, university students and staff across the world have sought to challenge Eurocentric paradigms that dominate in many academic domains (Peters 2015; Charles 2019). These moves to decolonise university curricula have been given substantial momentum by the horrific murder of George Floyd in the US, the rise of 'Black Lives Matter' (Lee 2020), and other events such as the Windrush scandal in the UK (JCWI 2020).

At the same time, the medical profession appears increasingly open to acknowledge, discuss and challenge the impact of racial discrimination on health outcomes (Hackett et al. 2020), and there is a growing consensus around the need for the development of a strong 'anti-racist' agenda (Cénat 2020). In the UK, the striking differential attainment of BAME

doctors has added urgency to this (Shah and Ahluwalia 2019). While a great deal of this disadvantage can be ascribed to discrimination against BAME candidates in job recruitment (Royal College of Physicians 2020), across higher education more generally curricular issues have been identified as one of the main drivers of unequal career outcomes, with evidence of ‘a link between the engagement of students and their perceptions of relevance to their own experiences and identities.’ (Mountford-Zimdars et al. 2015, 30).

In the United States, Critical Race Studies first emerged in the field of legal studies and the quest to decolonise curricula was first developed in relation to the humanities and social sciences. However, the view that the natural sciences are based on an epistemology that is ‘objective and neutral’ has meant that they have not faced the same level of scrutiny and the same demands for change (Akinbosede 2020). The same has been true for medicine. However, there is now a growing realisation that racist and colonial attitudes underscore much of traditional medical education and that, as well as efforts to root out racist policies and practices, there is also an urgent need to decolonise medical curricula (Hartland and Larkai 2020; Gishen and Lokugamage 2019).

While all medical disciplines are challenged by calls to decolonise, psychiatry faces issues that go to the very heart of its identity (Fernando 2017). Recent anti-racist statements from the American Psychiatric Association (2021) and the Royal College of Psychiatrists (2021) are to be welcomed, and make laudable commitments to tacking inequalities and discrimination within the profession. They also point to the differential experiences of people from BAME communities who interact with mental health services and pledge to struggle to overcome these. The APA apology contains an admission that ‘Since the APA’s inception, practitioners have at times subjected persons of African descent and Indigenous people who suffered from mental illness to abusive treatment, experimentation, victimization in the name of ‘scientific evidence’, along with racialized theories that attempted to confirm their deficit status.’ Furthermore, there is an acceptance that these ‘appalling past actions’ have become ‘ingrained in the structure of psychiatric practice.’

In this paper, we argue that nothing less than a full interrogation of psychiatry’s history and its in-built assumptions and practices will count as an adequate response to such an admission. The historical injustices experienced by members of our BAME communities in psychiatric services, injustices that continue into the 21st century, mean that nothing less will suffice. Such arguments are not new (Fernando 1988; Littlewood and Lipsedge 1997), but if we are truly to honour all the countless people whose lives have been distorted and damaged by bad psychiatry, they can no longer be ignored.

Colonialism, healing and psychiatry

Any effort to de-colonise our discipline must start from an acknowledgement of the role that psychiatry has played in the colonial characterisation of non-Western societies, their cultures and indigenous healing systems, as inferior (Ben-Cheikh et al. 2021; Mills 2014). The assumed superiority of concepts, curricula, and clinical practice guidelines of Euro-American centres, and their enthusiastic export across the globe, has served to divert attention from local moral and cultural worlds. In this process, rich emotional vocabularies and varying idioms of distress are often glossed over, or pruned to fit into conventional psychiatric nosological systems (Lynch 1990; Wig 1983). As a result, the process of systematically acquiring a culture-blind ‘ability’ is considered credible and even meritorious in the training

of mental health professionals. This lack of respect for local worlds in teaching and training has had the effect of undermining the ability of such professionals to consider the role of major social and cultural variables such as poverty, corruption, migration, urbanisation, gender, caste, stigma and other oppressive forces that work to undermine mental health. This ‘cultural cleansing’ of patient narratives removes the very questions that a genuinely culture-sensitive psychiatry would seek to investigate (Jadhav 1996; Jadhav 2009).

More importantly, this process undermines and marginalises indigenous forms of psychological healing, even though the empirical evidence supports the need for pluralism when it comes to mental health care (Halliburton 2004). Higginbotham and Marsella (1988) pointed to the long-term deleterious ‘after shocks’ of efforts to replace indigenous healing practices with psychiatry’s way of reasoning and systems of classification. Ultimately, such efforts led to ‘less help for those in need’ (559).

The damaging disrespect that psychiatry has shown towards local worlds and indigenous practices stems from the way in which the history of psychiatry is deeply entangled with the emergence of the European Enlightenment and its valorisation of a particular form of reason, alongside a particular focus on the individual self (Porter 1987). Its quest to explain, contain, and control states of madness, distress and dislocation was a product of these developments (Porter 1992). At the same time, justification of the 18th and 19th century European colonisation of the world was also based on the idea that a specifically Western form of rationality provided a superior way of understanding both the human and natural worlds (Said 1978). Colonial conquest and exploitation was often justified by the idea that people indigenous to lands colonised by Europeans were ‘primitive’ and less civilised or psychologically developed, and therefore less able to ‘rationalise’ than their European conquerors (Saini 2019). Toni Morrison has pointed out that the Enlightenment values of freedom and justice came on stream at a time when the Atlantic slave trade was at its peak (Morrison 1993). The works of Hume, Kant and Hegel ‘played a strong role in articulating Europe’s sense not only of its cultural but also of its racial superiority’ (Eze 1997, 5).

Colonisation did not involve a dialogue between cultures but, rather, a monological imposition of a particular way of seeing and speaking about the world, and the elimination of ways that did not fit with those of the colonisers. A similar arrogance has shaped the thinking and practice of psychiatry. In its encounters with states of madness, distress, and dislocation, psychiatry has been far from culture-neutral. Instead, it has embraced a language of pathology, it has been pre-occupied with creating a typology of human experience using classification systems similar to those used in the natural sciences, it has adopted reductionist forms of explanation, and it has put a priority on symptom suppression and risk avoidance. We believe that this agenda stems from a way of encountering ‘otherness’ that has a deep resonance with the colonial project. Michel Foucault famously wrote in the preface to *Madness and Civilization*, that since the time of the European Enlightenment, ‘the language of psychiatry (has been) a monologue of reason about madness’ (1971, xii-xiii).

The need for critical thinking

We are living through a time when the values and the assumptions of the Enlightenment are under critical scrutiny. This is not about a rejection of reason or Enlightenment, but represents a coming to terms with the idea that reason is not a singular phenomenon and is not without its limitations and contradictions. Critical post-colonial and feminist

scholarships challenge dominant conceptions of reason that are seen as ‘white’ and ‘male’. They point to the ways in which power, knowledge, and truth are intertwined, and highlight the manner in which discourses such as psychiatry and psychology incorporate a particular way of responding to human suffering. Growing numbers of people who have had negative encounters with the ideas and practices of psychiatry are calling for *epistemic justice* (Leblanc and Kinsella 2016), and the recognition of the validity of different perspectives and experiences. Mills (2014) speaks of *epistemicide* in relation to psychiatry’s assault on indigenous healing systems. The dominance of a biomedical framing of mental suffering is now regarded by many as one of the greatest obstacles to progress in mental health care across the world (Pūras 2017). There are increasing calls for international projects such as the WHO mhGAP programme to acknowledge this, and to recognise that ‘[a] more inclusive and sustainable approach to mental health system development and service delivery begins by recognising the diverse knowledges of stakeholders and the hierarchies of power that may privilege some voices while silencing others. Facilitating knowledge exchange requires cultural safety and ‘ethical space’ to establish a framework in which difference and diversity are respected’ (Gómez-Carrillo et al. 2020, 6).

If we are to confront the current challenges that face us as psychiatrists, we must acknowledge the way in which psychiatry has played a role in the suppression of indigenous healing systems around the world, how it was complicit in the justification of slavery and colonisation and how profoundly a particularly ‘Western’ mind-set underscores its deepest assumptions and theories (Paralikar, Agashe and Weiss 2004; Summerfield 2008).

Towards a de-colonised curriculum

Examples of efforts to tackle racism in the psychiatric curriculum already exist, such as the ‘racism-specific psychiatry residency’ developed at the Massachusetts General Hospital (Shtasel, Carlo, and Trinh 2019). We welcome the recent commitment by the Royal College of Psychiatrists, in its new Equality Action Plan, to review its core and higher training curricula (Royal College of Psychiatrists 2021).

Our fear, based on the history of previous attempts by our institutions to deal with this subject, is that such efforts will not genuinely engage with all the issues presented here. There is no defined script for how we might decolonise the psychiatric curriculum but perhaps we should start with Audre Lorde’s maxim that ‘the master’s tools will never dismantle the master’s house’ (Paton et al. 2020). We need to think beyond traditional sources of knowledge, wisdom and inspiration. The following linked themes might represent a beginning:

- An acceptance of *critical thinking as essential for any form of mental health practice*. Being able to reflect critically upon one’s own system of knowledge and to think outside it is an important skill that allows the practitioner to consider positively different ways of understanding and responding to suffering. This means that students would engage with forms of scholarship that interrogate and deconstruct the various ways in which knowledge systems, structures of power, and claims to truth are interrelated.
- A move beyond training in ‘cultural competence’ to an understanding of the *structural sources of disadvantage, health inequality and suffering* (Metzl and Hansen 2014).

Trainees should learn about ‘the history of institutional racism, the role of white privilege, the meaning and practice of cultural humility, and the development of structural competence’ (Shtasel, Carlo, and Trinh 2019, 214).

- An understanding of the social forces that led to the emergence of psychiatry and that have shaped its assumptions, priorities and practices over the course of its history. This will require *a non-defensive approach to teaching the history of our discipline*, including an appreciation of how many people have suffered at its hands. It will mean, for example, that students learn about the ways in which psychiatry has been deeply enmeshed in the colonial project, and how racist and eugenic assumptions, such as the degeneration hypothesis of schizophrenia (Zubin, Oppenheimer, and Neugebauer 1985), became built into its way of encountering people with mental health conditions. It should also include an exploration of the history of non-Western forms of mental health care (Fernando 2014) and mental health systems, such as that in the mental hospitals (māristāns) of the medieval Islamic world (Dols 1992).
- A positive exploration of how, in spite of centuries of silencing and oppression, *indigenous peoples across the world have developed powerful ways of responding to states of distress that do not involve the epistemology of Western psychiatry*. These different forms of ‘ethnopsychiatry’ (Gaines 1992) offer pathways to individual, family and communal healing that incorporate alternative narratives of healing that are often collective, ecological and spiritual (Gone and Kirmayer 2020). Furthermore, these discourses may have much to offer psychiatry if is willing and able to engage with them in a spirit of humility and receptivity (Bibeau and Corin 2010).
- *Engagement with research and service development that involves individuals with lived experience, survivor networks and grassroots BAME organisations* (King et al. 2021): A de-colonised curriculum will shed light on the dominant mental health research hierarchy that continues to devalue the voices of those with lived experience of mental illness and the mental health system (Faulkner 2017). Journal clubs should include research and narratives from the lived experience community, including those whose distress relates to racism and other intersectional discrimination (King 2016; Kalathil et al. 2011). Trainees should be familiar with participatory research and co-production methods, with awareness of the power dynamics and ethical issues that operate between the researcher, the researched and the institutions they relate to (Green and Johns 2019; Rose and Kalathil 2019). Opportunities to engage in service provision and development alongside local non-statutory BAME community organisations should also be available. In the USA, The Yale Department of Psychiatry has developed a Social Justice and Health Equity Curriculum which offers residents the chance to work alongside ‘peer advocates and community leaders’ and explore how ‘neighborhood dynamics influence access and engagement in mental health care’ (Yale School of Medicine 2019).

Conclusion

Decolonising the psychiatric curriculum will not be easy and will not happen until we overcome the epistemological, nosological, and normative assumptions that lie at the heart of psychiatry itself. However, we believe that progress can be made. Important insights are

available to us from discourses such as post-colonial scholarship, feminist philosophy, mad studies, queer theory, critical pedagogy, critical psychology, and liberation psychologies (Watkins and Shulman 2008; Fernando and Moodley 2018) and explorations of traditional psychologies of non-Western cultures (Fernando and Moodley 2018). The seminal works of Frantz Fanon on the emancipation of human beings from psychological ‘alienation’ (Khalfa and Young 2018) and on the psychology of colonialism (Fanon 1986; Fanon 1967) also stand as important resources.

Embracing critical thinking as a positive tool in this endeavour will be crucial. Gayatri Spivak (1990) argues that educators and scholars who are genuinely trying to get beyond the legacy of colonial forms of knowledge must be engaged in ‘the unlearning of one’s own privilege. So that, not only does one become able to listen to that other constituency, but one learns to speak in such a way that one will be taken seriously by that other constituency’ (42). This is the real challenge if we are genuinely to aim for a decolonised psychiatry.

Declaration of interests

All Authors Declare: No Support From Any Organisation For The Submitted Work; No Financial Relationships With Any Organisations That Might Have An Interest In The Submitted Work In The Previous Three Years, No Other Relationships Or Activities That Could Appear To Have Influenced The Submitted Work.

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