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Racialized Communities, Producing Madness and Dangerousness

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Abstract

This article seeks to explore how issues of dangerousness and madness inform the experiences of racialized groups in England. It draws on insights from critical race theory and intersectionality to analyze the intersections between "race," madness, and dangerousness. The understanding gained from this analysis is then applied to the evidence by drawing on two case studies of men who were perceived as dangerous. The article explores how issues of race are played out in social work and concludes that exploring the intersections between madness, race, and dangerousness should help us to move to a more nuanced understanding of the persistence of racial inequalities in mental health.

Keywords: critical race theory, dangerousness, intersectionality, madness, race, racialization

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Disparities for black racialized (minority) groups in relation to mental health and mental health care in England have been well documented (Bhui & O'Hara, 2014), but not always adequately understood or explained (Karlsen, Nazroo, McKenzie, Bhui, & Wiech, 2005). The term *racialized* in the context of this article refers to the notion that "social structures, social ideologies and attitudes have historically become imbued with 'racial' meaning, that such meanings are contingent and contested, and that they are shaped by a multitude of other variables, economic, political, religious" (Small, 1994, p. 36). Differences between groups of people are a natural and significant, if not an essential, dimension of human experience and the driving force for a diverse and evolving society (Fernando, 2014). However, when these differences are evaluated negatively or become disproportionate, they should be construed as disparities (Schwartz & Meyer, 2010). Such a conceptualization should aid an analysis of inequality and how this is sustained and maintained in contemporary society.

In order to fully appreciate and understand the contexts for racialized groups in relation to mental health, it is necessary to consider first their general status in England and then their particular position in terms of mental health. Black and minority ethnic communities constitute 12% of the population in England, yet fare worse across all indicators of economic, health, and social well-being. For example, findings from the 2011 census in the United Kingdom (Office of National Statistics, 2012) indicated that they have considerably higher rates of unemployment, are more likely to report poorer health and that racial harassment is still a common experience for these communities. Turning to mental health, the evidence shows that they are

three times more likely to be admitted to psychiatric care, 44% more likely to be compulsorily detained, have elevated rates of the diagnosis of schizophrenia, and are more likely to have police involvement in admissions to psychiatric care and to be on the receiving end of excessive use of control and restraint once there (Bhui & O'Hara, 2014; Care Quality Commission, 2010).

This article starts from the premise that mental health social work, despite its espoused commitment to anti-oppressive practice and social justice (O'Brien, 2011), has not paid adequate attention to explore the intersections between "race"[1] and madness. It follows the lead of Patel (2014, p. 201) to (a) explore how "racial logic intersects with the madness discourse" in the emergence of the mad, bad, and dangerousness stereotype, and (b) how race is played out in social work. The need to reflect on the intersections between madness and race seems obvious, but "there remains a gap in mapping relations of race *to* and *in* madness" (Tam, 2013, p. 283). Kanani (2011) supported this view and argued that the evidence to examine the intersections between race and madness is sparse. Ware, Ruzsa, & Dias (2014) in their writing on disability, suggested that if the links between race and disability (and in the case of this article, madness) are not made, then we cannot fully understand how they intersect to create the unique experiences of racialized groups. Moreover, Gorman (2013) highlighted how there has been a lack of critical race analysis in mad politics and urged us to connect the struggles of psychiatric survivor movements and those of racialized communities.

The critical theories that are used here to analyze the intersections between race and madness and the themes of dangerousness and racial hierarchies are outlined to set the context for this article. Insights from this are then applied to the evidence on the inequalities for racialized groups, drawing on two case studies to further explore how race is played out in social work.

The contribution of this article is to (a) explore the intersections between race, madness, and dangerousness and how these work together to construct the identities of black people and (b) to explore how critical race theory (CRT) and intersectionality can be utilized in mental health social work practice.

Theoretical Insights

Critical Race Theory

CRT suggests that racism is endemic to the experiences of racialized groups and that race is a social construction that has been used to create hierarchies between groups (Delgado & Stefancic, 2003). It describes the iterative ways in which race and racism determine the life chances of racialized groups. Fanon (1967) argued that the identities of black people are derived from the construction of white identities. Closely linked to CRT is the suggestion that racialized identities need to be understood in the context of whiteness, which according to Garner (2007) is the

[1] *Race* in the context of this paper is considered as a pseudo-scientific concept and therefore viewed as a social construct without biological meaning.

representation of normality, dominance, and control, but also the standard against which to measure "others."

Intersectionality

The theory of intersectionality was developed by black feminists such as Crenshaw (1991), hooks (1990), and Hill Collins (1989), who argued that any analysis of oppression should not subsume one form of oppression within another (Erevelles & Minear, 2010). Intersectionality theorists therefore suggest that human lives and experience cannot be reduced to an analysis of single characteristics, because categories such as class, race, gender, and sexuality are socially constructed, fluid, and intertwined (hooks, 1990). Intersectionality rejects the hierarchical ordering of oppression and argues that these social divisions mutually construct each other (Erevelles & Minear, 2010). Intersectionality has been used to make connections between, for example, race and disability (Erevelles & Minear, 2010) and madness and sex (Barker & Iantaffi, 2015). Erevelles and Minear (2010), for example, illustrated how a social characteristic such as disability can compound the stigma of race. I have noted above that there is limited work that considers the intersections between race and madness, so it is heartening to see that Meerai et al. (2016) have aimed to bridge this gap in their study to explore anti-Black Sanism. They acknowledge that linking Blackness and madness is not unproblematic, but it can help us to move beyond the narrow conceptualizations of cultural competence and multiculturalism that have been espoused as the desired social work approaches to work with racialized groups. Such an analysis can help to unearth and redress the injustice and pain that psychiatric services inflict on racialized groups.

Theorizing Madness

The discourse on what constitutes madness[2] is fraught with tensions and contradictions. There is no consensus, at a most basic level, about terminology (Rogers & Pilgrim, 2014); terms such as *mental illness*, *mental health*, *madness*, *distress*, *disorder*, and *mental health problems* abound. One view where there is consensus is that the medical model dominates the discourse on mental illness in the public, policy, and health care arena (Beresford, Nettle, & Perring, 2010). Biomedical perspectives seem to have a narrow conceptualization of mental illness, its etiology, and ways to treat it. It is construed as an object reality that can be measured and managed with set medical tools for establishing and diagnosing mental illness such as *ICD-10* and *DSM-5* (Johnstone, 2008). Mental illness is explained as a physical phenomenon, and as a matter of course the response to dealing with mental illness is psychotropic medicine (Rogers & Pilgrim, 2014). By implication,

[2] A note about terminology: The mainstream literature in England uses the terms *mental illness* or *people with mental health problems*, so these terms are used to the extent that they relate to the material being referenced. There have been challenges to these terms, and my own position is that mental illness is a social construct that is imposed on racialized groups and has been used to control, dominate, and oppress them.

professionals are seen as the ones with the knowledge and expertise, and service users are viewed as people with little or no agency (Tew, 2011).

There are a number of limitations when the medical model is invoked to understand and respond to mental distress. Beresford et al. (2010) argued that it involves labelling people and results in stigma and ultimately creates significant barriers. Poole et al. (2012) referred to this practice as *sanism* to capture the way in which people who have been assigned a psychiatric diagnosis have been dominated, controlled, and oppressed. Social work has been complicit in these oppressions by subscribing to the medical model (Casstevens, 2010), which, for example, is evident in its stance to question the competence of students with psychiatric histories who wish to embark on social work training (Poole et al., 2012). It locks people into a singular identity, that of the "sick role." Service users constantly report that mental health practitioners cannot see beyond their "illness"—that is what they treat and often their primary focus to the exclusion of other dimensions of the human existence (Keating, Robertson, Francis, & McCulloch, 2002). More generally, it has been argued that while our knowledge about the best ways to "treat" people who have been given a psychiatric diagnosis is inconclusive, biomedical approaches also fail to acknowledge that mental illness is a contested construct and that our knowledge about its etiology and treatment is indeterminate (Rogers & Pilgrim, 2014).

How Have Psychiatry and Mental Health Services in General Responded to Racialization?

It has been argued that a medicalized approach to madness has been unhelpful for racialized groups (Fernando, 2014; Robinson, Keating, & Robertson, 2011). There is a long history of coercive treatment for racialized people who have been assigned a psychiatric diagnosis (Rogers & Pilgrim, 2014), and Prospero & Kim (2009) have argued that such practices have a negative impact on how these groups seek out and use help. The medicalization of madness and associated practices of containment, control, and compliance have become essential features of mental health practices and the experiences of racialized groups (Fernando, 2014; Rogers & Pilgrim, 2014). These practices resemble their experiences in everyday life—that is, exclusion from school, stop and search practices, overrepresentation in the criminal justice system (Office of National Statistics, 2012). I have argued elsewhere (with others) that a solely medicalized approach locks people into a stalled cycle of recovery: People avoid mental health services at all costs, then they come to the attention of services in a more severe state of distress, receive coercive treatment; and when they are "better," they disengage from services and the cycle repeats itself (Keating et al., 2002; Robinson et al., 2011).

There have been attempts to shift the discourse of madness by locating the discussion in a culturalist framework by advocating a deeper understanding of the role of culture in mental illness and proposing cultural competence as a solution (Bhui & O'Hara, 2014). Culturalist approaches, though, have their own difficulties, as they locate the issue(s) at an individual level and ignore the deleterious consequences of racism, racial inequality, and structural disadvantage. Metzl (2009)

suggested that cultural competence is limited because it assumes fixed definitions of culture and, more importantly, conflates race with culture. Viruell-Fuentes, Miranda, & Abdulrahim (2012) posited that cultural explanations for health outcomes (and I would argue mental health outcomes, too) suggest that individual behaviour and social norms of minority groups (such as immigrants) are influenced by culture and in turn this has an impact on health outcomes. However, there is a growing body of evidence to challenge a culturalist approach to suggest that social, cultural, economic, and political factors play a role in the construction of madness in racialized context (Fernando, 2014). Fanon (1967) demonstrated how racism and other factors can cause trauma and how this can become fixed in the mind. Fernando (2014) also pointed to the role that ethnocentricity and racism play in the diagnostic process and suggested that "ideas of 'race' interacted with psychiatry to produce ways of thinking that fed into mainstream psychiatry itself" (p. 37). Fernando traced the racist roots of psychiatry and illustrated how those of "non-Western" stock were classed as uncivilized and savage (p. 37). Metzl (2009), who wrote about schizophrenia, furthered the discourse and argued that a diagnostic category such as schizophrenia became what he termed "a racialized disease" (p. 95) that selectively focuses on black men and invokes notions of violence and dangerousness.

Direct links and associations between racism and mental health have also been made (Karlsen, 2007). More recently a study by the Mental Health Foundation found that racism was overwhelmingly considered as a causal factor in mental illness (King, Fulford, Williamson, Dhillon, & Vasiliou-Theodore, 2009). How mental distress is embodied for racialized minorities is significantly different from other groups (Keating, 2015). Fernando (1991, 2003, 2008, 2014) has consistently argued that the classic separation or distinction between mind (mental), body (physical), and spirit (spiritual) does not apply to racialized minorities, which means that narrow biophysical and reductionist approaches are unhelpful (Fernando, 2002; Fernando & Keating, 2009). Ultimately, narrow medicalized approaches do not help to understand how racialized groups are othered, how people with psychiatric histories are othered, and how black people with psychiatric histories are othered (Nelson, 2006; Rosenfeld, 2012).

"Big, Black, Mad, and Dangerous"

One of the strongest stereotypes that persist about people's psychiatric histories is the notion of dangerousness and the consequent desire to maintain a social distance from them (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999; Patel, 2014). Dangerousness in this context has been articulated as "a fear that persons with mental illness represent a threat for violence to self and others" (Pescosolido, Tait, Medina, Martin, & Long, 2013, p. e2). Beliefs about dangerousness evoke fear, avoidance, and control or punishment (Corrigan et al., 2002). There is a view in the general public that dangerousness is common in mad people, in particular the association with psychotic forms of "illness" (Jorm, Reavley, & Ross, 2012). Dangerousness is also more likely to be associated with men and a diagnosis of schizophrenia (Marie & Miles, 2008). Overall, it has been suggested by Dallaire, McCubbin, Morin, & Cohen (2000) that the idea of "dangerousness mobilises

specific sets of norms, belief systems, discourses and practices" (p. 682). The stereotypes prevail despite evidence that shows that the majority of people with mental illness are not violent (Nielson et al., 2011).

The consequences of this categorization of racialized groups as mad and dangerous means that violent responses such as restraint and murder can be justified. For example, Patel (2014) argued that "those who are not part of the white race are locked outside the aspirational possibility of humanity, a space where violence is carried out on their bodies with impunity" (p. 205).

Drawing on the Evidence from Two Case Studies

There have been numerous seminal cases of deaths in police and psychiatric custody in the United Kingdom (Athwal, 2004; Coles, Edmundson, McNally, & Carmouche, 2015). The stereotype of big, black, and dangerous has been fixed in the popular perception with the cases of Orville Blackwood and Christopher Clunis (Keating, 2007; Prins, Blacker-Holst, Francis, & Keitch, 1993). The first is the case of a black man who died in psychiatric care as a result of restraint and forcible injection of tranquilizing medication (Prins et al., 1993). Blackwood had been in contact with the police since an early age, and at the age of 22 there were indications that he showed signs of "psychiatric illness." He was compulsorily detained in hospital with various relapses. In 1986 he was arrested for attempting to rob a shop with a toy gun. Despite suggestions at the time that he be referred for psychiatric treatment, he was sentenced to imprisonment. He became increasingly distressed while he was in prison, and he was subsequently transferred to a secure psychiatric hospital. In 1991 a review to determine his discharge was adjourned, which caused him further distress and led to his being placed in seclusion. On the 28th August the ward doctor visited him for a review. Blackwood punched the doctor and became abusive and was restrained and medicated. Soon afterwards, he stopped breathing and attempts to resuscitate him were unsuccessful.

The second case is that of Christopher Clunis, a black man with a diagnosis of schizophrenia, who killed a white man on the underground in London (Ritchie, Dick, & Lingham, 1994). Christopher was born in London, did well at school and worked as a member of a band. He was first diagnosed with schizophrenia in 1986 and following this had numerous hospital admissions. During this time there were a number of examples of failure of health and social services in his care. For example, each time he was admitted to hospital, it was treated as a new admission, which meant that his previous history was not taken into account. In 1992 he was discharged into the community without a clear aftercare plan. On the 17th December that year he stabbed a man on the underground. In the trial afterwards he was deemed to be mentally ill, dangerous, and a risk to society and was transferred to a secure hospital indefinitely.

Common features in both these cases are firstly, that perceptions about dangerousness and the risk these men posed to society influenced the care they received. Seclusion and medication seemed a common response, and there were no efforts made to understand why they became upset, angry, or aggressive. Both

inquiry reports (Prins et al., 1993; Ritchie et al., 1994) made reference to the fact the Blackwood and Clunis were likeable when "well," but yet the perceptions about dangerousness prevailed throughout. Secondly, that the failures on the part of mental health services to provide appropriate care and support were highlighted. The inquiry reports into these cases concluded that there could have been racial bias, but overwhelmingly suggested that poor practice and failure to protect public safety were at the heart of these cases rather than the well-being of these two men. The factor that was overlooked here is the perceptions of dangerousness linked to racialization and how this informed or failed to inform decisions about their care and treatment. Browne (1997), in a study to examine the impact of race on decision making involved in the application of the Mental Health Act (1983), found that perceptions of dangerousness informed decision making and ensuing treatment plans, which often included high doses of medication. This study quotes a general practitioner to illustrate this: "It seems there is something in the physical make-up of black people which predetermines the presence of schizophrenia. They [black people] would require higher doses of sedative drugs than white people as they don't respond to normal measures" (Browne, 1997, p. 19).

These are clear examples of how the constructs such as black, dangerous, and mad operate together to inform violent responses such as restraint and forcible treatment (Metzl, 2009). Fernando (2008) also suggested that these cases illustrate how psychiatry and mental health services dominate and suppress racialized groups. Keating et al. (2002) have demonstrated that stereotypical views of black people, racism, cultural ignorance, stigma, and anxiety associated with madness often combine to undermine the way in which mental health services assess and respond to the needs of racialized communities, which is evidence of an extremely racialized profile of their mental health status (Metzl, 2009). Being seen as "big, black, mad, and dangerous" can lead to conceptions that "they" are less deserving of treatment that would lead them to recovery (Patel, 2014). The evidence shows that more punitive and restrictive forms of treatment are meted out to these groups (Bhui & O'Hara, 2014). It is interesting to note that the institutional racism (a form of racism in the practice of social and political institutions; MacPherson, 1999) paradigm has not been invoked to inform the inquiries in the cases of Blackwood or Clunis as described above.

It is clear from the discussion above that how we theorize madness and how this is played out in the context of racialization and the resulting stereotype of "big, black, mad, and dangerous" leads to a situation where containment, coercion, and violence are central features in the experience of racialized groups—a clear example of anti-Black Sanism (Meerai et al., 2016). Patel (2014) suggested that linking race, dangerousness, and madness means that society, including mental health practitioners, can justify containment and violence as acceptable responses. The final section of this article explores how we can set about challenging this stereotype.

Challenging the Stereotype Drawing on Theoretical Insights

This section draws on insights from critical race theory (including whiteness) and intersectionality to explore how mental health social workers and Approved

Mental Health Professionals[3] can map race and madness and develop creative responses to the hegemony of whiteness and saneness.

Application to Mental Health Social Work Practice

Social work practice is at the intersection of multidisciplinary and interagency practice of mental health and has significant scope for linking race and madness given (as mentioned earlier) its espoused commitment to social justice (O'Brien, 2011). However, it seems to have engaged in what Lowe (2013) termed "invisibilising race." For example, I conducted a brief search in the *British Journal of Social Work* to see how and whether mental health has responded to the two cases cited above, but the search yielded no hits. This suggests a problem, in that mental health social work seems to have been complicit and silent about issues of race. Utilizing insights from intersectionality, mental health social workers can promote an understanding of the complexities of racialized identities and how social structures as well as anti-Black Sanism affect the conditions of daily living for racialized groups (Brown, 2003; Mattson, 2014; Meerai et al., 2016). Intersectionality can also aid an understanding of diversity within groups as well as not seeing identity as fixed and bound by social structures.

Intersectionality, CRT, and whiteness can be utilized to make the racialized experience of madness more visible (Brown, 2003). These approaches help us to examine how racism can lead to trauma and how it compromises the diagnostic process (Fanon, 1967; Fernando, 1991; Metzl, 2009). They can also help practitioners to challenge stereotypical views of dangerousness and the role hegemonic whiteness plays in sustaining and reinforcing these stereotypes. CRT can also be used to explore how Eurocentric and biomedical approaches to madness serve to reinforce racial inequalities. Due to its sensitivity to power differences between groups (Delgado & Stefancic, 2003), CRT can also be used to challenge domination and control of racialized groups. Overall, these ideas help us to consider racialized people with psychiatric histories as human beings and not just as a risk to society (Patel, 2014).

Conclusion

There is still a need to map the linkages between race and madness (Tam, 2013). This article has suggested that underpinning this relationship is the stereotype of dangerousness and madness that requires attention. As mental health social workers are located in multidisciplinary teams, there will be significant challenges to follow and implement the suggestions offered in this article. They may operate from a value base that inherently conflicts with mental health practitioners who operate from different theoretical perspectives and ideological stances, giving rise to value conflicts (Ray & Pugh, 2008). Fulford (2011) suggested that these value conflicts can be made transparent by adopting value-based practice. He further suggested that

[3] This term is used for mental health practitioners who have undergone specialist training to conduct assessments under the Mental Health Act 2007 of England and Wales.

this can also inform decision making and improve communication. Making the value base of different mental health practitioners more explicit requires that they pay close attention to mapping the relations of race and madness in this way they become less complicit in invisibilizing race. Poole et al. (2012), for example, suggested that we need to shift the discourse from danger to discrimination, from fear of a threat to benefits to the profession, and from physical and chemical restraints to rights and accommodations.

Mental health social work needs to acknowledge that categories based on mad and racialized identities are socially constructed; they are not fixed, but fluid, and therefore should not be essentialized (Rosenfeld, 2012). Exploring the intersections between madness, race, and dangerousness should help us to move to a more nuanced understanding of the persistence in racial inequalities (Edge, 2013). Forming or establishing alliances across madness and race should enable these marginalized groups to operate from a strong oppositional base: one that can counter the hierarchies of domination and subordination (Beckett & Campbell, 2015). If mental health social work continues to ignore the intersections between race, madness, and dangerousness and how these mutually construct each other, it will be complicit in reinforcing and sustaining racial inequalities and the coercive nature of treatment meted out to racialized groups.

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