

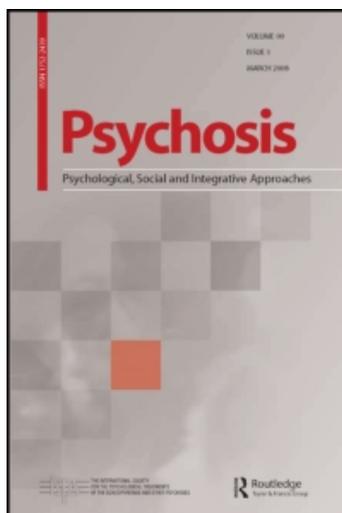
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DSM-5 and the ‘Psychosis Risk Syndrome’

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The current system of diagnosis in psychiatry, whereby complex human problems are reduced to reified entities denoting medical illnesses located in the individual “mind”, is value-laden and likely to be influenced by stereotypes and images of people held in society. The use of psychiatric diagnoses cross-culturally is problematic. Black British people of African-Caribbean ethnicity are over-represented among people given the diagnosis schizophrenia/psychosis. This situation is explicable in terms of cultural misunderstanding coupled with institutional racism. Extending the diagnosis of schizophrenia/psychosis to children and young people by incorporating a category “psychosis risk syndrome” in DSM-5 would have serious consequences for human rights.

Since psychiatric diagnoses have no established biological makers, there is no way of proving objectively their accuracy or scientific validity for indicating specific biological disease or disorder. Therefore “diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organizing and explaining the complexity of clinical experience in order to derive inferences about outcome and to guide decisions about treatment”. The danger in such pragmatic use of a diagnosis is its reification as “an entity of some kind that can be evoked to explain the patient’s symptoms and whose validity need not be questioned” (Kendell & Jablensky, 2003).

Cross-cultural perspectives

The evaluation of a person’s problems, feelings, beliefs and behaviour undertaken in the process of making diagnoses is inevitably value laden (Fulford, Smirnov, & Snow, 1993). The way the human being is dealt with in the psychiatric process is firmly tied up with the thinking about the human condition prevalent in what is roughly called “Western culture” with its values, ways of expressing emotions, beliefs about the self, illness, health, “mind”, etc. (Gaines, 1992; Marsella & White, 1982). Applying this system across cultures is problematic, the basic issue being “category fallacy” – the error of imposing a diagnostic category derived in one cultural context on the study of mental disorders in other cultures (Kleinman, 1977).

British context

Black British people of African-Caribbean ethnicity are over-represented among people given the diagnoses schizophrenia/psychosis (Fearon et al., 2006) – an issue that may be evident in the USA for African-Americans (Chien & Bell, 2008). Misunderstandings resulting from cultural differences may play some part, but evidence from experience of service users and examination of what happens on the ground point to “race” as the main explanation (Fernando, 2010). Racist stereotypes and myths about black people – for instance, about violence, anger and dangerousness – play through images and ideas about people held in society at large feeding into

psychiatric diagnostic practice. This process amounts to institutional racism defined as: “The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amounts to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people” (Home Department, 1999). Most psychiatric research avoids facing up to institutional racism in psychiatric practice, largely because it is based on data where diagnoses are thought of as “things” located within individual minds – *medical* illnesses, which may be acknowledged as being caused by a variety of factors including social ones but, in the final analysis, are assumed to represent biological pathology.

Racism and diagnosis

Research into racial bias in diagnostic habits of psychiatrists was reported by Loring and Powell (1988) in the USA. Using carefully constructed vignettes, they researched diagnostic approaches of 290 black and white psychiatrists to find that (a) overall, black clients compared to white clients were given a diagnosis of schizophrenia more frequently by both black and white clinicians – although to a lesser extent by the former; and (b) all the clinicians appeared to ascribe violence, suspiciousness and dangerousness to black clients even though the case studies were the same as those for white clients (with racial identities obscured). The researchers concluded that black and white people are “seen differentially even if they exhibit the same behaviour” and that these differences “are reflected and legitimized in official statistics on psychopathology”.

Psychiatric diagnosis is always based on a personal interaction involving at least two persons (the psychiatrist and the so-called patient), often influenced by perceptions of several others giving their interpretations of behaviour and emotional states of the person concerned. These may include police, neighbours and the general public with vested interests of various sorts. Diagnoses carry particular images and these get confounded with images about people. For example, alienness – or “otherness” – is an attribute attached to people who appear “foreign” based on how they *look* – their “race”. However, alienness is also linked to images of the mad, the schizophrenic or psychotic. Further, a view of schizophrenia as largely of genetic origin is one that is deeply imprinted in psychiatric thinking – and in general common-sense; and the ideology that black people are genetically tarnished is not an uncommon concept informing thinking about racial difference. This confounding of alienness and biological/genetic inferiority with race *and* schizophrenia/psychosis would promote the use of these diagnostic labels for black people.

Psychiatry is involved in control of people and restriction of their liberty, especially in the case of people diagnosed with schizophrenia or psychosis. If someone designated as a “patient” becomes agitated and perhaps frightened – and even angry – the context in which a psychiatrist makes decisions on management of the patient concerned is fraught by lack of clarity between what treatment is and what control is. So, if the psychiatrist wishes – or thinks it prudent – to prescribe high doses of psychotropic medication because the patient seems to need “control”, the schizophrenia/psychosis diagnosis becomes imperative. Black people get caught in these situations much more often than white people do partly because stereotypes and images play havoc in such situations.

Conclusions

The process of psychiatric diagnosis may appear robust, especially if the diagnostician uses a standardized procedure; yet, the diagnosis could be inappropriate because issues of social and political context are excluded when (as happens in the diagnostic process) complex psychological, social, spiritual, political and interpersonal issues are reduced to a single medical illness located in people’s minds. If, as is often the case in schizophrenia/psychosis, use of diagnosis leads to deprivation of personal liberty or forcible imposition of medication, or if conclusions are drawn about the group concerned (in the case of diagnosis-based research on groups of people, e.g. “African-Caribbean community” in the case of black British African-Caribbeans), the diagnostic process itself is unethical because it results in violating the human rights of the “patient” or misrepresenting communities – or both.

The excessive diagnosis of black people as suffering from schizophrenia/psychosis is very likely to result mainly from institutional racism inherent in society, represented in psychiatry within the diagnostic process. It is proposed that DSM-5 should include a new diagnostic category, “psychosis risk syndrome”, for young people, possibly children (APA, 2010). Since black people already suffer from being excessively diagnosed as “schizophrenic”, the introduction of the proposed new label of “psychosis risk syndrome” could have serious human rights implications for black youth.

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