CHAPTER IV

Fanon and Colonial Psychiatry

Background

It was not as a psychoanalyst but as a psychiatrist that Fanon sought to develop his insights. He was to increasingly focus on the cultural context of symptoms and the need to link therapy to the local culture of patients. After the completion of his degree in medicine, Fanon specialised in psychiatry. In the early 1950s he decided to study *thérapeutique institutionelle*. Its therapeutic focus on the importance of the social context must have had a strong appeal. He went to train with one of its leading lights in François Tosquelles whose goal was to 'restructure and transform the psychiatric hospital so that real psychotherapies could be practiced'. Influenced by psychodrama, developed in the USA in the late 1940s, milieu therapy sought to make the doctor one actor among many and the hospital community part of the wider community. Tosquelles argued that the mental patient is foremost a person who has become 'alien to his social environment' and though drug therapies remain useful the 'endeavour of re-structuration demanded the activist intervention of the social milieu'. To the psychiatrist the 'persistent and irreducible *sociality* of the patient' had to be the founding element of psychiatric practice. The focus then was on the relationship between the psychiatrist and the patient (rather than on symptoms) and the hospital as a micro environment to re-integrate patients back into community (Vergés 1996a: 87).

European psychiatry up to Fanon's time posited a fundamental difference between the psyches of Europeans and non-Europeans. The military doctor Antoine Porot, who set up the colonial mental health services in Algeria in 1913 pioneered this approach. The famous *École d'Algier de Psychaitrie* led the investigation into the 'native soul'. In 1918, Porot wrote the school's founding text *Notes de Psychiatric Musulmane*. In it he argued that clinical observations showed that the North African's lack of symbolisation was compounded by credulity, suggestibility and lack of curiosity. The school grappled with the question of how to link culture and the psyche. It proposed a series of features that characterised the colonised: an inferior language and thus an inability to conceptualise, a faith in magic, a belief in spirits and fatalism. Natives were seen as 'natural' criminals. 'Natives' were like children that needed a strong parent to help them on the road to maturity. However, they lacked the European child's curiosity (Vergés 1996a: 90).

Colonial psychiatry emerged in the second half of the nineteenth century. Its first subjects were the French working class, the poor and peasants who were said to be prone to excesses and displaying a pathology of degeneration that required preventative strategies. Psychiatry and psychology studied 'the pathology of the dangerous classes'. The social context was the industrialising French metropole that was turning peasants into Frenchmen. The development of social science, colonialism and anti-Semitism as well as rise of nationalism set the scene for the rise of new theories of social behaviour not necessarily based on biological conceptions of 'race' (Verges 1996a: 97).

The theories of the potential madness of the anarchist, communard or vagabond were extended to the colonised. In 1894 Gustave Le Bon proposed the idea of a 'psychological race', derived from Gobineau's racist theories. He was translated into ten languages and sold hundreds of thousands of books (Vergés 1996a: 98 n. 14). Le Bon also linked gender and race arguing that 'proof' of female

inferiority lay in the 'fact' of her cranial similarity with that of the Negro. Guided by Le Bon's approach Léopold de Saussure writing on the psychology of the colonised stated that:

> The acquisition of shared mental characteristics creates veritable 'psychological races'. The psychological characteristics are as stable as the anatomic characteristics upon which a classification of species was made. Psychological characteristics are reproduced, with regularity and constancy, like anatomic ones, through heredity (Vergés 1996a: 88).

With the growing knowledge of the heterogeneity of human beliefs these ideas struck at enlightenment ideals of the moral unity of humans by asserting a psychology of difference. The attention given to non-Europeans in a supposedly universalistic project of civilisation spawned a psychology where difference was a sign of inequality as it had been for Neitzsche. The advocates of a psychology of colonisation argued that it was necessary to learn about the traditions, customs, languages and cultures of native societies and defended a psychology based on ethnographic work. They advocated the training and importance of 'native informants' as a basis for and as disseminators of psychological knowledge. In 1912 Dr Reboull and Dr Régis spoke in favour of psychiatric services that were relative to the culture. While claiming to be empirical, the 'evidence' pointed to the 'fact' that the colonised were constitutionally inferior. This served assimilationist goals in tandem with more coercive measures.

The psychology of colonisation was given a forum in the *Revue de Psychologie des Peuples* founded in 1946. In July 1947 Georges Hardy published an influential article in it entitled '*La Psychologie des Populations Coloniales*'. Here he argued that 'classic psychology' was based on the concept of 'universal man' and this had resulted in 'backward populations' being understood only in relation to the vague term 'civilisation'. This had lead to a 'naive egocentrism.' Without a new colonial psychology there would only be 'violence without a future' and so he called for a 'new exploration of Africa, Asia and Oceania' to investigate 'native souls'. He opposed the use of the term 'race' preferring 'ethnic family'. He proposed to link colonial politics and psychology as this would enhance the understanding and cooperation between the peoples. He states:

> We saw, in the ideas and practices different from our own, only barbarism, and we thought that it was sufficient to transform these shadowy parts by throwing a European light on them. We had to renounce this form of colonisation, because the souls of the native populations, even when they appeared to submit, continued to move in their familiar atmosphere, and, by opposition, tended to adopt a different consciousness.
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> Colonisation had progressively abjured the forms of subjugation that, in its beginnings, made its enterprise a modern form of enslavement. Now, colonisation does not rely on force. It has transformed domination into tutelage; it has proposed, as its ends, association, reciprocal trust, and now dreams of grafting European buds on these exotic roots. Colonisation must know well the human groups on which it is working and psychology has become a preparatory school whose necessity is evident (Vergés 1996a: 89)

Hardy's work exemplifies the approach of the psychology of colonisation - positivist and assimilationist. Here a Frenchman in the colony writes back to the metropole using a scientific objectivity and his apparent respect for the natives to lay the groundwork for a justification of colonialism in psychological terms. As Vergés (1996a: 90) puts it: 'the conquering soldier lent his place to the psychologist, militarist rhetoric to humanitarian rhetoric. The land had been conquered, the soul of the native was the new territory to map and describe.'

After World War Two a new, more dynamic approach to colonial psychiatry developed starting with the Lacanian Octave Mannoni. It was with the critique of Mannoni's book in Black Skin

White Masks that Fanon first engaged with colonial psychiatry so this will be examined first as a prelude to his clinical writings.

Fanon and Mannoni

One of the new generation of post-war colonial psychiatrists was Octave Mannoni, whose 1950 book *Psychologie de la Colonization* (translated as Prospero and Caliban: Psychology of Colonisation) became something of a manual for colonial administrators. Mannoni explored the colonial relationship on the island of Madagascar, where the Malagasy people were colonised by the French in 1896. Mannoni's book was written after the bloody rebellion of 1947-48 in which 100 000 Malagasy people were slaughtered by the French using Senegalese troops. In this book the colonial relation was one of *mutual* dependence of coloniser and colonised. There was some progress here in examining both sides of the relation with a more cynical eye. No longer was it assumed that the coloniser was motivated by benevolent intentions but by a desire for privileges, both economic and sexual. Colonisers were psychologically suited to such a role (narcissistic/Adlerian overcompensation). Nor was this unselfish individual trying to uplift the lazy native, the representation of the native as lazy, criminal and dumb was a projection of the coloniser's fears, a rationalisation of their need to subjugate the natives.

The coloniser's violence was not innate but a product of the colonial relationship. All this cast doubt on the role of psychology as a tool for development. Nevertheless, it was insisted that psychology was still useful; it provided a language to describe the colonial relations beyond the strictly political. Psychology in this way began to question the coloniser's motives and laid a basis for a radical critique.

Fanon begins by stating that he sees this work as an honest and serious attempt to understand colonial psychology but that ultimately it fails. He sees Mannoni's important contribution as being two-fold. One is that Mannoni locates human psychology with a specific social situation, namely colonial society, and recognises that it is not just objective conditions but also human responses that must be explored. Fanon (1967a: 84) quotes Mannoni as follows:

> the central idea is that the confrontation of 'civilised' and 'primitive' men creates a special situation - the colonial situation - and brings about the *emergence* of a mass of illusions and misunderstandings that only a psychological analysis can place and define.

Fanon agrees that the conflict is pathological. Nevertheless, he baulks when Mannoni locates the inferiority complex of the native in childhood. Mannoni (cited in Fanon 1967a: 60) writes:

> The fact that when an adult Malagasy is isolated in a different environment he can become susceptible to the classical type of inferiority complex proves almost beyond doubt that the germ of the complex was latent in him from the childhood.

Fanon rightly argues that this is back to front. If the colonial situation leads to the complex then why does Mannoni try to make the cause antedate colonialism? Here one perceives, Fanon goes on, a common line of argument that locates the problem within the individual. For mainstream psychology psychosis is latent, brought on by a specific trauma rather than being related to social conditions, likewise varicose veins are caused by weak veins, not by standing at work for ten hours a day. In such cases the individualised diagnosis limits the companies, or in Mannoni's case the coloniser's, liability.

Fanon states his position clearly: 'A given society is racist or it is not'. Fanon argues that there is little difference between one racism and another; they are all dehumanising. Mannoni asserts that white contempt of South African negroes has nothing to do with economic factors, the white working class is just as racist as capitalists. Petty traders and officials promote such views. Fanon points out that 'the displacement of the white proletariat's aggression onto the black proletariat is fundamentally a result of the economic structure of South Africa' (p. 87). It is not because racists are resentful but because of the racist structure of society. Mannoni insists that colonial exploitation and racism are different from other forms. This may be true in the abstract. In the face of the concrete issue - human beings objectified and exploited - action is required. Our action or inaction in these circumstances reveals the type of people we are.

Contrary to Mannoni's claim that 'European civilisation and its best representatives are not responsible for colonial racialism', the colonial situation is not a special case. Fanon says Europe, like South Africa, has a racist structure. That Mannoni asserts 'France is unquestionably one of the least racialist-minded countries' is a merely a cipher for 'those niggers should be glad they were not colonised by another power'. Mannoni assumes that the common cases of the inferiority complex are when a coloured person lives as a minority with people of a different colour. Fanon argues that it is not about the numbers - white *minorities* feel quite superior (pp. 91-3).

Fanon, following Sartre, argues that 'it is the racist that creates his inferior'. Mannoni assumes a 'dependency complex'. Mannoni offers the colonised a choice between inferiority for a 'minority' and dependence for the majority whose propensity for such is related to a pre-colonial tendency to submit to ancestors. Mannoni forgets that the Malagasy no longer exists, they exist with the European (p. 97). The native before colonisation does not identify as a Malagasy or as black. After colonisation they know they are Malagasy, an Other to the white conqueror. They learn that the world is divided into white and black. At this point the native begins to question their humanity. They ask 'Am I a human?' which shows a change in their reality. They may try to make themselves white but Mannoni argues this is impossible due to the 'dependency complex' (p. 98). Mannoni goes on 'not all peoples can be colonised; only those who experience this need [for dependency]'. He continues:

> Wherever Europeans have founded colonies of the type we are considering, it can safely be said that their coming was unconsciously expected - even desired - by the future subject peoples. Everywhere there existed legends foretelling the arrival of strangers from the sea, bearing wondrous gifts with them (p. 99).

Stories of strangers from other lands being welcomed, shipwrecked sailors helped, are seen as more evidence, not of courtesy and good will, but as an unconscious desire to be dominated. Conversely as Fanon remarks ironically: 'The white man acts in obedience to an authority complex, a leadership complex, while the Malagasy obeys a dependency complex. Everyone is satisfied' (p. 99).

The inferiority complex manifests in dreams which Mannoni analyses. Fanon reinterprets these dreams noting the social location of the complex in a racist society that makes for the neurosis:

> What emerges is the need for combined action on the individual and on the group. As a psychoanalyst, I should help my patient to become *conscious* of his unconscious and abandon his attempts at an hallucinatory whitening, but also to act in the direction of a change in the social structure. In other words, the black man should no longer be confronted by the dilemma, *turn white or disappear*...my objective, once his motivations have been brought into consciousness, will be to put him in a position to *choose* action (or passivity) with respect to the real source of the conflict - that is, toward the social structures

(p. 100).

Mannoni uses dreams to access the unconscious of the Malagasy but his interpretations follow orthodox psychoanalytic lines - the opposite direction to Fanon's. Fanon argues that 'the discoveries of Freud are of no use to us here' (p. 104). These dreams need to be located in their proper place and time (of widespread massacres of the natives by black troops). He argues, following Pierre Naville (an early Freudian Marxist), that to speak of society's dreams as if they were the dreams of the individual's inverts the order of things. It is the social and economic conditions that shape how an individual's sexuality is expressed. Black bulls and black soldiers in dreams are symbolic but not of the phallus and the father. The rifle is not a penis but a real rifle, the black bull is a black soldier; these represent the 'irruption of real fantasies into sleep' (p. 106).

Next, Mannoni moves onto explaining the *raison d'être* of the coloniser. Here he introduces the 'Prospero Complex.' Mannoni defines it as the sum of unconscious neurotic tendencies:

> What the colonial in common with Prospero lacks, is awareness of the world of Others, a world in which Others have to be respected. This is the world from which the colonial has fled because he cannot accept men as they are. Rejection of that world is combined with an urge to dominate, an urge which is infantile in origin and which social adaptation has failed to discipline (p. 107-8).

Fanon argues that infancy is not the issue but that the Europeans go to the colonies to get rich quickly. These merchants and traders inculcate a feeling of inferiority into the natives. The 'dependency complex' also stems from contact with the coloniser and any attempts to draw conclusions about the pre-colonial period (or future potential) of the Malagasy are completely invalid.

Fanon's Clinical Work: An Introduction

This section now turns to Fanon's clinical articles. This began in 1953 when Fanon published three articles on 'milieu therapy' with Tosquelles. One was on the effects of ECT that they cautiously endorse if there is also appropriate group therapy. The other two papers were on milieu therapy and the building of a 'life community' within the hospital and describes the medium to long term results.

Later Fanon began work in Algeria. As Fanon conceptualised madness as one way of losing one's freedom it was clear that therapy was impossible in the colonial context, since the colonised were permanently unfree. A choice had to be made either resign oneself to the fact that the Algerians' best outcome from therapy was to become 'well-adjusted' slaves or to join the struggle for decolonisation. Later in independent Tunisia Fanon's therapeutic vision was easier to implement, though by then Fanon had moved beyond milieu therapy. Fanon with his colleagues set up a day-care hospital, which allowed greater contact between the world of the hospital and the social world of the patients. Fanon and Geromini wrote 'The re-introduction of psychiatry within general medicine strongly corrects the prejudices which are generally rooted in public opinion and transforms the mad person into a social person' (Vergés 1996a: 94).

The hospital was transformed into a 'society with its multiplicity of relations, duties, and possibilities so that patients can assume roles and fulfil functions'. In this way the social life of the hospital meshes with life outside. Based in the family, milieu therapy would take the 'patient away from his phantasms and force him to confront reality on a new register.' Thus Fanon and Geromini concluded that 'day-care centres represent the form of psychiatric service most suitable to treat mental illness even though it was developed in highly industrialised countries' (Vergés 1996a: 94).

This is in contrast to the dominant strand in Algerian psychiatry. The Algiers school viewed the Muslim as genetically inferior, sexually perverse, intellectually deficient, subhuman, a pathological liar, a thief, lazy, hysterical, a born criminal and prone to homicidal impulses. Apart from a direct participation in the struggle, Fanon's clinical work is part of his polemic against colonialism.

Decolonising Psychiatry: The Clinical Articles

Mental illness...presents itself as a veritable pathology of liberty
Fanon

Fanon's first engagement with colonial psychiatry in a medical context predates Black Skin White Masks. In February 1952, in the middle of his residency, the left-wing Catholic journal *Espirit* published the 'North African Syndrome'. This was based on his clinical work with North African emigrants who worked in the chemical and textile industries. In it Fanon examined the ways in which racism was reproduced in the interactions between the medical establishment and the North African emigrant workforce around Lyons.

The critique of the relations between French doctors and their Arab patients is drawn from first-hand experience. Fanon puts forward three theses: First, 'the behaviour of the North African often causes a medical staff to have misgivings as to the reality of his illness.' Here we see the Algiers school view of the North African as a 'simulator, a liar, a malingerer, a sluggard, a thief' in practice. The North African's symptoms are vague and they will not follow orders. Thesis two is 'that the

attitude of medical personnel is very often an *a priori* one' based on a European framework. In particular, the Arabs inability to identify specific symptoms that can be related to a lesion leads staff to reify the problem and locate it in the specific character of North African emigrants. They simply 'don't like work'; subsequent patients are interpreted through that lens and the symptoms ignored. This way of treating patients is then labelled 'North African Syndrome' such that all 'every Arab is a man who suffers from an imaginary complaint'. Fanon quips that this is not based on experiment but on 'oral tradition'.
Since there is no lesion one must look for the cause of the suffering in the 'situation'. Fanon lists plausible candidates, for example perhaps the problem lay in 'relations with associates'. Fanon, with heavy irony, dismisses this; emigrants have no relations in France. Perhaps it is 'inner tension', again mocking his colleagues, he concludes that this cannot be the case 'you might as well speak of the inner tension of a stone'. Fanon traces the symptoms to the conditions under which emigrants live without a family, without love. They become neurotic and empty. Life, for them, is 'a death on this side of death' no wonder physically healthy patients come and say 'Doctor I'm going to die'. Fanon's suggestion to his colleagues is not just a new treatment but a call to recognise their racism, and deal with the human being that is before them and the human being inside themselves (Fanon 1967b: 16-26).

After completing his training Fanon went to work in Algeria. Fanon was, with his colleagues, the first to apply milieu therapy in the colony. In 1954 they published an article 'Sociotherapy in a Ward for Muslim Men: Methodological Difficulties' that discussed the initial failure of the therapy. The conditions in Algeria were much the same as in France; patients left to their own devices, overcrowded with no places for patients to meet or work, no psychotherapy. In the colonial situation of Algeria this was combined with an explicit racism. The aim of the therapy was to humanise the hospital, turning the patient into a person among other people and facilitate their re-socialisation. Fanon moved against carceral measures and introduced a regime based on the new therapy. Doctors and nurses met to discuss patients, patients themselves met twice a week. A newspaper was introduced to facilitate communication and there was a holiday every two months. The ward began to show films, develop work therapy including the making of one's clothes, all of which were supposed to serve as a means to create a richer social life.

Blida hospital in Algeria was overcrowded and contained mostly poor Muslim men and some European women. For the European women the new therapy not only made asylum life less laborious but the pattern of departures increased. However, in the ward of Muslim men the new therapy was a complete failure as Fanon summed up:

> not only had we been unable after these months and after many efforts to interest Muslims patients in a type of collective life which operated in the European quarters, but the atmosphere of the service remained heavy and unbearable (McCulloch 1983: 110).

Fanon and Azoulay set about discovering why:

> These errors were only possible because of an attitude which excluded objectivity. One had to stop and think and discuss why every initiative had failed. Meetings and social occasions interested no-one and no-one attended the group therapy sessions. There was a deterioration in the relationship between nurses and patients which was caught in a vicious circle well known to all who work or live in psychiatric hospitals: 'agitation repression agitation.' (Razanajao et al. 1996: 512-513).

In retrospect it seems unsurprising that European therapeutic practices would need modification but it took time for Fanon to realise that he had assumed that Tosquelle's approach would work while putting 'in parenthesis the geographical, historical, cultural and social frameworks' (McCulloch

1983: 111). This, Fanon and Azoulay realised, meant that they had unwittingly brought a set of assimilationist assumptions to their work. Since the North African was seen as a Frenchman there was no need to understand the uniqueness of Muslim culture. Thus:

> the effort must be made by the indigene since he must attempt to be the type of man proposed for him. The assimilation does not assume a reciprocity of perspectives. There is one culture which must disappear to the gain of the other (McCulloch 1983: 111).

This opened up a new problem that Fanon faced. There was the lack of sociological information about emotional life and mental illness in Muslim culture, apart from the neurological focus of the Algiers School.

In this article Fanon and Azoulay sketched the structure and values of Algerian Muslim culture. The bulk of this sketch was devoted to economic factors and impact of colonialism on the class structure. They identified four key aspects of Muslim life. It was theocratic - Islam served as a legal framework, which included private and public morality. It was gerontocratic; the father ruled the family. Extended families were the most common; the clan was seen as the natural social unit, governed by the *Djema* (traditional council). It was the clan that was basis of identity (not the nation as in Europe). There is also a range of ethnic groups: various groups like the Kabyles have the same religion but different language and culture. Finally they nominated the key feature as social class. It was the rapid change caused by colonialism - the introduction of capitalism and proletarianisation of the peasantry - that explained many of the features of patients at Blida. There has been a breakdown of the tribal communal structure that undermined the extended families and tribal affiliation. Landless peasants became proletarianised day labourers working the large rural estates or trying to find work in the cities. The lack of industry meant there was little work and led to the formation of a *lumpenproletariat* living in shanty towns.

Looking at the milieu therapy in relation to Arab culture made it quite clear what had gone wrong. Islamic societies defined very different social roles for their members. Staff had little basis on which to confer with landless peasants, as opposed to the European women. Language was a one problem. The use of interpreters put a barrier between the doctor and patient. Group therapies that relied on speaking one's feelings were doomed as this was not a 'masculine' practice. Likewise celebrations and singing bore no resemblance to anything in Islamic culture; theatre and team sports again were irrelevant to men. American action films and newspapers meant little to illiterate peasants, who lived in an oral rather than a written culture that was strongly gendered.

Putting his findings to work Fanon began by organising gardens:

> if one succeeds in attaching them to a particular plot of land, to interest them in the produce of the work, thus the work will truly be a factor for re-equilibrium; then ergo-therapy would be able to be involved in a specific social activity (McCulloch 1983: 115).

This, a Moorish cafe and the introduction of Muslim festivals and visits by story-tellers saw the implementation of a new therapeutic environment.

Fanon continued to investigate Muslim culture in a series of ethnopsychiatric studies. In 1955 he published 'Considerations on Ethnopsychiatry' and 'Confessional Behaviour in North Africa'. The former is an explicit critique of the Algiers School the substance of which Fanon reproduced later in Wretched of the Earth, which is examined in Chapter Six. The latter was written in September 1955 by Fanon and Lacaton as a critique of the Algiers School's labelling of Algerians as pathological liars, who are unwilling to admit responsibility.

They begin by noting that it is a common experience in Algerian courts that a 'native' will deny committing an act and/or repudiate an earlier confession once in court even if the evidence is overwhelming. The 'native' shows no signs of psychosis but acts resigned. Rather than question whether due process was observed by the authorities, Fanon looks instead at the process of confession showing it to be a complex social relationship and exposing the pathologising of 'native' behaviour as ideological. Fanon notes that for confession to be the same act, the same social conditions must apply. The assumption is that all parties share a common understanding of the situation. In the European context a confession serves existentially to make the subject assume responsibility for their actions and socially leads to the conditions under which they can be re-inserted into society.

Fanon points out that even though the act is the same, in the colonial context the admission of guilt does not allow the confessor to regain access to the community from which their crime has excluded them. Firstly:

> The reintegration of the criminal through the confession of his act depends upon the relationship of the group to the individual. There cannot be a reintegration if there has not already been an integration (McCulloch 1983: 105).

If there is no bond to the community issuing the punishment then confession serves no purpose from the point of view of the criminal. The supposedly universal ethics that underlay the criminal code are not shared by all participants.
The divorce between the colonial legal system and the Muslim's sense of accountability are the key to understanding why there are no confessions:

> The refusal of the Algerian to authenticate the social contract by the confession of his act which is expected of him signifies that his often whole-hearted submission which we have noted must not be confused with his acceptance of his guilt (McCulloch 1983: 105).

This exposes the complexity of social act and the social basis for the belief that Muslims are congenital liars. It also exposes the absence of an underlying social contract between coloniser and the colonised.

Colonial psychiatry assumed that North Africans venerated the insane, further evidence of Arab primitiveness.[1] In 1956, Fanon with another colleague, Sanchez, looked at the issue of Muslims and mental illness in 'The Attitude of the Maghrebian Muslim Towards Madness'. They began by pointing out that Muslims had institutions for treating madness before the Middle Ages, although their therapies remain rudimentary. What they found was that madness in Arab society attracted a different social stigma and manifested a different psychology of the self than in Europe.

In Europe madness is a disease that alienates the self from others and one's sense of self. Despite an ideology that mental illness is beyond the control of the patient, this is ignored in practice. The patient is treated as responsible for their illness and as exploiting the moral obligation of others to look after them. Any offence is seen as deliberate, not as an effect of the illness and this leads to the punishment of patients. For Muslims the disorder is the result of spirit possession. Fanon explains 'the patient is an innocent victim of the spirits who possess him. It is not his fault if he is

[1] There was a class of Muslim mystics called *marabouts* who were venerated by rural Muslims. The marabouts were regarded by Europeans as mentally ill. Thus Europeans saw the Muslims as venerating madness. Of course they are not worshipped by Muslims because they were mad but because they are seen as having divine insight.

rude and threatening or if he persists in a total derangement' (McCulloch 1983: 102). Because the will of the patient is subordinated to the 'illness' the community never acts in a punitive way towards the sick person. Restraint may be needed to subdue the spirit but this does not imply a judgement upon the sick person. The underlying personality is intact; no shame attaches to the condition. Thus the idea that Muslims venerate the insane is mere prejudice, as Fanon put it: 'it is not the madness that arouses respect, patience, indulgence, it is the man attached by madness; it is the man who engenders respect' (McCulloch 1983: 102).

Aggression is dealt with by collective appeasement and confrontation. Punishment, exclusion and distrust are rare. The victim and their relatives discuss the condition openly since there is no genetic link there is no stigmatisation of either party. This facilitates recovery and re-integration. Crucially the affliction is not confused with the person; it is only the surface appearance not the deep self that is affected.

Fanon and Sanchez sum up:

> Resting solidly on a cultural basis, the system is of great human value which does not confine itself only to the efficacy of the North African therapy. This natural method of assistance is imprinted with a profoundly holistic thought which keeps intact the image of the normal man, in spite of the existence of affliction...[The North African] attitude is guided by a care of and respect to the person. It is not madness that creates the respect, the patience, the indulgence, it is rather the man affected by madness, attacked by spirits, it is man as such (Bulhan 1985: 233).

Here Fanon refutes the idea that Muslims venerate madness and shows moreover that Europeans have something to learn from their approach. Whilst Western psychology purports to treat the patient as an individual the reality is authoritarian. Fanon found the traditional Moslem view of the patient as one in the grip of a 'holy evil' provided the basis supporting the patient's morale and an ethic of the patient as an individual. Fanon's work is not only cross-cultural but radical, he links the cultural perspective of restoring integrity with a larger socio-political program of justice.

After his expulsion from Algeria Fanon published two more important papers. He turns his attention away from ethnology to a sociogenic analysis of the psychiatric hospital. The first of these written in 1957 entitled 'The Phenomenon of Agitation in the Psychiatric Environment: General Reflections, Psychopathological Meaning' deals with the management of the violent patient. In it Fanon articulates a break with Tosquelles inasmuch as he begins to question the idea of the hospital as a therapeutic milieu. He begins locating symptoms like violence and hallucinations as effects of the hospital.

Fanon argues that aggression, like most psychopathology, emerges out of reciprocal human relations (or the lack thereof) and the sadomasochistic nature of the institution makes it worse. The easiest means of dealing with violent patients had been confinement. The hospital, already a socially very deprived atmosphere, imposes confinement and this punishment provokes withdrawal and further aggression. It becomes a 'second internment'. The patient comes seeking refuge and finds an institution that 'amputates and punishes'. This legitimates society's attitude and provokes a retreat into fantasy. Alternatively patient hallucinations are interpreted in psychoanalytic terms as withdrawal to the oral stage and infantile frustration rather than as a response to the confinement.

Fanon argues that:

> The rejection, exclusion and isolation also provoke more psychopathology and a vicious cycle in which the patient remains entrapped is begun. Isolated from real, living relations, the patient is forced into the unreal world of fantasy and hallucination. Rejection of his *symptoms* - provoked in or out of the institution - leads him to infer that what is rejected is his very *being* (Bulhan 1985: 242).

For Fanon the real world of sensory and emotional ties is removed making a withdrawal into hallucination inevitable. If humans do not experience freedom in their social relations they will experience it in the world of phantoms. There is a lack of recognition of the isolated patient who has no opportunity to see themselves and their actions mirrored in the world of others. Hence there is a need for the hospital to be a meaningful social milieu. The patient is in an ambiguous position; they know and do not know that they are ill. The violent outbursts are attempts to reach such understanding - asking questions of the world. The staff need to understand the patient and what is more important help them to recover their understanding of themselves.

Fanon sums up his understanding of the situation of the mental patient saying 'even at the bottom of these disordered anarchical behaviours, of meaningless sentences the fundamental ambiguity of existence is entirely assumed' (McCulloch 1983: 93). Fanon assumes that psychiatric conflicts can be resolved by altering the social milieu. Having had the insight that hospitals might be part of the problem Fanon then initiated another radical step - the Day-Care hospital. The first day hospitals had been set up in Moscow in 1932, by the 1940s England, Canada and USA had experimented with them. However, it was bold step to introduce them into Tunisia in the midst of decolonisation. Tunisia was a poor and barely industrialised country. Whether severely disturbed patients in a Third World context would benefit was far from clear.

In a 1959 article 'Day-Care Psychiatry - its Value and Limits' Fanon with his colleague, Geromini, outlined his introduction of day care for patients that was rare at the time. The idea breaks with the idea of a therapeutic community within the hospital; abandoning the separation of patient and society. The idea was that patients would maintain contact with their families and culture more broadly and be treated like patients rather than prisoners. For Fanon the ideal of any therapy was that 'the doctor-patient relationship is at all times freely entered into in both sides' (Razanajao et al 1996: 516). In this way the patient can exercise their freedom, rather than escaping into fantasy to indulge it. Not being cut off from everyday life and free from the confines of an institution allows for a more individual analysis and exploration of pathological experiences. The patient is not sheltered from the world but the impact is cushioned as the neurosis is confronted.

Fanon argues that with confinement the hospital assumes total responsibility and thus the patient becomes less and less socialised. The sick person must surrender their autonomy, as Fanon says:

> Confinement breaks the narcissism of the patient, crucifies him in his tentative self confidence and engages him in a traumatic manner in the way of regression, of fear and anguish (McCulloch 1983: 96).

Cut off from family and abandoned:

> If the family in its decisive reproach to the patient signifies that they will recognise him no longer, that they participate in a life fundamentally different from his what possible disintegration and what possible (innumerable) bridges are offered to his phantasies and to his regressions? (McCulloch 1983: 96).

The structure of the hospital restricts behaviour and makes the hospital the focus for aggression later this subsides into apathy. To overcome these drawbacks Fanon proposed a system of daycare, which is directly based on his conception of mental illness.

He already called for legislation to protect patient rights. Seen in this context, the idea of a Day Hospital, which is less carceral and maintained links to the patient's community, is a logical development. Fanon composed a report on the empirical results of the Day Hospital. The hospital was refurbished and the staff retrained with a patient centred approach. There was to be 6-8 patients in a team with an emphasis on community. Treatment was personalised; use of psychotherapies tended to be eclectic. They borrowed from Pavlov or psychoanalysis with a focus on therapies in which the analyst took on a more active role. Socio-drama that was biographical rather than fictional, in which patients recounted personal experiences to the group and were offered feedback was common (Bulhan 1985: 243-6).

In this article it is clear that psychiatric services were to be integrated into the general hospital providing more care, and less separation of doctor and patient. The increased freedom and recognition of the patient and reduction of master/slave relationship between patients and staff proved its usefulness in practice.
Bulhan's (1985: 248) summation is worth quoting in full:

> The therapist therefore faced, on the one hand, a personality in crisis at the very heart of its environment and, on the other, a real, dynamic and active society in the very heart of the patient. It is from this perspective that one clearly observes the rupture in the 'synthetic unity' of the person to his milieu and seeks to restore that unity. Symptoms and troubled affectivity are no longer abstracted or isolated from their source. They are offered dialectically and the therapist thinks and acts dialectically. One is forced to abandon the symbolic and imaginary games of institutional therapy and becomes immersed in society itself, not its caricature.
>
> This orientation to a dynamic and living reality forces a re-thinking of conceptions and techniques. The reification of descriptive semiology and nosology gives way to an existential approach that takes into account the activities, assaults, and vulnerabilities of the self in a dynamic social milieu. It is in this psychosocial dialectic that the therapist decides the time, place, and type of his intervention. At the center, the patient is provided his own space, his privacy is respected, and no demand is made upon his liberty or immediate appearance. He wears and brings what he wants. What is questioned is not 'the form of this being' but rather 'the form of his existence'.

Racism and Culture: The Dialectics of Culture

In September 1956 at the First Congress of Negro Writers in Paris Fanon gave a speech that serves as a summation of his views up to this point.

In this speech he locates forms of racism and responses in historical context. First the coloniser sees the colonised as having no culture at all. Later there develops the idea of a hierarchy of cultures, and later cultural relativism. Colonisation is organised economic domination on one side and de-culturation on the other. 'Racism is not the whole but the most visible, the most day-to-day and, not to mince matters, the crudest element of a given structure' (Fanon 1967b: 32). Fanon then asks 'what is relation between culture and racism?'

He begins with a definition of culture:

> If culture is the combination of motor and mental behaviour patterns arising from the encounter of man with nature and his fellowman, it can be said that racism is indeed a cultural element (Fanon 1967b: 32).

Fanon notes racism is not frozen. Justifications of colonialism are based, in this first stage, on biology (brain studies, phrenology) and psychological notion of 'primitivism'. At the early stage of exploiting native bodies as slaves, we find claims of the native's biological inferiority that are the anatomical counterpart of the system. These claims were articulated by the leading lights of the Algiers School. This 'scientific' approach gives way to a cultural racism in which 'the object of racism is no longer the individual man but a certain form of existing' (Fanon 1967b: 32). Natives have a different style or different values. This shift is based on the indigenous challenges to the colonial system and the growing awareness of the metropolitan working class in the wake of Nazism that made crude racism unacceptable.

Colonisation requires enslaving the population. Force crushes resistance and values. The effect is not to destroy the culture but to 'mummify' it (Fanon 1967b: 34). Cultural institutions mimic old traditions but are now controlled by the oppressor. The population becomes apathetic. These institutions, like appointing of 'reliable' tribal chiefs are seen as 'respecting the native culture' but 'this behaviour betrays a determination to objectify' (Fanon 1967b: 34). Native culture becomes exotic - their culture is a curiosity, not a way of life.

In the first phase of military and economic repression brute force reduces the native to an object. It breaks their resistance and engenders a series of guilt and inferiority complexes in the native. Then as industrialisation, the exploitation of bodies begins, racist ideology based on biological inferiority emerges. As time passes, so does form of racism. It becomes less virulent, not because of evolution of individual attitudes, a progressive enlightenment, but because the exploitation is clearer. Based on the experience of the war working people are aware of the situation, the ideology becomes more subtle. Racism forms part of the culture. Resistance develops as people organise to liberate themselves. Accusations of 'fanaticism' (as opposed to primitivism) now emerge. For a time it may look as if racism has disappeared. This is not because it is unconscious but because the system makes the 'daily affirmation of a superiority superfluous'. It may even take on 'democratic' forms (for example, recognition of native councils) or be marketed like the blues as music of oppression. Racism is part of a 'characteristic whole' in which one technically advanced group exploits another. Force precedes it and makes it possible. It is not a 'mental quirk' or a 'psychological flaw' (Fanon 1967b: 37-8).

What reactions does colonialism provoke? Here Fanon articulates his dialectical theory of culture based on three stages. The first is assimilation. In the biological phase the 'inferior race' tries to deracialise itself and identifies with its 'superior'. Force imposes new ways of seeing, especially devaluing traditional culture. Alienation of the native - 'assimilation' - leads to an acceptance of the 'racist logic' that the natives' problems are their own fault. This leads to feelings of guilt and inferiority as 'the oppressed flings himself upon the imposed culture' (Fanon 1967b: 39). After a period natives still find, despite their efforts, that they are objects of racism. Again this is treated as an individual problem. The metropolitans argue that 'there are some racists but on the whole France is not racist and with time (and education) it will disappear' but Fanon (1967b: 50) argues:

> It is not possible to enslave men without logically making them inferior through and through. And racism is only the emotional, affective, sometimes intellectual explanation of this inferiorisation. The racist in a culture with racism is therefore normal. He has achieved a perfect harmony of economic relations and ideology.

This leads to a reaction. Racism is seen as the cause of injustice not the consequence. The colonising country condemns racism. Campaigns of detoxification are launched, complete with appeals to 'humanity', love and so on.

The second response is that of the traditionalists:

> Discovering the futility of his alienation, his progressive deprivation, the inferiorized individual, after this phase of deculturation, of extraneousness, comes back to his original positions (Fanon 1967b: 51).

This reaction begins in overvaluing the 'native' culture. Everything about Africa is good. It is the source of all truth and all peoples who originate there are beautiful. As Fanon (1967b: 51) puts it the native: 'formerly inferiorized, he is now in a state of grace'. When not at home, the emigre aggressively asserts, rather than denies, the value of the culture that has been 'sclerosed':

> The culture put into capsules, which has vegetated since the foreign domination, is revalorised. It is not reconceived, grasped anew, dynamised from within. It is shouted. And this headlong, unstructured, verbal revalorisation conceals paradoxical attitudes (Fanon 1967b: 52).

Negro intellectuals consult tribal healers, as Fanon (1967b: 52) remarks (ironically) 'the sense of the past is rediscovered, the worship of ancestors resumed'. Although unrealistic and unsustainable, subjectively this response is crucial. Ultimately the native realises that they need to fight exploitation, to liberate the national territory so that 'the plunge into the chasm of the past is the condition and source of freedom' (Fanon 1967b: 53). The natives move from looking upward at their oppressor to looking around at their fellow natives. The struggle emerges on a new 'more human' level; the colonialists try to revive the old arguments (about 'fanaticism' etc) but even the old assimilationists and cowards fight it. Racism ends, Fanon argues, when the culture is liberated, when the colonial status is removed. Universality emerges when each culture recognises the other.

This dialectical model of culture serves as a useful heuristic for investigating a range of cultures and struggles and this thesis draws upon it repeatedly. It also serves as a bridge between the structure and agent in social theory as the cultural stages can be mapped also as responses related to an individual's lived experience.

Summary

Thus in this chapter we have covered an often neglected aspect of Fanon's work as a trained psychiatrist. It also makes clear his thinking in a number of important areas and connects his earlier and later work. In his earliest published piece (the 'North African Syndrome') he examined the importance of social context for diagnosis and in his first book began a critique of colonial psychiatry in the form of the work of Octave Mannoni. This theoretical critique carried over into his practical work based on the inherent sociality of the patient which he developed earlier but which he continued to apply critically, extending it in the clinical setting. Failures and ethno-psychiatric research led to more radical conclusions including setting up Day Care facilities. Ultimately joining the independence struggle was a logical extension of his whole approach. Finally the chapter concluded with a speech in which Fanon specifically linked culture and the individual which serves as an important bridge in linking his later and earlier work.