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Similarities and differences in the management of psychiatric disorders by the colonial empires: an historical overview

Similitudini e differenze nella gestione dei disturbi psichiatrici da parte dei diversi imperi coloniali: una prospettiva storica

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SUMMARY. Colonial psychiatry represented the first, despite distorted, attempt to interpret psychiatric symptoms in non-Western cultures. This psychiatry, therefore, laid the roots for the subsequent development of ethnopsychiatry, but it also represented the first example of the political use of this discipline. Purpose of the present article is to provide a critical review about the management of psychiatric disorders in the different colonial empires. We critically summarized relevant literature about theory and practice of colonial psychiatry in the different European empires. All the colonial empires were characterized by few resources destined to mental health both for the colonizers, but especially for the local populations. The British used reports from psychiatric hospitals to maintain political control over the colonies. French colonial psychiatry focused more on cultural assimilation, while the Dutch one was based on theories of racial inferiority of local populations. In Italy, colonial psychiatry focused more on the differences between the north and south of the country than on non-European territories. Although with differences between the various empires, colonial psychiatry provided means and support for the political and social control of the occupied territories.

KEY WORDS: mental health, colonial empires, colonial psychiatry, cultural issues, inequality.

RIASSUNTO. La psichiatria coloniale ha rappresentato il primo, benché distorto tentativo di interpretare i sintomi psichiatrici nelle culture non occidentali. Questo approccio alla salute mentale gettò le basi per il successivo sviluppo dell'etnopsichiatria, ma rappresentò anche il primo esempio dell'uso politico di questa disciplina. Scopo di questa rassegna è di fornire una revisione critica della gestione dei disturbi psichiatrici nei diversi imperi coloniali. Sono stati sintetizzati e discussi in modo critico i dati presenti in letteratura circa la teoria e pratica della psichiatria coloniale nei diversi imperi europei. Tutti gli imperi coloniali erano caratterizzati dalla presenza di poche risorse economiche destinate alla gestione della salute mentale sia dei colonizzatori, ma soprattutto delle popolazioni locali. Gli inglesi hanno utilizzato i report provenienti dagli ospedali psichiatrici per mantenere il controllo politico sulle colonie. La psichiatria coloniale francese si concentrò maggiormente sull'assimilazione culturale, mentre quella olandese si basava principalmente su teorie razziste nei riguardi delle popolazioni locali. In Italia, la psichiatria coloniale si concentrò più sulle differenze tra il nord e il sud del paese che sui territori extraeuropei. Sebbene con differenze tra i vari imperi, la psichiatria coloniale fornì i mezzi e il supporto per il controllo politico e sociale dei territori occupati.

PAROLE CHIAVE: salute mentale, imperi coloniali, psichiatria coloniale, aspetti culturali, disuguaglianza.

INTRODUCTION

Psychiatry, as a discipline that deals with mental health, addresses many challenges in social sphere[1]. As a consequence of globalization, one of the current hottest topics is represented by the care in western societies of individuals coming from different cultures, which requires specific skills and knowledge globally known as ethnopsychiatry[2].

The first attempts of European countries to manage the mental health of individuals of non-Western culture dates from the late eighteenth to early nineteenth century in conjunction with the Industrial Revolution and the consolidation of colonial empires. Of note, colonial psychiatry, if on the one hand represented a first attempt to classify and manage the mental health of individuals in a different field from the European one, on the other it was functional to the economic and political aspects of colonial empires[3]. In this sense, colonial psychiatry may perhaps represent the first systematic use of the discipline for purposes not related to the health of individuals[4]. The political abuse of psychiatry has characterized in recent times totalitarian regimes[4], but also liberal democracies as showed by the scandal of forced sterilization of schizophrenia patients in many Western countries until at least the 1980s.

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Despite the political and economic interests common to colonial psychiatry, the empires, in the light of heterogeneous cultural background, managed in a different way the mental health of both colonizers and colonized people. This aspect is closely linked to the different evolution of relations between the different European countries and their own colonies, and more recently to the distinct management of phenomena linked to globalization such as immigration or suicide bombing. It is probably no coincidence that the countries most affected by Islamic terrorism (e.g. France) are precisely those that had the largest colonial empires[5]. Of note, religion is perceived as a cure for trauma suffered during the colonial period. The feelings of marginalization and cultural inferiority suffered under colonial rule have been transmitted through families in the new generations that are born in European countries. New generations of postcolonial families, if on the one hand adhere to the western lifestyle, on the other they perceive a sense of alienation within this system as demonstrated also by the fact that many of these families live on the suburbs of cities (e.g. French banlieue)[6]. In the case of France, after the independence of colonies, emigration involved especially Muslim people from the Maghreb so that second generations of families originating from this area are potentially more subject to marginalization[6].

In the light of these considerations, purpose of the present article is therefore to provide an overview of the different organization of colonial psychiatry in the main European empires. This analysis may help to explain the different current approach of European countries on the management of mental health of people of non-western culture.

METHODS

A comprehensive manual research of articles in the main database (MEDLINE, PsycINFO, Isi Web of Knowledge, Medscape, Google Scholar) was performed to address the topic of the present article. The words "colonialism" and "colonial empire" have been combined with "psychiatry", "mental health" for the research of articles inherent with the topic (last check on 15th May 2020). We have focused on European empires of 19th and first half of 20th century. The reason for this choice was driven by the fact that: 1) Western European countries knew a similar way in the management of mental disorders after the French Revolution with the establishment of several psychiatric hospitals, and it is therefore possible to make an easy comparison between the European countries and their colonies; 2) Spanish and Portuguese empires flourished in 17th and 18th century when the cure of "insane people" consisted mainly of physical punishment or prayer; in addition at that time the colonizers supported the domination of the colonized people more for religious reasons rather than in the light of a mission of civilization in the name of "Reason"[7].

Other exclusion criteria consisted of: a) articles in a language different from English; b) other topics related to colonialism (e.g. the impact of colonialism on colonized people' mental health or the psychology of colonialists).

BRITISH EMPIRE

General framework

The British Empire included a very large territory and one of the problems of the mother country was the political control of the colonies. The colonies had to be under a strict political control to promote trade, but this implied exaggerated military costs. The management of mental health in the colonies allowed a political control of these territories with a more limited cost compared to sending a large army. This principle, known as "enlightened and beneficent despotism" became even more important after 1860, when, following the detection of abuse in the Jamaican psychiatric hospital in Kingston, the central government had requested reports to the governors about the management of mental health in the various colonies[8]. These reports had to include detailed descriptions of the number and type of psychiatric services, legislation, type of coercive measures, number of doctors and presence of trained staff. The continuous request for reports and statistics after 1860 was a cheap method for claiming the presence of the homeland in the colonies: if, for example, an asylum was considered unpresentable then it became the object of public reproach. The fear of being discredited motivated the local governors to work more and at no cost. In the mid-nineteenth century the worst management of mental health characterized the smaller colonies with fewer resources such as Gibraltar or the Caribbean islands. In these situations, incarceration, punishment and other coercive measures (e.g. chains) were frequent. The best situations instead characterized territories such as Canada where there was a sort of convention with religious structures and physicians. Also the availability of psychiatric facilities was inhomogeneous; in Gibraltar the lunatic asylum consisted of some cells in the local prison, while in Canada there were real psychiatric hospitals. This different offer of facilities for mental health may mirror the different type of colonialism practiced by the British: settler colonialism (e.g. Canada) whereby the local population is assimilated or replaced by a population of colonizers, or exploitation colonialism whereby natural resources and wealth are being extracted from the colonial territory by the colonizing power (e.g. India)[9]. Furthermore, before the request of a detailed report about management of mental health by colonies in 1864, extra European lunatic asylums were so badly managed that racial segregation was not a priority, contrary to what will be established at the end of the 18th century. Psychiatric facilities for the wealthy English colonizers, who got rich from the progressive colonial exploitation, were totally lacking[8]. In the first half of 19th century both colonized people and colonizers were generally hosted in small buildings that had mainly a custodial function. The priority of these structures was the confinement of all people with behavioural disturbances without a distinction between colonizers and colonized people.

Most of the medical literature on the organization of mental health in the colonies concerns India and Oceania.

Oceania

The exploration of the continent started in the 18th century by James Cook and the first settlements on the south-eastern coast of Australia (Botany Bay) consisted of penal

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colonies. In 1787 the first English deportees were sent to this region and the land acquired a rapid and growing political interest due to the loss of the American colonies. New Zealand, Tasmania and West Wales will be incorporated in the British Empire only in the first half of 19th century when there was the need to free the areas of the most intense economic growth from prisoners to send them to more remote territories. West Wales had structures such as the Round House which was used for both prisoners and individuals who caused social disturbance[10]. While large hospitals were built in Europe, including Great Britain, prisoners and patients with mental disorders lived together in small rescue buildings. In the most distant colonies, in fact, where the advantages of economic exploitation could not yet be grasped, the priority was to use structures that would guarantee maximum social control at the lowest price. They did not plan to spend financial resources to create places of care for people who did not have any social utility[10]. The worse nightmare of local governors was to pay expenses to repatriate English colonizers affected by severe mental disorders[10]. In New Zealand the situation was even more precarious and the management of mental health was considered as a secondary problem until the end of the nineteenth century; in this case the central government had substantial problems in the control of the territory that will lead to the tragic extermination of the Maori native population between 1850 and 1870. The first small lunatic asylum was built in Wellington in 1853, until then the psychiatric facilities were limited and fragmented even though in New Zealand the training of staff was quite adequate and there was always the presence of a doctor in temporary asylums. However, there was no general supervision and the organization of mental health care was delegated to local realities. Between 1867 and 1876 the New Zealand psychiatric network became more consistent, but it maintained its own rules thus creating problems in the management of the territory by the central government[11,12]. New Zealand was slow in integrating the use of moral therapy in its facilities and in sending regular reports to the motherland, so it was necessary to resort to the army more frequently to control the territory[11,12].

India

India joined the British Empire in 1857 after the failure of the first Indian Independence War and obtained independence in 1947. The First War of Independence, alternatively named the Indian Mutiny, was a rebellion, driven by Indian troops (sepoys) in the service of East India Company, that began in Meerut and involved different Indian cities mainly in central-north India including Delhi[12]. This rebellion started as a reaction to the British attempt to erode the power of Indian kingdoms and to change local culture[13]. Of note, between the 17th century and 1857 the Indian territory was controlled by the East India Company which had taken advantage of the rivalry of the various local kingdoms. In 1795 the first Indian asylum was built to incarcerate the "mad sepoys" in Bihar[14]. The sepoys were the indigenous militaries who would have led the riots for Indian independence and had been involved during the Indian Mutiny. Between 1795 and 1858 the treatment of psychiatric patients in India consisted of: 1) imprisonment for the local inhabitants and 2) repatriation for the colonizers[11]. However, the latter practice had raised economic concerns in the mid-nineteenth century.

Between 1858 and 1914 the foundations of the Indian psychiatric organization are laid[14]. This period was characterized by 1) the construction of psychiatric hospitals and 2) the definition of a specific legislation designed to manage mental disorders in Indian population. Of note, the first important Indian psychiatric facilities were therefore built on the basis of racial tensions, exasperated after the Mutiny. In 1858 the Act 36 legalized the imprisonment of the Indians with mental illness even in the absence of a criminal record for the fear of the previous revolts. This Act was changed in 1912 with the approval of Lunacy Act that regulated psychiatry in India until 1987. Most psychiatric hospitals were built between 1860 and 1880; in 1900 India had 26 psychiatric hospitals. Each psychiatric hospital could accommodate about 300 people that were an irrelevant number compared to the Indian population of the time (about 300 millions). Until 1914 psychiatric hospitals housed the poorest social strata of the local Indian population, so that doctors complained that they had to do more social work than clinical one[14]. Some families relied on mental hospitals to get rid of family members who could be a financial burden[14]. The etiological theories of the German academy, that considered mental disorders as the consequence of infections, were very popular in the second half of the 19th century in India within the British colonial administration[15]. This theory was supported by the fact that mental disorders caused by cysticercosis are more common in warm and humid climate. In addition, syphilis was spread among British army (25% of European soldiers compared to 3% of Indian ones). Alternative theories about the origin of mental disorders included substance intoxication and misuse, and this was supported by the fact that alcoholism was epidemic in British white soldiers of 19th century, thus explaining the frequent occurrence of psychiatric symptoms in the army members. Treatment included physical restraint, frozen showers and other "moral" prescriptions, and at the end of the 19th century pharmacotherapy with morphine and chloral hydrate was introduced. Wine and spirits such as *arak* were used to favour sleep. Medical staff was constituted by the white British doctors who had not a specific training on mental health. Official psychiatry opposed to traditional medical practices mainly based on Ayurveda (ritual practices, sacrifice, spiritual healing, use of herbal medicines and restriction in diet)[16,17]. Western psychiatric nosography was introduced in India as an alien element, also creating specific diagnoses for the Indian population such as "hemp insanity" as cannabis use was widespread in the local population[14]. British doctors thought that many mental disorders of the Indians were caused by ignorance and superstition and therefore hospitalization was an opportunity for change[18]. They did not wonder if Indian traditional medicine had an alternative view of mental health; as highlighted by Shridhar Sharma[19], the spiritual motive dominated traditional life in India, the ultimate truths were truths of spirit and current life had to be defined in their light[20]. Traditional medicine, which had absorbed elements from mesmerism[21], was very popular among the high-class Indians (aristocracy, brahmins and administrators). Overall in the reports of the time the situation of the psychiatric services was described as more sweetened than the reality, given the request for specific reports by the central power after the scandals of the lunatic asylum in Kingston.

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Between 1914 and 1947 the first generation of Indian psychiatrists was established and Indian psychiatrists began to assume positions of responsibility from the 1930s. The British thought that greater access to medical positions to Indians would have limited nationalism and independence desire for a greater co-participation of locals in the administration of state[22]. Psychiatry was introduced as subject of study in Indian medical colleges from the Thirties[22]. With the outbreak of the First World War the places available in the existing psychiatric hospitals were insufficient, given the need to treat the Indian and British soldiers who had suffered war trauma. The most overcrowded psychiatric hospital was that of Mumbai (Bombay), which was the main western port of India where the wounded soldiers came from Mesopotamia (place of battles against the Ottoman Empire). Psychiatrists became an integral part of the Indian army during the Second World War due to heavy fighting against the Japanese army; the result was a separation between military psychiatry and civil one. In the first half of 20th century the segregation between the white British and Indian population continued. British doctors occupied preferentially military positions, while Indian ones were more involved in civil psychiatry. The middle class started to use psychiatric hospital as a mean to alleviate the economic burden of a relative with a psychiatric disorder, differently from the previous century when psychiatric hospitals were mainly social asylum reserved to poorest patients. In addition, as mentioned above, at the end of 19th century Indian high social class (aristocracy, brahmins and administrators) preferred to turn to traditional medicine that offered alternative treatments such as specific diets, yoga and meditation[14].

FRENCH EMPIRE

Most of the literature on psychiatric organization in the French colonies is about Algeria that was conquered by French army in 1830 after having been for three centuries part of Ottoman Empire[23]. This is because the wars for the independence of colonies such as Indochina or Algeria were particularly bloody. In fact, it is estimated that the independence war of Algeria caused between 1954 and 1962 about one million deaths out of a population of 10 million people. The psychiatrist Frantz Fanon, one of the main supporters of the Algerian war of independence, had introduced a series of changes in the care of patients admitted to psychiatric hospital in Blida in the Fifties before the outbreak of war. Fanon introduced principles of community psychiatry in Algeria at least ten years before Italy or United Kingdom[24]. He implemented occupational therapy, introduced open departments and prohibited racial segregation. As highlighted by Fanon in the book "Black Skin, White Masks", the Arabs or black people were educated according to white civilization; there was an insidious imposition of the French culture[25,26]. Besides the fact that a foreign language like French was introduced into the local culture, Fanon noticed that in fairy tales the hero was always white and the evil was represented by black people[25]. He was impressed by the participation of the local people in the cultural contamination of the colonizers. He argued that the white racist creates the black enemy, as well as the anti-semite creates the Jew; similarly, the exaltation of the chador by locals is emphasized by the demonization of this by the colonizers[26]. Specifically, after the independence of Algeria the past French colonizers saw the use of veil as the demonstration of the passivity of Algerian women, primitive customs and prominent patriarchy[27]. Fanon considers all these phenomena as the causes of violence during decolonization. According to Fanon, the colonized people learnt violent behaviours from the settlers and violence was applied against colonizers when local people began to organize into anti-colonial movements. For these reasons, according to Fanon, colonialism affected the mental health of colonized people, because of the psychological and political violence inflicted on the colonized[28].

Despite the innovative ideas on psychiatric patient care introduced by North African psychiatry, there was a kind of racial segregation in patient care. White French were mainly addressed to psychosocial treatments, while Muslims, considered more impulsive and superstitious believing in a spiritual origin of psychiatric disorders (jinn), were treated with more invasive treatments such as electroshock[29]. This discrimination was supported by the thesis introduced in 1884 by the medical doctor Adolphe Kocher who argued that violence among Arabs was especially a matter of race and of culture. According to this theory, French assimilation of Arab culture would have therefore improved mental health of Muslims[29].

As regards France some aspects of colonial psychiatry can be found in current affairs since this country has overseas departments. French Guiana is an overseas department which has all the characteristics of a colonized territory (considerable natural resources and poor social conditions compared to the motherland). It has been belonging to France since the 17th century. For two centuries, society was characterized by an organization based on slavery that was formally abolished in 1848, but that did not change the relations between maroons (the slaves of African origins) and the white masters[30]. The local population has high rates of HIV infection as well as widespread substance abuse and crime. The only detention centre houses people with significantly higher rates of mental illness than European penal institutions. Of note, it was calculated that about 72% of inmates show a psychiatric condition so that it is suspected that over psychiatric diagnosis in the detention centres is the consequence of a lack of proper psychiatric facilities. In low and middle income countries a lower budget for psychiatric care may favour a shift from mental care to incarceration[31].

DUTCH EMPIRE

Literature about colonial psychiatry in the Dutch Empire regards mainly Indonesia. Indonesia has been a Dutch colony since the seventeenth century and achieved independence in 1949. From the nineteenth century until independence the management of mental disorders was based on the classic asylum custody. The Indonesians were directed to a psychiatric hospital if they created problems of social order and a general practitioner declared their mental insanity. At independence, Indonesia could count on 4 enormous mental hospitals that housed over 5,000 patients each. The first huge psychiatric hospital was built in Bogor in 1882. Before the

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second half of 19th century patients with a psychiatric disorder were addressed to military hospitals, detention centers or were looked after by families. Both locals and European colonizers were admitted in Indonesian psychiatric hospitals.

Dutch colonial psychiatry was based on extremely racist ideas[32]. Even in post-colonial period many Dutch politicians perpetrated the idea that "whiteness" was one of the essential criteria of real "Dutchness"[33]. Dutch psychiatrists thought that mental illness was a consequence of modern society and therefore could not be present in primitive societies[34]. Kohlbrugge claimed that hot and wet climate together with animistic culture slowed the intellectual development of the Javanese. He proposed colonialism as a means to bring about social order, given that it was useless to educate locals who could not be civilized constitutionally and represented a non-receptive substrate. In 1920 Travaglino stated that the Javanese affected by schizophrenia had more frequently a violent behaviour (amok) than the Europeans and that it was useless to spend economic resources for people who belonged to a more primitive phase of social development; the only effective solution was institutionalization. He argued that the hypothesized less severity of schizophrenia in local populations than in the Europeans was the result of intellectual paucity: colonized populations were thought to be more emotional while the Europeans more rational. In 1928 Van Loon organized conferences during which he explained the behavioral inferiority of the local populations that were considered instinctive (Indonesia is inhabited by more than 300 different ethnic groups). Until 1927 the School for Education of Indies Physicians was reserved to the Caucasian Dutch. Local physicians fought against this discrimination and they obtained access to the school of medicine. Psychiatry training was generally complicated by the fact that patients with mental disorders were housed in wards far from the main general hospital. In rural areas local population has been always tolerant with regard to mental illness; in rural regions healers still practice Islamic medicine based on prayer, a balanced diet and baths[34]. Of note, a recent survey on healers in Indonesia reported that most practitioners were females more than 50 years old and prevalently used herbs and massages as remedies for illnesses[35].

ITALIAN EMPIRE

Italy had a colonial empire with a more limited territory (basically Libya and the Horn of Africa) controlled for a relatively short period of time from 1882 (occupation of Eritrea) to 1943. Until 1936 the Italian colonies had not felt the need to build psychiatric facilities because there was a certain tolerance for mental illness that was mainly managed by local healers. The management of mental health changed later as fascist propaganda had driven many Italians to emigrate to the colonies. One of the most popular diagnoses was that of tropical neurasthenia to indicate the discomfort of Italian colonizers to the new climatic and social conditions[36,37]. Psychiatric hospitals were never built in the Horn of Africa; patients with mental disorders were treated in specific wards in general hospitals (especially Italian colonizers) or were incarcerated (especially local patients who created social disturb). The most severe Italian patients were repatriated and sent to the psychiatric hospital in Naples. A similar situation characterized Libya where a psychiatric hospital was built in Tripoli only in 1939; severe patients were previously sent to the psychiatric hospital in Palermo[38]. Large psychiatric facilities were never built in Italian empire differently from other European countries.

DISCUSSION AND CONCLUSIONS

The various colonial empires beyond the differences have been characterized by an exploitation of local resources and by a social organization founded on racial segregation[32]. Despite the attempt to justify colonialism as a civilizing action, it is clear that colonialism was the result of organized military actions by the different European countries. Colonialism has not only resulted in economic losses of the occupied countries, but it has caused deep cultural fractures in local societies. For example, a small part of colonized people actively participated in the construction of political power and economy of colonial empires, and the native groups and classes, which were economically and culturally entangled with colonialism, were subsequently seen as intrusive elements in the realization of national sovereignty and autonomy[39]. The professionals (e.g. agronomists, engineers, technocrats) employed in larger numbers by colonial empires after the de-colonization largely migrated into the development agencies and other advisory boards that proliferated in the former colonial world from the Sixties[40]. The members of these families often use English or French as mother tongue and are more linked to European culture than local one. Even today in India a part of the population uses English as its main language and feels far from traditional culture[3]. In addition, while in some cases the indigenous populations have re-appropriated the government of their original country (e.g. the Indians or the Indonesians), in the other cases they have become minority (e.g. in New Zealand the Maori have been decimated between 1852 and 1870, the so called "Maori genocide"). These differences are also explained by the fact that countries like India were "exploitation" colonies, while New Zealand was a "settler" colony[41]. The colonizers aimed to occupy and create a new cultural identity in colonies like New Zealand, where a first attempt of integration of the local in the political decision of country was done only after the Treaty of Waitangi in 1840. Moreover, the colonial empires, as all the contemporary political models based on economic exploitation and lack of social solidarity and democracy (dictatorship), recurred to incarceration as one of the main instrument for the management of mental health and devoted little economic resources to health-care facilities. Political opponents and especially those who promoted colonial independence could be sent to psychiatric facilities; this happened for example to the first Surinamese trade unionist Louis Doedel in 1938[42]. The colonial empires, therefore, represent the first example of political use of psychiatry that will be typical of the subsequent totalitarian regimes[4]. The Nazi regime, for example, was inspired by colonial psychiatry in justifying the imprisonment and killing of thousands of people with mental illness as a sort of "euthanasia" for the lack of economic resources that could be devoted for the care of the most fragile citizens[4].

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Beyond the common aspects, colonial psychiatry presented differences in the various empires with regard to the theoretical structure and the organization.

The British had the problem of a great empire difficult to be controlled militarily, and they had experienced the American War of Independence. There was a need to control a large area with little money and for this there was a constant demand for reports that favoured the control of the motherland on the colonies[8]. Colonialism (including the export of Western psychiatry) was above all an economic affair and it is no coincidence that the British Empire would have evolved in the Commonwealth which is an intergovernmental organization aimed at the prosperity (including the economic one) of the member states. British colonial psychiatrists applied what later Michel Foucault will define as a power based on the discipline of writing[43]. In fact, if the motherland did not receive timely reports on the situation of the colonies, the local governors could be threatened to be subjected to public reproach[8].

The situation is different for France which still has overseas territories and which responded especially at the beginning with bloody wars at the request of independence of the colonial territories. In this case the attempt of cultural assimilation was more evident; the colonies had to assume the French culture. The Enlightenment born in France had to go beyond the territorial boundaries of the homeland. Despite a role of supposed biological inferiority in the discrimination of the French colonizers towards local populations (e.g. the theses by Antoine Porot)[44], the Arabs were mainly considered as characterized by primitive customs and superstition[28]. The French colonial psychiatry can therefore be seen as one of the means to counter the "madness" of a request of independence from the civilized mother country. From the point of view of the rulers of the motherland, only "fools" could in fact refuse the offer of a possibility of a greater civilization which would however imply remaining under the domination of the colonizers.

The Dutch colonial psychiatry supported more prominently racial theories. The Dutch colonial psychiatry claimed that biologically local people could never reach European civilization. The exploitation and violence on the local population were justified by the fact that the Indonesians had a primitive brain and therefore the maintenance of the social order had to be the sole objective of the colonial psychiatry. Offering civilization to rudimentary minds would have only generated confusion[31]. Moreover, racist ideas spread in Indonesia in the 1920s when the idea of independence started to materialize and this worried the owners of sugar cane plantations.

As regards Italy, less attention was given to mental health in the colonies compared to other countries. This is probably due to the fact that Italy (like Germany) is a country that achieved national unity more recently and in which psychiatry focused more on the so-called internal colonies. Italian colonial psychiatry paid more attention on the inhabitants of the poorest regions of Southern Italy and on their supposed cultural inferiority[38]. After the unification of Italy, similarly to what happened in overseas colonial territories, some authors tried to explain the different economic situation between North and South Italy in terms of biological or psychological characteristics of inhabitants. People from South Italy were described as more impulsive and with physical traits that were the result of a mixture with populations considered primitive such as the Africans or Albanians[45].

The colonial psychiatry (previously called comparative psychiatry) represented a first rudimentary attempt to interpret psychiatric symptoms in different geographical areas. Kraepelin had already noticed a lower incidence of hallucinations in local patients affected by "dementia praecox" during his trip to Java and he had attributed this aspect to a lifestyle different from that of urbanized western countries[46]. The Dutch psychiatrists of the time had therefore transformed Kraepelin's observations pertinent to anthropological psychology in political and social theories, describing the psyche of the Javanese as similar to a children's one. The main difference between colonial psychiatry and ethno-psychiatry is represented by the fact that the first is a psychiatry of race[47], while the second is driven by the possibility to understand symptoms in the framework of patients' cultural context.

This article represents a first attempt to illustrate the similarities and differences between the different colonial empires in the theory and practice of psychiatry. The study of these aspects can help to better understand some phenomena that characterize contemporary psychiatry. Despite considerable efforts, many European and American psychiatrists still rigidly apply Western diagnostic categories to patients from other cultures; this often implies diagnostic errors and therefore an inadequate treatment with a worsening of the prognosis of these patients. During the period of decolonization, Fanon had already prophesied a potential difficult encounter between the Western clinician and the immigrant patient[48]. Furthermore, some prejudices are still rooted among Western psychiatrists, fueling the sense of non-acceptance of patients coming from other cultures who often access to mental health services too late. This is particularly true for countries like Italy where immigration is more recent and that had a more limited colonial empire. Furthermore, the sense of lack of acceptance and cultural opposition has devastating social effects such as isolation until suicide bombing[49]. It is perhaps not a coincidence that France, which has a history characterized by bloody colonial wars, massive immigration after independence of colonies (e.g. Algeria) and where cultural assimilation was seen as a civilized mission, is one of the countries most tormented by terroristic attacks[50]. Of note, the feeling of frustration, marginalism and cultural inferiority has been transmitted to the new generations born in France. In support of this consideration, a recent article highlighted the potential association between the past experiences of domination and exclusion during colonialism and the frequent suburban riots in France[51].

This critical review has aimed to give a general framework about the management of mental health in the different European colonial empires. In this context the limits of the present review are represented by: 1) the exclusive inclusion of articles in English; and 2) the exclusion of manuscripts about psychology of colonialists and the impact of colonialism on the mental health of colonized people. Future research will have to focus on the single colonial empires and on the psychology of colonialism, including the effect of colonial domination on the mental health of colonized people.

Conflict of interests: the authors have no conflict of interests to declare.

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