The Protest Psychosis
HOW SCHIZOPHRENIA BECAME A BLACK DISEASE

Jonathan M. Metzl
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This book tells the story of how race gets written into the definition of mental illness. It uncovers the surprising ways anxieties about racial differences shape clinical encounters, even when the explicit races of doctors and patients are not at issue. The book also shows how historical concerns about racial protest reverberate through treatment institutions and subvert even well-intentioned efforts to diagnose people or to help them. Ultimately, the book explores the processes through which American society equates race with insanity; and through which our definitions of both terms change as a result.

It is well known, of course, that race and insanity share a long and troubled past. In the 1850s, American psychiatrists believed that African American slaves who ran away from their white masters did so because of a mental illness called drapetomania. Medical journals of the era also described a condition called dysesthesia aethiopis, a form of madness manifest by “rascality” and “disrespect for the master’s property” that was believed to be “cured” by extensive whipping. Even at the turn of the twentieth century, leading academic psychiatrists shamefully claimed that “Negroes” were “psychologically unfit” for freedom.1

We have undoubtedly progressed since that time. Terms such as drapetomania fill the dustbin of history, and rightly so. Yet, in unintended and often invisible ways, psychiatric definitions of insanity continue to police racial hierarchies, tensions, and unspoken codes in addition to separating normal from abnormal behavior. Sometimes, the boundaries of sanity align closely with the perceived borders of the racial status quo. Mainstream culture then defines threats to this racial order as a form of madness that is, still, overwhelmingly located in the minds and bodies of black men. At other times, members of minority communities use the language of insanity to describe the psychical effects of living in racist societies. In these instances and others, questions of who is mentally ill and why orbit around American race relations and their discontents. And seemingly hermetic clinical encounters between psychiatrists and patients unconsciously mirror larger conversations about the politics of race.
As a beginning illustration of the book's main point, consider a prominent story that appeared on the front page of the Washington Post on June 28, 2005. "Racial Disparities Found in Pinpointing Mental Illness" read the headline. The article detailed a discovery that was at once shocking and sadly familiar. Researchers had examined the largest American registry of psychiatric patient records looking for "ethnic trends" in schizophrenia diagnoses. As the Post described it, schizophrenia, "a disorder that often portends years of powerful brain-altering drugs, social ostracism and forced hospitalizations... has been shown to affect all ethnic groups at the same rate." And yet, the large government study uncovered striking categorical differences in its analysis of 134,523 case files: doctors diagnosed schizophrenia in African American patients, and particularly African American men, four times as often as in white patients. The Post cited the study's lead author, John Zeber, who explained that doctors overdiagnosed schizophrenia in African American men even though the research team uncovered no evidence that "black patients were any sicker than whites," or that patients in either group were more likely to suffer from drug addiction, poverty, depression, or a host of other variables. According to Zeber, "the only factor that was truly important was race."2

Paradoxically, we live in an era when the opposite is supposed to be the case: race should be entirely unimportant to psychiatric diagnosis. Present-day psychiatry believes that mental illness results from disordered brain biology at levels that are presumably the same in people of all races and ethnic backgrounds. And psychiatrists consider schizophrenia to be the most biologically based of the mental illnesses. Leading journals routinely attribute symptoms of the illness—officially defined as delusions, hallucinations, disorganized speech, disorganized or catatonic behavior, or so-called negative symptoms such as affective flattening—to defects in specific brain structures, peptides, or neurotransmitters. Articles that describe research into the causes of the illness thus carry titles such as "Conserved Regional Patterns of GABA-Related Transcript Expression in the Neocortex of Subjects with Schizophrenia" or, incredibly, "Smaller Nasal Volumes as Stigmata of Aberrant Neurodevelopment in Schizophrenia." Meanwhile, textbooks routinely claim that, as a biological disorder, schizophrenia is an illness that should occur in 1 percent of any given population, or one out of every hundred persons regardless of where they live, how they dress, who they know, or what type of music they happen to prefer.3

Yet, in the real world, 1 percent is a delusion. Not only do stories such as the Post article appear with regularity—they persist over time. In the 1960s, 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 schizophrenia diagnoses, and "significantly less likely" than white patients to receive diagnoses for other mental illnesses such as depression or bipolar disorder. Throughout the 1980s and 1990s, 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.4

Everyday racism seems a reasonable explanation for these findings. Though we might wish otherwise, medical training does not wholly free clinicians from preexisting racial beliefs, assumptions, or blind spots. While medicine has undoubtedly made significant progress toward addressing multicultural issues in clinical practice, some doctors undoubtedly harbor negative opinions about particular patients based on stereotyped cultural assumptions. As Francis Lu, a psychiatrist at the University of California at San Francisco, explains it "physician bias is a very real issue... we don't talk about it—it's upsetting. We see ourselves as unbiased and rational and scientific."5

This book makes a broader claim: from a historical perspective, race impacts medical communication because racial tensions are structured into clinical interactions long before doctors or patients enter examination rooms. To a remarkable extent, anxieties about racial difference shape diagnostic criteria, health-care policies, medical and popular attitudes about mentally ill persons, the structures of treatment facilities, and, ultimately, the conversations that take place there within.

Stokely Carmichael, the civil rights activist, once described such a process as institutional racism, by which he meant forms of bias embedded not in actions or beliefs of individuals, but in the functions of social structures and institutions. "I don't deal with the individual," he said. "I think it's a cop-out when people talk about the individual." Instead, Carmichael protested the silent racism of "established and respected forces in the society" that functioned above the level of individual perceptions or intentions, and that worked to maintain the status quo through such structures as zoning laws, economics, schools, and courts. Institutionalized racism, he argued, "is less overt, far more subtle, less identifiable in terms of specific individuals committing the acts, but is no less destructive of human life."6

In a perfect world, interactions between doctors and patients should be
immune from any process deemed destructive to health. The Hippocratic Oath decrees that the primary aim of medical encounters is to restore, not to harm. Most physicians, myself included, enter the practice of medicine out of a desire to help people. And most patients seek the aid of physicians in times when they require palliation and care.

However, as the pages that follow reveal, institutional forces supersede even the best individual intentions when race and insanity are the topics of diagnostic interaction. The book looks closely at changing twentieth-century American assumptions about race and schizophrenia through sources including American medical journals, newspapers, popular magazines, pharmaceutical advertisements, historically black newspapers, studies of popular opinion, music lyrics, films, and civil rights memoirs. Most important are a series of previously unstudied "White" and "Negro" case files from the archives of the Ionia State Hospital for the Criminally Insane in Ionia, Michigan, where racial tensions dominated interactions between doctors and patients. Taken together, these sources suggest that, far from being a timeless phenomenon, institutional racism waxes and wanes, becoming more powerful in the context of specific moments when racial tensions rise to the fore of American consciousness.

The Protest Psychosis traverses the period from the 1920s to the present day, but focuses mainly on a series of transformations that occurred during the American civil rights era of the 1960s and 1970s. During this vital period, new clinical ways of defining mental illness unintentionally combined with growing cultural anxieties about social change. Meanwhile, reports about new "psychochemical" technologies of control merged with concerns about the "uncontrolled" nature of urban unrest. As these historical contingencies evolved, the American public, and at times members of the scientific community, increasingly described schizophrenia as a violent social disease, even as psychiatry took its first steps toward defining schizophrenia as a disorder of biological brain function.

It was not always so. Prior to the civil rights movement, mainstream American medical and popular opinion often assumed that patients with schizophrenia were largely white, and generally harmless to society. From the 1920s to the 1950s, psychiatric textbooks depicted schizophrenia as an exceedingly broad, general condition, manifest by "emotional disharmony," that negatively impacted white people's abilities to "think and feel." Authors of research articles in leading psychiatric journals, many of whom were psychoanalysts, described patients with schizophrenia, and, all too often, their "schizophrenogenic mothers," as "native-born Americans" or immigrants of "white European ancestry." Psychiatric authors frequently assumed that such patients were nonthreatening, and were therefore to be psychotherapeutically nurtured by their doctors, as if unruly children, but certainly not feared.7

Leading mainstream American newspapers in the 1920s to the 1950s similarly described schizophrenia as an illness that occurred "in the exclusive, sensitive person with few friends who has been the model of behavior in childhood," or that afflicted white women or intellectuals. In 1935, for instance, the New York Times described how many white poets and novelists demonstrated a symptom called "grandiloquence," a propensity toward flowery prose believed to be "one of the telltale phrases of schizophrenia, the mild form of insanity known as split personality." Meanwhile, popular magazines such as Ladies' Home Journal and Better Homes and Gardens wrote of unhappily married, middle-class white women whose schizophrenic moods were suggestive of "Doctor Jekyll and Mrs. Hyde," a theme that also appeared in Olivia de Havilland's infamous depiction of a "schizophrenic housewife" named Virginia Stuart Cunningham in the 1948 Anatole Litvak film, The Snake Pit.8

Of course, it was far from the case that all persons who suffered from a disease called schizophrenia during the first half of the twentieth century were members of a category called white. Rather, American culture marked schizophrenia as a disease of the mainstream in ways that encouraged identification with certain groups of people while rendering other groups invisible. For example, popular magazines in the 1920s to the 1950s incorrectly assumed that schizophrenia was a psychoanalytic condition connected to neurosis, and as a result affixed the term to middle-class housewives. Meanwhile, researchers conducted most published clinical studies in white-only wards. Such strategies occluded recognition of the countless men and women diagnosed with schizophrenia who resided in so-called Negro hospitals and suffered well outside most realms of public awareness.9

American assumptions about the race, gender, and temperament of schizophrenia changed beginning in the 1960s. Many leading medical and popular sources suddenly described schizophrenia as an illness manifested not by docility, but by rage. Growing numbers of research articles from leading psychiatric journals asserted that schizophrenia was a condition that also afflicted "Negro men," and that black forms of the illness were marked by volatility and 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, Black Panthers, Nation of Islam, or other activist groups.
As but one example, the title of this book comes from a 1968 article that appeared in the prestigious Archives of General Psychiatry, in which psychiatrists Walter Bromberg and Frank Simon described schizophrenia as a "protest psychosis" whereby black men developed "hostile and aggressive feelings" and "delusional anti-whiteness" after listening to the words of Malcolm X, joining the Black Muslims, or aligning with groups that preached militant resistance to white society. According to the authors, the men required psychiatric treatment because their symptoms threatened not only their own sanity, but the social order of white America. Bromberg and Simon argued that black men who "espoused African or Islamic ideologies, adopted "Islamic names" that were changed in such a way so as to deny "the previous Anglicization of their names" in fact demonstrated a "delusional anti-whiteness" that manifest as "paranoid projections of the Negroses to the Caucasian group."10

Advertisements for new pharmaceutical treatments for schizophrenia in the 1960s and 1970s depicted similar themes. As I discuss in a later chapter, advertisements for the antipsychotic medication Haldol in leading psychiatric journals showed angry black men with clenched fists, Black Power fists in urban scenes whose symptoms of social belligerence required chemical management.

Meanwhile, mainstream white newspapers in the 1960s and 1970s described schizophrenia as a condition of angry black masculinity, or warned of crazed black schizophrenic killers on the loose. "FBI Adds Negro Mental Patient to '10 Most Wanted' List" warned a Chicago Tribune headline in July 1966, above an article that advised readers to remain clear of "Leroy Ambrosia Frazier, an extremely dangerous and mentally unbalanced schizophrenic escapee from a mental institution, who has a lengthy criminal record and history of violent assaults." Hollywood films such as Samuel Fuller's 1963 B-movie classic, Shock Corridor, similarly cast the illness as arising in black men, and particularly men who participated in civil rights protests.11

Schizophrenia's rhetorical transformation from an illness of white feminine docility to one of black male hostility resulted from a confluence of social and medical forces. Some of these forces were obvious, such as the biased actions of individual doctors, researchers, or drug advertisers, while others functioned at structural levels beyond individual perceptions. One of the key pieces of evidence I use to uncover this later process is an analysis of shifting language associated with the official psychiatric definition of schizophrenia. Prior to the 1960s, psychiatric classification systems 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 1960s. 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 (DSM). That text recast the paranoid subtype of schizophrenia as a disorder of masculinized belligerence. "The patient's attitude is frequently hostile and aggressive," the DSM-II claimed, "and his behavior tends to be consistent with his delusions." Growing numbers of research articles from the 1960s and 1970s used this language to assert that schizophrenia was a condition that also afflicted "Negro men," and that black forms of the illness were more hostile and aggressive than were white ones.12

As we will see, the shifting frame surrounding schizophrenia had dire consequences for African American men held at the Ionia State Hospital during the civil rights era. Prior to this era, Ionia doctors considered schizophrenia to be 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. By the early 1970s, however, schizophrenia was a diagnosis disproportionately applied to the hospital's growing population of African American men from urban Detroit. Ionia doctors used the DSM-II and other diagnostic tools to link these men's symptoms to a host of era-specific racial anxieties, even if the men had no direct involvement in the civil rights movement. As a result, individual attempts to help these men took a backseat to structural attempts to control them. And patients who by all reasonable criteria should have been treated based on their character and intellect were instead interned because of the color of their suddenly schizophrenic skins.

Changing notions of schizophrenia in the 1960s and 1970s had wider implications as well. New psychiatric definitions of schizophrenic illness 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. Emerging understandings of the illness shaped American cultural fears about mental illness more broadly, particularly regarding cultural stereotypes of persons with schizophrenia as being unduly hostile or violent. In an important counternarrative that I discuss extensively in later chapters, new notions of schizophrenia also provided powerful language for civil rights leaders, who argued that insanity and rage arose not because of defects in black bodies, but because of violent racist ideals that emanated from the white society in which these bodies lived and worked.\(^\text{13}\)

In no way is my telling of this history meant to suggest that schizophrenia is a socially fabricated disease 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 of whom are deeply aware of the sense of loss that their disease represents, even if society is less attuned. I agree with the clinician and activist E. Fuller Torrey, who writes that "the lives of those affected [by schizophrenia] are often chronicles of constricted experiences, muted emotions, missed opportunities, unfulfilled expectations . . . the fate of these patients has been worsened by our propensity to misunderstand."\(^\text{14}\)

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. This reality was largely overlooked by leaders of the largely white "anti-psychiatry" movement of the 1970s, who argued that schizophrenia was a wholly political diagnosis whose constraints needed to be lifted in the name of emancipation. Thomas Szasz, David Cooper, and R. D. Laing were but a few of the activist psychiatrists who contended that mental illness was a "myth," or that psychiatry merely policed societal norms by pathologizing and controlling deviance. Claims about the mythic nature of mental illness emerged during a social moment when mistrust of many forms of authority, including doctors, shaped political thought. Yet in formatting arguments that were later seamlessly taken up by conservative ideologues, anti-psychiatrists overlooked the reality that, once free of the constraints of psychiatric terms or institutions, the newly liberated psychiatric patients often had nowhere to go and no one to turn to for help.

At the same time, this book centrally explores how the material reality of schizophrenia is shaped by social, political, and, ultimately, institutional factors in addition to chemical or biological ones. Too often, we assume that medical and cultural explanations of illness are distinct entities, or engage in frustratingly pointless debates about whether certain mental illnesses are either socially constructed or real. These debates often position political forces as existing outside of psychiatry's purview. Psychiatry focuses on dopamine, the logic goes, and leaves the social stuff to others. The current edition of the DSM goes so far as to separate genuine psychiatric illness, termed an Axis I diagnosis, from "Psychosocial and Environmental Factors," which are relegated to Axis IV.

Arguments for a clean divide between dopamine and culture misrepresent the profound interrelatedness of these two seemingly distinct explanations in clinical settings. Make no mistake, we psychiatrists want to know what causes mental disease, and biological science offers promising clues about nosology. But we are not there yet. We do not diagnose schizophrenia, depression, traumatic stress, or a host of other illnesses solely through X-rays, brain scans, or specific laboratory tests. Instead, we query, listen, observe, categorize, and expertly surmise. Thus, even in an era dominated by neuroscience, diagnosis remains a projective act, one that combines scientific understanding with a complex set of ideological and, as I will show, political assumptions. Cloaking our observations under the seemingly objective rubric of biological science renders these ideological functions all the more difficult to discern or critique.\(^\text{15}\)
Another misnomer that this book takes aim at is the belief that stigma against psychiatric illness cannot be changed because stigmatizing attitudes against the mentally ill are timeless, eternal, and, ultimately, immutable. *Beliefs about the volatility of madmen are as old as time itself,* we might say, and indeed we would be right. As the eminent historian Roy Porter aptly describes it, narratives of insane violence “may be as old as mankind,” and course through disparate religious texts and object lessons. Yet arguments about the timeless nature of stigma against schizophrenia often fail to address the impact of relatively recent events on present-day attitudes and beliefs. As we will soon see, *schizophrenia* was a European term, invented in the early twentieth century and imported to the United States around 1915. For decades, schizophrenia connoted white, American neurosis. 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 in ways that altered not just stigma against the illness, but the definition of the illness itself. Ultimately, recent American racial history altered more than the meaning of mental illness: it changed the meaning of mental health as well.16

As the *Washington Post* article demonstrates, this history continues to impact the lives of African American men. Research suggests that even African American doctors overdiagnose schizophrenia in African American men. African American men also receive higher dosages of antipsychotic medications than do white male psychiatric patients, and are more likely to be described by health care professionals as being hostile or violent. Such disparities have been remarkably resistant to interventions such as “cultural competency training” or “standardized” diagnostic encounters. For instance, the U.S. Department of Health and Human Services recently developed “Cultural Competence Standards” to help clinicians better understand, and communicate with, patients of diverse ethnic backgrounds. And the San Francisco General Hospital psychiatry department opened a “Black Focus Unit,” complete with clinicians of color, African art, and, as reported in the *Post*, “pictures of Vanessa Williams, Maya Angelou and Oprah Winfrey” on the walls.17

Yet, the problem of race-based misdiagnosis persists. Perhaps part of the reason why such interventions fail is that they focus exclusively on the race of the patient and of the doctor, and define the problem as arising in the intersection of these two races. By so doing, they align with the work of scholars of social interactions, from Erving Goffman to Glenn Loury, who assume that stigmatizing encounters occur between individuals when visual markers of difference—such as skin color—stand in for larger assumptions about good and bad. While valid, such an approach leaves free from scrutiny the third race that functions in the examination room: *that of the diagnosis,* and its structurally developed links to protest, resistance, racism, and other associations that work against therapeutic communication between doctors and patients.

History also lives on in instances where associations between schizophrenia and race suggest a “loosening of associations,” to use historian Keith Wailoo’s insightful description of the ways assumptions about the virulence of particular racial groups expand to impact all sufferers of a particular disease. For instance, negative perceptions of persons with schizophrenia as being unduly hostile or violent thrive in American society, even though these persons are exponentially more likely to be the victims than the perpetrators of violent acts. Meanwhile, as is well-known, people diagnosed with schizophrenia in the present day reside more often in penal than in psychiatric care facilities. While many complex economic and social factors contribute to such issues, their current composition also depends on a racialized logic that comes directly from the 1960s and 1970s, whereby schizophrenia represents both a mental illness and a threat to civilized society.18

In sum, then, this book tells the story of how civil rights-era anxieties about racial protest catalyzed associations between schizophrenia, criminality, and violence. It deeply respects psychiatric attempts to uncover the ontology of mental illness. But it also recognizes that the search for ontology is an ongoing process, and that the frames aggregating certain symptoms into particular psychiatric diagnoses exist in an ongoing state of flux. Such flux can be a positive force, to be sure: it allows psychiatry to redefine illnesses in ways that are more scientifically precise. But flux can also have abjectifying or stigmatizing consequences if its politics are not closely watched. Thus was the case in the 1960s and 1970s, when the newly narrowed frame surrounding paranoid schizophrenia circumscribed and helped create the category of angry, black, male schizophrenic subjects, while casting women, neurotics, manic depressives, and other thereby nonthreatening persons into expanding categories of depression, bipolar disorder, or anxiety disorders. Racial concerns, and at times overt racism, were thereby written into diagnostic language in ways that are invisible to us now. The book concludes by discussing how understanding this past enables new ways of addressing the implications of racial schizophrenia in the present. I specifically discuss antistigma efforts,
approaches to the role of race in clinical interactions, ways of understanding mistrust of psychiatry by members of minority communities, and efforts to combat linkages between criminality and mental illness.

My argument is indebted to many important scholars whose work deals with similar themes in far more comprehensive ways than I do here. Vital texts such as Harriet Washington's *Medical Apartheid*, Wailoo's *Dying in the City of the Blues*, and W. Michael Byrd and Linda A. Clayton's *An American Health Dilemma* detail the long history of injustice perpetuated by the American medical system to African American patients and communities. Masterworks such as Michel Foucault's *Madness and Civilization*, Gerald Grob's *The Mad Among Us*, David Rothman's *The Discovery of the Asylum*, and Nancy Tomes's *The Art of Asylum-Keeping* document the complex genealogies of psychiatric institutions in ways that provide context for my reading of the Ionia charts. Taylor Branch's trilogy, *America in the King Years*, remains a gold standard of civil rights-era histories. And writings by critical race studies scholars such as Angela Davis (*Women, Race and Class; Are Prisons Obsolete?*), Ruth Frankenberg (*White Women, Race Matters*), and Kimberlé Crenshaw ("The Intersection of Race and Gender") uncover the vital ways in which social categories such as race are never inherently pure, but instead intersect with other categories such as gender and social class. Davis, for instance, details how economic, social, and, ultimately, gender anxieties lie beneath American cultural beliefs about the volatility of black men, while Frankenberg deploys a feminist analysis of whiteness to argue, in language reflective of Carmichael, that "racism appears not only as an ideology or political orientation chosen or rejected at will; it is also a system and set of ideas embedded in social relations."

To be sure, we inhabit a current cultural moment in which American racial systems, ideas, and social relations promise improvement. The election of an African American president and a new national attention to matters of race suggests transformation not just in governance, but in long-held attitudes, beliefs, and everyday practices. Change is here, the moment tells us, and change will come.

Yet, the hospital charts, medical writings, and popular documents I examine in this book provide cautionary tales about the complex ways in which moments of change, and particularly moments that portend changed race or gender relations, produce anxieties about the stability of the status quo. The battles that follow—when the idea of change begins to produce actual change—appear for all the world to play out on the public stage: in an election, for instance, or in the White House, or in other, highly visible sites where newfound leaders, freedoms, or rights become markers of progress for some people and symbols of iniquitude for others.

History teaches us, however, that the brunt of the pushback against change is borne most by persons who, for various reasons, are least able to defend themselves or, as this book shows, to protest. These persons then become doubly or triply stigmatized based on unfounded generalizations about deviance, perceived volatility, abnormality, or other characteristics that remain acceptable modes of discrimination. Public concern about the actions or proclivities of these persons then grows, even as they themselves are rendered less than full citizens or are progressively removed from public life. As we know all too well from plagues past, the rhetorics of health and illness become effective ways of policing the boundaries of civil society, and of keeping these people always outside.

Thus was the case with schizophrenia in the 1960s and 1970s. Far beneath the national glare of bus boycotts, sit-ins, and marches, another hidden civil rights-era history unfolded in response to national events. Here, the currency was neither liberation nor equality, but containment. And the result was not increased voting rights, legal protections, educational access, or other hard-fought liberties. Instead, the civil rights era catalyzed a shift in the structure of buildings, institutions, diagnostic codes, and even in the structure of minds, attitudes, and identities. Schizophrenia literally, and then figuratively, became a black disease. And prisons emerged where hospitals once stood.
for playing with dolls of lighter skin color provided evidence of internalized psychological racism. Wertham similarly called on clinical research to testify that segregation caused “unsolvable emotional conflicts” in the minds of segregated children. Meanwhile, Kenneth Clark’s 1965 text, Dark Ghetto, described a “ghetto pathology” that led to “some Negroes having a complex and debilitating prejudice against themselves.”

Like psychiatric journals, the popular media also explicitly suggested that mental illness resulted not just from conditions of poverty, prejudice, and segregation, but from political attempts to change them. Schizophrenia in this context was a split between regress and progress, or between the part of the black psyche that wished to build and the part that plotted to burn. “Negro students” went to college to assimilate and ascend, but even at Yale these students threatened to immolate the school. Black leaders deplored violence even while they admired its political benefits. Hari Rhodes’s character Trent in Shock Corridor sought to improve the system, but in the end he fell back on primal, ghetto brutality and self-loathing. The message was that each step forward carried the threat of two steps back. The mind wished to advance in a civilized manner, but the body aggressively defended the old ways of doing business. Or, as Plato might have put it, the enlightened leaders of the polis were constitutionally connected to, and dragged back into violence by, the unruly hoi polloi.

In this sense, the American press cast the insanity of the marginalized through the projected anxieties of the mainstream. In the aftermath of Watts, Detroit, and other internal and internalized moments of chaos, mass-circulation newspapers and magazines defined schizophrenia as a condition that divided “good” blacks from their “bad” selves. One part wished to lead, the other hissed in the streets. One part sought to build, the other to destroy. This division unsuitably collapsed class struggle into race struggle, and then collapsed both into a struggle for sanity. Schizophrenia also provided a framework for dividing civilized blacks from unruly ones, the Martin Luther Kings and Jackie Robinsons who espoused nonviolence from the LeRoi Joneses, Stokely Carmichaels, and Rap Browns who did not. As the Time article “The Negro After Watts” described it,

In LeRoi Jones’s The Toilet, eight Negroes abuse a white boy and then beat him up. . . . Love and nonviolence, by contrast, is the overriding message of Martin Luther King, yet after the riot in the Watts section of Los Angeles, Governor Brown thought it prudent to discourage even King from visiting California. King went anyway—and thus inadvertently re-