

Correspondence

EDITED BY KHALIDA ISMAIL

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Racial discrimination and mental illness

Chakraborty & McKenzie (2002) ask: 'Does racial discrimination cause mental illness?' In raising criticisms of their paper, one might risk allegations of political incorrectness, but hopefully readers will feel that science is a more important consideration.

The question that they pose is, to my mind, a simplistic one which 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.

That racial discrimination, like other aspects of social adversity, gives rise to an increased risk of depression is something that all psychiatrists almost certainly find entirely plausible. That it might cause schizophrenia, on the other hand, is surely much more contentious. Psychosocial stressors can undoubtedly precipitate relapse, but I know of no good evidence that such stressors can *cause* schizophrenia. Ethnic differences exist with regard to the epidemiology of multiple sclerosis (e.g. Warren *et al*, 1996) but it would be regarded as absurd to invoke racial discrimination as a causative (or indeed a protective) factor. 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?

Finally, in quoting the work of Boydell *et al* (2001), the authors may be confusing cause and effect. The fact that the incidence of schizophrenia is increased among ethnic minority groups living in London wards which have a lower percentage of ethnic minority inhabitants, may indicate that schizophrenia can give rise to people moving away from their families and their communities of origin.

Boydell, J., van Os, J., McKenzie, K., et al (2001)
Incidence of schizophrenia in ethnic minorities in London: ecological study into interaction with environment. *BMJ*, **323**, 1336–1338.

Chakraborty, A. & McKenzie, K. (2002) Does racial discrimination cause mental illness? *British Journal of Psychiatry*, **180**, 475–477.

Warren, S., Svenson, L., Woodhead, S., et al (1996)
Parental ancestry and risk of multiple sclerosis in Alberta, Canada. *Neuroepidemiology*, **15**, 1–9.

J. M. Eagles Adult Mental Health Directorate,
Block A, Clerkseat Building, Royal Cornhill Hospital,
Aberdeen AB25 2ZH, UK

Drs Chakraborty and McKenzie (2002) seek to answer the question, 'Does racial discrimination cause mental illness?', but in doing so they raise further concerns. They refer to high community prevalence rates of depression in the UK, compared with the countries of origin of minority groups, but very high rates have been reported in indigenous populations from Uganda, the Himalayas and the Indian subcontinent. Further reliable studies would be desirable, but this is not a fashionable field for research. In Manchester, Shaw *et al* (1999) found no difference in rates of common mental disorders between the White and African–Caribbean populations.

When the authors suggest that social and service-related risk factors 'may be better studied using qualitative' rather than 'quantitative epidemiological approaches', this should provoke serious disquiet. If attempts at scientific measurement are to be discarded, what will be put in their place? The accusation that, for example, 'this work is racist' is qualitative enough, but how can its truth be demonstrated or compared with others?

The statement that racism is 'widespread in the UK' is not helpful in itself. Is it worse than in Rwanda or Sri Lanka? And does 'phenotypic difference' refer only to skin colour? The all-White Jewish

population of Europe in the 1940s was not notably exempt from racism – a fact rarely mentioned in this literature. If 'some believe' that minor hostile incidents have a greater impact on health than racist attacks, they have not demonstrated this to be so. Similarly, 'paranoia' cannot, by definition, represent a healthy coping strategy, since it is separated from reality.

It is argued that 'racism produces and perpetuates socio-economic difference'. This may be true to some extent, but most socio-economic difference is unrelated to race. Pre-World War 2, Britain contained only minuscule numbers of non-Whites, yet was rigidly affected by social difference and advantage. Race merely adds an additional factor.

When the question is examined in terms of 'stress', it is usually assumed that this only applies to the host society. Yet the reason people migrate is primarily to escape the stress of their original home. This may take such forms as desperate poverty, corrupt government, climatic disasters, civil strife, absence of essential services, etc. Is it more stressful to live in a 'racist' welfare state or to die in the street of a monoracial African or Asian country?

Two authors are quoted who reported that African and Caribbean patients with psychosis in Britain were more likely to attribute their problems to racism, but in the absence of any comment, it is not clear what we are to make of this.

The relationship between the proportion of ethnic minorities in a local population and their prevalence of mental disorder is said to reflect 'complex interactions between exposure to discrimination, social support, socio-economic factors and social capital'. In other words, just about everything except the kitchen sink. How can any meaningful relationship between factors possibly be extracted from this *mélange*?

A relationship is then suggested between community-level racist attitudes and mental illness in American minority groups, but the only evidence cited is for all-cause mortality, which is totally different and largely unrelated.

Fernando (1991) is quoted as arguing that the European emphasis on an individualised pathology renders psychiatry a racist institution. But in fact, the opposite is more likely to be true. Considering each patient more as an individual respects his/her unique situation, whereas emphasis on 'race and culture' tends to reduce the