

## Guest editorial

# Schizophrenia and psychosis: the magical and troubling disappearance of race from the debate

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On the 27<sup>th</sup> November 2014, the British Psychological Society released a report, written by the Division of Clinical Psychology, entitled 'Understanding Psychosis and Schizophrenia'. The report outlined a number of features identified by professional psychological consensus as being salient in the process of understanding the experience of psychosis and schizophrenia. Amongst these were; defining psychoses, possible and perceived causes, formulating help seeking and support strategies, and the actions that need to be taken on the part of mental health services to ensure people who suffer from these symptoms are supported. At one level, this is a welcome, insightful and generally useful report, which explains voice hearing phenomena in a reassuring way. It de-stigmatises hearing voices by locating it at both an individual level, and the societal, collective and service provision level. This situates the responsibility for understanding, empathising and supporting psychoses sufferers within a wider constellation of factors. There is clearly an attempt at providing clear, accessible ways to understand the very many sociological and contextual factors that contribute to the social, cultural and political construction of 'mental illness' or 'mental health'. All the more reason that the complete omission of such vital societally embedded issues such as race and ethnicity prompted alarm amongst a variety of professionals who have worked in the area of mental health and diversity. Objections and concerns were raised in a letter (<http://www.sumanfernando.com/news.html>) to the editor of this report, expressing concern that the report had completely neglected an important feature of British society: race and ethnicity.

It is clear that like the rest of the population, members of Black and Minority Ethnic (BME) communities experience a range of mental health issues, including differential diagnoses, differential types of treatment, access to services and compulsory admissions. However, these experiences are compounded by institutional racism (MacPherson 1999; McKenzie and Bhui 2007a; McKenzie and Bhui 2007b) which creates fear and distrust. Even with existing explicit, overarching narratives of institutional culpability there are many conceptual and practical problems in how racism can be prevented and tackled within institutions (Bradby 2010). There is little shortage of research and writing which firmly indicates a range of problems in this arena: over representation of schizophrenia/psychosis diagnoses being given to Black British African Caribbean people; race and racism playing a substantial role in the diagnostic process; and race shaping the experiences of inequality at the healthcare access level (Fernando 2003; Fernando 2010a; Fernando 2010b; Fearon et al 2006; Littlewood and Lipsedge 1997; Singh and Burns 2006). Additionally, and with special reference to psychosis and schizophrenia related problems, Black people are more likely than White people to arrive at mental health services via the criminal justice system (Morgan et al 2005). As the Care Quality Commission (CQC) in 2011 reported, there is little

change from previous years. Admission rates, detention rates under the Mental Health Act, and seclusion rates (supervised confinement of a patient in a room) all remain higher amongst Black and White/Black Caribbean Mixed groups (CQC 2011). In summary, black people are more likely to be diagnosed with serious mental illness and labelled psychotic or schizophrenic; these communities receive unequal treatment.

Inequalities do not operate on just one level of society, or on one dimension of identity. Usually, they occur on lots of different axes, so that injustice and unequal treatment overlap with factors such as poverty, gender, racism, and socio-economic positioning. This overlap increases the impact on individuals and groups, but also makes it very difficult to pinpoint causes of differential patterns. Rather than issues of race, class or gender for example treated as epiphenomena, occupying a role on the periphery of the central debate, intersectional realities mean that 'classes are always gendered and racialised and gender is always classed and racialised...' (Anthias 2010: 241). This has fundamental implications for the entire healthcare arena, but certainly has specific ramifications when race has been completely missed. 'Race' cannot be disembodied from a systematic understanding of psychosis experience, because it is firmly embedded within a maelstrom of intersectional dimensions. As alluded to in the report itself, inequality, poverty, social disadvantage, and deprivation all have a powerful impact on the experience of psychoses.

The complexities of diversity and difference are linked to notions and practices of culture, cultural difference and cultural formulations of distress. This is given cursory treatment in the report. For example, ghosts, evil spirits and aliens are briefly discussed in the context of 'Our Different Cultures' (p14), thus situating cultural differences immediately within a paradigm of 'otherness'. There is one reference to black people, and unfortunately, it is an example of a form of equivalence (Song 2014), in that the stigma and discrimination associated with mental illness is equated with that directed at racialised minorities, which completely ignores the possibility of intersectional inequalities. Jonathon Freedland is quoted as saying 'We no longer tolerate headlines about 'yids' or 'niggers' yet 'psycho' is still acceptable...' (p 33). Perhaps the authors should take note of the current wave of xenophobia and racism parading as 'cultural' difference that is so prominent in local and national politics, or explore the Institute of Race Relations (IRR.org) regular and alarming reports of race related violence and detention, often related to issues surrounding schizophrenia. The insistence that we no longer tolerate racism while stigmatising psychosis undermines the intersectional possibilities of discrimination. Such 'equivalence' arguments have been heard before and do not contribute to insightful discussions; they merely distract us from the key objective of reducing suffering amongst all groups.

The report appears to symbolise a worrying trend in the way in which racial and ethnic difference is silenced, ignored, and not even acknowledged. The question is not how this was allowed to happen, but rather why the Division of Clinical Psychology has ignored black and other minority ethnic people in this report. This omission signals to BME communities and individuals and to mental health practitioners that the needs of and the persistent inequality meted out to specific groups are of no consequence. Poor or incorrect discursive treatment within the report would have been one outcome, but to systematically ignore all notions of Britain's long, rich, complex and often troubled history of race relations and mental health is truly problematic.

To ignore a group's identity, or deny that it exists, to misrecognise or withhold recognition is, according to Taylor (1992) a form of oppression. Equality in a multicultural society demands equality of dignity and equality of respect. The former refers to uniform, universal notions, while the latter points towards the need to respect difference, as a way of conceptualising and effecting equality between individuals and groups (Ibid). Modood (2010) extends this analysis of recognition by detailing how, dialogue, plural forms of representation, a framework of rights and practices, and being able to express commonalities and differences, constitutes multicultural citizenship. When discursive constructions misrecognise the mental health care needs of BME groups, an act of structural and symbolic violence is constituted, mobilised through a range of institutional policy and individually located actions. Similarly if the authors of the report concede that we do indeed live in a multi-ethnic polity which has fundamentally inscribed the rights of all citizens into the constitution than they also need to heed Parekh's (2000) cogent argument on what this diversity means: 'Different cultures thus correct and complement each other, expand each other's horizon of thought and alert each other to new forms of human fulfilment. The value of other cultures is independent of whether or not they are options for us' (Parekh, 2000: 167). Thus the overall symbolic communication in the misrecognition of groups seems to be that there is little left to learn from minority experiences. In addition since mental health care services are still operating under the overall architecture of the National Health Service, then debatably denying specific group recognition and acknowledgment performs an act of discriminatory withholding of care. People from BME communities have not been consulted, nor have their experiences as recorded in empirical research been even mentioned in this report. There are numerous examples of academic excellence, effective community-based interventions and activist campaigns forming robust resistance against racialised hegemony in this arena. Had the authors consulted with communities, service users, academics or clinicians who work in this area, the report would take on a rather different hue. I argue that such forms of communication are far from benign oversights, or strategic but harmless attempts at reducing the perceived 'race' element in models of intervention.

These discursive formulations of knowledge making delineate what is legitimate and valid as a mental health priority. If established work in the field testifies to the on-going racialised mental health problematic, and that much of this troubled terrain has been marked by systematic structural racism, then what is the implication of ignoring it? By discursively de-racialising the psychosis and schizophrenia debate, race does not

magically disappear. Rather, it points to the emergence of an absent presence – privilege and power as situated in other identities. As Clarke and Garner (2010) incisively point out, there is a need to probe 'whiteness', because it is a '...raced, privilege-holding location that is part of the social relationship in which structural racism flourishes' (2010: 3). I fear that while the report rightly encourages acknowledgment and respect for multi-vocal and multi-faceted expressions of psychosis and schizophrenia experience, it appears somehow to do this without really engaging with any of Britain's lived diversity. By denying the existence of categories of subjugation outside of a particular set of experiences, a prescriptive normalising discourse is perpetuated, and one in which BME experiences simply do not appear. So the move away from BME related race categories might be an intention to move away from race completely, but unfortunately it does not work. Just because the category White is not mobilised as a racial and ethnic category, does not indicate a removal of race-thinking. Rather it denotes a powerful invisibility, where, because of the universality of white indigenous categories, it is legitimated as the only experience that counts (Dyer 1997).

There appears to be widespread agreement that contemporary UK society, is in an era of 'super diversity' (Vertovec 2007) with a range of vast, accumulated historical experiences, contextualised by a range of linguistic and ethnic communities interacting at intersectional levels of experience. In the inevitability of this lived multiculturalism, failure to include any consideration of BME experiences, voices or even the vast range of evidence which indicates these problematic patterns, fundamentally undermines the confidence that all groups should be able to have in service provision. Additionally it functions to perpetuate a dysfunctional model of how ethnic, cultural and material factors can be ignored without consequence. Such omissions influence the way in which people who work in the services might administer health care, by shaping conceptualisations of 'difference', and mediating validity and legitimacy in racialised experiences.

#### Further developments?

Recently (30<sup>th</sup> January 2015) the editors issued a statement regarding the DCP's position in relation to these issues. In this statement some of the authors revealed they had met with some of the interested parties who had originally expressed concerns over the 'race' issue. They have in this statement submitted an apology, and conceded that there were indeed many serious problems with the report in its non-inclusion of 'race'. Amendments are to be made to the report, generated by a collaborative working partnership between the authors and concerned parties. As an outcome, this is at one level very positive, and indicates professional integrity on the part of the authors. It also means that when the report is amended, hopefully there will be a systematic treatment of race and ethnicity that does service to many of the issues raised above, and more. However, to date, there is no sign of this statement, or any related information on this specific problem on the BPS website, nor can this statement be found anywhere except through the channels provided by Suman Fernando, one of the originators of this debate. The issuing of a statement is however not quite a closed chapter. An additional problem is something familiar

in examples of institutional racism, and something recognisable to those who not only work in the area of race, ethnicity and health, but also all those who generally live and work within the shadow of invisible, embedded, and un-definable, or un-measurable racial meanings, potentially causing substantial psychological harm (Alleyne 2005). Being placed in a position where the 'issue' of race has to be raised at the most simplistic level (basic inclusion), often by those deemed to represent BME interests, is often a powerfully loaded, psycho-social dynamic that intersects with practical and symbolic power relations. The issue of race being missed from a report intended to be as comprehensive as this, then having to be identified and raised within a counter-discourse, is itself a sign of the process of racialised meaning making. Race and psychosis are viewable as sites of contested meanings, not only for the people who might experience these systems, but also within the working episteme of professionals.

Official discourses disseminate priorities, and mark the landscape of legitimate mental health care issues. By omitting the experiences of BME communities the BPS has made a clear, 'post-race' (Lentin 2012) era statement. Unfortunately, 'post-race' does not necessarily mean post-racial, and the enduring legacies of racialisation continue to infect the debate, implicitly and explicitly. In the discursively constructed spaces of this report, race may have 'magically' disappeared, but for many people its reality continues to be an oppressive and intersectionally mediated force.

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