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ETHNICITY, RACIAL DISCRIMINATION AND MENTAL ILLNESS IN BRITAIN

Introduction

Across British society, the prevalence (1) of mental disorders is not equally distributed. There are differences in the amount of mental disorders between social classes/wealth/income, gender, and ethnicity/race (2). This latter group is of interest here.

If there are differences in the rates of mental disorders among ethnic groups in Britain, what are the reasons for these? Could it be due to real differences in mental illness between ethnic groups, or due to racism/racial discrimination (3)?

The first thing to establish is the nature of the differences between ethnic groups in mental disorders in Britain. The nature of the differences were summarised by McKeown and Stowell-Smith (1998) who noted that:

> In addition to black people being over-represented in terms of the frequency of mental disorders, as reflected in the epidemiology of hospital admissions, it has also been argued that Black Britons are more likely than their white counterparts to be concentrated at the "hard" end (4) of psychiatric services (p190).

Cochrane (1977), in 1971, carried out the first national survey of mental hospitals for rates of mental illness between immigrants and the indigenous population. There were a total of 146 000 mental hospital admissions that year. The figures were adjusted to give rates of mental illness per 100 000 population: for immigrants 495, and "natives" 265.

Earlier smaller studies had failed to adjust for demographic differences, like age and social class. The raw data are not comparable because mental illness is not equally distributed across society, age or gender.

But the differential rates of mental illness can be narrowed down from overall rates between immigrants and the indigenous population to particular disorders, and particular ethnic groups.

For a recent large scale study, the British government commissioned EMPIRIC ("The Study of Ethnic Minority Psychiatric Illness Rates in the Community") with 4280 individuals (Nazroo and Sproston 2002).

This study showed differences in rates of particular mental disorders between ethnic groups (rather than immigrants, as individuals now born in this country from

immigrant parents or grandparents) (table 1).

	WHITE	IRISH	BLACK CARIBBEAN	BANGLA-DESHI	INDIAN	PAKISTANI
ANY DEPRESSIVE EPISODE IN LAST WEEK*						
	2.9	2.8	2.4	1.9	3.8	4.5
ANY ANXIETY DISORDER IN LAST WEEK*						
	3.5	5.6	4.3	2.8	4.4	4.9
ESTIMATED ANNUAL PREVALENCE OF PSYCHOSIS**						
	0.8	1.0	1.6	0.6	1.1	1.3

(* Welsh and McManus 2002)
(** Nazroo and King 2002)

Table 1 - Prevalence (%) of three categories of mental disorder (ICD-10) among ethnic groups in Britain.

EMPIRIC confirmed the findings of other smaller studies. For example, Shaw et al (1999) who recorded the one-month prevalence of anxiety and depression, using ICD-10 categories (WHO 1992), in central Manchester. There were differences in the rates of the two disorders based on ethnicity, but also gender (table 2).

	AFRO-CARIBBEAN			WHITE		
	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL
DEPRESSION						
	4	19	13	7	11	9
ANXIETY						
	0	5	3	7	10	9

(After Shaw et al 1999)

Table 2 - Percentages of sample showing anxiety or depression based on ethnicity and gender.

The most striking difference in mental disorders appears for schizophrenia. Table 3 shows the different rates for first admission to British mental hospitals with a diagnosis of schizophrenia (Cochrane and Bal 1987).

	MALE	FEMALE
BORN IN BRITAIN	9	9
BORN IN CARIBBEAN	39	35

(After Cochrane and Bal 1987)

Table 3 - Country of birth and hospital admission for schizophrenia (per 100 000 population).

Furthermore, how the individual is treated when disgnosed varies between ethnic groups. Takei et al (1998) followed up 81 patients (49 White, 32 Afro-Caribbean) first admitted to a psychiatric hospital in 1973-4 with a diagnosis of "functional psychosis" (5). The research found differences in the mean length of admission, and mean number of admissions to hospital based on ethnicity (table 4).

	SCHIZOPHRENIA		NON-SCHIZOPHRENIA	
	WHITE	AFRO-C	WHITE	AFRO-C
MEAN LENGTH OF ADMISSION TO PSYCHIATRIC HOSPITAL (days)	124.4	272.8	72.9	67.7
MEAN NUMBER OF ADMISSIONS TO PSYCHIATRIC HOSPITAL	3.4	5.3	2.8	3.1

(After Takei et al 1998)

Table 4 - Comparison of admission to psychiatric hospital based on ethnicity.

More recently, Tolmac and Hodes (2004) have found an over-representation of diagnosis of psychosis among Black (Black African, Black Caribbean, Black British) compared to White (White British, White Irish, White Other) adolescents (an odds ratio of 3.7 (6)).

The key observation seems to be the high rates of schizophrenia in individuals from the Caribbean in Britain, and this is higher than comparable groups in the Caribbean. But there is no increased rate of schizophrenia among South Asians living in Britain. The difference exists mainly for schizophrenia of all mental disorders (Rutter and Nikapota 2002).

The existence of these differences between ethnic groups could be explained in three ways:

i) Biological predisposition to different levels of incidence between ethnic groups; ie: some ethnic groups are more prone to mental disorders than others;

ii) Social causes for the difference, including racial discrimination;

iii) Distortions in the figures.

The first two explanations suggest that the differences in the figures are real, but caused in different ways, while the third explanation sees the figures as inaccurate.

Explanation 1 - Biological Differences Between Ethnic Groups

This explanation for the differences in rates of mental disorders between ethnic groups is suggesting that there are real ethnic differences in the rates of mental illness.

Eagles (2003) asked: "Is it politically incorrect to suggest that different ethnic groups may be biologically predisposed to different levels of risk with regard to developing illnesses which have predominantly biological aetiologies?" (p77).

If there were biological differences between ethnic groups in the prevalence of mental illness, then these differences would be evident around the world. But the rate of psychosis for Black Caribbeans in the Caribbean is the same as White British in the Britain (McKenzie and Chakraborty 2003).
However, Kleinman and Cohen (1997) argued that it is a myth that mental illnesses have the same prevalence throughout the world.

Care needs to be taken in suggesting that particular ethnic groups are biologically prone to mental disorders because of the underlying implications involved (7). Grier and Cobbs (1992), talking about black US males, are clear that they have no "special psychological or genetic determinants towards enhanced mental disorders". Furthermore, there is no evidence of an increased genetic predisposition for mental illness among Black Britons, for example (Boast and Chesterman 1995).

Littlewood and Lipsedge (1997) noted variations in the "biological differences between ethnic groups" argument, for which there is little evidence:

a) "Psychiatric illness in black people is different" - eg: "florid" (more anti-social and dangerous). In fact, black patients are actually less violent generally (Harrison et al 1984).

b) "Psychiatric illness in black people is the same as in whites but it is more severe and more common". Thus there are factors which cause the illness to be more common and severe. A key factor here could be, for example, cannabis use (Sugarman 1992). The arguments about "cannabis psychosis" continue to rage, but the establishing of a causal link is difficult (Arseneault et al 2004), and most research evidence is correlational only (Ernst 2002).

Other possibilities that exaggerate psychiatric disorders among black individuals include lack of immunity to viral infections common in Britain. Viral infection in a pregnant immigrant could explain the appearance of mental disorders in individuals born in Britain, it is argued.

MIGRATION

One explanation which links the biological differences between ethnic groups and the social causes of mental disorders concerns migration:

a) The experience of migration causes the psychiatric problem. For example, Selten and Sibjen (1994) found higher rates of schizophrenia among immigrants to the Netherlands from Surinam and Netherland Antilles.

Explanations here include the enforced separation between parent(s) and children through the migration of the parent(s) to work abroad (Glover 1989). But many individuals migrate and do not suffer from mental disorders.

This explanation also assumes that the home country is not changing and thereby causing stress, which could lead to mental disorders. The loss of "old culture" can occur at home as well as in the new country (Kiev 1972).

b) Those individuals who migrated are a particular type of individual more prone to mental illness. This is unlikely because the main post-war migration to the UK in the 1950s and 1960s was for employment, and only the most "healthy" would have come in this situation.

Furthermore, the differences in rates of mental illness among ethnic groups is evident in subsequent generations of individuals born in the UK as well as

immigrants: 2-8 times greater for psychotic disorders in British-born individuals with an Afro-Caribbean family background (Eaton and Harrison 2000).

Odegaard (1932) found, in an early study, higher rates of schizophrenia among Norwegian-born immigrants in Minnesota, USA than in Norway. One interpretation is that the migration caused the mental disorder (known as the social causation hypothesis; Cochrane 1983). Or the individuals who migrated may have had characteristics that made them unsettled in their country of origin, and also predisposed them to mental disorders (social selection hypothesis).

Attempts to distinguish the theories (eg: Dohrenwend and Dohrenwend 1969) have produced conflicting results. Gelder et al (1996) admitted that "there is no simple relationship between migration and mental disorders" (p91).

Explanation 2 - Social Causes of Mental Illness

This explanation for the different rates of mental illness among ethnic groups focuses upon the environment and society as causing the differences.

The belief that serious mental illness can be caused from scratch by social stressors is difficult for psychiatrists to accept, particularly with the current emphasis on the biological basis to mental illness (Brewer 2003).

Many studies show general differences in the rate of mental illness depending on social circumstances. For example, in Britain, unemployed females report a prevalence rate for any neurotic disorder as over twice the average rate, and unemployed males 25% above the average (Chief Medical Officer 1995).

Two classic studies (Hollingshead and Redlich 1958; Birtchnell 1971) showed clear differences in rates of mental illness based on social class. Table 5 shows the differences between the highest and lowest social classes in both these studies.

		(A) % OF GENERAL POPULATION	(B) % OF PATIENT POPULATION	RATIO OF B:A
Hollingshead & Redlich (1958) New Haven, Connecticut 1950				
SOCIAL CLASS	I/II*	11.4	8.0	0.70
	V**	18.4	38.2	2.08
Birtchell (1983) Aberdeen 1963-7				
	I	5.5	5.0	0.78
	V	9.0	14.1	2.28

* professional; ** unskilled manual
(After Cochrane 1983)

Table 5 - Rates of mental disorders among social classes I and V.

While, in an Iranian study, individuals unemployed showed a greater rate for any mental disorder (odds ratio 1.82) compared to the average (Noorbala et al 2004).

Harrison (2002) pointed out that compulsory detention is high for all those with psychotic disorders in inner urban areas. Many poorer individuals are found in urban areas. But:

> It is not city living as such that creates the risk but rather the accumulation of social adversities that include social disorganisation, poor job opportunities, disadvantaged housing, poor schooling, a lack of community resources, racial discrimination and social exclusion (Rutter and Nikapota 2002 p283).

In fact, Cockerham (2003) argued, from US data, that "social class is more significant than race in predicting mental disorders" (p192). Furthermore, "Blacks are more likely than whites to be poor, and poor people have higher overall rates of mental disorders" (p197).

RACIAL DISCRIMINATION AS A CAUSE OF MENTAL ILLNESS

McKenzie (2003) reported research that showed that racial discrimination can affect physical health. For example, victims of racial discrimination reported greater respiratory illness, and hypertension. While an increase in "racial disrespect" in a US state led to an increase in black all cause mortality.

To pose the question as to whether racial discrimination causes mental illness is a simplistic one for Eagles (2003), and "is likely to give rise to a simplistic answer. To ask 'does smoking cause physical illness?' would give rise to the answer that it causes some physical illnesses and not others. The same relationship is likely between racial discrimination and mental illness" (p77).

Eagles (2003) felt that it is acceptable to see racial discrimination as increasing the risk of depression, or precipitating the relapse in schizophrenia, but it is more contentious to say that racial discrimination can cause, say, schizophrenia.

In a US study, Kessler et al (1999) found that "major lifetime perceived discrimination", like being "hassled by the police" or "fired from a job" because of racial discrimination were associated by 50% of African-Americans with psychological distress and depression. While "day-to-day perceived discrimination" was reported by 25% of African-Americans, and related to psychological distress, and generalised anxiety. The authors, however, do not see racial discrimination as causing mental disorders because a small number of white individuals reported similar feelings in their study.

The Fourth National Survey of Ethnic Minorities in the UK interviewed 5196 individuals of Caribbean, African and Asian origin. Those suffering from depression or psychosis were twice as likely to have experienced verbal racial abuse or physical racial attack (quoted in Chakraborty and McKenzie 2002).

Burke (1984), in a Birmingham study of "West Indians", has suggested links between depression and life events felt to be due to racial discrimination. Bhugra and Cochrane (2001), however, criticised the methodology of this study. While research with qualitative interviews, found that patients of Caribbean origin with psychosis were more likely to see the origin of their problems as racial discrimination than as mental illness (quoted in Chakraborty and McKenzie 2002).

Interestingly, research has found a greater likelihood of mental illness among ethnic minorities in areas where they are a smaller proportion of the population than where they are the majority (eg: Laveist 1996 in USA; Boydell et al 2001 in London (8)).

In a recent study in the Netherlands, Janssen et al (2003) have found that perceived discrimination was associated with delusional thoughts, but not

hallucinations (9). Using over 4000 individuals with no history of psychosis as part of NEMESIS (The Netherlands Mental Health Survey and Incidence Study), discrimination was based on skin colour/ethnicity, gender, age, appearance, disability, or sexual orientation.

A possible mechanism for this association could be that regular experiences of discrimination affect the attribution of events, particular negative ones (Gilvarry et al 1999) leading to a "paranoid attributional style" (Sharpley and Peters 1999).

Racial discrimination could lead to "paranoia" about others in society against the individual. Rather than this behaviour being a sign of mental illness, it is a "healthy coping strategy in a discriminatory environment" (Chakraborty and McKenzie 2002).

RACIAL DISCRIMINATION AND MENTAL ILLNESS

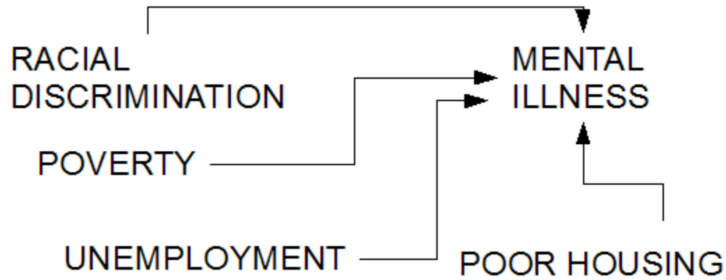
Freeman (2003) argued that there are many socio-economic stressors, like poverty, which individuals face, and "race merely adds an additional factor".

The relationship between racial discrimination as causing mental illness can be viewed in three ways (figure 1). Either all social stressors could cause mental illness and racial discrimination is no different, or the nature of racial discrimination is a different type of stressor. Alternatively, racial discrimination may be behind other social stressors, like the cause of unemployment and poor housing.

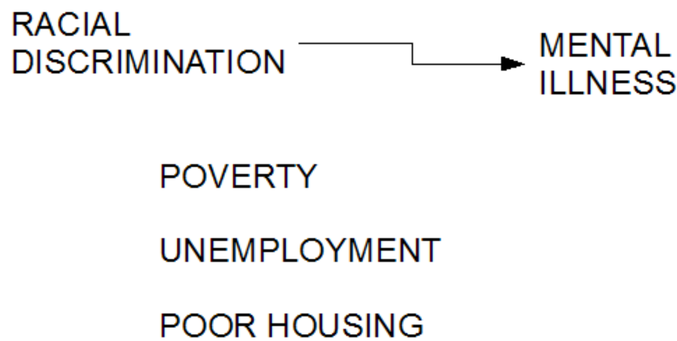
CONCLUSIONS

The reasons for the differences in the rates of mental illness among ethnic minorities in the UK are varied, and reflect "complex interactions between exposure to discrimination, social support, socio-economic factors and social capital" (Chakraborty and McKenzie 2002).

1. All social siressors, including racial discrimination, could cause mental illness.



2. Racial discrimination is a different type of social stressor, and is able to cause mental illness whereas the other social stressors cannot.



3. Racial discrimination is behind the other social stressors which together cause mental illness.

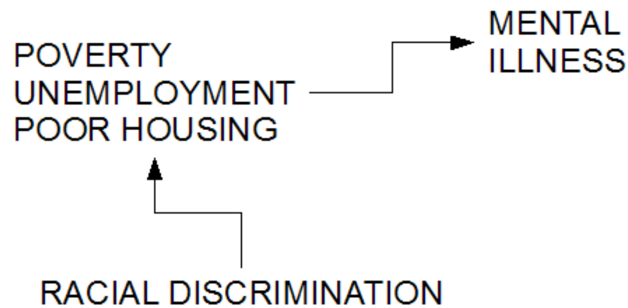


Figure 1 - Three possible relationships between racial discrimination, social stressors, and mental illness.

Explanation 3 - Distortions in the Figures

This explanation is based around the argument that "institutional processes alone" account for the differences in rate of mental illness between ethnic groups (McKeown and Stowell-Smith 1998). In other words, the differences in rates of mental illness are not true reflections of differences between ethnic groups.

BIAS IN DIAGNOSIS

One distortion in the figures for the prevalence of mental illness among ethnic groups could be bias in diagnosis by psychiatrists.

Fernando (2002) argued that racial discrimination is implicit in modern psychiatry, including the overmedicalisation of behaviour by ethnic minorities because of psychiatry's Western ethnocentrism.

> Two points are fundamental: first, racism in psychiatry is not an aberration - it is the normal condition; and secondly, it is not the recognition of cultural differences that is racist, but the attribution of values to these differences
> (Fernando 2002 p114).

Fernando lists the conclusions from research into ethnic minorities and the diagnosis of mental illness in the UK:

i) Over-diagnosis of schizophrenia among those of West Indian and African origin compared to the average rate.

ii) An excess of compulsory admission of those of West Indian origin; twice as many compared to whites (Sayal 1990).

Davies et al (1996) compared the level of detention under the Mental Health Act of 1983 (10) between ethnic groups, based on 439 psychotic patients in two areas of South London in 1993. They found an adjusted ratio of 3.67:1 for non-white to white. In other words, non-white individuals were over three times more likely to be detained. The authors concluded:

> Independent of psychiatric diagnosis and sociodemographic differences, black African and black Caribbean patients with psychosis in South London were more likely than white patients to have

been detained under the Mental Health Act of 1983 (Davies et al 1996 p533).

Bhui et al (1998) looked at 277 men in Brixton prison on remand with "potential mental illness". White males were less likely to be "sectioned" or diagnosed with schizophrenia compared to the other ethnic groups (table 6).

	WHITE	BLACK CARIBBEAN	BLACK AFRICAN	BLACK BRITISH	ASIAN/ OTHER
"SECTIONED"	17	25	27	46	17
DIAGNOSIS OF SCHIZOPHRENIA	18	37	44	58	42

(After Bhui et al 1998)

Table 6 - Percentage of each ethnic group "sectioned", and diagnosed with schizophrenia in Brixton prison on remand.

iii) An excessive transfer to locked wards of West Indian, Indian, and African British compared to the average rate.

Audini and Lelliott (2002) found detentions under Part II of the Mental Health Act of 1983 to be over six times more likely for Blacks than Whites, and the rate was 65% higher for Asian than White. While detentions of Black males was eight times greater than White males.

The authors suggested a number of reasons for the over-representation of Black individuals in the detained psychiatric population:

a) Higher prevalence of mental illness;

b) Mistrust of services, leading to delay in seeking help, and thus more severe when presented to psychiatric services;

c) Poorer compliance with medication;

d) Greater contact with the police;

e) More frequent history of violence with mental illness (Wall et al 1999);

f) "differences in the way in which mental health care workers respond to people from different ethnic minority groups" (p225).

The authors admitted that they did not know which factors explain the data.

Though there are higher rates of schizophrenia among immigrants to the Netherlands, there is no difference in the level of compulsory detention between immigrants and the indigenous population (Selten and Sibjen 1994) as found in Britain. This would suggest bias in the use of compulsory detention in Britain. Generally, however, the use of compulsory detention in Britain is comparable to other EU countries - 13.5% of all in-patient episodes in 1999 (Salize and Dressing 2004).

In cases of compulsory detention where the police were involved in "arresting" the patient, Reiner (1986) has argued that the police are acting in a process of "transmitted discrimination". In other words, the police are acting out the community's fears towards black individuals.

RACISM IN PSYCHIATRY

Fernando (2002), among others, was very critical of British, usually white, psychiatrists and their diagnosis of ethnic minorities. This led to research by the Royal College of Psychiatrists to establish if ethnic bias did exist among their members.

An experiment was set up with 200 psychiatrists using four case histories of patients. The independent variable was the ethnicity of the patient, either described as White or Afro-Caribbean. Where the patient was described as Afro-Caribbean, the psychiatrists tended to diagnose a shorter duration for the illness, suggested greater criminal proceedings (ie patient perceived as dangerous), and prescribed more neuroleptic drugs.

However, there was less common diagnosis of schizophrenia. But this may be because the psychiatrists were conscious of the criticisms of ethnic bias, yet they still responded to the ethnic stereotype in diagnosis otherwise (eg: perceived dangerousness)(Lewis 1994 reporting Lewis et al 1990).

Psychiatrists defend themselves (eg: Harrison et al 1988) by arguing that the use of the Present State Examination (11) (Wing et al 1974) avoids "misdiagnosis".

But Fernando (2002) argued that:

> deductions made from an "examination" of "the mental state" cannot be viewed as being equivalent to a medical description of the state of a bodily organ since these are described in terms that have objective

> validity - or at least some degree of such validity. What a doctor "finds" in a "mental state" is as much a reflection of the observer as the so-called patient. It is the result of an interaction rather than a one-sided observation (pp116-117).

A key variable of that interaction is ethnicity or race - particularly the black patient with the white psychiatrist, and this will influence how the diagnosis is made. It is a subjective process.

Ethnic groups are "seen differently even if they exhibit the same behaviour" (Loring and Powell 1988). But rediagnosis of a selection of British cases by a Jamaican psychiatrist has found similar diagnosis to the original (Hickling et al 1999). This could be said to remove the case for diagnostic bias. On the other hand, it may show how psychiatrists around the world all think in a similar way.

It is worth noting that diagnosis of mental disorders is not a static process, and differences have occurred over time. For example, in the 1960s, there were large differences in the diagnosis of schizophrenia between psychiatrists in the USA and the UK (Cooper et al 1972).

The Transcultural Psychiatry Society (UK) attempts to highlight implicit cultural bias in Western psychiatry, and since 1985, its primary object has been the opposition to racism (Transcultural Psychiatry Society 1985). Fernando (1989) quoted key beliefs of the Society:

a) Schizophrenia is a socially constructed concept rather than biologically determined, and "tells us as much about the biases in our society and in the person making the diagnosis, as it does about the 'patient'" (p251);

b) "It is naive to assume that research on issues involving race are value free when conducted in a racist society, within a discipline, such as psychiatry, with a powerful racist tradition" (p251);

c) Studies of the genetic basis of psychiatric illness in black people are of limited use if not "extremely misleading".

While Stephen (1997) spoke personally: "Mental health institutions are just places that large numbers of us will go through as we struggle to adapt to unnatural and unspiritual ways of living that are not of our making" (p18).

But psychiatrists are not necessarily showing racial discrimination more than other institutions in society. The behaviour of psychiatrists is within a society and culture structured around "race". McKeown and Stowell-Smith (1998) pointed out the example of the stereotypical image of "big, black, and dangerous". "To be young and black, particularly for males, is to be deemed a greater risk and in need of increased surveillance and greater control" (Browne 1995).

In other words, the emphasis upon the difference, and upon "Other" (who by their very nature are different in a negative sense) (Miles 1989). The origin of these ideas are in the history of colonialism, for Dalal (1993). The power to define difference, and particularly subordination, produced the notion of racial differences as real differences. But the "racial differences are socially defined" (McKeown and Stowell-Smith 1998).

For Miles (1989), the heart of racism is the making sense of the "Other", and the process by which "Us" and "Them" are formed in societies. Understanding the representation of "Other" in Britain today requires an awareness of the history of ethnic interactions (Rattansi 1995). For example, the images of black inferiority and savagery from Victorian times (Banton 1987).

Pilgrim and Rogers (1999) argued that psychiatry is part of the "repressive state apparatus" (Althusser 1971) to control "alien forces" and the "Other", which in this case are immigrants. For example, the Mental Health Act of 1959 allowed for compulsory repatriation of immigrants diagnosed with mental disorders. Rack (1982) reported 57 such cases between 1970 and 1976.

The "Other", or outsider, or "alien" (Littlewood and Lipsedge 1997) is often seen as a threat. It is a threat that must be dealt with - remove if possible, in the case of repatriation, but for those individuals born in Britain, this is not an option. But such individuals can be "removed" by placing them in psychiatric hospitals (ie: out of sight).

> Coercive psychiatry, as part of the wider repressive state apparatus, offers itself as a post colonial, Europeanised alternative to repatriation. Ideas about banishment to another country can be replaced by the mechanisms of exclusion and control afforded by the mental hospital, prison and physical treatments (Pilgrim and Rogers 1999 p81).

Horowitz (1983) suggested that the chances of labelling a person as mentally ill increases with

cultural distance between the observer/labeller and the person being labelled.

It should be pointed out that ethnic differences here are not always based on black/white skin colour. For example, admissions to psychiatric hospitals in the UK for women born in the Republic of Ireland are greater than other ethnic groups (Corduff 1997) (12), or, in the US, the suicide rate for young Native Americans and Native Alaskan males was twice that of white males (Cockerham 2003).

In such a situation of bias within the mental health system, is there then a case for separate psychiatric services for ethnic minority groups? For example, in San Francisco General Hospital, there are different psychiatric wards for East Asian Americans, African-Americans, and Hispanic Americans (Cannon et al 2003).

Bhui (2003) argued for such specialist services because of the bias in existing services. While Sashidharan (2003) argued that "the idea of separate services for different ethnic groups is based on the premise that the mental health needs of minority ethnic groups are somehow different to those of others" (p11).

PROBLEMS IN COLLECTION OF FIGURES

One problem is that some ethnic groups are more or less likely to use psychiatric services, and thus this affects the level of mental illness recorded. For example, Arshad and Johal (1999) pointed out:

> Mental illness among the Asian community is often culturally, religiously and spiritually defined rather than viewed as a medical problem. There is a deep belief in spiritual healers, and phenomena difficult to explain are attributed to "sorcery" or a cause placed on a person or family by an ill-meaning member of the family or community. There is therefore limited faith in the psychiatric medical model (p66).

Thus individuals from this group are less likely to come to the attention of psychiatrists.

But interestingly:

> Whilst high apparent rates of schizophrenia among West Indians are taken as valid, the relatively lower rates among Asians are seen as reflecting not better mental health, but the presumed existence of patients kept hidden at home away from medical facilities (Littlewood and Lipsedge 1997 p283).

Also there is a tendency to focus upon the problems only. Chakraborty and McKenzie (2002) argued that the focus of the research is important: "focusing on psychological differences between Blacks and Whites rather than on power disparities inherent in a predominately racist society serves only to reinforce the idea of racial differences" (p476).

The emphasis upon the higher rates of certain mental disorders among ethnic groups rather than the lower rates of other mental disorders. Afro-Caribbean patients showed a better clinical course than whites ie they were less likely to have a continuous illness of schizophrenia (McKenzie et al 1995; 2001).

In the study of 55 London adolescents, Tolmac and Hodes (2004) found no cases of eating disorders among the Black females compared to 21% of White females. Furthermore, in the Black group there were no cases of anxiety disorders or conduct disorders. While, in the US, the number of Chinese Americans in psychiatric hospitals is low (Cockerham 2003).

Littlewood and Lipsedge (1997) listed a number of technical problems with the data used to show ethnic differences in mental illness:

a) The actual number of patients from ethnic minorities is small, but appears larger because of the standardisation of the data. For example, in the Harrison et al (1988) study, misclassification of one case would lead to a 4% change in incidence (Francis et al 1989);

b) Problems with the definition of ethnicity, and the accuracy of the census details of ethnic groups;

c) "Considerable doubt" about the diagnosis of schizophrenia in black individuals by white psychiatrists (Adebimpe 1994).

Any comparison of ethnic or cultural groups in terms of rates of mental illness needs to consider the methodological issues of such studies. These include comparability of sampling, and awareness of features more applicable to one group than another (Rutter and Nikapota 2002). Furthermore, risk factors may be reflected differently in ethnic groups; eg: increase in anti-social behaviour among adolescents of second and third generation Asian-British as compared to their parents (Rutter and Nikapota 2002).

CULTURE-BOUND SYNDROMES?

The classification systems for mental illness used

by psychiatrists are assumed to be universal (found in all cultures). "Culture-bound syndromes" is a term used to cover mental illness seen in some cultures but not others: eg "koro" in East Asia (13).

DSM-IV (APA 1994) defined them as "recurrent, locality specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category" (p844) (14).

However, it has been argued that there are "culture-bound syndromes" that exist in the West only: eg anorexia nervosa (Russell 2000) or chronic fatigue syndrome (Sharpe and Wessley 2000).

It could well be that the variations in rates of mental illness among ethnic groups in Britain are part of this phenomenon, and, most importantly, highlight that the classification systems for mental disorders are not universal. This is supported by Littlewood and Lipsedge's (1985) definition of "culture-bound syndromes" as "episodic and dramatic reactions specific to a particular community - locally defined as discrete patterns of behaviour". And Hughes (1996) who noted that these syndromes only afflict those people who are outside the "mainstream" population.

Conclusion

Littlewood and Lipsedge (1997) are unhappy with explanations for the difference in rates of mental illness among ethnic groups that are based in biological differences between ethnic groups, and also unhappy with explanations emphasising the racism in society. Both are inadequate explanations by themselves.

The reasons for the differences in the rates of mental illness among ethnic minorities in the UK are varied, and reflect "complex interactions between exposure to discrimination, social support, socio-economic factors and social capital" (Chakraborty and McKenzie 2002).

Boast and Chesterman (1995), in accounting for the increase of Afro-Caribbean individuals in medium secure units and special hospitals, proposed a model that combined "institutional processes" with "disadvantage faced by black people", "thereby creating and maintaining stereotypes of black people".

"Institutional processes" are routes by which an individual is diagnosed as mentally ill, and specifically as an offender who is mentally ill. "Disadvantage" includes social deprivation as the cause of the problem, as well as less mental health facilities available. The stereotypes include the belief that black people are alienated from psychiatric services; ie: they

delay in presenting for help.

"The resulting increased rate of involuntary admission to the psychiatric system and subsequent hostility will reinforce stereotypes and produce mutual disenchantment between Afro-Caribbean patients and psychiatric staff" (p231).

Footnotes

1. The prevalence and the incidence of a disorder are technically different concepts. Prevalence rate is the number of cases, while incidence rate is a measurement of the development of the disorder. Different equation are used to calculate these figures (Kneisl et al 2004):

$$\text{PREVALENCE RATE} = \frac{\text{Number of existing cases of disorder at point in time}}{\text{Total population}}$$

$$\text{INCIDENCE RATE} = \frac{\text{Number of new cases of disorder over period of time}}{\text{Population at risk}}$$

2. "Race" is a social phenomenon based on superficial physical differences between individuals, and thus some writers place "race" in quotation marks for that reason (Miles 1989).

But the term "race" is seen to give credence to "real" differences between groups of individuals. However, "real" differences, like at a genetic level, do not exist between "races":

> Of all human genetic variation..85 per cent turns out to be between individuals within the same local population, tribe, or nation. A further 8 per cent is between tribes and nations within a major "race" and the remaining 7 per cent is between "races" (Lewontin 1987).

Fernando (2002) made the distinction between race, culture, and ethnicity for use in his book (table 7).

	CHARACTERISED BY	DETERMINED BY	PERCEIVED AS
RACE	physical appearance	genetics	permanent
CULTURE	behaviour attitudes	upbringing choice	changeable
ETHNICITY	sense of belonging	social pressure psychological need	partially changeable

(After Fernando 2002)

Table 7 - Comparison of race, culture and ethnicity.

3. "Racism is the process of marginalising, excluding and discriminating against those defined as different on the basis of their skin colour or ethnic group membership" (Wetherell 1996 p178).

4. "Hard" end of psychiatric services relates to detention in special hospitals and secure units.

5. "Functional psychosis" is a diagnostic category no longer used by psychiatrists today in DSM-IV-TR (APA 2000), and includes the categories of schizophrenia and other psychotic disorders.

6. Odds ratio gives the relative odds of behaviour in two groups. It can be defined as the "ratio of affected to unaffected individuals in one group divided by the same ratio in another group" (Petrie 1987 p230).

7. Jobanputra (1995) talked about "biological racism" which assumes that some groups, based on race, are inferior to others. It involves the use of "scientific facts" about race, which ends up affirming the superiority of white individuals, either directly or indirectly.

Disturbingly, Jobanputra (1995) argued that "on the surface, a person may openly deny that they are racist, yet they may be engaging in a subtle form of racism by justifying inequalities in a disguised way" (p42).

8. Boydell et al (2001): rate of mental disorders among ethnic minorities of 52.6 per 100 000 for low ethnic minority wards, and 36.9 for high ethnic minority wards.

9. Results from Janssen et al (2003) (table 8).

	NO DISCRIMINATION	DISCRIMINATION IN:	
		1 DOMAIN	MORE THAN ONE
DELUSIONAL THOUGHTS (%/n)	0.5/19	0.9/4	2.7/3*
HALLUCINATIONS	0.5/19	0.2/1	1.8/2**

* p = 0.027; ** p = 0.13

Table 8 - Number of cases of delusional thoughts and hallucinations based on level of discrimination.

10. Part II of the Mental Health Act 1983 allows for individuals to be compulsorily detained (or "sectioned") in a psychiatric hospital for between 72 hours, 28 days, or six months. This can be without the consent of the individual, and based upon the decision of one or two

doctors or psychiatrists. The police may also arrest the individual as part of the "removal to a place of safety from a public place" (Brewer 2001).

11. Present State Examination is a specialist type of clinical interview used by psychiatrists. It involves (Brewer 2002):

i) history-taking - details of the patient and relevant facts; eg: family history of depression;

ii) mental state examination - concentrating on the patient's mental state now;

iii) physical examination.

12. In the first national survey of England and Wales in 1971 based on mental hospital admissions, Irish born individuals showed an age-sex standardised rate of 1110 per 100 000 adults compared to 494 for "natives" (Cochrane and Stopes-Roe 1981).

13. "Koro" is the fear that the penis, usually, is retracting into the stomach, and this will lead eventually to death (Humphreys 1999).

14. "Culture-bound syndromes" are well debated among psychiatrists, particularly in terms of their origins and validity (eg: Humphreys 1999; Sumathipala et al 2004).

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SUICIDALITY IN PRE-PUBERTAL CHILDREN: AN INTRODUCTION

Introduction

Suicidality includes suicide ideation, attempts, and completions (Shaffer and Greenberg 2002). Suicidal ideation can vary from fleeting thoughts at moments of unhappiness or stress to an all-consuming preoccupation with killing oneself.

> It is not possible to attempt or commit suicide without thinking about it, but only one in three ideators will ever attempt suicide
> (Shaffer and Greenberg 2002 p129).

Suicide

HOW MUCH?

There is no universally accepted definition of suicide (Kenny 2001). Schneidman (1995), for instance, used the phrase: "a conscious act of self-induced annihilation".

Suicide in children before puberty or teen years (ie: before age of 12) is rare (Shaffer and Gutstein 2002). Rosenhan and Seligman (1995) felt it was fewer than two hundred a year in the US for under 14s, or 0.8 per 100 000 children in the late 1980s (Carr 1999).

Gould, Shaffer and Greenberg (2003) reported suicide in the US in 1999 of 192 boys and 50 girls, and a rate of 1.2 per 100 000 10-14 year-olds (1).

Figures collected by the World Health Organisation (WHO) for England and Wales showed a rate of 0.1 per 100 000 5-14 year-olds in 1997 (Shaffer and Gutstein 2002). Table 9 shows the range of rates of suicides from around the world using WHO data.

RISK FACTORS

Rosenthal and Rosenthal (1984), in one of the few studies of suicidality in young children, distinguished suicidal preschoolers as more impulsive and hyperactive, showed less pain and crying when hurt, and had experienced parental abuse and neglect compared to the general population.

There are many more studies on adolescent suicide,

and the risk factors associated here are probably also relevant to pre-teen children (table 10).

		COUNTRY	RATE PER 100 000
HIGHEST	MALE		
	1989	New Zealand	3.1
	1997	Russian Federation	3.0
	FEMALE		
	1990	Finland	0.4
	1997	New Zealand	1.5
LOWEST	MALE		
	1991	UK	0.1
	1997	UK	0.1
	FEMALE		
	1991	UK	1 death
	1997	Japan	0.03

(After Rioch 1994; Shaffer and Gutstein 2002)

Table 9 - Highest and lowest rates of suicide for 5-14 year-olds based on World Health Organisation data.

RISK FACTOR	EXAMPLE OF RESEARCH
Family history of suicide	Brent et al (1996) 2-4 times more likely to have first degree relative who committed suicide
Imitation/ contagion	Schmidtke and Hafner (1986) fictional account of 19 year-old student's railway suicide followed by brief increase in youth suicide (and the repeat of the programme one year later) in Germany
Psychiatric disorder	Shaffer et al (1996) New York study found that about half of suicides had past contact with mental health services
Previous known suicide attempt(s)	Brent et al (1999) 40% of suicides
Family circumstances	Brent et al (1994) greater amount of parent-child discord among 67 suicide victims

Table 10 - Risk factors for suicide among teens which may also be relevant to pre-teen suicides.

Attempted Suicide

DEFINITION

Attempted suicide was defined by the World Health Organisation as:

> ..an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences
> (Platt et al 1992 p99).

This definition does not include the term "wish to die" because it is difficult to establish the motivation of behaviours of self-harm. Some behaviours, like self-cutting, are usually not seen as lethal. Often the term "parasuicide" (Kreitman 1969) is used to cover all deliberate self-injury, irrelevant of motivation or the level of lethality.

While the Centers for Disease Control and Prevention (2000 quoted in Shaffer and Greenberg 2002) included any deliberate self injurious behaviour requiring medical attention as a suicide attempt.

Trying to assess the "seriousness" of the individual's suicide attempt must take into account the precautions taken to avoid discovery as well as the level of injury sustained. However, children will probably be ill-informed about the lethality of the method used.

For example, doctors estimated that only 2% of adolescent non-lethal overdoses were actually enough to be lethal (Shaffer and Gutstein 200). Thus poor methods used are not necessarily a sign of a "gesture" or attention-seeking, and could be a "serious" attempt at suicide (Shaffer and Gutstein 2002).

RISK FACTORS

There are few cases of parasuicide in pre-teen children, and specific studies of this age group are rare. Most often the research looks at children and adolescents together.

For example, Hawton (1996) described a survey of 750 under sixteens undergoing psychiatric treatment, and their experiences of deliberate self-harm (intentional

non-fatal self-inflicted injury or overdose). There was a clear female bias of 57:1.

The majority of cases (96.5%) were overdoses. The causes for the deliberate self-harm offered by the respondents included difficult family relationships, friends and boy/girlfriends, and schoolwork problems. Within the female sample, 16.7% had experienced sexual abuse.

The research from adolescent parasuicide studies have found a number of risk factors which will be relevant to pre-teen behaviour:

i) Stressful life events

In particular, related to "disciplinary crises" (eg: arrest), academic problems, or bullying. International adolescent studies have found higher levels of suicidal thoughts associated with bullying at school (both as victim and perpetrator)(Kaltiala-Heino et al 1999: Finland; Rigby and Slee 1999: Australia).

The same is true for suicide attempts and deliberate self-harm (Davies and Cunningham 1998: Ireland). Bullying is associated with a number of psychiatric problems for all age groups of children (Salmon and West 2000).

ii) Psychiatric disorders

Most commonly mood disorders, followed by conduct, anxiety, and eating disorders (Shaffer and Greenberg 2002). But about one-quarter of suicide attempters did not have evidence of psychiatric disorders (Gould et al 1998).

iii) Cognition

For example "problem-focused" thinking (ie dwelling on problem); feelings of hopelessness; or "grandoise attributions" (Shaffer and Greenberg 2002).

iv) Family factors

For example, single parented adolescents (Wichstrom 2000: Norway); experiences of abuse (Brand et al 1996); family conflicts; parental psychiatric problems.

v) Sexual orientation

Between 2-7 times more likely among gay, lesbian and

bisexual adolescents (eg: Fergusson et al 1999). Such individuals are also more prone to psychiatric problems generally.

"It is not clear if the psychiatric symptoms develop as a result of the stress associated with coming to terms with a minority sexual orientation within one's family or peer culture or by some other mechanism" (Waslick et al 2002 p25).

This may be less relevant to pre-pubertal children if they have not considered their sexual orientation fully.

vi) Substance abuse

Why Do Children Show Less Suicidality than Adolescents?

The rarity in the number of young suicides may be due to a number of possible explanations:

i) Lack of access to sophisticated lethal methods (eg: drugs) or opportunity.

But ordinary methods (eg: jumping into traffic) are available. Dominian (1990) reported the case of a three and half year old boy who threw himself out of 1st floor window.

Hanging is one of the most commonest methods used by children because of the availability of rope in most houses (Kenny 2001).

ii) The lack of major risk factors for adolescent suicide - affective illness, and alcohol abuse (Shaffer et al 1996).

However, the majority of children who do commit or attempt suicide are suffering from a psychiatric disorder at the time of death, and this resembles adolescent and adult suicides (Shaffer and Gutstein 2002).

iii) Limitations in ability to plan the event and lacking level of competence to carry it out.

iv) Younger children may lack a sense of agency or control to take action.

v) A lack of understanding by the child of what thoughts and fantasies about self-injury or death mean in

practice ie a lack of realisation that thoughts can become actions.

vi) The development of a concept of death in children.

Using Piaget's (1965) work on children's cognitive development, an understanding of death takes time to develop. Young children find difficulty in distinguishing between animate and inanimate objects, and thus between alive and dead.

Generally preschool children can see death as temporary, like sleep, or as another kind of existence. Such an understanding could, in fact, encourage young children to attempt suicide (Kenny 2001).

A full understanding of the abstract nature of death as "non-being" is associated with Piaget's formal operational stage of cognitive development after eleven years of age.

vii) Possibly "some as yet unknown biological promoter that only becomes active" after puberty (Shaffer and Gutstein 2002).

viii) Younger children may manifest their unhappiness in ways other than self-harm. They may externalise the unhappiness as disruptive behaviour, or internalise it as anxiety and immaturity.

Physical symptoms, like loss of appetite, stomach pains or sleepwalking, can also be manifestations of unhappiness (depression), even in children as young as four years old (Frommer 1968).

However, all these could be just as true for adolescents.

ix) Misdiagnosis of the cause of death.

For example, a child hit by a vehicle tends to be seen usually as a road traffic accident rather than as a suicide attempt.

Bird and Faulkner (2000) investigated suicide deaths and those from "undetermined injury" (which may or may not be self-inflicted, and also includes accidents).

In England and Wales in 1998, there were no recorded suicides or deaths from self-inflicted injuries for under one year-olds, but 22 deaths by "undetermined injury". For the age group 1-14 years-old, the figures were three and thirty respectively.

CONCLUSION

However, "despite any differences in children's understanding of death, they would, if sufficiently distressed, contemplate suicide although the meaning behind the intention to do so would differ from that of adults" (Kenny 2001 p11).

Footnote

1. In USA 1999 suicide among 10-14 year olds varied between ethnicity and gender: rates per 100 000 were 2.1 (white males), 0.6 (white females), 1.4 (Afro-American males), and no cases for Afro-American females. The preferred methods were hanging and firearms (Gould, Shaffer and Greenberg 2003).

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