HHS Public Access

Author manuscript

Community Dent Health. Author manuscript; available in PMC 2022 June 01.

Published in final edited form as:

Community Dent Health. ; 39(2): 137–142. doi:10.1922/CDH_IADR22Kearns06.

Dominant Power and the Concept of Caste: Implications for Dentistry and Oral Health Inequality

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Abstract

This paper explores the issues of caste and casteism in the U.S. as described by Pulitzer Prize winning journalist Isabel Wilkerson in her 2020 book "Caste: The Origin of Our Discontents". Wilkerson argues that a caste system not only exists in the U.S. but operates as a hidden force affecting social inequality. The paper draws on Wilkerson's work to explore caste as an analytical concept. It begins by defining caste and casteism in contrast with racism, the eight pillars of a caste system, the consequences of casteism, and the psychological drivers of casteism. The paper then applies to concept of caste to understanding power, dentistry, and oral health inequality. The paper concludes by emphasizing that the concept of caste and its relationship to oral health inequality must be understood it if we want to create real social change.

Keywords

Racism; Oral Health; Dentists; Dental Societies

Introduction

In her 2020 book "Caste: The Origin of Our Discontents," Pulitzer Prize winning journalist Isabel Wilkerson argues that the concept of racism is "one of the most contentious and misunderstood in the American culture" (Wilkerson, 2020, p. 68). Whereas academics have developed frameworks for understanding racism on multiple levels such as institutionalized racism, personally mediated racism, and internalized racism (Jones, 2000), in popular culture, Wilkerson argues that racism "has come to mean overt and declared hatred of a person or group because of the race ascribed to them, a perspective few would ever own up to" (Wilkerson, 2020, p. 68). If few people admit to being racist, yet institutionalized racism persists, then Wilkerson asserts that "racism may not stand as the only term or the most useful term to describe the phenomena and tensions we experience in our era" (Wilkerson, 2020, p. 69).

Building on nearly 20 years of studying the experiences of Black Americans who migrated from the south to northern U.S. cities during the post-Civil War era, Wilkerson calls on Americans to recognize caste and casteism as an "unseen force" affecting social inequality in the U.S (Wilkerson, 2020, p. 19). The concept of caste is most often thought of in the

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context of India. The Indian caste system is a means of social stratification with ancient origins linked to Hinduism, that separates Indians by highest value to lowest: Brahmin, Ksyhatriya, Vaishya, Shudra, and an additional fifth category of Untouchables. Although officially banned in 1950 (Drzewiecki, 2020), its social effects remain. A persons' caste affects their social, economic, and political status and lower castes experience poorer access to resources including healthcare, leading to worse health outcomes (Jacob, 2009).

Drawing on caste scholarship in India, studies of the vanquished caste system of World-War II Germany, and early 20th-century American caste scholars (whose work has been overlooked by mainstream sociology), Wilkerson weaves together a narrative explicating the concept of caste and why we must understand it if we want to create real social change. While racism must still be recognized as integral to the problem of social inequality, Wilkerson argues that a focus on casteism makes structural issues harder to deny. In this paper, we draw on Wilkerson's work to explore caste as an analytical concept and suggest how the concept may be relevant to understanding power, dentistry, and oral health inequality.

Defining Caste and Casteism

The word caste originates from the Portuguese word "casta" for "race" or "breed" and was used by Renaissance-era traders to describe the Hindu divisions they observed in South Asia. (Wilkerson, 2020, p. 67). A caste system is a human hierarchy which maintains inequality by valuing one group of people over another. Race and caste are intertwined in the American caste system, Wilkerson argues. Racism is "any action or institution that mocks, harms, assumes, or attaches inferiority or stereotype on the basis of the social construct of race" (Wilkerson, 2020, p. 70). Caste "is the granting or with-holding of respect, status, honor, attention, privileges, resources, benefit of the doubt, and human kindness to someone on the basis of their perceived rank or standing in the hierarchy" (Wilkerson, 2020, p. 70). Race is the means by which rank is assigned within the caste system. Casteism is defined as "the investment in keeping the hierarchy as it is in order to maintain your own ranking, advantage, privilege, or to elevate yourself above others to keep others beneath you" (Wilkerson, 2020, p. 70).

The Eight Pillars of Caste

Throughout 8 chapters, Wilkerson identifies the historic origins, parallels, overlap and commonalities of caste hierarchies in India, World-War II Germany, and the U.S. and distills them into the principles upon which a caste system is constructed (Table 1). In America, she points out, it was religion, not race that was the original means for ranking. Christianity "is what condemned, first, indigenous people, and then, Africans…to the lowest rung of an emerging hierarchy before the concept of race had congealed" (Wilkerson, 2020, p. 41). Perhaps most insidiously, two key foundational pillars of a caste system are that it is ordained by God and that the superiority of a dominant caste is innate and conforms to the laws of nature. These pillars substantiated a series of restrictive and abusive beliefs that materialized into state-sanctioned laws during the first 200 years of America's existence (Wilkerson, 2020, p.99). After the U.S. Civil War (1864–1865), new federal laws ended

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slavery and provided a brief period of civil rights protections for Black Americans during the Reconstruction Period (1865–1877). However, the state-sanctioned caste system soon re-emerged in Southern states, during the era known as the "Jim Crow South," and remained in place until a new era of civil rights protests in the 1960s forced change.

Consequences of Casteism

Even with the civil rights laws of the 1960s, the U.S. caste system persists. Beyond current examples of structural inequalities in the legal, education, business, government and health care systems (among others), the caste system is manifested by people in the dominant caste carrying out "the unspoken rules," in which their "job it is to correct, direct, discipline, and police the people in the lowest caste (Wilkerson, 2020, p. 273). They are to be ever vigilant to any rise or breach on the part of those beneath them" (Wilkerson, 2020, p. 273). In additional to the structural and psychologic consequences of caste experienced by subordinate castes, Wilkerson also notes the physiological effects such as an increased and repetitive autonomic response that can cause cardiovascular and immune system damage.

Causes of Casteism

Wilkerson quotes Bhimrao Ambedkar, an Indian jurist, economist, and social reformer, to emphasize where she thinks the cause of the casteism lies: "Caste is not a physical object like a wall of bricks or a line of barbed wire. Caste is a notion; it is *a state of mind*." (emphasis added) (Wilkerson, 2020, p. 383). Wilkerson draws on psychology, sociology, political science, and scientific literature to gain insight into psychological drivers casteist behavior. If caste is a state of mind, then we must understand the psychological drivers of that state of mind before we can identify solutions to change it. Wilkerson summarizes a number of psychological drivers throughout her book. In this paper, we have selected three: scapegoating, dominant group status threat, and narcissistic isolation (Table 2) to apply to understanding power, dentistry, and oral health inequality.

Viewing Power, Dentistry, and Oral Health Inequality through the Lens of Caste

Before applying the lens of caste, first we examine the U.S. dental profession's undeniable history of overt racism. In 1867, two years after the end of the Civil War, Robert T. Freedman, the first Black man to receive a formal dental education in the United States, was admitted to Harvard University's first dental class after being rejected at two other dental schools due to his race (Dixon & Byrd, 1949). While this marked the beginning of an openness to admission of Black candidates in Northern dental schools, the first formal dental education offered to Black students in the South wouldn't occur for nearly 20 years (Lloyd Jr., 2006). Howard University was incorporated in 1867 by a charter approved by the U.S. Congress to primarily educate Black Americans, especially those recently freed from slavery (Lloyd Jr., 2006). Howard's first dental lectures occurred in 1881--originally designed for medical students wanting to address oral health problems when practicing in small rural communities. Howard's Dental College was formally launched in 1883 (Barrier,

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1934). Central Tennessee College, later renamed Meharry Medical College, launched a dental department in 1886 as did the University of West Tennessee in 1917 (Barrier, 1934).

After new standards for medical education were endorsed in the landmark Flexner Report of 1910 (Flexner, 1910), seven predominantly Black medical schools would close, including The University of West Tennessee (and its dental school) in 1923 (Anonymous, 2021). The conventional view of the Flexner Report is that it ushered in a new era of high-standards and Evidence-Based education. A more critical perspective (Redford, 2020) points to Abraham Flexner's racist views that the majority of Black medical schools were not worth supporting, suggesting that Black students should be trained as sanitarians instead: "A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous" (Flexner, 1910, p. 180). Campbell et al. estimated that if all seven medical schools had remained open, an additional 35,315 Black physicians would have entered the workforce between the time the schools closed and 2019 (Campbell *et al.*, 2020). In addition to the loss of the University of West Tennessee and its dental program, one wonders whether the 6 other medical schools might have opened dental schools if given the support and funding, and how that would have impacted the Black dental workforce today. A recent analysis estimated that, to achieve parity with the U.S. population an additional 19,714 Black dentists are needed in the U.S (Mertz *et al.*, 2017). Achieving parity would improve race concordance between minority patients and practitioners, which is associated with increased access to care, better communication, and increased likelihood of being offered and accepting appropriate care (Health Resources and Services Administration, 2006).

Black health professionals who attempted to join White health professional organizations were also met with vicious opposition. Dr. Karen Morris, in her thesis on the origin of The National Medical Association, chronicles the experiences of three esteemed Black physicians as they attempted to join the all-White Medical Society of the District of Columbia (MSDC), a local society of the American Medical Association (Morris, 2007). In 1869, after being recommended for membership by progressive White MSDC members and meeting eligibility requirements, all 3 physicians failed to receive the number of votes required to confirm their nominations. This was the beginning of a four-year battle for inclusion in the MSDC, that, even with an attempted intervention at the level of the U.S. Congress, ultimately failed. Morris documents that during this time, White physicians in powerful leadership positions "espoused beliefs that the Negro originated from a different and inferior species" (Morris, 2007, p. xvi). Battles to integrate White medical societies continued for 26 years and their failure culminated in the founding of the separate National Association of Colored Physicians, Dentists, and Pharmacists in 1895, later renamed the National Medical Association.

Unlike the American Medical Association which remained a unified national organization through the Civil War, dentist professional organizations divided across political lines (Glenner & Willey, 1998). White Southern dentists ended their participation in the two major organizations of the time--the American Dental Convention, founded in 1855, and the American Dental Association, founded in 1859—and in 1869 created the Southern Dental Association. The American Dental Association and Southern Dental Association ultimately converged in 1897 to form the National Dental Association. In 1922, the National Dental

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Association name was dropped, and the unified organization reclaimed the name American Dental Association. Although the specifics of the exclusionary membership practices in the ADA are less well documented than the AMA, it is clear that attempts at integration were met with flagrant resistance, leading Black dentists to participate in the founding of the National Medical Association (Dummett, 1997). In 1913, Black dentists founded the Tri-State Dental Association representing Maryland, Virginia, and Washington D.C., which developed into the National Dental Association in 1932. Subsequently, the National Medical Association discontinued its dental section in 1940 (Dummett, 1997).

According to Morris, the AMA's exclusionary membership practices served to limit professional advancement opportunities for Black physicians. AMA membership was "either a direct or tacit requirement for positions in most hospital internships, professional appointments, and attendance at continuing education programs" and led to the publication of separate journals (Morris, 2007, p. xix). These ramifications almost certainly applied to Black dentists as well. Exclusionary practices also meant that Black dentists had no say in the formation of the dental regulatory structure that emerged between 1841 and the late 1880s, which codified the structure of dental education and practice, including requirements for licensure (Gies, 1926). As of 1961, Black dentists were still excluded from membership in the state dental societies in Georgia, Texas, Louisiana, and Florida ("Negro Dentists Break Race Barriers in 6 Cities," 1961). It would take a series of lawsuits filed on behalf of Black dentists by NAACP Legal Defense and Educational Fund lawyers to fully integrate all branches of the ADA by the end of the 1963 (Anonymous, 1964).

Casteism in U.S. Dentistry

In the 21st century, while the U.S. dental profession no longer sanctions overtly racist exclusionary practices, when looking through the lens of caste, it seems clear that we have retained a hierarchical system built to privilege White dentists who prefer to see White wealthy patients. As of 2020, just 3.8% of U.S. dentists were Black, while Black individuals represent 12.4% of the population (Salsberg *et al.*, 2021). More than 80% of all Black dentists were trained at Howard University and Meharry Medical College (U.S. Department of Education Office for Civil Rights, 2020). Today, these institutions still account for 19.7% of the degrees awarded in dentistry to Black students. Of the 63 dental schools in operation in 2017–2019, five dental schools reported no Black graduates (Salsberg *et al.*, 2021). Black dentists also care for a disproportionate share of Black patients, with an average patient mix that is 44.9% Black (Mertz *et al.*, 2017). Fewer than half of U.S. dentists accept Medicaid (jointly funded dental insurance by state and Federal government for patients with low income), while more than 60% of NDA members do (Sable-Smith, 2021).

Three dental organizations that serve as the main dentists' voice for social justice in the health of traditionally disenfranchised populations are the National Dental Association, Hispanic Dental Association, the Society of American Indian Dentists. While not segregated, their memberships are predominately Black, Hispanic/Latino, or American Indian, respectively (The Editors, 2021). In 2008, the NDA demanded and received an apology from the ADA for membership practices "based on institutionalized racism that resulted in the systematic exclusion of Black dentists from participation in the ADA from

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1856 through 1963…that contributed to irreparable harm and adverse health conditions for generations of African Americans, that adversely affected the health care of millions of Americans" (National Dental Association, 2013). The NDA highlighted that these actions were "in stark contrast to the ADA's claims to be the voice of dentistry for ALL Americans" (National Dental Association, 2013).

While the NDA welcomed the ADA's apology (National Dental Association, 2013), the differences in mission between the NDA and ADA remains polarized as evident in the recent debate over the expansion of Medicare (federal health insurance for people over 65) to include dental benefits. Nearly half of seniors covered by Medicare did not visit a dentist in 2018, with Black, Hispanic, and seniors with low-income foregoing dental services at even higher rates (Sable-Smith, 2021). The NDA firmly endorsed the comprehensive dental benefit proposed to be provided to all Medicare beneficiaries as critical to improving oral health equity (National Dental Association, 2021). The larger and better funded ADA, who is still seen by the media and Congress as the voice of dentistry, opposed universal dental benefits in Medicare coverage and provided a counterproposal to limit dental benefits only to seniors who earn up to three times the poverty level, cutting the 60 million Americans who would have been eligible in the original proposal by half. The ADA's opposition to the Medicare expansion mirrors their opposition to dental's inclusion in Medicare and Medicaid when they were initially proposed in the 1960s (Waldman, 1973).

Scapegoating, Narcissistic Isolation, and Dominant Group Status Threat

The most common motivation attributed to the ADA's actions in opposing Medicare expansion is economic – e.g., low reimbursement rates not allowing services to be profitable. Viewed through the lens of caste, however, another motivation could include negative attitudes toward the poor (Loignon *et al.*, 2012) – as a form of scapegoating or blaming the victim for their circumstances. In a 2021 interview with National Public Radio, NDA president Nathan Fletcher also described a form of narcissistic isolation within the ADA: "The face and demographic of the ADA is white male, 65 years old. Understand that those who make decisions for the ADA are usually the ones who have been in practice for 25 to 30 years, doing well, ready to retire. [Their patient population] looks nothing like the [patients] we are talking about" (Sable-Smith, 2021).

Using tactics that are disturbingly similar to Jim Crow-Era psychological coercion, the ADA has nearly iron-clad power over the structure of the 21st century dental workforce. A community driven approach to addressing oral health inequality by introducing and expanding dental therapists in dentistry, who are primary dental care providers similar to physician assistants in medicine, has unleashed ADA opposition that has been likened to the power of the National Rifle Association (Jordan, 2017; Mertz *et al.*, 2021). Similar to Flexner who in 1910 argued that Black students should be educated as sanitarians because "an essentially untrained negro wearing an M.D. degree is dangerous" (Flexner, 1910, p. 180) the party line of the ADA and its constituent societies is that dental therapists (who are predominantly female and racially diverse) are incapable of being trained to provide safe and effective dental services at the performance level of dentists. Dentist supporters of legislative proposals to expand dental therapists have reported receiving

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physical threats from colleagues, and dental schools exploring training dental therapists have been threatened by alumni (Mertz, 2021). Workforce researchers presenting evidence on the benefits of dental therapists in addressing inequality have been accused of promoting harm and intimidated with comments such as “if you were in my chair, I’d pull out all your teeth” (Mertz, 2021). Viewed through the lens of caste, ADA opposition to dental therapists is grounded in a belief in female inferiority, mixed with dominant group status threat.

Conclusion

What value can a caste analysis provide to the intractable problem of oral health inequality in the U.S.? Our analysis suggests that the outsized power which organized dentistry retains over the current ineffective structure and delivery of dental services is rooted in casteist attitudes and requires psychological coercion to maintain. Motivations for the actions within the dental profession are not simply rooted in protecting business profits or saving patients from harm – but go much deeper into the realm of beliefs in the inherent inferiority of subordinate castes, whether they be patients or other providers, and fears of losing status. In the professions’ echo chamber of narcissistic isolation, newer generations of dentists are socialized to remain quiet, and the 164-year-old status quo goes unchallenged. How can this cycle be broken? In applying the lens of caste to the historical record preserved and reported by so many others, we hope to follow Wilkerson’s lead in contributing to the accurate diagnosis of the problem. Additionally, we hope to spark new thinking about developing caste-based conceptual frameworks to understand oral health inequality and drawing connections to potentially relevant theoretical approaches such as decoloniality, conflict theories, and Marxist feminist scholarship.

Acknowledgements

CK would like to acknowledge funding from the National Institute of Dental & Craniofacial Research of the National Institutes of Health under Award Number K08DE028947.

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Table 1.

Beliefs Common to Caste Systems Adapted from Wilkerson (2020)

Pillars	Description
Divine Will and the Laws of Nature	Belief that a caste system is willed by God, with the lowest castes deserving of their debasements.
Inherent Superiority vs. Inherent Inferiority	Belief that there is an inherent superiority in beauty, deservedness, and intellect of dominant caste.
Heritability	Belief that rank in a caste system is assigned by birth.
Endogamy	Belief that marriages should be restricted to people within the same caste.
Purity vs. Pollution	Belief that the dominant caste is the purest and can be polluted by subordinate castes.
Occupational Hierarchy	Belief in the division of labor based on one's place in the caste system; performing a dominant or subservient role.
Dehumanization and Stigma	Belief that members of the subordinate caste are objects over whom the dominant caste can exert total control.
Terror as Enforcement, Cruelty as a Means of Control	Belief in the use of psychological coercion and/or physical violence to keep subordinate castes in their place.

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Table 2.

Selected Psychological Drivers of a Caste System Adapted from Wilkerson (2020)

Psychological Drivers of a Caste System	Description
Scapegoating	Scapegoating occurs when one person or group blames another for misfortune. In the context of casteism, the dominant caste blames “societal ills on the groups with the least power and the least say in how the country operates while allowing the larger framework and those who control and reap the dividends of these divisions to go unchecked” (Wilkerson, 2020, p. 193). Scapegoating becomes acute in times of economic hardship, when a subsection of the dominant caste – the White working-class is the primary group engaged in scapegoating subordinate castes.
Dominant Group Status Threat	According to political scientist Diana Murtz, the White working class looks down on the subordinate caste for doing too well. Social economist Gunnar Myrdal surmised that the White working-class needs the caste system more than the White upper class due to a constant fear of downward social mobility. W.E.B. Du Bois, W. Lloyd Warner, and Allison Davis identified the “psychological security” that the caste system provides the White working class through the assurance of their higher status. Through this lens, Wilkerson explains, that “if a lower-caste person goes up a rung, an upper caste person goes down. The elevation of others amounts to the demotion of oneself, thus equality feels like a demotion” (Wilkerson, 2020, p. 183). The White working-class malaise that results is not just economic, but emotional, psychological, and spiritual.
Narcissistic Isolation	In a casteist system, the dominant caste is the gold standard of “normalcy, of intellect, of beauty, against which all others are ranked in descending order” (Wilkerson, 2020, p. 268).Through the myriad ways that the dominant caste is privileged in all forms of media, this socialization results in the “narcissistic isolation” of the dominant caste from the lower castes. It also drives lower castes to “covet proximity to the dominant caste” (Wilkerson, 2020, p. 269). Narcissistic isolation is related to dominant group status threat in that a narcissistic dominant caste needs lower castes to sustain itself. Psychologist and social theorist Erich Fromm described people who are invested in group narcissism as having “a euphoric ‘on-top-of-the-world’ feeling, while in reality he is in a state of self-inflation…This leads to severe distortion of his capacity to think and to judge…He and his are overevaluated. Everything outside is under-evaluated” (Wilkerson, 2020, p. 270).