

Weaning off Colonial Psychiatry in Kenya

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The western scientific project has been intricately bound up with colonialism and in perpetuating its racist, sexist, sanist, heterosexist and abelist effects. Physicians, including psychiatrists and other mental health professionals, have often been complicit in colonial projects that perpetrate human rights violations and pathologize Indigenous and racialized populations. Indeed the interconnectedness of racism, colonialism, and mental illness can be found in the ways in which racialized ‘Others’ have historically been pathologized through the tools of psychiatry (Metzl, 2009; Kanani, 2011; Mills, 2013) and how psychiatry, social work and the mental health professions have been used in the service of colonialist and imperialist aims. In the context of Canada, for example, colonialism was animated through psychiatry and the child welfare system to bolster the Canadian state’s racist assimilation policies towards First Nations, Métis and Inuit people (Waldrum, 2004). In the context of Africa (the subject of this paper) the western biomedical paradigm has been used as an important tool for colonial powers to justify oppression and gross human right abuses (Ibrahim, 2014; Keller, 2007; Mahone & Vaughan, 2007). Stressing the important role of medicine and doctors as agents of colonization in North Africa, Herbert Lyautey (the French conqueror of Morocco) in 1933 stated “In Morocco, between the medical corps and myself, there is only one spirit, one doctrine,” (Amster, 2013:72) and that is, “to help Morocco evolve towards greater justice, well-being and liberty under the guidance of France”. Lyautey went on to explain that for that to happen; doctors must be at the forefront and be “agents of penetration, attraction and pacification” (pg.72-73). The colonial role of psychiatry did not stop at penetration and pacification but continued to be one of the most potent and effective apparatuses for aiding colonization, oppression, and racialization of African peoples by European powers (see Heaton, 2013, Ibrahim, 2014, McCulloch, 1995).

In this paper we begin by situating ourselves as non-indigenous settlers in Canada – one of us Kenyan and a recent immigrant from Kenya, the other German/Irish, born and raised on Indigenous land in Canada. By locating ourselves we acknowledge the particular situatedness of our work in the context of Canadian

Indigenous/settler relationships. From this place we draw out the history of western science in its intersections with the colonial projects with a specific focus on the emergence of biomedicine. We argue that colonial practices, as embedded in the very origins of western science, find expression contemporarily in biomedical dominance in psychiatry. Biomedical dominance obscures the social context in which mental distress occurs and effectively eclipses the effects of colonialism and the inequities that flow from it. The hegemony of western scientific thought is solidified through biomedicine and the marginalization of Indigenous forms of knowledge. Furthermore, colonialism and other forms of structural violence (Galtung, 1969; Farmer, 1996) are held in place through the institutional practices, laws and policies that govern mental health care systems. As such, we apply our analysis to the specific case of Kenya through a discussion of the Mental Health ACT of 1989 and the recently passed Marriage ACT of 2014 by the Kenyan Parliament. This new law effectively denies any person deemed “insane” or “mentally ill” the right to get married (Kenya Gazette Supplement, 2014). It mandates and empowers psychiatrists to determine the sanity of an individual and to provide the required medical expertise and authority to formally exclude individuals from the institution of marriage. We use this example to illustrate the far-reaching power of colonialism and its contemporary effects. At the end of the paper we raise critical questions about current trends in global mental health which, in our view re-inscribe colonial relations between the west and Africa. We suggest a way forward is through supporting and bolstering psychiatric user/survivor networks in Africa.

Situating ourselves

Mohamed is a Kenyan Somali who was born and grew up in a small village at the northern tip of the North Eastern Province of Kenya, a contested land between the British and Italian powers during the colonial period and, contemporarily between Kenya, Somalia, and Ethiopia. This geopolitical contestation often has led to generational trauma and displacement of Indigenous

communities. This colonial legacy has directly impacted Mohamed and his family. Mohamed comes from a traditional medicinal family who have philanthropically treated and healed their local communities for many decades. In the early 1960s when Kenya had just gained independence but was still operating from a colonial constitutional framework, Mohamed's grandfather (now in his 90s) was arrested and jailed for six months by the nascent Kenyan government for practicing surgery. The surgery involved a teenager, who sustained a head injury after falling off the back of a camel – unfortunately the camel stepped on the boy's head severely injuring him. The community at that time relied entirely on the Indigenous health care system, and so Mohamed's grandfather attended to the boy's injury with several sutures and advised him to attend the local government dispensary for antibiotic treatment. That trip to the dispensary culminated in the jailing of Mohamed's grandfather. This generational experience of governmental sanctions explains why many among Mohamed's extended family (including Mohamed) unconsciously or consciously decided to carry on the family tradition of caring for others but from the safe side of western medicine. But in the end the Kenyan community has lost health care providers, just like in other parts of Kenya and Africa where significant numbers of western educated health professionals emigrated to the west, Mohamed and his relations have mostly ended up practicing in western countries, thus denying the local community a more robust health care system (Kirigia, Gbary, Muthuri, Nyoni, & Seddoh, 2006).

Mohamed's critical perspective on colonial psychiatry and, by extension, biomedical psychiatry started at an early age as explained above but also during his schooling where the educational system remains deeply ingrained in colonial ideologies and where western knowledge is privileged over African knowledge (Ibrahim, 2014). Mohamed further appreciated the global significance of colonial psychiatry after moving to North America as a mental health clinician and realizing the connection between colonial Kenya, the United States, and Canada with respect to criminalizing, othering, and psychiatrizing Indigenous populations and African Americans. Of note is how the work of medical practitioners and researchers across the Atlantic shared similar ideologies in relation to race, psychiatry, eugenics, and violence. Reading the work of Metzger (2009), Keller (2007), McCulloch (1995), Mills (2013), and Vaughan (1991) influenced Mohamed's current scholarly work on decolonizing psychiatry.

Marina was born and raised in Canada and is from mixed European background, primarily German and Irish. Living on the Canadian prairies in the 60s and 70s Marina grew up in a context where everyday racism against Indigenous peoples was normalized, and at a time when the education system did nothing to dispel this racism, and, in fact, reinforced it. Thus, Marina knew virtually nothing about the history of colonization and ongoing colonial practices until she entered university and became active in the feminist anti-violence movement in the 80s. Through her front line anti-violence work and primarily through her engagement with Indigenous women who were also anti-violence activists she began to come to a deeper understanding of Canada's colonial legacy and its day to day impact on the lives of women and children. During her time as a rape crisis worker, Indigenous women started to go missing from the downtown eastside in Vancouver,

underscoring, for her, the intersections of misogyny, racism, and colonial power. Later, as a feminist community psychologist, Marina's understanding of her role as a settler ally began to consolidate by reading the powerful works of writers like Lee Maracle (1988). Further, the works of women writing about the role of colonialism and imperialism in the Global South (e.g., Mohanty, Russo, Torres, 1991; Mohanty, 2003), and the work of intersectional theorists (e.g., Crenshaw, 1989; 1991) amplified for her the critical importance of understanding colonialism as a key analytic frame for understanding oppression and its impacts. Currently, in her work looking at biomedical dominance and mental health, Marina has become increasingly interested in understanding the role that psychiatry as a profession and biomedicine as an ideology have played in colonial projects. Together Mohamed and Marina take Tuck and Yang's (2012) criticism of the use of decolonization as a metaphor and "settler moves to innocence" to mean that as theorists, teachers, and practitioners it is not enough to make calls for decolonization but that one must actively work to recognize that what decolonization wants and needs is different from other forms of social justice (Tuck and Yang, 2012). That is, as Tuck and Yang (2012) argue, decolonization cannot just be added to other social justice and civil rights projects uncritically, but rather one must work to more deeply understand the specific histories of colonialism, its effects, and the work of indigenous activists to reclaim indigenous knowledge and indigenous land. This paper is an attempt to illustrate what decolonization might look like in one example in the contemporary Kenyan context. But first we begin with some history of the ways in which colonialism, psychiatry, and biomedicine have intersected and mutually reinforced each other.

Biomedicine, Psychiatry, and Colonialism

Tam (2013), like Kanani (2011), argues that there remains a gap in the literature with respect to "mapping relations of race to and in madness" (pg. 283). Tam suggests that, "It is this epistemic gap that fails to account for how race-thinking inherently constitutes psy knowledge" (p. 283). One way to begin this mapping is to return to the history of the development of western science. Western science and the scientific method have been presented as value-free, objective ways of knowing and assessing the world, and yet the pursuits of western science have always been intimately tied to projects of colonization underpinned by scientific racism and the science of Eugenics (Harding, 1998; Fausto-Sterling, 1995; Proctor, 1993; Ordover, 1996; Fearnley, 2007). Historians and social scientists have traced the inextricable links between, for example, the early voyages of "discovery", the development of scientific classification schemes, and the imperialist and colonialist aims of Britain and France (Harding, 1998; Fausto-Sterling, 1995). For example, in the Kenyan context the interconnection between the colonial project and biomedicine could not be more clear when a physician explained the various roles of a medical officer as that of, "a clinician, a lecturer in eugenics, a medical officer of health, an educationalist and an amateur agriculturalist" (Campbell, 2007:40). Scientific racism, through the theory of social Darwinism, was used to prop up the European imperialist project and the claims to white superiority. With the rise of the

western scientific tradition also came the denigration and erasure of local knowledge systems, including women's knowledge as midwives and other forms of Indigenous knowledge pertaining to health and well-being (Amster, 2013, Benoit, Carroll, & Westfall, 2007). Amster (2013) discusses the tension and conflict between French male doctors and Moroccan midwives in French colonized Morocco. The French doctors saw Moroccan midwives as a threat to their privilege and power over the dominance of women bodies. Under the Islamic monarchy, which pre-dates French colonization, midwives were the sole practitioners of gynaecology and female health in Morocco and larger North Africa (Amster, 2013). The French colonial administration and doctors recruited French female doctors, nurses and social workers to penetrate midwifery and biomedicalize the field. They regulated and disbanded the traditional Moroccan midwifery practices and finally outlawed them.

This crackdown on healers has strong historical connections to the British colonial government in Kenya who used laws to delegitimize non-western knowledge and practices as a way to perpetuate their colonial agenda. Kenya inherited many colonial laws but those governing health care such as the Mental Health Act (MHA) of 1933 and the Witchcraft Suppression Act (WSA) of 1925, remain two of the most draconian and detrimental to the health and rights of those labelled with mental illness (Ibrahim, 2014, HelpAge International, 2011). The WSA, despite being obsolete, has left an indelible mark with respect to policing, delegitimizing, criminalizing and basically wiping out traditional and Indigenous healers. To date, the security apparatus, especially the police service, continues to harass and detain traditional healers who provide alternative and culturally appropriate mental health services in Northern Kenya (Ibrahim, 2014). Despite the fact that the Northern region lacks any formal mental health services, the government, just like its colonial predecessor, continues to dismantle age old community resources and, worse, still fails to provide alternative essential health care services (Ibrahim, 2014).

Parallels are found in North America where the representation of Indigenous people as either "The 'noble savage' which refers to the perception of Aboriginal people as simple, childlike, and uncorrupt by civilization" or as "primitive", that is, "as wild, degenerate and brutish" (Kanani, 2011, p. 6), enabled the brutal decimation of Indigenous peoples and the subsequent racist assimilationist policies, residential schooling, and the establishment of the paternalistic Indian Act.

Thus, in Africa and beyond, medicine and psychiatry as a sub-sets of western Science were (and continue to be) employed in the service of imperialist and colonialist projects. Psychiatry has reinforced the racist ideas underpinning slavery (Fernando, 2010) and the dehumanization of Indigenous populations in North America (Kanani, 2011; Waldron, 2002; Waldram, 2004). In a review of the literature on the history of psychiatry in Canada and the US, Kanani (2011) concludes "that psychiatric constructions of racialized people have allowed for the rationalization and justification of both historical and ongoing colonial and imperialist domination, slavery, and exclusionary immigration policies" (pg. 3). Kanani and others (Metzl, 2009; Fernando, 2010; Tam, 2013) have shown the ways in which madness or mental illness is

co-constructed with race in ways that perpetuate racist beliefs, violence, and inhumane treatment of people of colour.

Within the psychiatric profession and in mental health, more generally, biomedicine has come to dominate western thinking to the point that biomedicine has become dogmatically ideological and has entered numerous spheres of life as an explanatory framework (Rose, 2006; Morrow, 2013). Biomedicalism, in its rigid application of biological and natural science principles to clinical practice in mental health, leaves no epistemological space for a discussion of the role of the social in the construction of mental illness/madness and thus the psychological harms of colonialism are dismissed or interpreted as madness. Biomedicalism also does not allow for a discussion of how social conditions (like sexism, racism, and poverty) impact mental health. During colonial times, mental health laws across British ruled countries such as Kenya, Zimbabwe and South Africa were used as powerful political tools to suppress opposition to colonial policies which enforced oppression, racism and exploitation by declaring those individuals insane and through the use of the knowledge, expertise and power of biopsychiatry. The well documented story of the South African female spiritual leader Nontetha Nkwenke who resisted apartheid and was subsequently declared mentally ill and incarcerated for life at a psychiatric facility where she eventually died, is a classic example of the role of biomedicine in colonial practices (Edgar & Sapire, 2000). Similarly, the incarceration of Kenya's Elijah Masinde, a prominent freedom fighter and the founder of the spiritual Dini Ya Msambwa (faith through spirits of our ancestors) sect at Mathari Mental Hospital after been declared insane, illustrates the degree to which psychiatry colludes with the colonial regime (Mahone, 2006). Even the labelling of Somalia's hero and freedom fighter Mohamed Abdullah Hassan as the 'Mad Mullah' by the British during the independence war of 1920-1940 reflects the pervasive use of psychopathology as a colonial propaganda war machine (Ibrahim, 2014; Lewis, 2002).

The MHA (1989) and Marriage ACT of 2014: A Kenyan Example.

After 51 years of independence in Kenya, colonial laws and practices continue to persecute its citizens, especially those deemed mentally ill. A cogent example of how this works is the recent passing (2014) of the controversial Marriage ACT which declares that those with mental illness or substance abuse problems cannot: 1) officiate marriage, 2) be a witness to a marriage and, 3) be legally married under the laws of the land. The ACT also allows the annulment of a marriage based on the insanity of one partner (Kenya Gazette Supplement, 2014). The Marriage ACT empowers physicians, especially psychiatrists, to use their western biomedical knowledge, expertise, and authority to declare an individual insane or mentally ill and hence exclude the person from being an equal citizen of Kenya with basic civil and human rights. This is coupled with the equally stigmatizing MHA of 1989 which has barely changed since independence and defines a person with psychological distress as a "psychopathic person with mental illness" (National Council for Law Reporting, 2012, pg. 7). The MHA essentially calls for the incarceration and institutionalization of persons deemed

mentally ill and gives no opportunity for community treatments and integration. Just as psychiatrists and colonial law makers colluded to other, criminalize, and pathologize a significant sector of the population during colonial times, post-colonial Kenya seems to be following its master blindly.

During the colonial period of late 1800s to 1950s the government, its scientists, and medical practitioners were well known across the colonized world, as well as in Europe and the Americas, for their strong affinity for eugenic pseudo-science, racial prejudice, and scientific colonization (see Jackson, 2013; Mahone & Vaughan, 2007; McCulloch, 1995; Campbell, 2007; Ibrahim, 2014). Under the banner of the Kenya Society for the Study of Race Improvement (KSSRI) formed in the 1930s, men, especially famous colonial psychiatrists like Henry Gordon and J. C. Carothers, both senior psychiatrists at the Nairobi Mathari Mental Hospital, raised the profile of Kenya as an international base for eugenic research with a focus on medical eugenics. The KSSRI was formed around the same time as the South Africa's Race Welfare Society (RWS). Both these groups were concerned with maintaining the white settler vs. black/native hierarchical relationship, where the former maintains the superior position not only in terms of wealth, power, and prestige but supposedly intelligence as well (Campbell, 2007; Jackson, 2013). The eugenics community constantly warned the settler community of the deleterious health effects of mixing with natives and the dangers of bridging the economic, educational, and political gap between whites and natives (Jackson, 2013). To counter these concerns KSSRI and RWS were at the forefront of advising their respective governments on issues related to reproduction and mental health, education, and welfare for natives and settlers alike in order to preserve the integrity of the white settler society and keep the natives in their place. In fact the RWS went even further to open up birth control clinics in major cities in South Africa for both poor whites and African women alike in an attempt to control and balance their population in favor of the preferred middle and upper class whites (Campbell, 2007). While KSSRI did not explicitly engage in direct birth control practices, nevertheless they led a public health propaganda campaign to restrict education for natives, restrict white immigration to upper and middle classes, and encourage this group to reproduce more offspring and simultaneously deport mentally ill, alcoholic, and derelict whites who tarnish the image of the settler society (Jackson, 2013).

The colonial interconnection between eugenics, politics, and psychiatry is still manifested in the current MHA as a significant part of the ACT remains dedicated to the procedures and process of removing mentally ill patients to another country and the sale, disposal, and management of their properties (National Council for Law Reporting, 2012). Inasmuch as (this part of the ACT) may be irrelevant in the current Kenyan context, historically, it facilitated the removal of whites afflicted by mental illness or those who had "gone native" to maintain the honor of the superior white settler status (Jackson, 2013). It is within this historical context that laws pertaining to marriage and mental health come into being and are directly connected to the colonial and eugenics legacies.

Countering neo-colonial biopsychiatry

On the heels of continued colonization of people deemed mentally ill by the biomedico-legal framework in post-colonial Kenya comes the global mental health agenda which is driven by the World Health Organization (WHO) and its global ally, the Movement for Global Mental Health (MGMH) (Mills, 2013). The WHO and its allies are pushing for what the United Nation (UN) calls the scaling up of psychiatric interventions in developing countries under its Mental Health Gap Action Program (mhGAP) with a focus on ensuring the easy accessibility and affordability of psychotropic medications (WHO, 2008).

With this new campaign sweeping across the African continent, Kenya included, the powerful voices of psychosocial disability groups and other allies are pushing back, calling for a paradigm shift in mental health treatments in Africa (PANUSP, 2012).

At the forefront of this critical work is the continental Pan African Network of Persons with Psychosocial Disabilities (PNUSP) based in South Africa and affiliated with the Kenyan chapters of Users and Survivors of Psychiatry-Kenya (USP-K). These national and regional civil rights and disability-oriented organizations, with strong grass roots and survivor connections, are confronting and challenging biomedical psychiatry and its negative effects. They are agitating for a paradigm shift from a biomedical to a disability focus in line with the UN Convention on the Rights of Persons with Disabilities (CRPD).

In support of this, voices of resistance are scholars who are critically questioning the effectiveness of the western biomedical framework in the global south considering its ineffectiveness in the global north contemporarily (see Mills, 2013; Summerfield, 2008; Fernando, 2011; Whitaker, 2010).

The CRPD, which was adopted by the UN in 2006, addresses issues of discrimination, torture, socioeconomic, justice, and access to health and education for persons living with disabilities (Kayess & French, 2008). Importantly, and in line with what disability organizations have rooted for, the CRPD champions individual consent to treatments and the avoidance of harmful, torturous, and degrading treatments (Minkowitz, 2006). The Convention, which Kenya and many African countries are signatories to, obligates governments around the world to uphold the dignity and human rights of all people with disabilities. Using the CRPD as a legal and global platform for change, disability advocates and allies are pushing the Kenyan and other African governments to remain faithful to their obligations by formulating policies and practices that do not contravene international treaties and laws, which is clearly the case with the Marriage and MHA laws in Kenya. In addition, these groups are explicitly calling for decolonizing mental health laws and practices, opening up possibilities for alternative and complementary approaches to mental health treatments and, finally, incorporating the views and voices of those with lived experiences of mental illness. As PANUSP and other disability advocates have made clear, there should be "nothing about us without us".

As settler allies with vastly different histories and relationships to the processes of colonialism and racism, we are united in our conviction that decolonizing theory and practice in mental health requires, first and foremost, that the histories and experiences of colonization in their relationship to medicine and psychiatry be accurately documented. Further, the work of Indigenous activists and scholars and local resistance movements must be respected and foregrounded in attempts to address the historical and contemporary effects of these practices.

Footnotes:

- i. The concept of the 'other' is originally a Hegelian concept that expresses the idea of an individual or group's difference or alienation from the dominant group. The term has been used by numerous Continental philosophers, notably Simone DeBeauvoir to underscore women's interiority to men. Many scholars and activists have applied the term 'othering' to describe the effects of racialization (see for example, Fanon, 1967 and Said, 1978).

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