REPORT TO THE CONVENOR OF

THE BSA MEDICAL SOCIOLOGY STUDY GROUP

PHIL STRONG MEMORIAL PRIZE

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KNOWING AND EXPLAINING SCHIZOPHRENIA AMONG BLACK AFRICAN-CARIBBEAN PEOPLE[1]

The Research Question

For several decades, psychiatric epidemiology and other survey data has suggested that, compared to non−Black ethnic groups, Black African Caribbeans are anything between 2−17 times more likely to be admitted to psychiatric in-patient and low to medium secure mental health facilities, with diagnoses of schizophrenia. Although these ethnic disparities have become established as an epidemiological truism, explanations for why they occur remain fraught with controversy, especially among two key groups of professionals: psychiatric epidemiologists and Black mental health activists (a diverse group united by a commitment to anti-racist mental health, but working in varied roles such as research, policy, charities, voluntary organisations, including psychiatry).

Previous sociological research has been policy driven, looking at strategic and operational possibilities and limitations of different kinds of service delivery in the context of debates about cultural competency and racism in mental health policy and provision. Some of this research, including more conceptually informed contributions have tended to supplant the realist commitments of bio-medical and social epidemiology, with its *own* anti-racist realism about the incontrovertible reality of racism. Contributions about cause and effect have implicitly and explicitly been central to the explanations proposed by epidemiologists and activists/commentators in attempts to establish authority over their knowledge claims.

[1] The original, provisional title of my Ph.D. research was *Bio-medical and Social Explanations for Schizophrenia among Black African-Caribbean People*.

In this light, the principal research question which informed my research was: *How and why do epidemiologists and activists award authority and credibility to their explanations for these ethnic disparities?* I attempted to understand the production of authoritative knowledge claims by epidemiologists and activists, and how those knowledge claims are stabilised and awarded technical and moral assent, as a fundamentally reflexive activity. In other words, all knowledge claims emerge from situated identities and interests. In my research, I wanted to treat the claims and counter claims of epidemiologists and activists/commentators as both requiring critical attention in order to avoid colluding with activists' views about the intrinsic flaws of psychiatry. Appeals to treat the indignity of racism do not absolve those appeals from sociological scrutiny. The logic of this relativist position suggests that all perspectives must be treated by the sociologist equally for the purpose of sociological analysis.

Methods and Methodology

The dataset for the research was collected between January 2006 and April 2010.[2] This is a highly original study because of the broad empirical canvas generated by the amount of research done for this project. This empirical latitude covers a broad spectrum of perspectives. It goes beyond the sociological and policy realism of previous contributions by engaging with the attribution of authority to knowledge through the reflexive situated interests of a diverse range of commentators. In sum, the research moves sociological discussion in this area forward in two key ways. *One*, this is the first project to address this topic by obtaining access to the Institute of Psychiatry (IoP) to conduct qualitative interviews with epidemiologists.[3] Access to the IoP was most important given that a significant number of published papers about Black African Caribbean psychiatric epidemiology have emerged from the IoP. *Two*, I used participant observation to go beyond the two main perspectives which have informed this topic - published psychiatric epidemiology and anti-racist critiques - to access and record three other key perspectives, around critical psychiatry, psychotherapy and Afro-centric politics of mental health, and policy professionals, to enable a broader appreciation of the range of perspectives which inform this topic.

Furthermore, the confluence of at least four developments during the research phase for this study added unique empirical value to this work. *One*, the *Delivering Race Equality* (DRE) programme which ran from 2005-2010 permitted the collection of fieldwork data, especially from Black African Caribbean activists/commentators. *Two*, revisions to the Mental Health Act (1983) which received Royal Assent on 19 July 2007[4] was the outcome of extensive input and debate among Black

[2] In practice, I had already started attending events in the last quarter of 2005 prior to registration at the Open University. A small number of remaining key interviews were conducted post-April 2010.
[3] The *Institute of Psychiatry* is a postgraduate institute of the University of London and, since August 1997, a school of King's College London. It shares the same site as the Maudsley Hospital which is now part of the South London and Maudsley NHS Trust.
[4] It amends the Mental Health Act 1983 (the 1983 Act), the Mental Capacity Act 2005 (MCA) and the Domestic Violence, Crime and Victims Act 2004.

African Caribbean activists/commentators and fieldwork data was collected from activities in this area. *Three*, 2007 marked the bi-centennial anniversary of the 1807 Abolition of the Slave Trade Act. This occasion was used by commentators and activists to raise issues about Black African Caribbean mental health. *Four*, the IoPs major in-depth AESOP[5] case study of race/ethnicity and schizophrenia provided a fulcrum from which to leverage qualitative interviews among epidemiologists (sometimes with additional clinical roles) from the IoP and other research centres.

Key Research Findings

In broad terms, the following points highlight the key research findings.

(1) Different explanations continue to be proposed for ethnic disparities by epidemiologists, activists/commentators, critical psychiatrists, therapists, and policy professionals. Of course, the explanations were not mutually exclusive as there was some overlap and occupants from different groups forged strategic alliances with one another in order to trump other explanatory antagonists.

(2) In broad terms, epidemiologists considered disparities to be a reflection of 'real' mental illness, associated with higher levels of social disadvantage and adversity among Black African-Caribbeans. This was the main finding from the AESOP research. The primacy attached to social disadvantage and adversity superseded the importance given to the variable of race/ethnicity in explaining disparities. Simultaneously, though, this causal primacy attached to social adversity and disadvantage did not explain *all* the race/ethnic disparities between and within the category of Black African-Caribbeans and the White majority. The residual leftover gave race/ethnicity explanatory significance and reinforced race/ethnicity as a relevant variable.

For activists/commentators, this retention of race/ethnicity was neither inconsequential or insignificant. It implicated the role of biological factors which, in turn, created the basis for potentially racist interpretations and connotations; namely that, the problem also resided within the 'racial/ethnic' background of Black African Caribbean people. One counter response to this claim of racialization of Black people by epidemiologists and psychiatrists was that research findings showed that racial/ethnic disparities were not, in fact, an 'ethnic' issue at all. That is, research in both the UK and other European countries showed that all migrants, of any racial/ethnic background, were more likely to be admitted to, and diagnosed with some kind of psychoses.

(3) Activists/commentators considered disparities to reflect more coercive admissions, misdiagnosis, and institutional racism inside and outside psychiatry. They also considered the AESOP research to be unoriginal, flawed, and shrouded in the language of moral objectivity, namely, difference, susceptibility, and risk aversion. First, it was unoriginal because the link

[5] Aetiology and Ethnicity in Schizophrenia and Other Psychoses.

between social adversity and disadvantage and mental ill health was not new, especially when looking at health inequalities. Second, it was flawed because the AESOP research used orthodox diagnostic labels which have both problematic validity and reliability. Third, the AESOP research, activists/commentators alleged, expounded scientific objectivity as a vehicle for a latent *moral* objectivity. The epidemiological project was essentially a form of cryptography. Encryption was the process of transforming information (about race/ethnicity and psychoses) using statistical algorithms to make information complex and meaningful to those trained in such techniques. Epidemiologists then decrypted the statistics to make the results meaningful and intelligible for academic and lay interpretation.

In contrast, activists/commentators cultivated their own kind of epistemological alchemy by claiming that AESOPs purpose was really to perpetuate a bio-medical, neo-colonial project which 'assessed' differences and risk profiles, through racialization, rather than accounting for race/ethnic groups as populations. The real significance of social and economic inequalities needed to be considered historically, in tandem with scientific racism and the inter-generational transmission of psychic trauma from slavery to current times. This thematic emphasis on the generational transmission of trauma resonated with the preoccupations of critical psychiatrists and therapists.

(4) The very sharp contrast in views expressed by epidemiologists and activists suggested very different approaches, or epistemological decorum, to the way in which ethnic disparities were known and explained. In short:

- There was little consensus between these two main groups about (a) how ethnic disparities should be described, explained, or ‘known’ through research; (b) what ‘race/ethnicity’ and ‘schizophrenia’ are, or mean; (c) what constitutes permissible evidence about ethnic disparities; (d) and how evidence should be interpreted.
- Both epidemiologists and activists contested the meanings of science, politics, and ideology, and constructed descriptive, evidential, and explanatory boundaries about, and around, what is deemed to be appropriate and necessary ways of knowing and explaining ethnic disparities. In particular, there was dispute about the political and scientific virtue of 'facts'.
- There was considerable mutual distrust between epidemiologists and activists about the appropriateness and value of mental health policy for Black African Caribbeans.

(5) Broadly, the three secondary points in (4) above can be loosely extended to the other professional perspectives that were also considered in the research: critical psychiatrists, psychotherapists, and policy professionals, but the polarisation of views were less stark. There was much greater tolerance of conflicting perspectives. Candidates of these three remaining positions, tended to embrace a combination of perspectives or align themselves with epidemiologists or activists/commentators with varying degrees of emphasis, commitment, and public visibility.

Critical psychiatrists were a relative minority in the final sample. They were more supportive of activists/commentators than epidemiologists and inclined to give precedence to the *experiences* of those with 'mental illness' rather than diagnostic labels. In awarding primacy to experience, critical psychiatrists also considered peoples' responses to their diagnostic labels and the conditions which gave rise to their 'illness', as the basis for an existentially infused political protest.[6] Black African-Caribbeans were prime candidates for this marriage of personal and the political. Critical psychiatrists strategically deployed a position which was largely critical of AESOP's conclusions, highlighted the reality of systemic institutional racism, and deployed the inscrutable character of 'mental illness' as a way of undermining orthodox or bio-social epidemiological accounts about Black African Caribbean people.

Critical psychiatrists with their principal commitment to experience, for instance, aligned themselves squarely with the Black African Caribbean experience of psychiatric services and the value of understanding racism, oppression, and cultivation of the African Caribbean identity. At the same time, these critical psychiatrists were *psychiatrists* (retired or current clinicians of psychiatry) and they embraced psychiatry to some extent, although the nature and extent of that commitment was ambiguous. In some cases, this dual commitment seemed to be blatantly contradictory, in theory and practice, if not in professional decorum.

(6) Psychotherapists did not emerge as principal vocal correspondents but rather significant allies of activists/commentators. They appeared in large conferences as a relative minority, at events specifically for psychotherapists, or in tandem with preachers and members of the clergy. Therapists were quietly emphatic about institutional racism but from the vantage point of psychoanalytic or post-colonial theorists like Frantz Fanon. Internalised oppression, the racialized 'Other', relations between fathers and sons, absent fathers, responsibility, and the importance of cultivating an Afro-centric racial identity, were some of their key areas of focus. Many of these latter topics were rarely, if at all, discussed on occasions where institutional racism was the predominant narrative. The arc of the institutional racism narrative was so circumscribing that, unlike the vivid arc of a rainbow, the only colours on display were those which polarised Black African Caribbeans from a racist society. As such, a whole array of conversations, about psychoanalytic interpretations of racism, or the role of the father in the life of a Black teenager with

[6] Usually, it meant that 'mental illness' to which were attached diagnostic categories, were not actually 'mental illnesses' at all. This so called 'illness' was actually a pernicious proxy for racism, discrimination, and other unequal structures. Protest flowed from recognition of this conflation between experience and psychiatric labels. It challenged the status quo and the psychiatric profession which colluded with the status quo. Sometimes, critical psychiatrist and activists/commentators used the idiom of protest in a way which suggested that Black African Caribbeans did really experience illness but *through* racism and inequality, not by some pathology. As such, inequalities as well as the experience of schizophrenia needed to be addressed.

a first episode of 'schizophrenia', were more subtle and accommodating than those about institutional racism.

(7) Policy professionals, primarily civil servants, considered the issue of ethnic disparities to be a difficult one. The issue was mired in competing explanations with contrasting interpretations of evidence. To this was added the pressure of producing positive outcomes in light of government funded initiatives such as the DRE and the larger politics of mental health in the NHS. Difficulty was expressed with the need to take many views into account. Policy professionals tried to reconcile information and evidence from many sources to generate the kind of tangible values and outcomes which could be taken forward within a political process which was imbued with politics.

(8) The issue of ethnic disparities among Black African Caribbeans has been a major issue within psychiatry for several decades. Arguments and counter arguments have ebbed and flowed in line with methodological and conceptual advances within psychiatric epidemiology and in response to appeals for greater accountability and understanding from activists and commentators. Activists have been highly responsive to claims about progress within psychiatry. Few if any of these claims have met with enthusiasm although the involvement of some psychiatrists in waving the banner of mental health equality has been appreciated. Most significantly, deaths in hospitals and police custody, and incidents of police racism, have done little to diffuse concerns or anger about systemic racism inside and outside psychiatric consultations. Alliances and allegiances, and the identities which animate them, shift, falter, and are renewed in line with changes in knowledge, interests, and power. The two main oppositional stances between epidemiologists and activists/commentators are supported in different ways by critical psychiatrists, psychotherapists and policy professionals. Overall, many disagreements remain but small steps have been taken to achieve consensus in ways that may help to address the range of concerns that reside under the umbrella of racial/ethnic disparities.

Contribution of Funds to Degree and Sociological Development

I am very grateful for receiving £1200 for the 2010 Phil Strong Memorial Prize presided by the *British Sociological Association*. £200 was used for travelling expenses for 3-5 additional interviews with policy professionals. The remaining sum was used as a stipend for subsistence as my funding had ended.

The title and money enhanced my degree and contributed to my development in three ways:

- The additional interviews enriched the project.
- I believe that my research is a good ‘ambassador’ for the Prize because the empirical focus on knowledge, identity, and interests, the use of interviews and participant observation, and a

multi-disciplinary approach, resonates with the spirit of Phil Strong's scholarship.[7] The research is original. It addresses an enduring and controversial topic, and contributes to a gap in the medical sociology literature. It is a good example of a multi-disciplinary approach to a multi-layered problem where claims to scientific objectivity, experience as the basis of true knowledge, notions of sameness and difference, and tensions between research findings and principles of equality, manifest and compete for authority and credibility.

- This Ph.D. remains work in progress. There is considerable scope for me to transform the thesis into major publications and pursue further questions generated by my research, both nationally and comparatively. A number of presentations have been delivered from the research.[8]

[7] Michael Bloor (1996) "Philip M. Strong (1945-1995): An Appreciation of an Essayist", *Sociology of Health and Illness*, 18, 4, pp. 551-564; Chamba, R. Review of Erving Goffman's *Presentation of Self in Everyday Life*, (Course: Sociological Writing & Instructor: Steven Shapin), University of California, San Diego. Unpublished. Available on request.

[8] [*Forthcoming*] "*The Inter-Generational Transmission of Psychic Trauma: Black African-Caribbean Responses to Ethnic Disparities in Schizophrenia*" 'Emotions, Health & Wellbeing', Society for the Social History of Medicine Conference 2012 Queen Mary, University of London (10-12 Sep. 2012).

"*Epidemiologists and Activist Perspectives on the Role of Socio-economic Inequalities in Explaining Ethnic Disparities in Schizophrenia among Black African Caribbeans*", Sociology In An Age Of Austerity, British Sociological Association Annual Conference, University of Leeds (11–13 April 2012).

"*Racialization and Embodiment: Black African-Caribbean Perspectives on Ethnic Disparities in Schizophrenia*" Making (In)Appropriate Bodies: Between Medical Models of Health, Moral Economies and Everyday Practices", University of Vienna (December 1-2, 2011).

"*De-Coupling Facts And Experiences: Epidemiologist And Activist Perspectives On Ethnic Disparities In Schizophrenia*" British Sociological Association, West Midlands Medical Sociology Group Conference: Translating Health Related Research Into Practice: Issues And Opportunities, University of Coventry (9 Nov. 2011)

"Bio-medical and Social Explanations for Schizophrenia Among Black African Caribbean People", British Sociological Association Medical Sociology Group 43rd Annual Conference University of Chester (14-16 Sep. 2011)

"*Trust in Numbers, Distrust of Interpretation*", Count Me in Census Science Park, Wolverhampton (29 May 2009)