CASE STUDY: CALVIN JOHNSON

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"The scientific study of man is impeded by an anxiety-arousing over-lap between subject and observer."

George Devereux

Introduction

The essay aims to present to the reader the case study of Mr. Calvin Johnson, as documented in Roland Littlewood and Maurice Lipsedge's book "Aliens and Alienists. Ethnic Minorities and Psychiatry" (1989), shedding light on the role that systemic institutional racism had in exacerbating the mental distress of the patient while living in the United Kingdom from 1961 onwards. Fifty years have passed since Johnson was treated by the British National Health Service (NHS) for multiple psychotic episodes. However, his psychological and psychiatric development is here considered still a textbook case, emblematic primarily because it features both the biological and individual predisposition of the subject to mental disorder, and the "intrinsic violence" (Framer, 2009) he suffered from his context as an immigrant black man. From a methodological perspective, Calvin Johnson experience cannot be interpreted by strictly relying on the categories of Cultural Relativity or Universality, because, while political and social implications must be taken into account when discussing his case, he showed also objective symptoms of biologically determined psychotic behaviour. The text will firstly present the case clinic of Johnson, focusing on his personal history and tracing the stages of his experience while being a Jamaican immigrant in the UK. As it will be clarified, Calvin Johnson started experiencing severe issues with his mental health only after migrating abroad with his wife, Alice Johnson, although he attempted to rely on different ways to cope with his frustration (i.e. his spirituality). The second part of the essay will attempt a psychological assessment of the subject, focusing primarily on the circumstantial factors which aggravated his mental state, namely the racial biases he faced from the police who arrested him and the mental health professionals who made their clinical reports. Therefore, the central thesis of this essay is that Calvin Johnson, although on same occasions objectively deliriant and paranoid, was the victim of racial prejudices which impacted his treatment and, potentially, diagnosis, because of the inherently Western approach applied to psychology and psychiatry at the time of his hospitalizations. Finally, although the reader is provided with four categories of assessment, the essay focuses mostly on the experiences that Mr. Calvin Johnson suffered from a political perspective, with the support of a selection of academic theories which covers the topic, extensively based on the research led by Professor Suman Fernando during the past twenty years in the field of decolonizing psychology. While it is acknowledged the importance of all the factors in influencing Mr. Johnson's behaviour, it would not have been possible to explicate all aspects which characterized his psyche in a limited amount of space. Secondly, the author of this is not a psychologist nor a psychiatrist, and therefore is not qualified to submit clinical diagnosis without resulting inappropriate. However, the features of the subject are still highlighted in Table 1 to provide the reader with an explanatory summary. The author recognizes the importance to transmit cases and testimonies as Calvin Johnson's, and

reinforces how no progress nor awareness in the field of Psychology would be possible without the contribution and generosity of those who lived its tremendous flaws in the first place.

First Part

Description of Calvin Johnson's story

It is now introduced Calvin Johnson's case study as reported by Littlewood and Lipsedge in "Aliens and Alienist" (1989). From now on, he will be addressed as 'the patient' or Mr. Johnson.

1. The Childhood

As a child, Mr. Johnson is described as intelligent, although "never able to concentrate on anything for very long". Constantly teased at school for being tall and thin, he often uses to get into fights, which leads to his official expulsion when he is 12 years old. At home, Mr. Johnson's family, still based in Spanish Town, right outside Kingston, lives a seemingly serene life. His father, a mason, died when he was just a child, but he gets along with his mother and sisters. Out of school, the patient moves to Kingston, where he starts reading voraciously and becomes an apprentice as a carpenter. Notably, Mr. Johnson gains almost immediately a reputation of "skilled and friendly craftsman". While in Kingston, the patient marries Alice, reported as "his opposite, dull where he is bright, prosaic where he is imaginative, careful where he is sometimes over-hasty". However, both are ambitious, and when the competitiveness of the market does not favor Mr. Johnson and he finds himself out of job, they emigrate together to Britain. It's the 1961.

2. Challenges in the United Kingdom

Reportedly, things went bad from the beginning. Once in the UK, Mr. Johnson is forced to take a job as a cleaner in a factory, soon developing his first depressive symptoms. His marital relationship also starts to derail, as Alice is frustrated by the fact she also has to work, while the husband is considering her resistances as "acting superior". Nonetheless, the couple has three children. The Johnsons live in an exclusively Jamaican neighborhood in South London, described as lively although neglected, where they share a ground-floor Victorian terraced house with four other families. While being in the UK, Mr. Johnson starts saving money to his trip back to Jamaica. Once there, he has a peculiar experience, hearing the voice of God telling him to read some verses from the Bible. After that, he becomes a vegetarian and a Rastafarian. Although he starts developing some doubts about his faith when he is back to London, he attributes it to the temptations of the Devil.

3. Encounters with the Law Enforcement

One day, after his return from Jamaica, Mr. Johnson goes to the local postal office with his daughter Victoria, to check an advanced payment for a job he was commissioned. At the counter, the cashier who serves him, after looking at the couple suspiciously, disappears to come back right after with three policemen. The officers begin questioning Mr. Johnson over that money. The patient, already upset by an argument he had a few hours prior with one of Victoria's teachers at school, reacts aggressively, "hitting a policeman more

by chance than intention". He is promptly handcuffed and arrested in front of his daughter and bystanders. During the struggle, the patient takes out of his pocket a 1966 shilling he uses to always carry with him and points it to the officers saying:

'The sun was shining on it as if the lion would step out. I began to sing "The Lord is my shepherd". The police said, "You black bastard – you believe in God?" They took me to a mad house – Oh God since when are we religious mad?'.

4. Encounters with Medical Professionals

Mr. Johnson is escorted to a psychiatric hospital where he stays for some weeks before the charge was withdrawn. When he comes back home, the job was lost. The situation is now degenerated and his relationship with the police takes the shape of a vendetta. His behavior becomes more violent, he assaults two cousins and is now "well known at the local magistrates' court".
This is the report of one the prison psychiatrist who assess Mr. Johnson:

"This man belongs to Rastafarian – a mystical Jamaican cult, the members of which think they are God – like. This man has ringlet hair, a goatee straggly beard and a type of turban. He appears eccentric in his appearance and very vague in answering questions. He is an irritable character, and he has got arrogant behavior. His religious ideas are cultural. He denied any hallucinations. He is therefore not schizophrenic at the moment. He came to England in 1961 but he has obviously been unable to adjust to the culture of his society. He tells me that he would like to be repatriated to his homeland and I am of the opinion that this certainly would be a most desirable outcome because if he continues to live in the United Kingdom there is no doubt that he will be a constant burden to society".

At this point, Mr. Johnson's frustration has escalated. He had been smoking Marijuana and arguing with Alice. A second arrest follows for throwing kitchen supplies out of the window of his house. At the psychiatric hospital, the Indian doctor on duty reports:

"He was lying in the lift with two policemen on top of him. The patient was unkempt with long matted hair, talking in broken English and was difficult to follow. He frequently mentioned Christ and lions. There were ragged lacerations on his hands where he had been handcuffed. Probably a relapsed schizophrenic. Observe carefully".

Mr. Johnson's wife, Alice, is also concerned about the patient's increasingly violent behaviour, although she thinks his closeness to Rastafarianism started after the episode in the postal office, as she reports to a nurse on duty. However, "she doesn't think her husband is mentally ill and was anxious for him to leave the hospital". The nurse, who also saw Mr. Johnson, observes:

"Overactive but did not feel ill. He felt God had been using him to try and put the world right. I would say he is very mad, and I think a lot of this is due to smoking marijuana".

5. Mr. Johnson's perception

As assessed by Littlewood and Lipsedge, who also met the patient, Mr. Johnson is humiliated by this series of event, but tries to hide it behind a humorous behaviour. He believes to be targeted by the police because of racial prejudices. He also thinks "God talks through him". Mr. Johnson doesn't follow up on the appointments with the psychiatrist. He is admitted again one year later for with a diagnosis of "mania or marijuana psychosis". The patient says:

"The police are still beating me, they have given me a terrible beating. I keep running from them. I am very much afraid of the police. My father told me to stay away from the police when I was young because they are not nice. They are going to put me into prison. No trouble till they beat me up. I think the whole world has come to an end – the prophecy has been fulfilled. A man is a weakness against his whole self – I see the testing in my heart. He loves us all – a man can break the Devil – we are all Jesus if we live the life. If you know God you feel things inside you: I hear voices and I get visions every night. When I close my eyes, I see a light".

The patient is not considered in need of hospitalization and sent home.

Second Part

An assessment

	Positive	Negative
Individual factors	• Bright • Skilled craftsman • Friendly • Ambitious / hard worker	• Depressive symptoms (melancholic tendency) • Psychosis • Difficulties to concentrate • Addiction
Circumstantial factors	• Good relationship with family of origin • Spirituality / Rastafarian • Diet / Vegetarian • Living in a lively neighborhood	• Fatherless • Immigrant • Unhappy marriage • Professional unfulfillment • Challenging living accommodation • Three children / financial distress • Racial biases and mistreatment from police and mental health professionals / systemic racism

Table 1: Individual and circumstantial factors for Calvin Johnson

The second part of the essay will now focus on the psychological assessment of Mr. Johnson, by taking into consideration the variables which have allegedly led him to experience such an unsuccessful treatment. Before delving into this, it will be necessary to clarify the approach. The aim of the essay doesn't concern a clinical assessment. Although for the sake of clarity some specific words are explained (i.e. what is intended with Psychosis, as per the National Institute for Health and Care Excellence, NICE, Guidelines,

2014), the main focus will remain on the circumstantial events which played a role in escalating the patient's distress, namely the prejudices he faced as a black man immigrated in the UK, the financial difficulties he had to manage, and the intrinsic violence the society acted upon him altogether (Framer, 2009). To do that, it is firstly important to provide the reader with a brief framework of what it is intended with mental health and mental disorder in a multicultural environment. To borrow from Sabshin's definition (1967) of the classification used by psychiatrists in the US, the concept of normality in mental health has been described as "the absence of illness; an ideal state of mind; the average level of functioning of individuals within the context of a total group; and as process that is judged by the functioning of individuals over a period of time". Notably, as highlighted by Suman Fernando in "Mental Health, Race and Culture" (1991), among many others, when discussing this classification is necessary to consider the exclusively Western approach still adopted in psychiatry, and that "not only do we need to recognise that each culture has its own norms for health, for ideal states of mind and for the functioning of individuals in society, but that these norms are perceived though race-tinted spectacles". Kakar (1984) defines mental health as "a rubric, a label which covers different perspective and concerns, such as the absence of incapacitating symptoms, integration of psychological functioning, effective conduct of personal and social life, feelings of ethical and spiritual well-being and so on", all matters that cannot be analysed without considering also the cultural arena in which they flourish, as the idea of mental health must be considered "in the relevant political and social context" (Fernando, 1991). A valid example is the one provided by Lambo (1994), discussing the concept of health in African culture. The author writes: "Health is not an isolated phenomenon but part of the entire magico-religious fabric; it is more than the absence of disease", comparatively making it hard to be assessed by Western professionals, for whom "religion and illness are now in separate cultural environments" (Fernando, 1991). It results then that describing mental health and multiculturality is at the very least problematic. Looking at the case study covered in this essay, Alice Johnson – the patient's wife - doesn't consider him as "mentally ill", but just deeply traumatised by the episode at the postal office. Bearing in mind she could also simply have been in denial, it is worth at least questioning the assessment's criteria of Mr Johnson's psychopathology, also considering that Black men "are ten times more likely to be diagnosed with schizophrenia than their white counterparts" (Sowemimo, 2023). On the one hand, the patient displayed objective symptoms of delirium – by affirming he is being Jesus Christ. On the other hand, to say it with Fernando Suman (1991), in this case "an artificial structure derived from Western thinking is inevitably being imposed; the descriptions are thereby distorted and the understanding of [...] the way these cultures work is very limited", as can be clearly deducted by the prison psychiatrist's testimony.

In Transcultural Psychiatry, the two approaches utilised to navigate this impasse are either Cultural Relativity, which declines mental disorders as socially and culturally filtered, and Cultural Invariance (or Universality), for which the diseases are biologically originated and the external variables' impact is contained (Fernando, 1991). The thesis advanced in here does not embrace blindly any of these systems. Always to say it with Fernando Suman (1991), the "social construction of illness within a cultural context is important but not the only consideration, [...] and cultures are not distinct and unchanging".

Having provided a theoretical framework to the concept of mental health, it is possible to come back to Calvin Johnson's case study. As per Table 1, Mr. Johnson's assessment is dissected through four categories: positive individual factors, negative individual factors, positive circumstantial factors, and negative circumstantial factors, all allegedly accountable for his psychological functioning. These factors have been extrapolated from Littlewood's and Lipsedge's (1989) report on Mr. Johnson.

The patient is described as a bright man, ambitious and hard worker. Except for the unfortunate and prematurely decease of the father, there is nothing in his family history which denounce great distress or adversities. Although during his childhood episodes of violence are notified (i.e. he got into fights at school), these cannot be listed as pathological or antisocial behaviours, as they appear more than anything to have been the proud response against attempts of bullying him. Furthermore, during his years as a carpenter, the patient is defined as a "skilled and friendly craftsman" by others. However, according to their testimony, the patient also displays difficulties to concentrate, a predisposition to psychosis (which will be later on triggered while being an immigrant in the UK), depressive tendencies (which, again, may have been inducted by the many adversities he was facing), and an addicted personality (Mr. Johnson will start consuming a high percentage of marijuana when he becomes a Rastafarian. However, also in this case it has to be considered the role played by cultural habits in the consume of drugs for Mr. Johnson). To look a little bit closer at the psychotic episodes the patient suffered during his lifespan (i.e. the belief of being Jesus), it is important to clarify what is meant with psychosis. As per the NICE guidelines (2014), Psychosis is a major mental disorder (or "personality cluster") characterized by significant repercussions on the individual's life who is affected by it. Clinically significant alterations in perception, thoughts, mood, and behaviour are its most common effects (NICE Guidelines, 2014). More specifically, psychotic symptoms are divided into Positive and Negative. Delusions and hallucinations are part of positive symptoms. Delusion refers to an improbable and often obscure thought, experienced as egosyntonic by the psychotic individual but impenetrable and bizarre to anyone else. In Mr. Johnson's case, the belief of "God talking through him" or of being Jesus can be seen as examples of delirium. Reflecting the subjective experience, delusions can have various contents, from threats to persecutions, although among the most recurrent themes seem to be those concerning religion, sciences, morality, and eroticism. One of the reasons because Mr. Johnson's case is so interesting when it comes to the intersectionality between psychology, race, and the decolonial approach to it, it's that if on the one hand he shows severe psychotic symptoms, reinforcing Fernando Suman's approach on overcoming the dichotomy "cultural relativity vs. universality", on the other hand it appears clear from the patient's report how lucid he was in understanding the racist feedback he was given by the professionals who treated him and the police. Littlewood and Lipsedge in "Aliens and Alienists. Ethnic minorities and psychiatry" (1989) wrote how the children disciplined by punishment are more likely to blame their difficulties on others once they're adults (what they called the "seed of paranoia"), and that the "so called Victorian Caribbean family has been held responsible for the comparative frequency of paranoid reactions among West Indians". However, they argue, "paranoia is a common response in any disadvantaged or isolated group, including linguistic and ethnic minorities and

the deaf". It seems important to remember Mr. Johnson expressed on multiple occasions frustration and distress towards the behaviour of the police, that was, according to his opinion, targeting him. The patient may then have appeared as paranoid towards these persecutions, also because the arrests were also due to violent acts he performed in the household. However, always Littlewood and Lipsedge (1989) write clearly how "the cause of feelings of persecution is colour prejudice" and that "perhaps 'delusions of persecution' are merely a strong reiteration of the experience of discrimination". In short, the patient may have been suffering delusions, but it seems obvious that the paranoia he experienced was motivated by facts. Indeed, in his book "Mental Health in a Multi-ethnic Society" (1995), Suman Fernando reports how "Black/ethnic minorities are more often: diagnosed as schizophrenic; compulsorily detained under Mental Health Act; admitted as 'offender patients'; held by police under s. 136 of Mental Health Act; transferred to locked wards; not referred for psychotherapy; given high doses of medication; sent to psychiatrists by courts; suffer from unmet needs". To focus on the mental health professionals who treated Mr. Johnson, it is legit to recognise overt racism towards the patient, like for example in the testimony of one of the psychiatrists whom he met while hospitalised. Taking into consideration Mr. Johnson lived the UK through the '60s and the '70s, it is interesting to look forward at the literature of the following years, bearing in mind, to look at recent statistics, that according to a survey released by YouGov UK in 2016, the"44% of the population is proud of the legacy of the British empire, and only the 21% is ashamed by its colonial inheritance (Sowemimo, 2023). In 1989, almost 30 years later Mr. Johnson's hospitalisations, Littlewood and Lipsedge write: "psychoanalysis was based on the bond between patient and physician, independent of the social context in which this relationship occurred. It was initially able to ignore cultural differences between the two because both came from essentially the same social milieu", and "we know that even within the National Health Service there are differences in the facilities offered to different classes". Furthermore, supporting Suman Fernando's list of mistreatments suffered by black and ethnic minorities, also these scholars state "although less likely than the British-born to see a GP for psychiatric reasons, West Indians men are more likely to be admitted to psychiatric hospitals. Psychotic black patients are twice as likely as British-born and white immigrants to be in hospital detained involuntarily, sectioned under the Mental Health Act" (1989). Annabel Sowemimo's book "Divided. Racism, Medicine and why we need to decolonise healthcare" (2023) opens with the author writing: "At no point in my medical education – nearly a decade of university, three degrees and countless hours spent on the wards – did anyone mention how the legacies of colonialism and racism affect my decision as a doctor". What happened to Mr. Johnson, then? It appears reasonable to state how he faced many of the discriminations listed in this essay, which further contributed to escalating his mental distress. Furthermore, in the aforementioned book "Mental Health, Race and Culture" (1991), Fernando clearly explains how "in addition to the (racist) pressures arising from the context in which diagnoses are made, the diagnostic process is affected by racism at various points – during the recognition and evaluation of symptoms or psychopathology, in their assessment for the purpose of illness recognition, and in making the decision of the propriety of designating illness" (Suman, 1991). Also, the scholar reinforces, "what happens after diagnosis – the 'management of the patient – is also affected by racism" (Suman, 1991). Understandably so, Mr. Johnson

never followed up on any of his appointments with the psychiatrists. Interestingly, among the categories of physicians, British psychiatrists describe themselves as the most liberal: “70 per cent of the sample are agnostics or atheists and half of those who are politically committed support the Labour Party” (Littlewood and Lipsedge, 1989). However, the matter is more complicated than this, as “racism within psychiatry derives from the traditions of the discipline, its history, its way of assessing and diagnosing, the criteria it uses to for designating treatment, its organisation, its involvement with the powers of the state and with Western power internationally [...], and its struggle to be accepted as a scientific discipline” (Fernando, 1991). More generally, it’s worth citing Broad and Wade’s description of the ‘scientist’ as quoted in Romanucci-Ross and Moerman’s essay “The Extraneous Factor in Western Medicine” (1991): “The myth of science as a purely logical process, constantly reaffirmed in every textbook, article and lecture has an overwhelming influence on scientists’ perception of what they do. Even though scientists are aware of non-logical elements of their work, they tend to suppress them or at least dismiss them as being of little consequence. A major element of the scientific process is thus denied existence or significance”.

Conclusion

In conclusion, Calvin Johnson’s experience is here seen as a poignant example of a multifaceted case, in which the patient, psychotic, had to cope with multiple circumstantial factors which led him to aggravate his distress. Despite occurring over five decades ago, Johnson's experiences continue to resonate with contemporary debates on the intersectionality between psychology, race, and culture. His narrative highlights the challenges faced by ethnic minorities within the British National Health Service (NHS) and stresses the urgent need for decolonizing mental health practices. The discriminatory attitudes exhibited by law enforcement and mental health professionals not only led to Johnson's mistreatment, but also influenced diagnostic assessments and therapeutic interventions. Furthermore, his story emphasizes the limitations of conventional psychiatric frameworks rooted in Western paradigms. The insistence on a unilateral, Eurocentric perspective in mental health care reinforces inequalities of treatment for diverse populations. To decolonize psychiatric practices, it is compelling to prioritize cultural competence and humility. By integrating diverse perspectives and confronting systemic biases, mental health professionals can better serve marginalized communities and ensure equitable access to compassionate care.

Bibliography

Farmer, P. (Author), & Sen, A. (Foreword). (2005). Pathologies of Power: Health, Human Rights, and the New War on the Poor, With a New Preface by the Author. University of California Press.

Moerman, D., Romanucci-Ross, L., & Tancredi, L. R. (1997). The Anthropology of Medicine: From Culture to Method (3rd ed.). Bloomsbury Publishing.

Lipsedge, M., & Littlewood, R. (1997). Aliens and Alienists: Ethnic Minorities and Psychiatry. Routledge.

Fernando, S., & Keating, F. (Eds.). (2009). Mental Health in a Multi-Ethnic Society: A Multidisciplinary Handbook. Routledge.

Fernando, S. (2010). Mental Health, Race and Culture (3rd ed.). Red Globe Press.

Sowemimo, A. (2023). Divided: Racism, Medicine and Why We Need to Decolonise Healthcare (Main ed.). Profile Books Ltd

National Institute for Health and Care Excellence. (2014). Psychosis and schizophrenia in adults: prevention and management (Clinical guideline [CG178]). Published: 12 February 2014. Last updated: 01 March 2014. Retrieved from https://www.nice.org.uk/guidance/cg178