

Racializing Mental Illness: Understanding African-Caribbean Schizophrenia in the UK

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Abstract

All multiracial societies have to grapple with the benefits versus the costs of the integration of minorities into majority communities. Indeed, in relation to the costs of integration, it could be argued that integration and assimilation increases non-White people's exposure to racialized experiences and racism, which in turn predisposes them to mental illness. As such, it is worth considering the case of the UK, where Black integration and assimilation is particularly intense, and where the high rates of schizophrenia in the African-Caribbean population have been an area of concern for over three decades. This paper argues that the interplay between racial minority status stress, racism-induced stress, and racial bias in diagnosis may be significant factors influencing the high Black incidence rate of schizophrenia in the UK.

Introduction

Racialized experiences have long been linked with the mental health and illness of Black people (See Fanon, 1952; Grier & Cobbs, 1968; Pierce, 1970). At the same time, integration of non-White minorities into majority White populations (a common feature of multiracial societies) arguably results in an increase in racialized experiences, and exposure to White racism. Of particular interest is the case of the UK, a country where the integration and assimilation of the Black population is particularly intense. This paper considers the role of the UK racial situation in the very high rates of schizophrenia found in the UK African Caribbean population.

Schizophrenia is the most chronically disabling of all the major mental disorders and typically affects only one percent of any given population. However, there is a six- to eighteen-fold elevated rate of diagnosed schizophrenia in the UK African-Caribbean population compared to Whites (Hickling, 2005). Moreover, the Black incidence rate of schizophrenia is higher in the UK than anywhere else in the world (Cochrane & Sashidharan, 1996).

The issue of extremely high rates of schizophrenia in African-Caribbeans in the UK has been a topic of interest to British scholars since the 1960s. However, much of the British research has been criticized with regard to its preoccupation with biological explanations for this issue (See Sashidharan, 2001). Indeed, it is only recently that sociological factors have been given recognition with regard to the dynamics of ethnic schizophrenia in the UK (See Boydell et al., 2001, Mallett, Leff, Bhugra, Pang & Zhao, 2002; Whitley, Prince, McKenzie & Stewart, 2006). In 2001, Boydell et al. demonstrated that the incidence of schizophrenia in non-White ethnic minorities in London was higher when they constituted a smaller proportion of the local population, indicating that social factors were having an influence on the elevated rate of diagnosed schizophrenia. Additionally, in 2002, Mallett et al. found that the rates of schizophrenia among African-Caribbeans in London were significantly higher than those in Trinidad and Barbados, again suggesting that social factors played a key role in the Black incidence rate of schizophrenia. In a similar vein, Whitley et al. (2006) demonstrated that mental illness was greater among minorities in areas where they comprised a smaller proportion of the population.

While the above research studies indicate a willingness to consider how society may play a role in ethnic schizophrenia, there is a lack of discussion on how “racialized experiences” could be influencing the elevated rates of diagnosed schizophrenia. For example, while Mallet et al’s (2002) study draws attention to the importance of social factors in the high rates of schizophrenia in African-Caribbeans in the UK, there is little reference to African-Caribbeans as “racial minorities”, and the role that racism might play in the Black incidence rate of schizophrenia. While their research highlights the significance of “social disadvantage” as a cause of severe mental illness, Mallet et al. (2002) focus on issues such as unemployment, and on individuals who had been separated from one or both parents during childhood.

It is argued here that more attention needs to be given to the experience of African-Caribbeans as racial minorities with regard to this topic. As Jamaican scholar and psychiatrist, Frederick Hickling (2005) points out, the evidence regarding the Black incidence rate of schizophrenia is shifting in favor of factors of social alienation and racism experienced by Black people in the UK, and to misdiagnosis by White British psychiatrists. Hammack (2003) notes that an individual’s minority status represents an intrinsic stressor, and Bhugra & Ayonrinde (2001) draw attention to the idea that racism is likely to act as a chronic stressor, and that chronic racism may well precipitate psychiatric disorders. Moreover, it has been suggested that psychiatry as a discipline is inextricably linked with racism (See Littlewood & Lipsedge, 1982; Fernando, 1988; Sashidaran, 2001; Timimi, 2005); as such racial bias in psychiatric diagnosis might also be an important factor in the Black incidence rate of schizophrenia. For these reasons, racialized experiences (racial minority status stress, racism-induced stress, and racial bias in diagnosis) need to be seriously considered in the analysis of the elevated rate of diagnosed schizophrenia in the UK African-Caribbean population.

Racial minority status stress

“Racial minority status stress” will be defined here as the stress which minorities experience due to being a visible minority, in terms of social isolation and heightened vulnerability. The UK African-Caribbean population is very small (less than two percent of the total population) and many Black people live in settings where the availability of Black social networks are limited. Thus, African-Caribbeans may frequently face being the “lone Black” in employment, in educational settings, and in neighborhoods. Consequently, it could be argued that African-Caribbeans are particularly vulnerable as racial minorities in that the psychological safety associated with numbers is often not available. Research on the relationship between ethnic density and mental illness seems to support this hypothesis. For example, in a US study conducted in 1979, Rabkin explored the relationship between ethnic density and psychiatric hospitalization rate in relation to Black, White, and Puerto Rican residents of New York City's three hundred and thirty-eight health areas. Rabkin found that the lower the proportion of the ethnic group, the greater its psychiatric hospitalization rate. Similarly in a UK study, Boydell et al. (2001) explored the relationship between ethnic density and the incidence of schizophrenia in relation to non-White ethnic minorities in fifteen electoral wards in South London. Boydell et al. (2001) found that the smaller the proportion of a Non-White ethnic minority living in an area, the greater their incidence of schizophrenia. Boydell et al. (2001) demonstrated that in the third of electoral wards where non-White minorities formed the largest proportion of the local population, the incidence rate ratio was 2.38 (95% confidence interval 1.49 to 3.79). At the same time, in the third of electoral wards where non-White ethnic minorities formed the smallest proportion of the local population, the incidence rate ratio was 4.4 (2.49 to 7.75) (See Table 1). They speculated that

members of ethnic minorities might be more likely to experience discrimination when in a small minority leading to increased stress. In turn, the more isolated a member of an ethnic minority, the less protection they gained from social networks which could shield them from the effect of the stressors associated with being a minority.

A recent Netherlands study yielded similar findings; in low ethnic density neighborhoods, immigrants had a significantly greater incidence of psychotic disorders, while in high ethnic density neighborhoods, the incidence rate was similar to that of the indigenous Dutch population (Veling et al. 2008).

A case could be made then, that racial minority status stress might be an important factor in the elevated rate of diagnosed schizophrenia in the UK African-Caribbean population.

Table 1 Effects of proportion of non-White ethnic minorities on incidence of schizophrenia

Proportion of non-White ethnic minorities*	Adjusted incidence rate ratio† (95% CI)‡
Lowest third (8-22.8%)	4.4 (2.49 to 7.75)
Middle third (23-28.1%)	3.63 (2.38 to 5.54)
Highest third (28.2-57%)	2.38 (1.49 to 3.79)

*Analysis stratified by thirds of proportion of non-White ethnic minorities

†Adjusted for age, sex, and electoral ward deprivation z score.

‡ CI = confidence interval

Source: Adapted from Boydell et al. 2001

Racism-induced stress

In the context of this paper, “racism-induced stress” describes the stress which emanates from the experience of racial discrimination and harassment. Racial prejudice and discrimination directed towards those of African descent is rooted in Britain’s history of slavery and colonialism, and continues to influence modern British culture, pervading every aspect of British society. Today, systematic barriers to the upward mobility of African-Caribbeans persist, and social statistics relating to key social policy areas demonstrate major inequalities between African-Caribbeans and Whites in all spheres of public life, for example, in the labour market, health care services, education, and the criminal justice system (See Commission for Racial Equality, 2006). Additionally, racial harassment is still a common occurrence; it was estimated that there were one hundred and seventy-nine thousand racially motivated crimes in England and Wales in 2004/05 (Jansson, 2006).

As well as the obvious stressors caused by the sheer experience of discrimination and harassment, it has long been argued that the “racial” aspect of the discrimination and harassment may have a profound impact on the mental health of the victims. For example, the world-renowned Black-Caribbean psychiatrist, Frantz Fanon (1952) argued that racism psychologically damaged Blacks when they internalized the societal norms of White superiority and Black inferiority, and African-American psychiatrist Chester Pierce (1970) developed the concept of “microaggressions”, which illuminates how even minor occurrences of racial discrimination in everyday life can in total have a significant impact on a Black individual’s mental health.

In a Netherlands study, the findings of Veling et al. (2007) suggest that discrimination perceived by minorities may contribute to their increased risk of schizophrenia. Their results showed that the incidence rate ratios (IRRs) of schizophrenic disorders for ethnic minority groups exposed to high, medium, low, and very low discrimination were 3.52, 1.84, 1.41 and 1.17 respectively. Thus the figures indicate that higher the level of discrimination, the higher the incidence of schizophrenic disorders (See Table 2).

Additionally, the impact of racial discrimination on mental health has recently started to be given serious consideration by British-based scholars. Bhugra & Bhui (2001) acknowledge that if African–Caribbean people born in the UK are exposed to a discriminatory social environment, this might explain a higher risk of psychological distress. In a similar vein, Chakraborty & McKenzie (2002) point out that widespread discriminatory social policy may influence the rates of mental illnesses, their presentation and outcome.

Accordingly, it could be argued that racism-induced stress in the UK African-Caribbean population could be playing a significant role in the Black incidence rate of schizophrenia.

Table 2 Effects of discrimination experienced by ethnic minority groups on incidence of schizophrenic disorders

Level of discrimination experienced by ethnic minority groups	Adjusted incidence rate ratio* (95% CI)†
High discrimination	3.52 (2.56–4.83)
Medium discrimination	1.84 (1.44–2.36)
Low discrimination	1.41 (0.96–2.07)
Very low discrimination	1.17 (0.76–1.81)

*Adjusted for age and sex and socioeconomic level of neighborhood

† CI = confidence interval

Source: Adapted from Veling et al. 2007

Racial bias in psychiatric diagnosis

In common with other public institutions, racism is a problem within British psychiatry (See Sashidharan, 2001). Indeed, it has been argued that racism lies at the core of the theoretical and conceptual foundations of psychiatry (See Timimi, 2005; Sashidharan, 2001;

Fernando, 1988; Littlewood & Lipsedge, 1982). For example, it has been argued that mental illness classifications are not objective

http://www1.uwindsor.ca/criticalsocialwork/racializing-mental-illness-understanding-african-caribbean-schizophrenia-in-the-uk

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Fernando, 1988, Littlewood & Lipsedge, 1982). For example, it has been argued that mental illness classifications are not objective but are derived from White European culture, and thus are inappropriate for labeling the experiences of non-European people (Sashidharan, 1990). As such, “color-blind” psychiatrists are likely to disregard racial and ethnic differences in symptom expression, and may therefore make diagnostic errors (See Neighbors, Trierweiler, Ford & Muroff, 2003). For example, Grier & Cobbs (1968, p 161, p178) coined the term “healthy cultural paranoia”, to describe an adaptive device developed in response to a racist environment; in other words, in a hostile society, Black people, for their own survival have to be a little “paranoid”. However, psychiatrists who are insensitive to the racialized experiences of their Black patients may pathologize such coping mechanisms.

Concurrently, because of the nature of the condition, schizophrenia is notoriously difficult to diagnose; since there is currently no physical test that verifies the existence of schizophrenia, and because schizophrenia often shares a number of symptoms with other disorders, misdiagnosis is a frequent problem (See Schizophrenia.com 2004).

For the aforementioned reasons there have been concerns that in the current system, diagnoses will invariably be underpinned by a racial bias, and that Black patients are frequently misdiagnosed with schizophrenia. Research supports these concerns. For example, Hickling, McKenzie, Mullen, & Murray (1999) conducted a study which compared the diagnoses made by a Black Jamaican psychiatrist with those of White British psychiatrists, and demonstrated that consensus between the Jamaican psychiatrist and his UK counterparts was weak with regard to which patients had schizophrenia. Moreover, older American research has indicated that there are racial biases against Black clients in terms of overdiagnosis of schizophrenia and underdiagnosis of depression (See for example Bell & Mehta, 1980; Bell, & Mehta 1981).

A case could be made then, that racial bias in psychiatric diagnosis might be an important factor in the Black incidence rate of schizophrenia.

Conclusion

It is argued that UK African-Caribbeans who have to cope with racial minority status stress, and racism-induced stress may experience psychological distress (See Boydell et al., 2001; Bhugra & Bhui 2001). In turn, psychiatric institutions due to racial bias and/ or lack of cultural sensitivity might be misinterpreting psychological distress (less serious illnesses) and overdiagnosing schizophrenia (see Bell & Mehta, 1980; Bell, & Mehta 1981). It is posited then that there is an interplay between racial minority status stress, racism-induced stress, and racial bias in psychiatric diagnosis, which could be influencing the high Black incidence rate of schizophrenia.

Ultimately, a case could be made that the African-Caribbean schizophrenia crisis is inextricably linked with the racial situation in the UK; African-Caribbeans are a racial minority in the UK, and consideration needs to be given to racialized experiences. Generally, there needs to be an increased effort to promote culturally competent mental health services. In particular, mental health policy makers need to promote awareness of the impact of racial minority status stress and racism-induced stress on mental health in order to safeguard against misdiagnosis and provide a culturally sensitive service. Additionally, the mental health profession must develop diagnostic instruments which reflect a consideration of the experience of racial minority status stress and racism-induced stress. The mental health profession must also become innovative in terms of adapting treatments to fit the needs of minority populations, for example, Granello and Hanna (2003) refer to the potential benefits of a “cognitive therapy for members of oppressed groups.” Moreover, it is possible to argue that meaningful cultural competency may require that mandatory modules on cultural competency issues are incorporated into academic and professional mental health training programmes. Additionally, ethnic matching of the client and mental health professional is another way of improving services for ethnic minorities since ethnic minority mental health professionals have a first-hand understanding of the impact of race-related stressors on mental health. Due to the relative scarcity of black mental health professionals in countries such as the UK (and also the US) (See Robinson 1995; Moran 2004; Scott & Davis 2005; Edge 2006) there must be an increased effort to recruit black psychiatrists and psychologists. Finally there needs to be a greater readiness on the part of scholars - particularly in the UK - to address the role that racialized experiences play in the development and diagnosis of mental illness. Future research could usefully examine the interrelationship between racial minority status stress, racism-induced stress, and racial bias in psychiatric diagnosis, with reference to this issue.

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