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Colonization by/in Psychiatry: From Over-Medicalization to Democratization

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ABSTRACT

Critics of medicalization accuse psychiatry of colonizing areas of life where medicine does not properly belong. But, so far as these critiques fail to challenge mainstream ontological assumptions about the nature of mental disorders, they will fail to address important sources of colonization within psychiatry. The demand that *real* mental disorders be conceptualized as facts of nature that transcend questions of social interest has a particularly pernicious effect on psychiatry. If these assumptions are not challenged, unjust imbalances of epistemic authority within psychiatry will never be addressed. By examining the relationship between oppression and depression we can see that the type of thing we conceive depression to be goes a long way in determining whether psychiatry plays a liberatory role that mediates the cycle of oppression and depression or merely a colonizing role that obscures sources of oppression and therefore serves to further marginalize the already marginalized.

Key Words: Liberatory Psychiatry, Ontology, Epistemic Authority, Oppression, Medicalization

Introduction

The nature of psychiatry is not fixed. Psychiatry can act as a colonizing force, a force that facilitates subjugation and exploitation. And psychiatry can act as a liberating force that mediates the suffering associated with subjugation and exploitation. It is my contention that certain assumptions about the nature of mental disorders play an important role in determining whether or not psychiatry acts as a colonizing force. Common sense assumptions about the nature of mental disorders act to colonize psychiatry from within and steer psychiatry in a nefarious direction. These assumptions are a peculiarly insidious form of colonization because they often work implicitly; and when they are adopted explicitly it is not with the intention to harm but with the intention of doing good science. Psychiatry has been accused of acts of "over-medicalization", of colonizing areas of life where it simply does not belong. But, so long as these forms of critique accept, in an unquestioning manner, mainstream ontological assumptions about what psychiatric disorders really are, they will fail to address these important ideological sources of colonization within psychiatry.

The forms of suffering that psychiatry attempts to address intersect with forms of suffering associated with societal oppression. By exploring the relationship between oppression and depression we can see that the type of thing we conceive depression to be has an important impact in determining whether psychiatry will play a progressive and liberatory role that mediates the cycle of oppression and depression or merely a colonizing role that obscures sources of oppression and therefore serves to further marginalize the already marginalized. Attempts to conceptualize psychiatric disorders as discoverable facts of nature that somehow transcend questions of social interest have a pernicious effect on psychiatry. These ontological assumptions have important implications with regard to epistemic authority. They imply that psychiatric disorders are atomistic facts, fixed and static givens in a closed system that can be passively discovered by scientific experts. I will examine three different attempts to conceptualize psychiatric disorders as discoverable facts and show how they break down on empirical and conceptual grounds. It is only when we acknowledge the plausibility of conceptualizing psychiatric disorders with reference to social interests that we can begin to examine the interests that guide our conceptions specifically in terms of their impact upon marginalized communities. Do our psychiatric conceptions conceal, legitimize, and sustain harmful forms of domination and oppression? Or do they provide a platform for emancipatory transformation by promoting the democratization of psychiatric scientific research and the recognition of people seeking help in the clinic? The manner in which these questions are resolved determines whether psychiatry serves as a nidus in the struggle against repression or merely performs a colonizing social function.

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Mental Disorders as Discoverable Facts of Nature

Major Depressive Disorder as it has been defined since the third edition of the Diagnostic and Statistical Manual of Mental Disorders implicates many social parameters as risk factors for the development of the disorder. Because these risk factors include childhood parental loss, lifetime traumas, lack of social support, and recent stress, a moment's reflection reveals that marginalized populations who suffer from oppression appear to be especially vulnerable to the social risks for developing depression. Links have been traced between depression and poverty and race and gender (Brown, 2012; Chakraborty & McKenzie, 2002; Fernando, 1984; Keita, 2007). Indeed it is becoming more apparent that discrimination itself places people at increased risk for depression (Tummala-Narra & Claudius, 2013). The association between oppression and depression is strong enough that psychiatry could be accused of further victimizing the oppressed by labeling them as mentally disordered. Psychiatry's treatment of Major Depression could be construed as a medical colonization of what is essentially a matter of social pathology (Ussher, 2010). Critics of medicalization interpret evidence of social factors at play in the development of depression to mean that understanding depression properly will "require social not psychiatric methods of inquiry" (Pilgrim & Bentall, 1999, p. 272). The implication is that real psychiatric disorders can be understood as biological phenomena without residue and that social phenomena can be rigidly demarcated from these biological phenomena. These assumptions are shared by many mainstream psychiatry advocates and have been described in terms of a "medical model" for psychiatry. This medical model will be the first of three attempts to understand psychiatric disorders as discoverable facts of nature that I will scrutinize.

Robins and Guze (1972) developed an influential theory on how to prove the validity of a diagnostic construct for Schizophrenia. Kendell and Jablensky (2003) noted the "disease realist" assumptions at play in the work of Robins and Guze. The assumption is that a *real* disease is one in which we understand the causal mechanisms behind the signs and symptoms, and validity can be considered synonymous with "delineating a specific, necessary, and sufficient biological mechanism" (Kendell & Jablensky, 2003, p.6). Compton and Guze (1995) explained that the notion of validity first elaborated by Robins and Guze was part and parcel of a "medical model" of psychiatry in which, "the brain and how brain mechanisms are related to functional impairment would be considered the first goal of medical-model psychiatry" (Compton & Guze, 1995, p. 200). Dubbing this 'brain-first' view the medical model is a bit of Orwellian doublespeak. The meaning of medicine is not a fixed and static one. There is contention within medicine about how to best conceptualize medicine. Alternative views from within medicine, such as the biopsychosocial model (Engel, 1977) challenge the primacy of biological explanations. But, the assertion that a form of biological reductionism is the "medical model" implies a level of uncontroversial and universal assent to this model within medicine that may be accepted unquestioningly by those outside of medicine.

Empirical research has demonstrated that Major Depression does not unfold in a law-like manner on the basis of a genetic blueprint. Instead, depression develops in a socially contingent manner. For example, genetic vulnerability to depression may never manifest in a clinical depression outside of a social context of childhood parental loss or childhood abuse (Mitchell, 2008). The socially contingent types of problems that psychiatrists deal with are not "real diseases" in the manner envisioned by Robins and Guze because they cannot be explained sufficiently by reference to a specific and necessary biological mechanism. This is not the radical assertion of anti-psychiatry zealots. The leadership entrusted by the American Psychiatric Association with the development of the 5th edition of the DSM conceded that the diagnostic entities contained heretofore in the DSM were not "valid" in the specific sense of the term developed by Robins and Guze (Regier, Narrow, Kuhl, & Kupfer, 2009). To be sure, there would be nothing inherently harmful in the discovery that certain forms of mental illness could be explained by a necessary and sufficient biological mechanism. But, the demand that mental illnesses are real and warrant clinical attention only if they have a necessary and sufficient biological mechanism seems like a perverse inversion of priorities. Under these terms, problems that arise through complex interactions of biology and social environment would be systematically ignored simply by virtue of their complexity. For what it is worth, the acknowledgement on the part of the DSM 5 leadership that the diagnostic entities contained in the DSM are not valid in the specific sense of the term developed by Robins and Guze certainly did not prompt them to question whether psychiatric disorders are best conceptualized as value-neutral discoverable facts of nature. Instead of questioning what concept of disorder best addresses the concerns of patients, they confidently proclaimed that psychiatric nosology would eventually "carve nature at the joints" (Regier et al., 2009).

The work of Jerome Wakefield is probably the most influential contemporary attempt to "carve nature at the joints". His ideas will be the second attempt to understand mental disorders as discoverable facts that I will examine. Wakefield (2007) has developed a 'harmful dysfunction' analysis to discern when a mental condition should properly be considered a medical disorder as opposed to an instance of ordinary human suffering. Wakefield believes that a harmful condition must involve dysfunction of a designed mechanism for it to fall legitimately within the purview of the medical discipline of psychiatry. Dysfunction is a failure to perform a natural function in the sense of a function for which it was designed by evolution. The use of the word "natural" here has a connotation of a matter of fact that transcends social interests. Wakefield (1995) regards dysfunction to be a value-free objective matter theoretically discernible by evolutionary science. Wakefield acknowledges the fact that science has not, as of yet, elucidated the designed mechanisms of normal sadness but he nonetheless concludes that recent DSM formulations of Major Depression lead to over-medicalization, or false-positive diagnosis of medical disorder in psychiatrically normal persons (Wakefield, Schmitz, First, & Horwitz, 2007). Specifically, Wakefield believes that the failure of the DSM to take account of stressful contexts in which depression occurs leads to false positive diagnosis. For Wakefield, depression occurring for no reason constitutes dysfunction while depression that occurs in the wake of a stressful event constitutes normal human suffering.

By pathologizing only depression that occurs for no reason, Wakefield is appealing to intuitive notions that, under certain circumstances, depression is understandable and proportionate to the stress incurred. But, clinically things are often not so clear

cut. When someone develops depression in the wake of a job loss, for example, we can assert that the job loss was the cause of the depression. But, we must be careful about the meaning of this use of causation. We are not speaking of job loss as a specific, sufficient, and necessary mechanism such that if job loss caused a depression then getting a job will cure depression. For someone who has stopped sleeping and eating and whose concentration is impaired in the wake of a job loss, giving them a job will not "cure" their depression. Instead that person may require treatment to regain his or her capacity to work again. The notion that social problems are purely social and biological problems are purely biological belies the complex interactions that occur between biological and social levels of analysis of human problems. Socio-cultural phenomena become incorporated in the soma. Scientists use the language of "stress" to translate interpretations of social environment into a chemical language of hormone release and contingent development of the nervous system under the rubric of neuroplasticity (Shonkoff & Phillips, 2000). To question whether depression is a biological problem or a social problem demonstrates an inability to comprehend the socio-biological nature of depression.

Wakefield believes that depression in response to loss is normal and natural. But even Wakefield notes, "Treatment, including psychotherapy or medication, may sometimes be appropriate for intense normal sadness" (Wakefield et al., 2007, p.439). This seemingly paradoxical claim that cases of over-medicalization may be *appropriate* points to the problems inherent in Wakefield's analysis. Ultimately, the appropriateness of medical intervention properly hinges upon judgments about the intensity and proportionality of the sadness. Wakefield and Horwitz (2007) acknowledge the tremendous individual and cultural variation in response to loss. This implies that whether or not a response is proportionate to a loss will not be a natural fact to be discovered, but a value-laden and potentially contentious judgment. Of course, Wakefield can hold out the promise of future developments in evolutionary science as the ultimate arbitrator of what is normal versus pathological. But, this idea seems horribly misguided to me. In the example we were using of someone becoming severely depressed in the wake of a job loss, it seems nonsensical to turn toward evolutionary science for answers. The whole concept of "job loss" only makes sense in a modern context that represents a miniscule proportion of our evolutionary history. Even if evolutionary science were able to discern that we were designed *by nature* to develop a crippling depression in the wake of a job loss, it seems that this capricious fact of our ancient history would hardly constitute an appropriate normative fulcrum for deciding when medical intervention is appropriate. An appropriate normative fulcrum is not an arbitrary fact of nature but instead an evaluatively thick judgment of severity and proportionality—in other words, a judgment of social interest that Wakefield's concept of dysfunction was meant to transcend. Unfortunately, Wakefield's rhetoric of equating natural dysfunction with real medical disorders implies that people who suffer depression in the wake of social stressors do not have a "real" medical problem. As noted earlier, the oppressed suffer disproportionately from depression and the connotation that their problems are not real only seems to unfairly delegitimize their claim for care, further marginalizing the oppressed.

The work of Ken Kendler is the third attempt to understand psychiatric disorders as discoverable facts that I will examine. Kendler's work presents an important alternative to the demand that mental disorders have a necessary and sufficient biological explanation. Kendler (2008) has noted complex, multi-level causal mechanisms that sustain psychiatric syndromes such as depression. Genes, cell-receptors, neural systems, psychological states, environmental inputs and social-cultural variables can all be implicated in sustaining the patterns of signs and symptoms that unfold in psychiatric disorders. Kendler's approach has the advantage of recognizing the social dimension to causation of psychiatric disorders and the importance of social scientific approaches in understanding them. But Kendler's attempt to understand psychiatric disorders as discoverable facts that transcend matters of social interest manifests in his attempt to understand disorders merely or entirely in terms of their causal structures.

Kendler recognizes that the causal networks that underlie and maintain the signs and symptoms of psychiatric disorder are highly heterogenous such that there are multiple causal pathways to the same signs and symptoms, and entering the same causal network can result in different signs and symptoms. But, Kendler asserts that these causal networks are transcultural and transhistorical (Kendler, Zachar, & Craver, 2011). Kendler et al. (2011) therefore argues that defining psychiatric disorder on the basis of a causal network is an alternative to a social constructionist view that would define psychiatric disorder with reference to the value system of a particular culture. But, even if a transcultural and transhistorical causal network existed it would certainly be possible to enter the causal/symptomatic network in a myriad of ways. Clearly a person can enter the network in such a way that, in view of the social context, the signs and symptoms are too mild to warrant disorder status. If we define depression strictly in terms of entering the causal network, then we must awkwardly concede, as Zachar (2014) notes, that we can have depression without having depressive disorder. Entering the causal network will not differentiate depression that is orderly and normal and does not require clinical intervention from depression that is disordered, pathological, and warrants treatment. In moving from depression to depressive disorder the same evaluatively thick normative questions regarding what level of severity and proportionality warrant disorder status appear in Kendler's analysis just as they did in Wakefield's. Judgments of severity and proportionality are matters of social interest and, far from being invariant, are likely to vary from culture to culture, and historical epoch to historical epoch, even individual to individual.

Social Interests and Well-Ordered Science

The commonality I traced in Guze's attempt to define mental disorder in terms of a necessary and sufficient biological mechanism, Wakefield's attempt to define disorder in terms of dysfunction of a naturally evolved mechanism, and Kendler's attempt to define disorder strictly in terms of a causal nexus, is the desire to define disorder on the basis of discoverable and uncontroversial facts of nature that exist regardless of human interests. It is probably the desire to transcend contentious evaluative issues and place medical knowledge on an incontrovertible foundation that prompts the demand that real medical problems be based solely on facts of nature. Another motivation may be the belief

that the only alternative to basing knowledge of psychiatric disorders on value-neutral discoverable facts is a capricious social construction that does not comport to empirical realities. But, this is a false dichotomy. Developing knowledge according to a social interest in relief from suffering from mental illness would hardly be accomplished by fanciful acts of wish-fulfillment that ignore material realities. The three attempts to base psychiatric disorders on discovery of natural fact that I have reviewed have not transcended contentious evaluative issues; they have merely concealed or ignored them. These evaluative issues are concealed and ignored at our peril. The demand that knowledge be based strictly on discoverable value-neutral facts of nature takes us away from the ethical foundation of medical knowledge, which is the profession of knowledge of interest and value to the patients who are being treated. The concept of well-ordered science introduced by the philosopher Phillip Kitcher is a much more helpful notion in achieving this kind of knowledge than the demand for discovery of value-neutral natural kinds. Kitcher (2001) notes that well-ordered science should satisfy the needs and interests of the citizens of the society in which it is practiced. This notion is indebted to John Rawls' theory of justice and by accenting the facet of justice involved in scientific questions it highlights rather than retreats from the ethical and ultimately political elements involved in scientific inquiry.

Derek Bolton (2008) has criticized attempts to understand psychiatric disorders on the basis of theories of natural facts. Instead he believes the disorders delineated in the DSM are better understood as the types of problems that people bring to the clinic. These problems can loosely be characterized as conditions that cause distress and/or disability and are associated with various forms of psychological dysfunction, with definitions of psychological dysfunction trading quite liberally in folk concepts. Some would accuse this argument of being circular and unscientific. But, we can see that by moving toward problems that people are concerned with and seek help for, we are actually moving a long way toward well-ordered or "just" science, science developed to satisfy the needs and interests of the citizenry. Alan Horwitz (2014) introduces the important question of what interest groups are benefitted by the current diagnostic conception of major depression and he goes on to assert that the pharmaceutical industry has been a disproportionate beneficiary. Ironically, Horwitz's and Wakefield's (2007) assertion with that medical disorders be based on discoverable facts of nature that transcend social interests marginalizes the importance of just these kinds of questions for establishing the legitimacy of psychiatric science. But if we shift to Kitcher's normative concept of "well-ordered" science or science that comports with matters of justice, then interrogating the science regarding matters of social interest becomes an important and appropriate part of the process of doing science. Horwitz (2014) is accusing recent DSM formulations of major depression of not being well-ordered. But, at first blush it is hard to understand just why pharmaceutical companies should disproportionately benefit from the DSM formulation of Major Depression. Major Depression appears to be the kind of thing for which people seek clinical help. Following Bolton it is the type of problem that causes distress and disability and is associated with psychological dysfunction. Depression could, therefore be a matter of general interest. In fact, because oppressed populations suffer disproportionately from depression, it seems that the oppressed could particularly stand to benefit from the current formulation of depression. As we have noted, current DSM formulations of Major Depression implicate psychosocial factors as being as important as biological factors. So there is nothing in the DSM formulation of Major Depression per se that is geared toward pharmaceutical company interest.

However, if we assume that Horwitz is correct in his accusation that pharmaceutical companies are disproportionate beneficiaries of the current formulation of Major Depression, we must look beyond the specific content of the formulation contained in the DSM for an explanation. No doubt the social forces that go into the making of a social or economic beneficiary are myriad and complex. They certainly go beyond the intentions of any specific actor. But we can see that pharmaceutical companies do benefit from ontological assumptions that maintain a rigid divide between the biological and the social. I noted earlier that one dilemma associated with the demand that real medical disorders be the result of natural as opposed to social problems is that it tends to discount the reality of problems that arise in part due to social factors and neglects the biological dimension of these social problems. The flip side to the problems created by a rigid social/biological divide is that when a biological dimension is recognized, the social aspects of the problem are discounted. In other words, if we really maintain the divide, if something is in some sense biological, it must be all biological. For example, the philosopher Paul Churchland (2013, p.225) asserted:

> Fluoxetine controls chronic depression, lithium salts control mania, and chlorpromazine controls schizophrenia. Imperfectly, it must be said, but the qualified success of these drugs lends strong support to the idea that the victims of mental illness are the victims primarily of sheer chemical circumstance, whose origins are more metabolic and biological than they are social or psychological.

Nick Haslam (2014) notes that these ontological assumptions are also prevalent in folk psychology where evidence of a biological basis for disorder was taken to mean that the disorder must be discrete and historically invariant and that medication rather than psychotherapeutic intervention would be efficacious. Mental disorders become reified when the social factors that went into the development of the biology are forgotten (Honneth, 2008). Such a view is inherently conservative. Instead of the social context being a contingency that can be called into question, social issues become marginalized. While the pharmaceutical companies are beneficiaries of a rigid ontological divide between the biological and the social, the oppressed are not. Depression that occurs in the context of oppression is either not a real medical problem because it has social antecedents or it is merely an internal biological problem with a biological solution. Either way the oppression never gets addressed.

A strict ontological divide between the biological and the social is harmful because it actually serves as a buttress of conditions of oppression. Characterizing depression as strictly a problem inside the brains of the depressed serves to hide, cover, conceal, and ignore the damage done to people through oppression. Biological therapies can mediate the suffering associated with depression, but the illusion that depression is a fact of nature that unfolds according to law-like biological mechanisms has

bolstered an atmosphere where biological therapies are developed in a manner that maximizes the interests of the pharmaceutical industry. Evaluative contingencies in the development of biological therapies are portrayed as merely technical issues, discounting the potential role of the public in assuring that evaluative contingencies are being resolved according to the public interest, while the pharmaceutical industry interest in commodification and maximizing profit is concealed in a guise of value-neutral science (Porter, 2009). Instead of depression being a nidus for addressing societal sources of oppression, the colonizing force of natural-fact assumptions facilitates the transformation of depression into a source of corporate profit and aggrandizement.

We saw in Ken Kendler's work an appreciation of a complex causal intersection between biological, psychological, and social explanatory factors in psychiatric disorder. But his suggestion that disorder be understood strictly in terms of a causal nexus elided *over* important evaluative issues. Merely entering this causal nexus is not enough to warrant the status of psychiatric disorder. What is a proportionate response to stress? What level of distress is severe enough to be deemed clinically significant? What symptoms and explanations are the most significant? As noted earlier, judgments of proportionality and intensity will vary significantly from individual to individual, culture to culture, even historical epoch to historical epoch. Answers to questions regarding proportionality and intensity and significance are seemingly left open to a reasonable plurality of positions. These conclusions have ramifications with regard to epistemic authority both at the clinical level and at the level of scientific research. Redressing imbalances of power at the level of epistemic authority provides an important means of moving psychiatry away from colonizing forces that perpetuate or at the very least fail to address societal sources of oppression (Shiva, 1988).

Recognition and Democratization

At the clinical level, sensitivity to the many ways of expressing, interpreting, and explaining depression promotes epistemic humility on the part of the clinician: the kind of epistemic humility that facilitates what Nancy Potter (2009) has called the virtue of giving uptake in the clinical encounter. Giving uptake involves attending to the patient's values and perspective about the meaning of their experience. Giving uptake is not equivalent to acquiescence to the patient's interpretations of meaning. For example, depression is often associated with interpretations of worthlessness on the part of the patient that may need to be challenged. But, a willingness to suspend preconceptions and be open to patient interpretations of salience with regard to what aspects of the illness warrant attention and what kinds of explanation should be emphasized is entirely consistent with the reasonable plurality of interpretations of depression. Bradley Lewis (2011) has noted that clinical problems can be approached from a variety of perspectives spanning biopsychiatric, humanistic, spiritual, political and feminist forms of therapy. Openness to sociopolitical explanations challenges the inherently conservative tendency to marginalize these issues in clinical encounters (Waitzkin, 1991). A dogmatic assertion of epistemic authority on the part of the clinician may only serve to create a coercive atmosphere that perpetuates the cycle of oppression and depression. But, when clinicians are oriented toward understanding patient perspectives, it demonstrates on the part of the clinician recognition of the worth of the patient's perspective. This kind of recognition entails a reversal of the type of power disparity and conditions of oppression that promote depression.

At the level of scientific research, the imperative of developing just or well-ordered science emphasizes that the knowledge developed should be of benefit to the patients, families, and communities that will be affected by that knowledge. David Healy (2004, p.255) has lamented that in the current climate, "Medical research would follow the money potentially benefiting the favored few rather than the community at large." Instilling democratic values is a means of combating elitist and authoritarian practice in scientific inquiry (Lewis, 2008). Anthropological critics of mainstream psychiatry such as Arthur Kleinman have provided conceptual tools for the democratization of science by moving scientific research towards the community interests. Kleinman (1988) has asserted that empiricist methodologies that rely solely upon observation smuggle in the assumption that this methodology grants unmediated access to "things." But, access to psychiatric phenomena is mediated by cultural tools of language, values, and rules for interpretation. Cross-cultural empirical studies have tended to foist unquestioned western interpretations of meaning on non-western cultures, perpetuating a form of cultural colonization. Alternative methods attuned to interpretation of meaning are required in order to detect cultural variance. It can be seen more generally that research methods attuned to detecting cultural variance in meaning, so far as they prevent the imposition of the worldview of a powerful interest group upon those that are disempowered, are a means of assuring well-ordered science that is attending to the needs and interests of those being affected by scientific research.

Participatory research methods can also be seen as a means of democratizing science by developing knowledge not merely from the perspective of the researchers but also from the perspective of the researched (De Koning & Martin, 1996; McTaggart, 1997). Community participation can take place at many stages in the research process: research design, data collection, interpretation of data, etc. Beyond being a means to access diverse cultural interpretations, participatory research can be a means to give voice to the needs and interests of marginalized and oppressed sectors of the community and has been seen as part of a process of empowerment and emancipation (De Koning & Martin, 1996; McTaggart, 1997). Accordingly, mental health service user-led research has an important and neglected role to play in democratizing psychiatric science (Faulkner & Thomas, 2002; Perkins, 2001; Rose, 2003).

Concluding Remarks

The nature of psychiatry is not fixed but evolving. Concerns about psychiatry as a source of colonization cannot be addressed unless certain assumptions about psychiatry are challenged. An important buttress of colonizing forces within psychiatry is the assumption that psychiatric disorders are discoverable facts of nature that

transcend questions of social interest. These assumptions obscure and conceal evaluative conceptual contingencies within psychiatry that can be resolved according to oppressive interests. Overcoming these assumptions is therefore a necessary moment in establishing a fulcrum for developing psychiatry in a manner that is progressive rather than oppressive. Liberatory psychiatry addresses questions of social justice that occur within psychiatry. Social justice within psychiatry calls for a shift in epistemic authority within the clinic, where the value of the mental health service user's knowledge must be recognized, and within arenas of scientific inquiry, where processes of democratization can serve to mediate disparities in power. It is when psychiatry becomes of, by, and for the people that it becomes a source of emancipation rather than colonization.

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