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Reflections on things we don't want to think about: Intersections of colonialism, transgenerational trauma, and oppression within psychiatry

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In this essay, I identify a particular way that the institution of psychiatry can be harmful to people and to patients. Even though individual psychiatrists are well-intended and deeply committed to helping their patients, they may be caught in socially produced mechanisms that harm patients. Specifically, I focus on colonizing strategies as they are embedded in psychiatry and their effects; the idea is that certain socially shaped ways of knowing perpetuate colonizing of people and patients. However, my ultimate interest is in what psychiatrists can do differently, and so, in the last section, I briefly introduce an ethical concept I have coined 'the virtue of giving uptake.'

First, let me say that this is not an anti-psychiatry piece. I believe that some people suffer from mental distress, sometimes severely, and that psychiatrists can and have helped many people heal or at least manage their distress. Psychiatrists have many tools upon which to draw to assist people who are in distress. It is always important, though, to identify areas of vulnerability in one's profession and to understand what is involved in challenging entrenched and invisible problems. Sandra Harding calls this 'strong objectivity,' by which she means that scientific communities need critically to examine their own practices, interests, assumptions, and biases. They need to notice and, often, contest, the tools and measures and the attitudes toward their objects of study—in the case of psychiatry, the people or patients themselves (Harding, 1993). Because none of us is an infallible knower or is invulnerable to errors in belief and reasoning or to [unintentionally] reproducing structurally damaging practices, a stance of strong objectivity is required by all those who practice psychiatry. Even those psychiatrists who already are critically reflective and do not complacently endorse potentially harmful practices need to participate in dialogue with other psychiatrists and with service users: constructive change in practices is a collective, not an individual, endeavor. The scope of those to whom this article is addressed, therefore, includes all those whose lives are touched by psychiatry, mental health services, service users and their loved ones of all colors, classes, and genders. We learn from each other—including the voices of patients who currently are silenced or misunderstood—about the mistakes in thinking, the assumptions, disagreements, weaknesses, and strengths of our practices. Those psychiatrists who already engage in strong objectivity play an important role in identifying with others the aspects of psychiatry that need to be changed in order better to provide care to all service users.

Thinkers like Franz Fanon (cf. 1968) and Michel Foucault (cf. 1988) provided early critical analyses of psychoanalysis and psychiatry, respectively, but the work of stemming colonizing forces in psychiatry is ongoing. I focus on epistemic issues in psychiatry (issues in what counts as knowledge-claims, who counts as a knower, and how bodies of knowledge are maintained) because these issues are one of the least analyzed aspects of psychiatric practices. A clear sense of what the concerns are, how they can produce structural harms for some groups of people, and what can be done on an epistemological level can make a difference in resisting the reproduction of colonizing practices. The level of epistemic concerns I analyze is broad in that it traverses not only the narrower scientific questions of nosological and diagnostic knowledge claims, but the deep ways that an entire domain of attitudes, standards, commitments, reasoning patterns, and qualities of character is implicated in this 'thick' account of epistemological underpinnings of psychiatric practice.

Epistemologies of resistance

I begin this essay by introducing Traveling Thunder, member of the Fort Belknap tribe. When Joseph Gone asked him under what conditions he would take a grandchild to a psychiatric clinic in Indian Health Services, he replied:

> 'I would say that's kind of like taboo. You know, we don't do that. We never did do that.'… That's like saying, you know, 'What's the purpose of this reservation?' ….The Whiteman can't see no purpose for it. But to the Indian people they say, 'Well, this is my last stronghold', you know. 'This is all I got left. I mean you took 99% of our land. You took our way of life. You wiped out all the buffalo…. And then you'd rather slaughter the elk and the deer in the [National] Parks than give them to the Indian people on these reservations that are hungry ….' I guess it's like a war, but they're not using bullets anymore ….[Sigh] Like ethnic cleansing, I guess you could say. They want to wipe us out. Wipe the Indian reservations out so they could join the melting pot of the modern White society. And therefore the Indian problem will be gone forever…. But they're using a more shrewder way than the old style of bullets. (Gone 2008, p. 383)

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'The Indian problem.' Traveling Thunder knows what it is to be a problem for 'civilizing' White society. He also knows that, although Native people are often out of balance with the spirits, beset by addiction, depression, and high suicide rates, Indian Health Services represents a domain in which Native people are expected to conform to White solutions through psychiatric diagnosis and treatment. Traveling Thunder defies those expectations, calling out Indian Health Services on their collusion with Western psychiatry to bend the will of Natives.

Indigenous ways and Western psychiatry are at an impasse, and one might wonder why. Indeed, many researchers propose a melding of diverse treatment approaches, with an emphasis on indigenous-led formats. But on one account, a mixed approach is unfeasible and unwise because (a) there exists a clash in world-views between Enlightenment-based Western psychiatry and Native American world-views; and (b) the underlying broad values of Western psychiatry and its commitment to a particular cosmology and ontology is assumed to be superior to that of Native Americans.

> To be clear, adapting therapy with multicultural techniques—for example, matching clients on the basis of gender, factoring in level of acculturation, or tailoring communication style to match that of the client—in and of itself, does little to mitigate the colonization. Such techniques function to repackage the counseling project in more palatable dress while leaving its central colonizing function intact. The fact must be faced that professional therapy is a thoroughly enculturated project. As such, it is time to consider revaluating or even abandoning this project and rebuilding the helping process on an indigenous knowledge foundation. (Hodge, Limb, & Cross, 2009, p. 213).

Multicultural outreach, medical education in cross-cultural competencies, and sensitivity training, then, miss the mark in understanding the historical effects of colonization on the colonized (more on this below.) Below, I propose a third reason why psychiatry has difficulty understanding the effects of colonization, in particular focusing on ongoing transgenerational trauma and systematic and interlocking oppressions. I argue that a certain sort of epistemology of resistance can be a powerful impediment to correct diagnosis and treatment.

With the continuation of colonizing practices, the question arises: *W*hat does it mean genuinely to see and be seen? King (2012) says that 'Dead Indians' are not only dead people, 'they are the stereotypes and clichés that North America has conjured up out of experience and out of its collective imaginings and fears. North America has had a long association with Native people, but despite the history that the two groups have shared, North America no longer sees Indians' (King 2012, p. 53; emphasis in original). Why are marginalized and historically colonized groups not seen and heard in their own right? Why do well-meaning, even enlightened people fail to see that their ways of seeing, of constructing other persons as Other, and that treating them can undermine the best of intentions and sometimes do harm? In this section, I place claims of good intentions, best interests, and not-knowing, under scrutiny. I draw upon the work of José Medina (2013) on epistemologies of resistance for this discussion. As I explain what he means by 'epistemologies of resistance,' I suggest how his theory might apply to psychiatry.

'In a situation of oppression, epistemic relations are screwed up.' Thus begins Medina's theory and analysis of the epistemology of resistance (Medina 2013, p. 27). His interest is in the ways that epistemic resistances to knowledge and to ignorance can impede or foster fighting against injustices and oppression and, at the same time, those social injustices affect our ways of knowing.

Medina argues that epistemologies of resistance are found both in the privileged and in the oppressed but that the form of resistance tends to vary in fairly typical patterns for each group.

For purposes of this essay, I focus on epistemologies of resistance that members of advantaged groups develop as part of their character. Epistemic resistances affect our capacity to hear and to be heard correctly. But being seen and heard correctly are of central importance to good practices in psychiatry and other mental health practices. The social position of privileged people, including that of psychiatrists, affords them the ability not to know certain things and the assumption that they do not need to know. Medina is careful to emphasize that there is no simple equation between privilege and epistemic vice on the one hand, and oppression and epistemic virtue, on the other hand. As he says, we cannot determine a person's epistemic character just by identifying the social position of that person. The point is that systems of oppression and domination create *patterns* that are found in these different social groupings.

Differentially situated people form resistances that shape the experiences one has, the kinds of concepts one forms, and the beliefs one holds about what is true about the world (Mills as quoted in Medina, 2013, p. 48). These resistances are the source of what Medina calls 'epistemic friction,' by which he means *opposing forces* in strategies of epistemology that both form the trajectory of belief-formation and the external forces that steer the course of epistemic character development in differentially situated people (Medina 2013, p. 48; emphasis in original). This phenomenon can be seen in the history of psychiatric practices, as when the threat to white people that Black power became during the civil rights movement prompted a new diagnosis called 'the protest psychosis,' which diagnosis gave rise to an increase in the number of African American males viewed as schizophrenic (cf. Metzl, 2009). This is an example of epistemic friction: on the one hand, the opposing forces of mental health as manifested by the desire to address injustices; and white people's anxiety and distress over what the acknowledgement of the right of Black folks to have equal civil and social rights will cost them, on the other hand). These resistances are *active*, even though they may not be deliberate. For example, as Medina says, 'there is *not needing to know* and *needing not to know*' (Medina 2013, p. 34, emphasis in original). Needing not to know, in his view, is a defense mechanism, a kind of epistemic hiding that functions to preserve privilege. It is a culpable form of ignorance and, if it becomes part of one's character, is a vice.

To say that such gaps actively can be produced is to say that it takes *effort* to not-know the effects on others of historical and persistent systematic oppressions. In analyzing how this applies to racialization, Linda Alcoff states that

> …whites have a *positive* interest in 'seeing the world wrongly,' to paraphrase Mills. Here, ignorance is not primarily understood as a *lack*—a lack of motivation or experience as the result of social location—but as a substantive

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> epistemological practice that differentiates the dominant group. (Alcoff, 2007, p. 47)

For example, color- and gender-blindness involves actively embracing one's own positionality without attending either to self-knowledge or to knowledge of other persons with their own historically and socially situated backgrounds, experiences, values, and beliefs. The epistemic character flaw here is that it assumes that there is nothing to see and that another's historical and social situatedness is not significant (Medina, 2013, p. 38). One's character is that of an actively ignorant subject (p. 39). Actively ignorant subjects are

> those who can be blamed not just for lacking particular pieces of knowledge, but also for having epistemic habits and attitudes that contribute to create and maintain bodies of ignorance. These subjects are at fault for their complicity (often unconscious and involuntary) with epistemic injustices that support and contribute to situations of oppression. (Medina, 2013, p. 39)

Epistemic resistance, in the form of not knowing, not needing to know and, sometimes, needing not to know are dispositional tendencies that people in situations of privilege develop as they attempt to reduce epistemic friction and hold on to the confidence of their positions as knowers. Such dispositional tendencies are a vulnerability for psychiatrists and other mental health professionals because their training, as well as the emphasis on Evidence-Based Medicine and the role of the DSM, often work together to create clinicians with an epistemology of resistance to the historical and socially-situated persons with whom they come in contact. That is, they are expected—indeed, may even be required—to narrowly focus on the person as a generic individual as they decide whether to diagnose or not. It is true that the DSM-5 allows for more attention to the social self than previous versions but, as I say, the DSM works together with other epistemic practices that constrict many clinicians' access to accurate and complete knowing. Thus, clinicians make themselves into, and are made into, a privileged way of knowing that elides many crucial factors that influence the experiences and needs of the person in front of them.

As Medina argues, and I concur, epistemic flaws are grounded in and exhibit our character (Medina, 2013, p. 29). Vices (and virtues) are not temporary or one-off flaws or strengths but are partly constitutive of who we are and how we perceive, respond to, and help shape the world. Thus they also are not only individual flaws or strengths but systemic and structural ones: epistemology is a social endeavor that involves others in deciding what counts as knowledge and knowers, and so on. Cognitive and social development work together to cultivate our epistemic strategies for navigating the world, which strategies simultaneously create our characters. By calling these epistemes 'strategies,' I mean that they are schemas or blueprints that shape our bodies of knowledge: who we count as knowers, what we count as evidence, who we count as credible, and who determines the structure of various practices. Like other institutions of privilege and power, psychiatry inculcates in its practice such resistance to certain bodies of knowledge that can affect their character and, hence, diagnosis. Epistemic resistance of the kind I have been talking about may affect perception and interpretation of behavior that end up being mistaken.[i]

Although we typically are not aware of our everyday attitudes, beliefs, and assumptions, and usually are not critically evaluating our own epistemic frameworks, we are responsible for them because we *can* be critically aware, we *can* evaluate and change our own epistemic character, and we *can* learn to understand who we are and who others are in a more epistemically and socially accurate way. We *can* engage in strong objectivity both in science and in ethics. And because epistemic vices are integrally tied to social injustice, we not only *can*, but *should*, make the necessary cognitive corrections in order to cultivate more virtuous characters. Thus, Medina argues that one form epistemic character flaws take is a resistance to self-correction and openness to correction from others (Medina, 2013, p. 31). This is a vice when it becomes a habit, part of our disposition, because 'letting one's perspective go unchecked results in an unavoidable, mundane accumulation of oversights, errors, biased stereotypes, and distortions. In this way, racist and sexist biases become undetectable and incorrigible blind spots…' (Medina, 2013, p. 32).

> Being sensitive to the presence and influence of cognitive forces is crucial to the achievement of epistemic virtues… the willingness to put one's cognitive perspective in relation to that of others—calibrating the different cognitive forces, impulses, and compulsions one is exposed to—is the path to the epistemic virtues. (Medina, 2013, p. 51)

Although Medina is talking about epistemic virtues in the oppressed in this passage, he also applies the normative claim to the privileged. Regardless of where we are situated in relation to structures of domination and subordination, we need to develop a character with epistemic virtues in order to serve social justice and fight against injustice. But the road to epistemic virtue is, in many ways, more challenging and more difficult for the privileged. In particular, it presents a challenge to psychiatrists and other mental health professionals.

These substantive epistemological practices include an editing of memory of colonialist history that 'enables a self-representation in which differential white privilege, and the need to correct for it, does not exist' (Mills. 2007, p. 31). That is, mechanisms of oppression such as Young discusses— exploitation, marginalization, powerlessness, cultural imperialism, and violence (Young, 2011) —are 'put out of cognitive reach' of privileged people and those in positions of authority (Medina, 2013, p. 33).

To accomplish such demanding tasks—the tasks of epistemic resistance to knowing oneself and others within the historically situated context of their lives—relies on a strategic epistemology of resistance—resistance to the meaning and significance to those most affected of the historical context of colonization, transgenerational trauma, and an oppressive gender system; ignorance of the historical context in which patients struggle against but continually are molded, immobilized, and set back by hegemonic power. The next section focuses on colonizing and its aftermath.

Historicizing an Epistemology of Resistance

Charles Mills emphasizes that any understanding of structurally unjust epistemologies must be placed in an historical context

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(cf. Mills, 2007). The historical context is that of colonization, of marginalization, and of oppression of those marked as different. In this section, I discuss some colonizing strategies and suggest that epistemologies of ignorance are one of the colonizing strategies that have been, and continue to be, practiced against indigenous people, those marked as 'non-White,' and the 'deviant.' In Thomas King's *The Inconvenient Indian: A Curious Account of Native People in North America* (2012), King recounts the colonialist history of governmental policies and cultural ideology, and drives home the myriad ways that White people have dealt with what they constructed as 'the Indian problem.' Whites have engaged in outright genocide, stolen and destroyed lands, robbed people of their legal right to traditional ways and practices, and enforced White assimilation. King analogizes the latter with Beckett's *Waiting for Godot*:

> This idea that Native people were waiting for Europeans to lead us to civilization is just a variation on the old savagism versus civilization dichotomy, but it is a dichotomy that North America trusts without question. It is so powerful a toxin that it contaminates all of our major institutions. (King, 2012, p. 79)

The inconvenient Indian in North America was faced with eradication, then removal, and then erasure. What is erased is an absent presence; its ontological status is altered to another meaning, or hidden, or suppressed. Traditional ways have been erased, in the sense I've given, but those ways themselves have never been annihilated entirely. In presenting the account of the American Indian Movement's confrontation with federal marshals and the FBI, King explains that the idea that Natives should 'have more faith in the laws of the land and the political system' is outlandish given the history of colonization in North America.

> Were there ways to frame Native concerns other than with demonstrations, confrontations, and, on occasion, violence?
>
> No.
>
> I'm not trying to be provocative here. The fact is, the primary way that Ottawa and Washington deal with Native people is to ignore us. They know that the court system favours the powerful and the wealthy and the influential, and that, if we buy into the notion of an impartial justice system, tribes and bands can be forced through a long, convoluted, and expensive process designed to wear us down and bankrupt our economies.
>
> Be good. Play by our rules. Don't cause a disturbance. It is a fool's game. (King, 2012, p. 157-158)

Ignore. Erase. Civilize. A long and tenacious history of management and resistance in psychiatry, governance, and policy-making persists in colonialist North America.

The study of colonization is a theoretical approach to understanding the history and legacy of colonizing strategies and imperialism. It analyzes not only the material lived conditions of the colonized during colonization, but the very discourses, representations, and knowledge-productions that enable the continuation of those ways of thinking, positioning, and dominating non-western Others (cf Said, 1979; Spivak, 1988). Colonizing strategies, in other words, include not only the methods of land usurpation and the imposition of laws, government, policies, and language, but also colonizing of ontologies, thought, and epistemes. As Alejandro Vallega argues with respect to colonized Latin American people, a historically situated critique of racialized Others must not only recognize the subjectivity, agency, and power-knowledge potential of people now subjugated under modern Western thought; it must also interrogate and undo those epistemic structures that sustain colonizing concepts such as 'subjectivity,' 'agency,' and 'power/knowledge' (Vallega, 2012, p. 230-231). To do that is beyond the scope of this essay, but Vallega highlights my point: colonizing strategies infiltrate the very possibility of what can be thought and known.

Erasure and other forms of containment, management, and assimilation into 'civil'—i.e. colonialist—norms for behaving, knowing, and interacting are strategies that are embedded in the violence and trauma of modernity. And, as we might infer from clinicians' privileged positions where not knowing, not needing to know, and needing not to know, epistemic character vices work together with colonizing, the result of which is the colonizing of mental health itself: the 'well' sometimes being positioned as 'not-well'; mental health and mental illness, then, are binary constructs that situate the colonizer and the colonized in relation to one another as reasonable, trustworthy, and civilized, or as unreasonable, untrustworthy, and primitive, unruly, untamed—and in need of being tamed, treated, or detained. Thus the binary opposites of colonizer/colonized recursively reproduces other binaries such as White/non-White, superior/inferior, and normal/abnormal.

A related binary is that of male/female, with all of its accompanying assumptions about gender identity, gender expression, and sexual object of choice. As María Lugones argues, the simultaneous rise of colonialism and modernity enforced not only the construction of naturalized racial binaries with their inherent hegemonic relations, but also the imposition of a gender system that did not exist prior to the colonial/modern period (Lugones, 2007). Lugones defends this claim with anthropological data of societies in which nongendered egalitarian relations existed such as in Yoruban cultures and in many Native American tribal cultures. 'The scope of the gender system colonialism imposed encompasses the subordination of females in every aspect of life', Lugones writes (Lugones, 2007, p. 196). This includes the erasure of gynecentric constructions of knowledge that ground and shape what counts as reality—an understanding of the very ontology of the world that counters the episteme of colonialist modernity (Lugones, 2007). As Jacob Hale puts it, gender is regimented and policed so as to remain within strict binaries that reproduce misogynist and pathologizing purity genres (Hale, 2009, p. 47). But such policing, whether of gender or of race, does not imply that that policing is successful in enacting a totalizing colonization. Lugones' point is that it is imperative that we include and attend to enforced and all-pervasive gender binaries that intersect with racialization. The gender system that was and is imposed through colonization carries with it the question of complicity and ethical responsibility when alliances and loyalties hold to the colonial powers and thereby turn on, harm, thwart, and devastate the subordinated (Lugones, 2007), questions at the heart of this essay.

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I opened with the voice of Traveling Thunder, who articulates the ongoing colonizing of Native people in North America. Another example discussed above—that of gender colonization—is found in the culturally-inflected and damaging meanings of being transsexual in a transphobic culture. Specifically, these colonizing discourses and politics erase, damage, and perversely distort female-to-male (ftm) feminist voice and agency. This occurs, among other domains, in the medical establishment, because of the double-bind transsexuals face by engaging medicine in order to effect trans change. The problem is that doing so legitimizes the very ideologies that transsexuals are stepping outside of—namely, gender ideologies. 'For transsexuals, inserting ourselves into this nosology is often necessary for exercising agency over our own bodies' (Hale, 2009, p. 47). 'Having' agency, then, is constrained by the coercive apparatus of the medical establishment that forces trans people into making tough choices about how they exercise power over their own bodies (Hale 2009, p. 48). Gender colonization, Hale argues, is inscribed by psychiatry onto bodies that do not fit into any available categories of being, even feminist rethinkings of gender. As he puts it,

> These conditions not only regulate culturally meaningful gendered embodiment, they constitute it by establishing, marking, and policing boundaries between those embodiments that have cultural meaning and those that are abjected from social ontology. (Hale, 2009, p. 49)

Hale cites the determination by surgeons of 'adequate vaginal depth' when performing male-to-female (mtf) surgery, the overriding of ftm patients' wishes not to have their nipples reduced on the grounds that such reduction is needed for proper proportionality, and other examples. He concludes that medical practice refuses to grant agency to transsexuals over their own embodiments (Hale, 2009, p. 49). The colonizing double-bind entails the necessarily reciprocal venture between trans people and medicine that gives the lie to reciprocity. These practices compromise and, sometimes so restrict agency as to call into question the meaning of saying one has agency under such coercive measures.

As Hale's critique of psychiatry highlights, a historically grounded critique of colonialism challenges and resists binaries such as oppressor/oppressed and colonizer/colonized because to hold to those dichotomies represents the Other as passive recipients of violence and more covert aggression (such as global corporatism). Instead, it considers ways that enduring effects of colonizing on particular populations has been one of struggle and resistance as well as of victimization. This is the case even with the mentally ill, many of whose own voices tell of both the need for psychiatric interventions and the damage they experience. The need for what postcolonial theorists call 'the subaltern' to speak, though, is compromised in psychiatry, as elsewhere, by representations of the mentally ill as 'psychiatric patient'; this may be especially true for people living a legacy of colonialism.[ii] In order to understand and adequately address the persistence and recalcitrance of health care injustices as they appear in the diagnosis and treatment of mental distress, we must grapple with the transgenerational effects of colonialism and racism (Rentmeester, 2012). Thus, 'the projects of freeing healthcare from the damage wrought by those forces, of thinking rigorously about the nature and scope of our obligations to eliminate their lingering harms, and of strategizing about how to improve clinical practice, health outcomes, and health experiences of people of color with mental illnesses require the insights of postcolonial thought' (Rentmeester, 2012, p. 367). Transgenerational trauma and psychic trauma of not being at home in the world have profound effects on immigrants, and refugees, displaced people. Yet all too often, transgenerational trauma is ignored or erased. Taking colonialist analyses into account in caring for the mental distress and mental health needs of these populations not only provides better treatment but is an ethical imperative so as not to replicate past historical and systemic harms.

How should psychiatrists respond who want to engage positively with injustice and change not only their own epistemic commitments but that of others? And what might make it difficult for psychiatrists to respond appropriately? Medina's work suggests that the project of change is substantial and difficult.

> Active ignorance has deep psychological and sociopolitical roots: it is supported by psychological structures and social arrangements that prevent subjects from correcting misconceptions and acquiring knowledge because they would have to change so much of themselves and their communities before they can start seeing things differently. (Medina, 2013, p. 58)

Given colonizing strategies and transgenerational trauma, grasping the patient's world from the patient's experiential ground can be very challenging—if that is even an appropriate goal in all circumstances. It may not be appropriate, for example, for indigenous peoples. Even if it is a good aim, readers may be skeptical of commensurability across radical difference. It is difficult enough to understand what it is like to live with a mental illness like schizophrenia or borderline personality disorder because it is difficult to imagine what the world looks like and feels like from the perspective of the patient (cf. Potter, 2003). It is even more challenging to expect psychiatrists to try to grasp the lived experiences of a patient with a mental illness in the context I have set—that of ongoing colonialist policies and practices that perpetuate relations of domination and subordination. The psychiatric episteme powerfully impedes accurate understanding of an oppressed person where an historical legacy interacts with current systemic oppressions. Nevertheless, I believe there is way to grapple with structures of oppression and domination, and that is for psychiatrists and other health care professionals to cultivate the virtue of giving uptake. The last section briefly explains what giving uptake entails.

The virtue of giving uptake

For those whose positions of psychiatric authority are vulnerable to epistemic resistances such as I described in §1—but who consciously do not want to collude in structural harms to patients— I propose developing a disposition to give uptake rightly (cf. Potter, 2000; Potter, 2009.) To give uptake requires a certain kind and quality of listening. One listens to the communicator, taking in her full self in all its situatedness and distress while being ready to suspend or abandon the norms, values, and epistemic commitments one has been habituated into. As such, it involves an epistemic, moral, and political shift of the listening *self* as one works to grasp the meaning of the communicator's words and

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body language. In giving uptake, the listener makes an earnest attempt to understand the communicator from her point of view without imposing meanings or closing off interpretations. It does not require agreement, but it may require letting go of preconceived dispositional ideas about value and meaning. It involves an openness to meaning-making where the communicator is counted as a knower and full participant in determining what is true about the world.

As I argue elsewhere (Potter, 2013), empathy is analytically distinct from uptake. Both are virtues, and they enhance and strengthen one another, but they draw upon different skills and capacities, and they require different dispositions of one's character. Empathy is concerned with cognitive and emotional perspective-taking of others as a response to another's distress, while giving uptake well is concerned with dialogic interactions in a pluralistic and unequal society. Methodologically, empathy differs in that it requires that one maintain boundaries and a centered self in order not to lose oneself in perspective-taking. Giving uptake, on the other hand, cannot be done well unless one de-centers the self.

Let me give an example that deals with transgenerational trauma. Hanna S., a Holocaust survivor, is being interviewed about her experiences in a concentration camp. When asked how she survived the experience, she replies, 'I survived the Holocaust through luck and stupidity.' The interviewer responds by saying 'No, you were plucky' (Langer, 1991). Lawrence Langer examined transcripts of many interviews with Holocaust survivors and found that the interviewers consistently drew on their more comfortable moral lexicon of heroism, courage, strength, and so on, instead of hearing what the survivors actually communicated: a moral lexicon that was unfamiliar, uncomfortable, and filled with an unacceptable (to the interviewers) narrative. They were not giving uptake to the actual testimony of the speaker—they were resisting it—and the result was not only the silencing and erasure of the experience and meaning-making of the communicator, it was a subtle perpetuation of colonizing where the interpreter held the privilege of deciding what counts as the correct narrative.

Giving uptake is integrally bound up in addressing social injustices and properly addressing transgenerational trauma and the disabling effects of living under oppression. As such, it works in tandem with the correcting of epistemic resistances of the privileged. When giving uptake rightly, a clinician interrogates the norms that he or she is enforcing, norms and practices that benefit the clinician but, often, not the other person. To take seriously the full person in her or his historically and socially situated life means that a clinician is willing to consider the possibility that he or she is implicated in systemic, harmful relations and oppressive regimes. It indicates that the clinician recognizes the historically and experientially grounded effects of colonization on the communicator. One shifts one's epistemic authority by decentering oneself and learning to suspend or bracket off one's own world view in favor of moving into the world-view of the communicator.[iii]

Conclusion

This account argues that psychiatry is another colonizing strategy and that epistemologies of resistance of the privilege are integrally bound up in this colonizing. The nexus of psychiatry and strategic epistemic resistances function to continue the colonizing that is necessary to the hegemony of white power and domination. Therefore, attempts to 'combine' Western psychiatry with traditional healing ways is a perpetuation of colonization. The idea that American Indians need mental health assistance from White psychiatry in the face of colonial and postcolonial trauma, by which he means 'unresolved grief in tribal communities' is fraught with contradiction (Gone, 2008, p. 373). As Gone says, 'owing to the shattering legacy of Euro-American colonialism, it is crucial to recognize that these divergent cultural formations meet on especially uneven ideological terrain in Indian country' (2008, p. 370). Traveling Thunder puts it bluntly:

> Going to the Indian Mental Health Services for a problem like substance abuse is just another form of continuing ethnic cleansing of Indians: the United States/Indian wars are just continuing in cultural terms, forcing 'their White ways and White beliefs' on Indian peoples (Gone, 2008, p. 381).

It may be, then, that the best—indeed, the only—way to avoid perpetuating colonization with people in indigenous cultures through psychiatric interventions is for white, Western psychiatry not to try to practice 'multicultural' approaches to healing. When we listen attentively and give uptake to the voices of people who follow the traditional ways, we may find that the only way to avoid doing harm is not to insist that psychiatric practices are necessary interventions for traditional Indians.

Others, though, may want to seek out mental health care. In those cases, if clinicians want not (even inadvertently) to perpetuate systemic injustices such as ongoing colonizing and oppressions, they will need to engage in self-reflection on their tendencies toward epistemic vices and the potential for character change. Self-reflection on epistemic resistances most likely will require that clinicians call upon others to help them see themselves and each other more clearly and, working together, to move toward corrective and more complete knowing. Giving uptake properly is one way that clinicians can begin to undo the presumptions of knowing and resistances to knowing while, at the same time, diagnosing and treating people more accurately and helpfully.

Footnotes

i. For example, see Potter (2014) on the potential for misdiagnosis of Oppositional Defiant Disorder given to Black boys.

ii. The subaltern typically refers to those groups that historically have been situated outside colonialist power structures, including discourse, ideology, norms, laws, and even historicizing itself.

iii. I want to emphasize that giving uptake to another does not require agreement, although this claim is complex because where one stands in relation to oppression and domination may enhance or distort one's ability to be a good knower. To unpack this, I would draw on Medina again, but to do so is beyond the scope of this paper.

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