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NEW PERSPECTIVES ON MIGRATION, ETHNICITY AND SCHIZOPHRENIA

Abstract
After a quarter century in which biomedical approaches have dominated discussions about schizophrenia and the influence of environmental factors has been neglected, interest in social determinants is reviving. Research in the Netherlands and other countries has demonstrated that the risk of a diagnosis of schizophrenia among certain migrant groups is strikingly higher than the norm and that social factors play a major role in this. In the UK, however, many members of minority ethnic groups regard the increased frequencies of these diagnoses and of compulsory admission as evidence of racism.

This paper examines this new wave of research studies. The hypothesis of ethnic bias in diagnoses of schizophrenia and compulsory admission orders has never been satisfactorily ruled out. In spite of this, there are many indications that the raised incidence of schizophrenia among certain groups of migrants is genuine. Various explanations of this phenomenon are discussed; quantitative and qualitative research methods can usefully complement each other in this area. In conclusion, ways of improving the care of psychotic patients and reducing the frequency of compulsory admissions are examined.

Keywords: Migration, Ethnicity, Schizophrenia
Introduction
Until recently, schizophrenia and related psychotic disorders had never figured large in debates on migration and health. According to received psychiatric wisdom, these disturbances were mainly biological phenomena: schizophrenia was supposed to be a brain disease – moreover, one with a strong genetic component. Regrettably, over a century of research had failed to come up with a ‘biological marker’ for this disease, or to track down the genes responsible, but this was only a question of time. Meanwhile, there was not much point in pursuing research into environmental factors. Especially for the drug companies which financed most of the research, this line of research promised little.

Despite this, since 2000 there has been a remarkable growth of interest in the relations between schizophrenia, ethnicity and migration. This interest stands in a dialectical relation to growing doubts about the validity of the biomedical model. At the same time, criticism is increasingly directed at shortcomings in the care of patients from minority ethnic groups, as well as the pitfalls accompanying compulsory admission of these patients. Cautiously, new treatment approaches are being experimented with.

In this article I will try to review these developments, concentrating particularly on the situation in the UK, the Netherlands, Sweden and Denmark. For reasons of brevity I will leave aside fundamental discussions about the concept of schizophrenia itself. Nevertheless, recent controversies surrounding this topic (see, e.g. Boyle 2002; Blom 2004) are highly relevant to our theme.

The role of environmental factors in schizophrenia
In the past 100 years major shifts of viewpoint have occurred regarding the nature and causes of schizophrenia. At the beginning of the 20th century Emiel Kraepelin considered *dementia praecox* to be a ‘degenerative’ illness. Not only was the patient’s condition certain to deteriorate: the cause of the illness resided in the ‘degeneration’ of the genetic material of the race. Although Eugen Bleuler (who coined the term ‘schizophrenia’ in 1908) held less rigid views, it was Kraepelin’s pessimistic biological determinism which came to dominate psychiatry until the 1960’s.

In that period, against a background of growing criticism of mainstream asylum psychiatry, alternative views of schizophrenia began to be propagated. The spectacular growth of ambulant mental health services was accompanied by a wave of new disciplinary paradigms, therapies and insights. For the ‘anti-psychiatrists’, schizophrenia was not an illness at all, but an exceptional variety of human experience or a normal reaction to abnormal situations. Others did not go as far as this, regarding it as
a mental disturbance – but one originating in ‘pathogenic’ mother-child relationships or patterns of family interaction. Still others sought for the origins of schizophrenia in the collective insanity of modern societies, or the inhumanity of materialistic cultures. The most famous writer of this period on schizophrenia, R.D. Laing, actually held all of these different beliefs at various times.

These theories went hand in hand with an enormous ‘therapeutic optimism’. The regime of the closed psychiatric institution was to be replaced by therapeutic communities, ‘community care’, system therapy or individual psychotherapy.

In practice, however, the new approaches seldom lived up to the high expectations that had been created for them. At the same time biomedical psychiatry launched a determined counter-attack, enabling the traditional view of schizophrenia to make a triumphant comeback during the 1970’s. From about 1980 onwards, few dared to voice doubts about the doctrine that schizophrenia was a brain disease. Only physical treatments (drugs or surgery) were deemed relevant and the search for environmental factors was seen as at best a waste of money, at worst a form of charlatanry.

This consensus held psychiatry in its grip for over twenty years, but since the turn of the century it has come increasingly under fire. Book titles such as the following speak for themselves: Mad in America: bad science, bad medicine, and the enduring mistreatment of the mentally ill (Whitaker 2002); Doing psychiatry wrong: a critical and prescriptive look at a faltering profession (Muller 2007); Alternatives beyond psychiatry (Stastny & Lehmann 2007).

At the same time, researchers within the scientific mainstream have increasingly begun to take an interest in environmental factors. Cantor-Graae (2007) reviewed publications on this topic since 1996. It has been known for a long time that schizophrenia is associated with negative social factors: according to the medical model, this was the result of the illness, not the cause (the ‘social drift’ hypothesis). To determine the direction of causality, longitudinal population studies were necessary. Moreover, because the prevalence of schizophrenia was only 0.4% (Saha, Chant et al. 2005; Bhugra 2005), these studies would need to be very large indeed.

Only in Denmark and Sweden were sufficiently extensive population data available to make adequate longitudinal studies of schizophrenia possible. Using a sample of 1.89 million residents of Denmark, Pedersen & Mortensen (2001) found that urbanisation (the size of the community in which one lives) increases the risk of schizophrenia. Subsequently, Byrne, Agerbo et al. (2004) demonstrated that this was not simply the result of socio-economic differences. In Sweden, Wicks, Hjern et al. (2005) showed
that the risk of schizophrenia was increased by each of the following childhood factors: living in rented accommodation, in a one-parent family, with unemployed parents and in a household receiving social welfare benefits. The presence of all four indicators of ‘social adversity’ increased the risk by a factor of 2.7.

We may note that there is a striking difference between these kinds of environmental factors and those emphasised by writers in the 1960’s and 1970’s. Whereas attention previously focussed on existential issues, recent studies emphasize mainly material factors. The ‘counter-culture’ of the 1960’s and 1970’s was more concerned with liberating the human spirit than with raising the standard of living. Paradoxical demands (‘double-binds’), stifling mother-love, a lack of human recognition and respect for one’s autonomy – these were the things that were supposed to drive people crazy, not a lack of material well-being. In the most recent studies on schizophrenia, however, existential themes such as exclusion, stigmatisation and discrimination are once again coming to the fore.

**Schizophrenia, migration and ethnicity**

In her 2007 review article (*op.cit.*), Cantor-Graae observes that the most convincing evidence concerning the role of the social environment in schizophrenia comes from studies on migration. Alongside socio-economic factors, a personal or family history of migration is increasingly implicated in the development of schizophrenia. In the USA this applies particularly to the figures for ‘African Americans’ (Neighbors, Trierweiler *et al.* 2003) – though the factor ‘race’ would appear to be a more relevant concept here than ‘migration’.

The correlation between schizophrenia and migration has been known about for a long time. For example, Ødegaard (1932) found that the prevalence of schizophrenia among Norwegian immigrants in the State of Minnesota was doubled. However, proponents of the biomedical model had no difficulty explaining this phenomenon. Such differences could reflect genetic variations between races, or they could be the result of selection processes (mentally vulnerable individuals being supposedly more likely to emigrate). To explain the link between schizophrenia, migration and ethnicity in more depth, I will examine recent studies from the four European countries in which this topic has been studied most intensively.

**British studies**

In the UK, large-scale immigration got under way almost immediately after the Second World War. Since that time, dozens of psychiatric studies have demonstrated a raised prevalence of schizophrenia among certain
ethnic groups – in particular, ‘Afro-Carribbean’ and ‘Black African’ (for an overview see Bhugra & Bhui 2001; Bhugra 2005; Fearon & Morgan 2006). The most recent and extensive of these investigations is the AESOP study (Fearon, Kirkbride et al. 2005, 2006; Fearon & Morgan op. cit.). This revealed that for the latter two groups, the risk of being diagnosed schizophrenia is increased by a factor of 9.1 and 5.8. Other ethnic groups showed an increase of 2 or 3 times. The most pronounced effects were found among the second generation – a finding repeated in many other studies. This would appear to shift the emphasis from the migration itself to the circumstances of life in the host country. However, another explanation could be that first generation migrants were less disposed to make use of mental health care services.

Morgan and Fearon (2007) conclude that ‘social adversity’ over the life course is an important factor underlying these increased rates of schizophrenia. However, the exact nature of this ‘adversity’ remains in doubt. These authors found nothing to suggest that the increased rates were due to genetic factors or selective migration.

**Dutch Studies**

Dutch investigations of this topic started to appear much later than in the UK. In this area, the psychiatrist J.-P. Selten has played a pioneering role. Selten & Sijben (1994) and Selten, Slaets et al. (1997) showed on the basis of hospital admissions that there was a higher incidence of schizophrenia among Moroccan, Surinamese and Antillian men, as well as Surinamese women. In out-patient care, Schrier, Selten et al. (1996) found that schizophrenic men from Surinam and Morocco, as well as women from Surinam, the Dutch Antilles and Cape Verde, were overrepresented. This was not the case, however, for people of Turkish origin or Moroccan women.

In a study of first contacts with doctors, Selten, Veen et al. (2001) showed an increased rate of schizophrenia among patients from Morocco, Suriname, the Dutch Antilles and other non-Western countries. Among the second generation, the risk was increased for those with a Moroccan or Surinamese background. No significant increase was found for migrants from Turkey or Western countries.

This study was repeated on a larger scale by Veling, Selten et al. (2006), who found an increased risk among all non-Western immigrants, especially among the second generation. Among second-generation Moroccans, the increase was 7 times compared to the native Dutch population. An analysis of the presenting symptoms (Veling, Selten et al. 2007a) showed that the symptoms of Moroccans on first contact with a doctor were more serious. The authors ascribed the increased risk of schizophrenia among Moroccans
to the low socio-economic status and high rate of perceived discrimination of this group in the Netherlands.

The latter theme was explored in more detail by Veling, Selten et al. (2007b), who found a direct relationship between the level of discrimination and the increased incidence of schizophrenia. In an extensive review of British and American studies, Chakraborty & McKenzie (2002) had posited a similar relationship. Veling, Susser et al. 2008 investigated neighbourhood variations in the incidence of schizophrenia among non-Western immigrants and found that it was lower in neighbourhoods where such migrants were surrounded by many members of their own ethnic group. This echoed studies in the US during the 1930’s (Faris & Dunham 1939) and recent research in London (Boydell et al. 2001).

Characteristic of the studies by J.-P. Selten and his collaborators is an emphasis on ‘social defeat’ as cause of schizophrenia, together with the hypothesis of a specific neural mechanism (see for example Cantor-Graae & Selten 2005). Studies with rats and monkeys have shown that forced submission to other, more dominant animals can lead to increased levels of dopamine in the brain – something also found among humans diagnosed as schizophrenic. However, as these authors themselves admit, it would be pure speculation to assume that this mechanism also underlies the higher prevalence of schizophrenia among migrants. Moreover, it is highly questionable whether dominance-submission relationships among rats and monkeys bear more than a metaphorical resemblance to class, race and ethnic hierarchies among *homo sapiens*. Where humans are concerned, disadvantage and marginalisation often characterise a whole lifetime – they may even go back over generations. Such historical and ideological dimensions are presumably lacking from the ‘social defeat’ experienced by animals in such experiments.

**Swedish and Danish studies**
The relationship between migration, ethnicity and health has also been investigated in these countries. We should bear in mind, however, that the migrant populations here are different: in particular, unlike the Netherlands and the UK, Scandinavian countries have no post-colonial migrants. This is not to say that the legacy of Western colonialism has no influence on ethnic relations in these countries.

In Denmark, Mortensen, Cantor-Graae et al. (1997) discovered that the risk of schizophrenia and other non-affective psychoses among first and second-generation migrants was increased by a factor of 1.7 and 1.9 respectively. A longitudinal study involving more than two million people (Cantor-Graae, Pedersen et al. 2003) found increased rates for schizophrenia
of 2.4 and 1.9. Strikingly, this study also found an increase of 1.6 among ethnic Danes who had returned to their country after a period of living abroad, suggesting a causal role for the migration process itself.

In Sweden, Zolkowska, Cantor-Graae et al. (2001) analysed hospital admissions in Malmö and found a raised incidence of schizophrenia and ‘schizophrenia-like psychoses’ among migrants, particularly those from Africa. Hjern, Wicks et al. (2004), using a nation-wide sample of 2.6 million subjects, also demonstrated a raised incidence among both first and second-generation migrants. However, by linking these clinical data to information about the circumstances in which subjects had grown up, these researchers reached different conclusions from their Danish colleagues. The most likely explanation did not have to do with migration, but with the social situation of migrants in Sweden. “The focus needs to be shifted from immigrant-specific factors to more general themes of social adversity” (op. cit., p. 1032).

Current state of the art
Cantor-Graae & Selten (2005) carried out a meta-analysis on the basis of 18 recent studies of migration, ethnicity and schizophrenia. These studies were drawn from the UK, Netherlands, Denmark and Sweden, as well as one Australian study. The overall conclusion is that a personal or family history of migration, even among the second generation, is an important risk factor for schizophrenia. ‘Psychosocial adversity’ was named as a possible causal mechanism, but the precise content of this notion was not specified. Later, Selten, Cantor-Graae et al. (2007) published a further review of studies on this topic and reached the same conclusions. Veling (2008) gives details of even more recent studies.

Within a remarkably short period of time, we can see that a new consensus has been shaped concerning the importance of environmental factors in the causation of schizophrenia among migrants. Nevertheless, the nature of the social processes underlying this connection remains unclear: the evidence points in different directions. Some studies implicate the migration process itself, while others emphasise the situation in the host country. There is a considerable, though inconclusive, literature on the possible contribution of drug use (especially cannabis) to the onset of schizophrenia among migrants, while other studies emphasise trauma and childhood problems. The concept of ‘social adversity’ remains unpacked: what are the precise features of the social disadvantage that migrants experience which lead to a higher incidence of schizophrenia? It remains highly likely that biological factors, or other types of individual vulnerability, are also involved. After
all, large numbers of migrants experience ‘psychosocial adversity’, while only a tiny percentage of them develop psychotic symptoms.

Qualitative studies may have an important role to play in unravelling the relations between schizophrenia, migration and ethnicity. Oliemeulen & Thung (2007) carried out extensive interviews with patients diagnosed as having a chronic psychosis, 20 of native Dutch origin, 17 Hindustani Surinamese and 16 from Turkey. The original aim of the study was to investigate the ‘explanatory models’ held by patients regarding their illness. However, the patients themselves had little interest in this topic: they did not see their main problem in terms of illness, but regarded their life experiences, living conditions and related hardships as much more important. For example, patients talked at length about relationship problems involving their families, partners or children, about housing, work, migration, poverty and drug use. Alongside all these problems, patients often complained about symptoms which in psychiatry are labelled as ‘psychotic’, such as confusion, hearing voices and feelings of persecution. However, they ascribed a far more important role to their real-life difficulties than to the symptoms of the supposed illness.

In the life-world of these patients, elements could be identified which made recovery exceptionally difficult, if not impossible. On the one hand, a number of risk factors were present, such as violence, loss and longstanding social disadvantage. These factors were particularly noticeable among the patients with a personal history of migration. On the other hand, there was a lack of protective factors, such as secure attachments and a supportive social network. This was evident, for example, when Hindustani families fell apart during and after the migration from Surinam to the Netherlands.

These results, of course, come from a small-scale study, the representativeness of which is unknown. Nevertheless, the research of Oliemeulen and Thung suggests that there may be another way to find out about the adversities people have experienced in their lives, apart from performing multivariate analyses on quantitative data: namely, by asking the people themselves. The answers may not give certainty about cause-effect relationships, but they may yield important clues about the directions in which quantitative studies need to look.

**Doubts about diagnostic validity**

We have been talking up to now about research on schizophrenia, but in reality what we have described are data on diagnoses of schizophrenia. Because there is still no reliable ‘biological marker’ of this supposed brain disease, diagnosis remains a matter of human judgement. Therefore, it is
relevant to ask whether some or all of the differences which we have found among migrants can be ascribed to variations in the diagnostic process. If such variations exist, then most of the studies we have examined come to stand in a very different light. Could the drastically increased prevalences among certain groups be simply the result of bias? Are some psychiatrists \textit{a priori} more inclined to label migrants schizophrenic?

The use of Western diagnostic instruments with people who may have a different cultural background is in any case problematic. The assumption that these instruments (and the assumptions that underpin their use) are universally applicable is, according to Kleinman (1977), a ‘category mistake’. However, if we take this warning too seriously, we end up being unable to make \textit{any} quantitative comparisons between rates of illness among different populations. Besides, a lack of cross-cultural validity does not in itself explain a systematic over-diagnosis of schizophrenia among migrants: it could just as well lead us to expect under-diagnosis.

Nevertheless, a lowered threshold for diagnosing schizophrenia could plausibly be the result of ignorance about the frame of reference within which migrants’ behaviour should be interpreted. If one is not familiar with a person’s cultural and social background, one will be more inclined to experience their behaviour as ‘unintelligible’ or ‘unreasonable’ and to ascribe it to a mental disturbance of some kind. Zandi, Havenaar \textit{et al.} (2007) showed that the use of a standardised diagnostic instrument (CASH) to make diagnoses of schizophrenia in Morocco led to overestimation of the ‘true’ prevalences. When the instrument was adapted to take account of relevant cultural factors, there were fewer diagnoses of schizophrenia and the agreement with assessments by local psychiatrists was improved.

In the view of the distinguished British transcultural psychiatrist Suman Fernando (1991), lack of relevant cultural and social insight can be an important factor underlying the raised levels of diagnosis of psychosis among migrants and minorities. Psychiatrists often have little personal knowledge of the cultural and social milieu from which their patients originate, and are thus poorly qualified to judge their behaviour. For example, some forms of supernatural belief are commonplace among certain groups, while being regarded by psychiatrists as symptoms of ‘paranoia’. White middle-class psychiatrists are not likely to have much notion of the day-to-day reality of migrants – or, for that matter, of other socially disadvantaged groups: for this reason, they may not be able to comprehend what their (sometimes extreme) emotions have to do with. The social gulf separating the life-worlds of most mental health professionals from those of their patients is clearly illustrated in the findings of Oliemeulen and Thung (2007).
Although strictly speaking such ignorance does not constitute ‘racism’, the stereotypes with which many mental health workers fill in this ignorance certainly are racist. The most shocking recent illustration of this was the death of the black mental patient David ‘Rocky’ Bennet in an English mental hospital in 1998. Following a dispute with a fellow patient, Bennet was pinned to the floor for 25 minutes by at least four members of staff, as a result of which he suffocated and died. An independent investigation concluded in 2003 that institutional racism and lack of cultural awareness played a significant role in his death – in particular, the stereotype ‘big, black and dangerous’.

The following scenario (based on Fernando, 1991) shows that stereotyping should not be seen as a static, cognitive phenomenon taking place inside peoples’ heads, but as a dynamic social process which often works as a self-fulfilling prophecy. Consider the case of a black man apprehended by the police because of ‘strange’ or ‘disturbing’ behaviour, which in fact when judged in its context and by the norms of his own community is quite intelligible. The man is taken in custody to await the arrival of a psychiatrist. Being locked up a police cell makes him even more anxious, suspicious and angry and by the time the psychiatrist arrives he is extremely distraught. The psychiatrist is confronted with a confused, highly agitated, incoherent and aggressive individual, convinced that everybody is out to get him, and has little difficulty in reaching the appropriate diagnosis: paranoid schizophrenia. In the hospital, increasing levels of coercion – forcible medication, physical restraint, an isolation cell – have to be applied and in no time, the relationship between the man and his environment is virtually beyond repair.

Fernando’s views have received strong support from many in the British BME (Black and Minority Ethnic) community, who have joined forces in the organisation ‘Black Mental Health UK’. Sashidaran (1993) is another British psychiatrist who sees clear racist tendencies in current mental health care. In the USA, a heated discussion on this topic has raged since the beginning of the 1980’s. Neighbors, Trierweiler et al. (2003) present a review of dozens of studies purporting to show the presence of ethnic bias in the diagnosis of schizophrenia, particularly among black males.

A few studies on the prevalence of schizophrenia (for example Mortensen, Cantor-Graae et al. 1997) refer in passing to the problem of diagnostic bias, but hardly any researchers have really tackled this problem head-on. Unfortunately, the only study in which a serious attempt has been made to control for diagnostic bias – the British AESOP study (Fearon, Kirkbride et al. 2006) – adopts a methodology which on closer examination turns out to be quite incapable of eliminating the possibility of ethnic bias.
In this study a vignette was made of each patient, containing a summary of his or her symptoms and history from which all clues concerning ethnicity had been removed. These vignettes were subsequently judged by a group of experts in order to reach a diagnosis. These ‘blind’ diagnoses agreed in nearly every case with the diagnoses that had originally been made.

The problem with this method, however, is that the ‘blind’ diagnoses were not arrived at on the basis on objective information, but using records written up by the staff involved in admission and treatment. Such clinical notes cannot be treated as a photographic record of behaviour. They are interpretations of the interactions that took place, written from the viewpoint of one participant, and as such are anything but blind. The way the information about the patient is written down will already contain a host of judgements and hypotheses about what is going on. The method used here is therefore quite unable to eliminate the possibility of ethnic bias, any more than a person can pick themselves up by their bootstraps. The only thing which is clearly demonstrated here is that the researchers have not really understood what psychiatry’s critics have in mind when they talk about ‘bias’.

**Ethnic differences in compulsory admission**

Closely related to the issue of the prevalence of schizophrenia is the topic of compulsory admission. Much of the opposition to current psychiatric practice within the British BME community centres on this topic, because the chance that a diagnosis of schizophrenia will be made in the context of a compulsory admission is for ethnic minorities – in particular, for black males – dramatically increased.

Figures on compulsory admission are indeed alarming. On the basis of a meta-analysis of 23 publications prior to 2000, Bhui, Stansfeld et al. (2003) calculated that the chance of compulsory admission was more than four times higher for black patients than for whites. Black patients were also more likely to be referred via Accident and Emergency Departments or crisis services.

The most recent figures (Health Care Commission, 2007) show that the situation has not improved. Black patients are more likely to have entered treatment after contact with the police, and are less likely to use other routes. Forcible restraint and isolation rooms are more often used on these patients; they are more likely to receive medication, and to be given higher doses of medication, as well as being less likely to receive psychotherapy (SCMH, 2002). The UK700 study (McKenzie et al, 2001) also demonstrated that people of Caribbean origin were more likely to receive medication, less likely to receive psychotherapy and more likely to attempt suicide.
Against this background it is very easy to understand why BME groups regard mental health care as ‘racist’. Recent efforts by the British Government to streamline the procedures for compulsory admission, culminating in the Mental Health Act of 2007, have been judged not only by these groups, but also by the Commission for Racial Equality (CRE 2007), to be a serious threat to their civil liberties. Already in 1999, Sashidaran and Francis had this to say about psychiatry:

Psychiatry comes closest to the police among medical specialties in pursuing practices and procedures that explicitly discriminate against minority ethnic groups in the United Kingdom. The disproportionate numbers of black people in psychiatric detention, the overdiagnosis of schizophrenia in black people, the exclusion of black people from the ‘softer end’ of psychiatric practice because they are deemed psychologically unsuitable, the alienation of black patients from mainstream psychiatric services, the general lack of trust and extreme scepticism about psychiatric practice that is evident in minority communities, and the professional preoccupation with theories of ethnic vulnerability or inferiority, which continue to echo the sentiments of 19th century race science, all confirm the similarities between policing the black communities and controlling their minds. (Sashidaran & Francis, 1999:254)

However, orthodox psychiatrists in Britain were quick to organise a defensive reaction. Singh & Burns (2006), for example, argue the case for conventional research methods and claim that the concept of racism is totally out of place in discussions about modern psychiatry. Compulsory admissions have nothing to do with stereotyping: they are purely the result of the high rates of schizophrenia among certain groups and the misguided resistance of patients and their families, who refuse to seek professional help until it is too late. Indeed, talk of ‘racism’ will only exacerbate this situation by increasing the mistrust of psychiatry among minority ethnic groups. Moreover, nobody ascribes the increased prevalence of diabetes among certain BME groups to racism: why should anyone think it affects the rates of schizophrenia?

The last remark – besides revealing the one-sided biological disease model of schizophrenia that used to dominate psychiatry – shows how completely these authors have failed to understand what the critics are concerned about. The point is that a diagnosis of schizophrenia is an extremely serious event in someone’s life. It entails a drastic loss of social status and rights: from that moment on, everything a person says, thinks
or feels can be dismissed as symptoms of their illness. Such a diagnosis is, in fact, an act of social exclusion. It is hard to think of any other condition which is accompanied by so serious a stigma as schizophrenia: to be given this diagnosis is tantamount to receiving a social death sentence. In the study of Oliemeulen & Thung (2007), patients were told by the medical staff that they should abandon any hope of marriage, parenthood or a career – in short, anything approaching a normal life. Without doubt, it can be very upsetting to hear that one has diabetes: nobody in their right minds, however, would regard it as a social death sentence.

The discussions around migrants and compulsory admission are much less heated in the Netherlands than in the UK, but is the real situation actually any better? In the Netherlands there is also ample evidence that people of migrant origin with a diagnosis of schizophrenia are more likely to have been referred to psychiatry by crisis services and to experience compulsorily admission (Mulder, Koopmans et al. 2006). The latter authors attempted to analyse the role of ethnicity in more detail. Using multivariate regression analysis they showed that the effect of the factor ‘ethnicity’ disappears when the severity of the symptoms, the estimated danger to others, and the patient’s insight, motivation and level of functioning are taken into account. Like the authors of the AESOP study described above, these writers conclude that the role of ethnicity itself is negligible.

However, this Dutch study is flawed in precisely the same way as the British one. How free of stereotyping were the judgements concerning symptom severity, danger to others, insight, motivation and level of functioning? The authors admit candidly that these judgements were not made blind and were not even independent of the decision to order compulsory treatment. In fact, they were often made by the same person who signed the order! As the authors themselves say, it would have been far better to try and obtain independent judgements about the severity of the patient’s condition. However, the question remains how objective such judgements could ever be. Bhui (2001) reviews studies showing that black patients are judged to be more dangerous even when their level of pathology is less serious.

In the Netherlands, the Pandora Foundation (an organisation that has been defending the rights of mental patients since 1964) has devoted special attention to the problems surrounding compulsory admission of migrant and minority ethnic patients (Pandora 2007). Netteb (2005) has carried out a qualitative study on these problems. The fact that this issue has been more passionately debated in the UK than in the Netherlands is probably due to the fact that the British ‘BME lobby’ is much stronger and better organised than Dutch migrant organisations. It should not be taken to mean that there is no cause for concern in Holland.
Increased prevalence versus bias: could both sides be right?

As we have seen, recent discussions in the UK about racism and psychiatry have been heated and at times bitter. Despite the fact that the British Government has invested large sums of money since 2003 in a ‘Race Equality Action Plan’ and has elevated the person who master-minded this plan (Professor Kamlesh Patel) to the House of Lords, tensions between the BME lobby and the psychiatric mainstream remain high. Suman Fernando was also offered a high honour for his long record of service to BME mental health care: however, in May 2007 he wrote an open letter to the then Prime Minister, Tony Blair, explaining that he could not possibly accept the honour while the government was pursuing its present policy regarding mental health legislation – in particular, compulsory admission (see The Guardian, 2007). At the heart of the strained relations between psychiatry and the BME community lie the questions of the increased frequency of diagnoses of schizophrenia and of compulsory admissions.

So heated has this discussion become, in fact, that both sides seem to have overlooked the possibility that both of them might actually be right. They seem to share the assumption that if there is a higher prevalence of schizophrenia, then there can be no question of diagnostic bias and excessive use of compulsory admission – and vice versa.

However, these two possibilities are in no way mutually exclusive. In the studies we have been examining, the increased risk of schizophrenia among certain groups (in particular, ‘Black Caribbeans’ in the UK and Moroccan men in the Netherlands) is in the order of 7 to 9 times. According to the latest British figures (Health Care Commission 2007), the relative risk for the group ‘Black Other’ is actually increased 18 times. These are spectacular increases, way above the level usually associated with causal factors in epidemiological research. It seems unlikely, therefore, that only one factor is at work here. In other words: it may be possible – in fact, it seems to me highly likely – that members of certain groups are more prone to develop schizophrenia, and that psychiatrists are more inclined to diagnose schizophrenia in them and are more ready to opt for compulsory admission.

It is clear that far more research attention needs to be devoted to the problems of diagnosis in relation to schizophrenia among migrants. The ‘brain disease’ model of schizophrenia which held sway during the last 25 years led to a certain nonchalance in this regard: schizophrenia was something which you either had or didn’t have, and a trained psychiatrist could be relied upon to spot the difference in anybody. In fact, however, the whole concept of schizophrenia as a diagnostic entity is currently under fire, and not only in relation to cross-cultural differences. There is no single
feature that schizophrenic patients uniquely display, and there may be very little resemblance between the symptom patterns of two people with the same diagnosis.

In relation to migrants, one possibility that deserves to be investigated particularly carefully is that the content of the symptoms may differ between different ethnic groups. Oliemeulen & Thung (2007) reported that chronic psychotic patients with a migration background seemed to have a different profile from the native-born Dutch patients in their study. Morgan & Fearon (2005:120) also discuss evidence from the AESOP study and other sources that indicates a different symptom pattern in ‘black’ patients.

**New approaches to treatment**

Up to now we have been talking about the occurrence and diagnosis of schizophrenia among migrants and ethnic minorities, as well as the pathways to care in these groups. In this section we will look briefly at what happens to these patients once they are in care.

The treatment of schizophrenia cannot be regarded as one of the success stories on modern psychiatry. Despite more than a century of intensive research, surprisingly little progress has been made in finding a treatment for this condition. Symptoms can to a certain extent be suppressed, but a cure is seldom achieved.

According to Whitaker (2002), the predicament of schizophrenic patients in the USA today is actually worse than it was a century ago. This bold assertion is backed up by reference to international studies by the WHO (Jablenksy, Sartorius et al. 1992), which revealed that patients in developing countries diagnosed as schizophrenic actually showed a higher rate of recovery and reintegration into society than patients in the West. A follow-up study (Hopper & Wanderling 2000) confirmed these findings. Cohen, Patel et al. (2007) attempted to soften the blow by emphasising the exceptions and the methodological problems, but for Western psychiatry these findings remain extremely awkward.

The fact that the prognosis for patients in non-Western countries is often better appears to have more to do with the way in which after-care and social reintegration are dealt with in these countries than with treatment itself. Particularly good prognoses are found in India, where (ex-) patients are usually cared for by their families: in industrial societies this is much less likely to happen. In these societies it is also harder for a person with a diagnosis of schizophrenia to make their way back into the labour market.

Oliemeulen & Thung (2007) carried out qualitative research on the care for chronic psychotic patients of migrant origin. The picture that emerged among these patients was one of extreme neglect and hopelessness.
Treatment was often limited to a periodic depot injection. Despite the fact that the problems of migrant patients were often more complex and persistent than those of the native population, these patients were more likely to be entrusted to the care of nursing staff than to psychiatrists or psychotherapists. Few members of staff had much interest in their life-world and social context: after all, most of the staff had been trained according to a biomedical model, in which the focus lay on the symptoms rather than the patient and his or her social environment. In particular, staff members made little effort to involve the family in the care of the patient.

Oliemeulen and Thung conclude that the biomedical model, in particular the strongly reductionistic and deterministic Kraepelinian version which has dominated psychiatry since the 1980’s, is in large measure responsible for the desperate situation of these patients. Recently, sophisticated multidisciplinary guidelines for the care of psychotic patients have been introduced in the Netherlands, in which attention is paid to all aspects of the patient’s life (Landelijke Stuurgroep Multidisciplinaire Richtlijontwikkeling in de GGZ 2005). However, this research suggests that there is a yawning gulf between these recommendations and the reality of existing practice – certainly for migrants.

As already mentioned, this research was based on a small sample of unknown representativeness. Nevertheless, the authors found no indications that practices elsewhere in the Netherlands are very different. Their impression was that chronic psychotic patients with a migrant background are more or less written off in present-day psychiatry. Even worse, the patients are encouraged to write themselves off. At the same time, these patients become impoverished and seriously marginalised – precisely the factors which, according to most recent research, increase the risk of schizophrenia. Therapeutically, this makes about as much sense as handing out packets of cigarettes on a lung cancer ward.

In their book Social Inclusion of People with Mental Illness, Leff and Warner (2006) make a plea for more attention to the living situation and the social integration of patients, in place of the current one-sided emphasis on symptom alleviation. Since the 1990’s, indeed, a ‘recovery movement’ has come into being in the USA, which aims to present an alternative to the exclusion and writing-off of patients with disorders such as schizophrenia (Office of the Surgeon General 1999). It is to be hoped that the new wave of research studies on the causal role of ‘social adversity’ in schizophrenia will give new impetus to these efforts.
How can compulsory admission be avoided?
Recent quantitative studies on compulsory admission of migrant patients are also reflected in the qualitative research of Oliemeulen and Thung (2007). In their study, too, the police station was a more frequent stop on the way to psychiatric care than for non-migrant patients. All too often, professional help was only sought when problems had completely escalated. In spite of this, the compulsory admissions were not experienced by the patients as help, but rather as humiliating and traumatic episodes. Nevertheless, what emerged from the patients’ stories was that the compulsory admissions were often an almost inevitable way of dealing with a situation that had got completely out of hand. The patient’s social environment was unable to cope with him or her any longer. Other research studies have also confirmed that patients with a migrant background are often in a worse condition at the point of admission than other patients. How could this be avoided?

The importance of early intervention
As we have seen, there are indications that this group of migrant and minority ethnic patients are less inclined to seek assistance from out-patient services. This can be due to lack of knowledge about the help available, concern about gossip and stigmatisation, divergent notions about mental health and illness, a poor image of mental health care and a general mistrust of agencies run by the white majority. (The level of participation by ethnic minorities in mental health services is generally very low – see e.g. De Freitas, 2008; Sozomenou et al., 2000). It is well known that such factors can exacerbate and maintain the gap between health care provisions and the migrant and minority population. Against this background, it is particularly incomprehensible that the Dutch government since 2002 has removed all forms of government support for attempts to adapt health care to the demands of a diverse society – all the more so, because in the rest of Europe and in the policies of the EU itself, increasing importance is attached to this issue.

Possible alternatives to compulsory admission
In some countries experiments are already being carried out with measures designed to reduce the frequency of compulsory admissions. Following the example of studies in the USA, Lorant, Depuydt et al. (2007) have shown in Belgium that the most important factor determining compulsory admission is quite simply the lack of any alternative. This factor weighs even more heavily than the seriousness of the symptoms or the danger that patients pose to themselves or others. Among patients with a migrant background, the lack of alternative provisions is particularly acute.
Possible alternatives include ‘assertive outreach’ (Wright, Burns et al. 2003), more intensive cooperation with patients’ families, and making arrangements in advance about what is to be done when a new crisis situation arises. Henderson, Flood et al. (2004) have demonstrated that the use of such ‘joint crisis plans’ can halve the length of compulsory admissions.

However, both reducing the threshold for early intervention and creating alternatives to compulsory admission require an improvement in inter-ethnic relations. What has mainly emerged from our study of the literature is the great degree of mistrust between on the one side, the migrant groups in which a high prevalence of schizophrenia has been found, and on the other side the mental health care system. In England this concerns mainly the Black population; in the Netherlands, the Moroccan, Antillean and Surinamese communities. The gap between these groups and the mental health care system can sometimes be very large indeed. Neither party has much understanding of the other’s point of view – and this reflects the serious tensions and inequalities of power which exist at the social level.

This is probably the most fundamental reason why people from these ethnic groups are only inclined to seek psychiatric help when all other means have failed. All too often, the first professional that they encounter is a police officer. Especially in services for children and youth – where the real task of prevention of schizophrenia lies – there is often a gaping chasm between the care system and the population it is supposed to be helping.

This alienation (which, incidentally, is a lot more than merely a ‘cultural gap’) may also explain why caregivers and managers are often not motivated to improve the quality of care, and why clients are less inclined to follow the advice of the caregivers and take their medicine as prescribed. In my view, proposals for improving health care which ignore these fundamental social realities are doomed to failure.
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The paper draws heavily for its inspiration on the work of Oliemeulen and Thung (2007). Ferdinand Thung was a Dutch psychiatrist who died in 2005 at the tragically early age of 50. His research partner, Lisette Oliemeulen, brought this work to completion despite contracting a serious illness herself. It was a privilege for me to be involved in this project as Ph.D. supervisor and to learn from the insight and dedication of these researchers. In particular, Ferdinand Thung’s approach to schizophrenia was far ahead of its time: hardly a month goes by without a new study being published which shows the far-sightedness and wisdom of his ideas.

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David Ingleby (b. 1942) graduated in Psychology from Cambridge University in 1965. He subsequently worked as a researcher for the Medical Research Council (Applied Psychology Research Unit and Unit on Environmental Factors in Mental & Physical Illness) and taught at Cambridge University (Social and Political Sciences). In 1982 he emigrated to the Netherlands and was appointed Professor of Developmental Psychology at Utrecht University in 1984. From 1985-1988 he was chairman of the Department of Development and Socialisation within the Faculty of Social Sciences and from 1984-1989 member of the steering group responsible for setting up the degree course in Interdisciplinary Social Science.

Since the early 1990’s his work has focussed on health care, cultural differences and the situation of migrants and minority groups. He designed and implemented a programme on Intercultural Psychology within the psychology degree course at Utrecht and in 1999 was awarded a chair in Intercultural Psychology. From 1998 onwards he has been involved in developing the European MA course “Migration, mental health and social care”, initiated by Dr. Charles Watters of the University of Kent.

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David Ingleby was Guest Professor in memory of Willy Brandt at IMER/MIM in spring/summer term 2007.

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