Postcolonial Bioethics

A Lens for Considering the Historical Roots of Racial and Ethnic Inequalities in Mental Health

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Legacies of Colonialism and Racial and Ethnic Inequalities in Mental Health

Inequalities in healthcare access and health status include not only racial and ethnic inequalities but also underservice to people with mental illnesses. This article shows how postcolonial theory illuminates the interesting, important, and complex intersections of these two kinds of health injustice. I apply postcolonial bioethics to health justice inquiry. Specifically, I articulate how postcolonial bioethics generates a vocabulary useful for considering important conceptual and temporal connections (1) between historical trauma suffered by people of color and current racial and ethnic inequalities in healthcare access and health status and (2) between colonial domination of people of color, epistemic violence, and underservice to people of color with mental illnesses.

Transgenerational relationships between current inequalities in healthcare access and health status and colonialist oppression of people of color have been neglected by bioethics. I take as my starting point that these relationships deserve bioethicists' close attention and that one of the important projects of professional bioethics should be to motivate elimination of racial and ethnic inequalities in health status and healthcare access. Postcolonial thought, particularly when considered in tandem with recent public health literature on historical trauma, gives bioethicists a vocabulary in which to articulate how relationships between past trends in pathogenesis and disease susceptibility can be epidemiologically and clinically relevant to the care of present-day individuals, families, and children.

Evidence that "traditional" theories of bioethics—deontology, consequentialism, casuistry, and principlism, to name a few—have not productively illuminated the intersections of racial and ethnic injustice in healthcare and underservice to people with mental illnesses resides in the persistence and recalcitrance of these health injustices. An account of the inadequacy of these theories to address these intersections might very well begin with the observation that they lack sensitivity about how injustice is historically situated. Postcolonial discourses enable

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bioethicists' development of a broader range of conceptual apparatuses and theoretical resources that better position us to eliminate centuries-old health injustices. Important for bioethicists' engagement with inequalities in healthcare access and health status is the idea that Western medical practices, with their origins in nineteenth-century physical and biological scientific development, sprang from the same objectifying tendencies that nourished nineteenth-century racism, sexism, and imperialism. The projects of freeing healthcare from the damage wrought by those forces, of thinking rigorously about the nature and scope of our obligations to eliminate their lingering harms, and of strategizing about how to improve clinical practice, health outcomes, and health experiences of people of color with mental illnesses require the insights of postcolonial thought that I recommend here.

Background

Colonization included practices of forced migration, genocide, slavery, forced internment, relocation, resettlement, dispossession, and war. Broadly construed, *postcolonialism* is a multidisciplinary theoretical approach devoted to cultivating responses to conquest and to strategizing resistance to hierarchies that express legacies of colonial hegemony. Bioethicists have not typically employed postcolonial frameworks to approach clinical ethics or health justice issues. One reason is probably bioethics' roots in Western "analytical" philosophy, which emphasizes argumentative clarity and logical precision. "Continental" philosophy, by contrast, is minimally influential in bioethics but influential in postcolonialist thought, as it emphasizes historical, political, cultural, aesthetic, and literary conceptions of meaning.

The public health literature has also adopted a historical approach to health justice problems. The concept *historical trauma*, or *transgenerational trauma*, for example, helps characterize health experiences of and responses to colonial oppression. Evidence shows that such historical trauma has adversely affected the health of diverse groups, including immigrants,[1,2,3] refugees,[4,5,6,7] and racial and ethnic minorities.[8,9,10] In epidemiological research, the concept of historical trauma promotes psychosocial and ecological investigations of how interdependent geopolitical, cultural, and economic determinants of health work transgenerationally.[11]

Colonialism has powerfully stigmatized *psychic citizenship*[12]—a person's community-based ways of being in the world—in communities of color. "Denial, depersonalization, isolation, memory loss, nightmares, psychic numbing, [and] hypervigilance"[13] can be psychological consequences of historical insults that can transgenerationally influence what it means to occupy psychic citizenship in a community. Mental health symptoms of colonization trauma, including anxiety, depression, fixation on trauma of historical insults, survivor guilt, and unresolved grief,[14] are also psychological consequences of the resettlement of aboriginal communities, for example, in which entire families and communities are restructured "around a long-lasting traumatic situation."[15] These concepts of psychic citizenship and transgenerational trauma, then, are key for postcolonial bioethics' interrogations of injustice in healthcare; they are reminders of the political, historical, and ethical importance of how identities of one's self and one's communities are shaped over time.

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Stigma, Narratives, World Travel, and Epistemic Violence

Some postcolonial critiques explain how colonial medicine has adversely affected people of color. Guyatri Spivak and Edward Said, for example, argue that it helped colonial powers subjugate people of color. From their arguments we can identify four key ideas for postcolonial bioethics:

1) Two projects of colonial medicine were to "identify and measure"[16] traits and behaviors of people targeted for conquest.
2) Colonial medicine used its social authority to render judgments about "normal" or "deviant" traits and behaviors.
3) Whiteness was the presumed norm, and bodies and minds of people of color were pathologized.[17,18]
4) Colonial medicine stigmatized people of color.[19]

Anthropologists Erving Goffman and Veena Das suggest that one function of stigma is to pathologize a condition, trait, or behavior that "marks" the bearer as unacceptable or inferior, imposing shame, guilt, and disgrace.[20,21] Anthropologist and psychiatrist Arthur Kleinman further explains that stigmatization undermines a person's humanity and promotes "moral exclusion"[22] of people with mental illness. Stigma motivates persons so marked to self-alteration ("passing"), self-erasure, or nullification of their apparent group identity[23] to try to meet majoritarian norms. In these cases, a dark-skinned and/or ill person's self-conception is vulnerable to being damaged by stigmatized views of her self in ways that a white, well person's is not. A postcolonial view of stigma suggests not only its capacity to negatively influence individuals' self-conceptions but its capacity to pathologize psychic citizenship among members of entire communities targeted for conquest.

The late contemporary novelist and mental health advocate Bebe Moore Campbell suggested that people of color can feel the stigma of mental illness more intensely than white people because of fear of being perceived as having "yet another deficit."[24] She suggests that the number of ways in which one is perceived as deviant contributes to how damaging stigma can be, but more can be said about how stigma actually damages a person's self-conception. The concept *infiltrated consciousness*[25] is instructive here, because it suggests the importance of narrative in transmitting damaging representations of members of colonized groups. A person's consciousness is infiltrated when she begins internalizing dominant groups' views of herself as damaged.[26] Infiltrated consciousness also illustrates how others' views can strongly influence a person's agency and capacity to direct her own life. When a person's consciousness becomes infiltrated, she defines herself in terms set for her by her (or her ancestors') oppressors and internalizes limitations on what she imagines herself to be capable of.

Bioethicists can fruitfully use this narrative conception of identity to consider how imperialism marginalizes psychic citizenship of people of color. One kind of marginalization has been characterized as "straddling worlds" or "being caught between worlds": in one "world" a person of color can feel pressure to assimilate to white, majoritarian norms, but in another "world," he might feel pressure to be authentically "ethnic." Navigation between worlds can adversely affect one's sense of self; as W.E.B. DuBois suggests when he coined the term "double

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consciousness,''[27] a person of color must be able to respond to situations *as she sees herself* as well as *how she is seen by others.* Philosopher María Lugones explains that a metaphor of travel can encompass and extend the ideas of navigating worlds and double consciousness. *World traveling* is how she describes ''the shift from being one person to being a different person'' in the white world and in the world in which she is ''at ease'' as a person of color. To be ''at ease'' in a world is to ''experience oneself as an agent in a fuller sense than one experiences oneself in other worlds.''[28] Lugones also argues that world travel is ''a matter of necessity and of survival.'' Furthermore, she argues that the mental and emotional stamina required for world travel are skills undervalued by dominant, presumptively normal cultures.[29]

An upshot for bioethics, then, is that analytical work toward health justice requires recognizing and problematizing the roles played by colonial medicine in stigmatizing psychic citizenship in communities of color. Clinically, world travel must be acknowledged as a survival skill. At the policy level, social and cultural barriers that make world travel unnecessarily difficult need to be named and eliminated. Postcolonial bioethics motivates these goals.

Spivak also argues that stories can be vectors by which colonizers' damaging views of people of color have inflicted *epistemic violence* on people of color because their identities have been ''re-codified'' to be more easily discernible to white, well community members.[30] A person suffers epistemic violence when her ways of knowing about and expressing thoughts about her world are eliminated and she must adopt colonizers' ways of knowing, even about herself. So, a fifth key idea for postcolonial bioethics at the intersection of racial and ethnic inequalities in healthcare and underservice to people with mental illnesses is as follows:

5) Narrative legacies of colonial medicine can continue to exacerbate epistemic violence suffered by persons of color.

Postcolonial bioethicists might investigate, for example, how present-day racial microaggressions[31] in clinical encounters and elsewhere perpetuate damaging views of people of color and undermine their epistemic authority and agency.

Postcolonial Bioethics and Health Justice

Historically, normative concepts of Western whiteness regarding healthy physical and mental ways of being once justified conscripting the bodies of people of color to fortify power, wealth, and continued superiority of white colonizers. But present inferior health status, worse healthcare access, and geographic marginalization of black Americans and Native Americans suggest reasons to rigorously interrogate current health policy and practice, too. For example, people of color die at younger ages than white people; evidence suggests that transgenerational inequalities reinforced by colonialisms cumulatively ''pile up''[32,33] to promote premature death. Understanding these risk factors is not only a clinical matter but a matter of justice, demanding closer scrutiny from bioethics through a postcolonial lens.

Globally, mental illnesses constitute about 14 percent of disease burden,[34] and in the United States, the yearly prevalence is 20 percent.[35] People with chronic mental illnesses sometimes get their needs met during acute exacerbations, but policy decisions since 1950 are a cause of their worse quality of and access to

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healthcare.[36] Although mental illnesses are leading causes of disability, services for mental illness are one of the least funded and lowest reimbursed medical conditions by U.S. health insurers.[37]

Postcolonial bioethics is equipped to interrogate the history and legacy of such marginalization of mental health services. The health injustice literature thus far has inadequately considered influences of infiltrated consciousness, epistemic violence, and social devaluation on the mental health status of members of communities whose ancestors were targets for conquest, slavery, or annihilation. Although Hispanic Americans, Asian Americans, and black Americans apparently have fewer mental disorders than white Americans,[38] these same groups are more persistently ill when they do suffer mental illnesses.[39] Clinicians also tend to misdiagnose and inadequately manage symptoms of mental illnesses in patients of color.[40] Depression is more likely to be "chronic, severe, disabling and untreated" among black Americans; schizophrenia is overdiagnosed, and mood disorders are underdiagnosed.[41] Unequal application of restraints is another problem: "Local nonclinical factors, such as cultural biases . . . have a greater influence on rates of restraint and seclusion"[42] than symptom management or regard for an individual patient's safety.

The historical trauma of colonialism is an important cause of American Indians' increased risk for posttraumatic stress disorder (PTSD) and alcohol dependence.[43] The highest rates of suicide in the United States are among American Indians and Alaska Natives.[44] Asian Americans are 25 percent less likely than whites to seek outpatient care and are less likely than whites to receive inpatient care. Perhaps because Asian Americans are so frequently stereotyped as model minorities, when Asian Americans do seek mental healthcare, they are more likely to be misdiagnosed or have the severity of their symptoms underestimated.[45]

Compared to traditional bioethical theoretical approaches, a postcolonial framework can more powerfully consider ethical and historical dimensions of these inequalities. I suggested five key points postcolonial bioethicists can use to interrogate intersections of racial and ethnic inequalities in healthcare, emphasizing underservice to people with mental illnesses. I explained how a postcolonial viewpoint illuminates how poor health and healthcare system outcomes for people of color are not mere unfortunate accidents but public health crises that are legacies of historical trauma. For example, one point readily illuminated through a postcolonialist lens is that Asian Americans and Native Americans tend to have their cultural backgrounds pathologized in ways that mask the importance of past and present struggles for political and historical recognition.[46,47] This phenomenon is a good example of a class of health experiences related to historical trauma and mental healthcare that draw attention to two important things: cross-cultural communication in clinical encounters and multicultural education for health professions students.

The work of literary critic David Eng and social worker Shinhee Han suggests that current clinical approaches retain aspects of "old" ethnopsychiatry steeped in "an ecology of whiteness bent on the obliteration of cherished minoritarian subjectivities."[48] They write, "When Asian Americans seek therapy, for example, their mental health issues—overwhelmingly perceived as intergenerational family conflicts—are often diagnosed as being exclusively symptomatic of *cultural* (not political) conflicts."[49] Eng and Han suggest that professional caregivers sometimes assume that a person's culture or family is a more significant source of mental health problems than the possible transgenerational impact of historical

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insults on their political status—such as the anti-Chinese immigration policies of the late nineteenth and early twentieth centuries or the internment of Japanese Americans during World War II.

I have drawn on the public health literature and postcolonial thought to explain how historical trauma has transgenerational impact. Symptoms such as depression, anxiety, grief, anger, aggression, shame, reduced self-worth, fear, withdrawal, and isolation are all mental illnesses or symptoms that can be expressed by those who suffer legacies of racism and other oppressions and historical insults wrought by colonialisms. Because it is passed on in the stories of families, communities, and societies, historical trauma can "obliterate" a person's sense of time, temporal self, and ancestral connection.[50] Such experiences are not only clinically relevant but ethically important in health justice analyses.

One such justice concern would be how the transgenerational impact of epistemic violence in communities of color influences clinical encounters and health policy. Another relates to cross-cultural clinical practice. A significant literature has now addressed needs for educating caregivers in multiculturalism, including how social location informs illness experiences and how (conscious or unconscious) oppressive expressions and stances can influence caregivers' relationship with patients.[51] Some accounts stress the cultural limitations of Eurocentric approaches, typical in Western (allopathic) medicine,[52] in meeting needs of patients of color. Other accounts suggest that the ways in which we teach medical students about multiculturalism are problematic. Bioethicist Delese Wear, for example, describes how the process of teaching medical students about the characteristics and health beliefs of "others" is flawed:

> When medical students learn *characteristics* of . . . groups, they can provide better health care because they will no longer hold ignorant or biased beliefs about those groups. The problem with this approach is that groups of people are often essentialized, lumped together, all of their members possessing traits unilaterally. Within this orientation people are rarely viewed as complex interplays of identities . . . but rather are viewed as one overarching identity, so that care givers' attitudes toward such patients can sometimes remain simplistic.[53]

Wear suggests that Henry Giroux's notion of *insurgent multiculturalism*[54] be used to characterize educational efforts in cross-cultural healthcare practice, instead of "cultural proficiency" or "cultural competency." Like postcolonialism, insurgent multiculturalism emphasizes the influence of power and authority distribution in social structures (including those in healthcare), rather than making minoritarian perspectives a subject of study by members of health professions.

Insurgent multiculturalism efforts in health professions education can be effectively reinforced with the key ideas from postcolonial thought I introduced earlier. Wear echoes the concerns of Eng and Han, who suggest that using culture-based lists of traits and lists of dos and don'ts[55] dehumanize patients of color as mere subjects of a "multicultural fantasy."[56] Furthermore, terms such as "proficiency" and "competency" are problematic when they presuppose that the cultural diversity of "others" is a variable that falls under the purview of clinicians' expertise. From a postcolonial point of view, such approaches are suspicious because they are presumptively managerial.

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Kleinman proposes that training health professionals in ethnography should replace proficiency- and competency-based approaches to multiculturalism in clinical encounters. He suggests how ethnography can help clinicians promote discussions with patients about the meanings of illness in their lives.[57] With this approach, patients determine what information to share, a power-sharing move that fosters clinicians' humility.[58] Ethnographers' capacities to learn about people are dependent on the degree to which they are seen as trustworthy, so they must work to cultivate awareness of the influences of their own cultural background on their ability to identify issues of interest and collect information. An ethnographic approach to multiculturalism can be helpful in healthcare because every encounter between a clinician and a patient is a cross-cultural one; medicine, nursing, pharmacy, dentistry, social work, occupational therapy, and physical therapy are cultures (with their own standards of socialization, merits, and drawbacks) that can strongly influence practitioners' relationships with patients and communities. A possible role for bioethicists would be to examine, empirically and ethically, whether and how ethnographic approaches effectively motivate clinicians' capacities to better account for transgenerational features of patients' health or motivate more just clinical practice and policies.

Conclusion

Bioethicist Catherine Myser suggests generally that postcolonial thought can make bioethics "more self-reflective and inclusive."[59] Specific key points from postcolonial thought identified here suggest reasons why distrust rather than trust might reasonably be the default position from which many patients of color orient themselves to Western (allopathic) medicine. Important recent projects of professional bioethics have been to strengthen clinicians' cross-cultural practice skills and motivate progress in health policy to eliminate racial and ethnic inequalities in health status and healthcare access. I've argued here that postcolonial bioethics enables richer understandings of the intersections of those inequalities with underservice to people with mental illnesses; forges new avenues of scholarly inquiry into these areas of health justice, public health research, and historical trauma; and illuminates ways to improve our teaching of cross-cultural practice with health professions students. Postcolonial thought challenges medicine to account for its colonial history and for having wielded its authority in ways that stigmatized and pathologized psychic citizenship in communities of color. It also challenges bioethicists to attend carefully to the complex conceptual and practical features of historically entrenched patterns of oppression that are the roots of some continuing, current, and neglected health injustices.

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