Black Disease: An Interview with Jonathan Metzl

In the late-1960s, schizophrenia's profile as a disease changed dramatically
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First, some preliminaries about your fascinating book, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Beacon, 2010). How did you come to unearth such a trove of important documents at Ionia State Hospital in northeastern Michigan?

Ionia State Hospital for the Criminally Insane was, for much of the twentieth century, one of the nation's more notorious mental asylums, occupying an incredible 529 acres, and its annual census hovered above 2,000 patients. But, like many American asylums, Ionia suffered a rapid fall from grace in the late 1960s and early 70s, during the so-called era of deinstitutionalization. By 1974, the census was a paltry 300, and in 1975 the facility closed, then quickly reopened—as a prison.

That rapid transformation fascinated me. What had happened to the patients? What had changed? Why did the hospital become a prison? I spent a long time searching for the records, and ultimately discovered that much of the hospital's institutional memory—nearly a century of patient charts, reports, photographs, ledgers, and other artifacts—had been placed randomly in storage in the State Archive of Michigan, in Lansing. I spent another year gaining clearance from various review boards since of course the archive contains highly personal and confidential information, then spent the next four years reviewing the charts of over 800 patients.

What I found troubled me greatly. As I write in the book, "the charts documented in minute detail the tragedy of what it meant to be warehoused in a state asylum at mid-century—and, in particular, in an asylum where short court sentences devolved into lifelong incarceration. A number of charts contained yearly notes from patients to their doctors voicing such sentiments as *Doc, I really think I am cured* or *Dear Doctor, I believe I am ready to go home, or, You have no right to keep me here.* These letters stacked thirty-deep in some charts, signifying years of pleading and longing and anger, together with thirty years of responses from clinicians urging, *You are almost there*, or: *Perhaps next year*. Invariably, the last note in each stack was a death certificate from the Ionia coroner."

When did you first suspect that diagnostic patterns with schizophrenia had become heavily racialized?

I found dramatic racial and gender shifts in persons diagnosed with schizophrenia at Ionia during the 1960s—so much so that schizophrenia's racial and gendered transformation became the central narrative of my book. This shift became apparent very early in my research. Before the 60s, Ionia doctors viewed schizophrenia as an illness that afflicted nonviolent, white, petty criminals, including the hospital's considerable population of women from rural Michigan. Charts emphasized the negative impact of "schizophrenogenic styles" on these women's abilities to perform their duties as mothers and wives.

To say the least, these patients were not seen as threatening. *This patient wasn't able to take care of her family as she should,* read one chart; another, *This patient is not well adjusted and can't do her housework*; and another, *She got confused and talked too loudly and embarrassed her husband.*

By the mid- to late-1960s, however, schizophrenia was a diagnosis disproportionately applied to the hospital's growing population of African American men from urban Detroit. Perhaps the most shocking evidence I uncovered was that hospital charts "diagnosed" these men in part because of their symptoms, but also because of their connections to the civil rights movement. Many of the men were sent to Ionia after convictions for crimes that ranged from armed robbery to participation in civil-rights protests, to property destruction during periods of civil unrest, such as the Detroit riots of 1968. Charts stressed how hallucinations and delusions rendered these men as threats not only to other patients, but also to clinicians, ward attendants, and to society itself. You'd see comments like *Paranoid against his doctors and the police*. Or, *Would be a danger to society were he not in an institution.*

Did the second edition of the *DSM*, released in 1968, have a significant influence on that shift in emphasis?

One of the key pieces of evidence I use to help explain the shifts seen at Ionia is through an extensive analysis of the changing language associated with the official psychiatric definition of schizophrenia. Before the 60s, psychiatry often posited that schizophrenia was a psychological "reaction" to a splitting of the basic functions of personality. Official descriptors emphasized the generally calm nature of such persons, in ways that encouraged associations with middle-class housewives.

But the frame changed in the 60s. In 1968, in the midst of a political climate marked by profound protest and social unrest, psychiatry published the second edition of the *Diagnostic and Statistical Manual*. That text recast the paranoid subtype of schizophrenia as a disorder of masculinized belligerence. "The patient's attitude is frequently hostile and aggressive," *DSM-II* claimed, "and his behavior tends to be consistent with his delusions." I have a lot of data in my book that shows how this language—particularly terms such as "hostility" and "aggression"—was used to justify schizophrenia diagnoses in black men at Ionia in the 1960s and 1970s.

How would you explain that shift, and would you view American psychiatry in those years as exhibiting either manifest or unconscious racism? Was it just coincidence that the *DSM-II* language enabled the diagnosis of schizophrenia among increasing numbers of African Americans?

That's a very important question. I argue extensively in my book that the purpose of my analysis is not to lay blame for individual racism, because I feel that such blame-games oversimplify what was going on. Many of the doctors at Ionia genuinely wanted to help their patients. I also talk to psychiatrists who worked on the *DSM-II* who told me that they were trying to do the best they could to produce scientific, objective diagnostic criteria.

At the same time, my evidence shows how even the most scientific diagnostic criteria can reflect the social environments in which they are produced, a process I discuss through the language of structural or institutional violence.

This was certainly the case for the *DSM-II*. As I show, the manual's emphasis on hostility and aggression reflected a much-wider set of national conversations and anxieties about civil rights. The shifting frame surrounding schizophrenia had dire consequences for African American men held at the Ionia State Hospital during the civil-rights era. More broadly, my evidence also shows that growing numbers of research articles in professional journals used this language to cast schizophrenia as a disorder of racialized aggression.

In the worst cases, psychiatric authors conflated the schizophrenic symptoms of African American patients with the perceived schizophrenia of civil rights protests, particularly those organized by Black Power, the Black Panthers, the Nation of Islam, or other activist groups. Ultimately, new psychiatric definitions of schizophrenic illness in the 60s impacted persons of many different racial and ethnic backgrounds. Some patients became schizophrenic because of changes in diagnostic criteria rather than in their clinical symptoms. Others saw their diagnoses changed to depression, anxiety, or other conditions because they did not manifest hostility or aggression.

How did the psychiatric profession characterize schizophrenia before the first and second editions of the *DSM*?

Insanity has a long and fascinating history. Before the advent of what we call "modern psychiatry," conventional wisdom had it that specific actions and life events caused specific types of insanity. Paupers Lunacy was thought to result from habitual intemperance, poverty, and destitution, treated by a diet of wholesome digestible bread and milk porridge, along with occasional topical bleedings. Masturbatory Insanity came from onanistic self-corruption and led to a form of idiocy manifest by sallow skin, lusterless eyes, flabby muscles, loose stools, and, of course, cold and clammy hands. And Old Maid's Insanity was, as the name implied, the insanity of old maids.

Two key figures helped to change the course of how we think about insanity. Emil Kraepelin was foremost among a group of European clinicians who defined insanity not according to causes or symptoms, but according to course and prognosis. In 1899, he coined the term *dementia praecox* to describe the "development of a peculiar simple condition of mental weakness occurring at a youthful age." And in 1911, Swiss psychiatrist Paul Eugen Bleuler argued that the underlying mechanism in *praecox* was a "loosening of associations," a process in which patients existed in the real world and at the same time turned away from reality ("autism") into the world of fantasy, wishes, fears, and symbols.

As an early proponent of Freudianism, Bleuler placed psychosis on a spectrum with neurosis as a developmental disorder with childhood origins. He maintained that the term *dementia praecox* should be replaced by a name that combined the Greek words for split (*schizo*) and mind (*phrene*). "I call dementia praecox ‘schizophrenia,' " he wrote, "because the ‘splitting' of the different psychic functions is one of its most important characteristics."

You make a powerful case for the way schizophrenia was transformed into a racialized disease at Michigan's Ionia State Hospital. To what extent can one extrapolate from that large psychiatric hospital broader trends across the country?

As a cultural historian and psychiatrist, I'm able to show how trends at Ionia reflect a series of larger cultural trends. One key literature that emerges in the 60s concerns the persistent race-based overdiagnosis of schizophrenia in African American men. For instance, in the 60s, National Institute of Mental Health studies found that "blacks have a 65% higher rate of schizophrenia than whites." In 1973, a series of studies in the *Archives of General Psychiatry* discovered that African-American patients were "significantly more likely" than white patients to receive diagnoses of schizophrenia, and "significantly less likely" than white patients to receive diagnoses for other mental illnesses such as depression or bipolar disorder. Throughout the 1980s and 90s, a host of articles from leading psychiatric and medical journals showed that doctors diagnosed the paranoid subtype of schizophrenia in African-American men *five to seven times* more often than in white men, and also more frequently than in other ethnic minority groups.

I also document in the book how associations between insanity and the civil rights movement played out extensively in American popular culture, and helped to shape the emergence of a much wider set of stigmatizations of schizophrenia—that it was an unduly hostile or violent disorder. I look closely at changing twentieth-century American assumptions about the race and temperament of schizophrenia through sources including American medical journals, newspapers, popular magazines, historically Black newspapers, studies of popular opinion, music lyrics, films, and civil-rights memoirs. I also reproduce unbelievable pharmaceutical advertisements that show angry black men protesting in the streets as ways of selling antipsychotic drugs.

I don't know if you're following *DSM-5* developments closely, but there's been an enormous amount of controversy over "psychosis risk syndrome," which is being proposed for inclusion in 2013 as a way of improving the "early detection" of psychosis, especially in teens and children. Given the history you've unearthed about schizophrenia, are you confident that "psychosis risk" will function largely as the APA intends or are there likely to be unintended consequences if it's included in *DSM-5*?

Yes, I'm following this very closely. On one hand, I have to say that there is something very admirable about a profession that is willing to throw its entire diagnostic system up for grabs every fifteen years or so, and to seriously consider each and every word of its diagnostic bible. I also think that psychiatry has made great strides toward understanding the causes of mental disease, so in this sense the revision of the *DSM* represents progress on many fronts.

Yet history teaches us to be wary of language that might broaden diagnostic categories (or, in this case, might pathologize *risk* in addition to *illness*), especially when that broadening is not supported by clear-cut scientific facts. Also, it goes without saying that the language that appears in the *DSM* has tremendous implications for the lives of a great many people, patients and doctors both. Even in an era dominated by neuroscience, diagnosis remains a projective act—one that combines scientific understanding with a complex set of ideological assumptions.

You're a psychiatrist, and one who's critical of your profession's history, as is clear from both this book and your earlier one, *Prozac on the Couch* (Duke, 2003). How do you personally negotiate such professional tensions, and what in your opinion would help to narrow and alleviate them for other psychiatrists concerned about the state of their discipline?

Let me say, first, that in no way is my work meant to suggest that mental illness is socially fabricated, or, worse, that people's suffering is somehow inauthentic. As a psychiatrist, I have seen the tragic ways in which hallucinations, delusions, social withdrawal, cognitive decline, and profound isolation rupture lives, careers, families, and dreams in profoundly material ways. I know that such symptoms afflict persons of many different social, economic, and racial backgrounds, most all of whom are deeply aware of the sense of loss that their disease represents, even if society is less attuned. I also strongly believe that persons diagnosed with schizophrenia and other mental illnesses benefit from various forms of treatment or social support, and that our society should invest more in the care and well-being of the severely mentally ill.

I also believe that vigorous debate is good for psychiatry—both from outside the profession, and from within it. In previous eras, critics adopted a so-called antipsychiatric stance that advocated the near-overthrow of the profession. And to be sure, important critics still advocate for massive change. We know all too well from plagues past that the rhetoric of mental health and mental illness can become effective ways of policing the boundaries of civil society, and of keeping undesirable persons always outside.

But today you also see increasing numbers of scholars like myself who believe in the therapeutic and even potentially liberatory promise of the profession, while remaining deeply concerned about such issues as the impact of the pharmaceutical industry, the stigma surrounding diagnosis, and the expanded use of psychotropic medications, to name but a few.

I would like to think that books like mine help us understand how tensions that seem timeless or eternal—whether related to mental illness stigma, the overuse of psychotropic drugs, racial stereotypes surrounding psychiatric diagnosis, or even mistrust of psychiatry by members of minority communities—in fact result from particular decisions made at specific moments in time. I write in the book, "only during the civil-rights era did emerging scientific understandings of schizophrenia become enmeshed in a set of historical currents that marked particular bodies, and particular psyches, as crazy in particular ways. The tensions of that era then changed the associations that many Americans made about persons with schizophrenia. Ultimately, recent American racial history altered more than the meaning of mental illness: it changed the meaning of mental health as well."

Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Beacon Press, 2010).