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COLLABORATIVE CENTRE

- ETHNIC INEQUALITIES
- SEVERE MENTAL ILLNESS
- MULTIPLE DISADVANTAGE

BRIEFING PAPER

Ethnicity, severe mental illness and a critical approach to the problem with categories

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The Synergi Collaborative Centre

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The Synergi Collaborative Centre is a national initiative, to reframe, rethink and transform the realities of ethnic inequalities in severe mental illness and multiple disadvantage. Taking a collaborative approach, the centre aims to use the principles of co-production of knowledge and a creative mix of robust research methods. The centre will work closely with commissioners, policymakers and politicians, as well as public service providers, citizens and those experiencing mental distress, to create and deliver a vision to help eradicate ethnic inequalities in severe mental illness and their fundamental causes.

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INTRODUCTION

We use categories in order to make sense of the world. A simple example is how we categorise furniture – a chair as opposed to a table, for example. Categories are not just descriptions though, they carry meaning. But meaning cannot be read from just appearance or function. A chair is an example of this, even if only a crude example.

In terms of description, how many legs does a chair have (four or three)? Is it high or low? Does it have a back rest or not? And how do recognised forms of a chair change across contexts and with fashion? In terms of function, is it just something we sit on (as we sit on tables, beds, etc, as well)?

So, the chair is in part about form and in part about how we use/interact with the object. But it is also in part about the meanings that the object carries, meanings that are shared across members of a community. We know what a chair is, what it is used for and where it should be.

The focus of the Synergi Collaborative Centre forefronts three types of category. First disadvantage and, second and third, and more contentiously, ethnicity and severe mental illness. Given that we use categories to define the Synergi agenda, it is worth discussing the advantages and disadvantages of adopting such categories, and how we might make use of them in a critical way to highlight and address problems of inequality, rather than using them in stereotypical and potentially harmful ways.

THE PROBLEM WITH CATEGORIES

The problem with categories is that they are imbued with everyday meanings. They are lay constructs whose meanings we use to make sense of the world, but whose meanings are often not voiced, or directly expressed, and almost never interrogated. Rather, these meanings are taken as given.

This becomes particularly acute when categories are used in relation to social and personal identities. Such categories (gender, race, sexuality, among others) feature in our everyday social interactions. They influence how we make sense of and orientate ourselves to others. See here, at seven minutes and 23 seconds into the video, how Aronda Atkinson talks about her experience of labels/categories. And where such categories carry differential value, which they almost always do, this has material consequences for both those included in, and those excluded from, particular category labels.[1]

Also when a category label is stigmatised and has the potential to subsume other elements of a person's identity, to become a spoiled 'Master Status', as in the case of severe mental illness, the consequences for the individual may reach into all elements of her/his life in profound ways.[2,3]

In addition, social categories are no more than crude and inaccurate summaries of our personal experience and evaluation of a particular dimension of our identity. And this is the case, even if the categorisation is relatively refined. For example, the increasingly refined categories of South Asian, Indian and Hindu each encompass enormous variations of experiences, beliefs, practices and outcomes.[4]

This variation becomes obscured by the use of the category label, because the social meanings attached to the category – in this case they are typically racialised meanings – become applied to all of those falling into that category. For example, here all of those within the category Hindu are racialised in a particular way, even if the ways in which their identities are experienced relate to their particular circumstances, motivations and other dimensions of their social identities, such as gender, age, class and caste, where they live and whether a migrant or refugee.

CATEGORIES, MEANING AND CONTEXT

It is important to note that the categories are lay constructs,[5] and, therefore, their meanings are socially constructed and context dependant. In part this relates to the possibility that in some contexts we may choose to emphasise one dimension of our identity, even just one dimension of our ethnic identity, while in other contexts we may choose to forefront other dimensions.

However, in part this also relates to how externally defined social meanings vary across time and place. Henry Louis Gates famously described how he stated in his application to Yale that: 'My grandfather was colored, my father was Negro, and I am black'.[6] The changing terms reflect the changing meanings and boundaries of categories and how they operate in everyday and official use. So, even when these evolving categories are very negatively racialised, the details of this, as well as their positive connotations, have varied over time, and also vary across contexts.

CATEGORIES, ESSENTIALISATION AND A MORE CRITICAL VIEW OF CAUSE

In the case of the relationship between ethnicity and (mental) illness, these features of categories become particularly problematic. The socially constructed meanings associated with both an ethnic category and an illness category become reified, or essentialised – that is, they are seen to be inherent properties of those in the category rather than reflecting lay understandings of the category.

Those academics, policymakers and practitioners who accept such meanings then consider the correlation between an ethnic category and an illness to be caused by some inherent characteristic of that category. The category becomes the explanation. We have seen this in relation to discussions of the reported higher risk of heart disease for South Asian people. It is widely assumed that unique elements of the genetic make-up of South Asian people produce a metabolic risk, and that core elements of South Asian culture produce behavioural risks, for heart disease.[7]

A more critical examination of the evidence shows, however, that South Asian people in some parts of the world do not have a higher risk of heart disease,[8] that rich South Asian people do not have a higher risk of heart disease,[9,10] and that the higher risk is not shared across all sub-groups (ethnic and religious) in the South Asian category.[9,10] Of course, this evidence does not allow us to entirely escape from deeply embedded racialised meanings – if the higher risk is mainly found in poorer, Muslim, South Asian people – which it is – instead of seeking explanation within an essentialised notion of South Asian, it becomes just as easy to identify explanations that relate to essentialised notions of what it is to be a Muslim South Asian. Explanation can be 'found' in both cultural and genetic characteristics that are claimed to be central to this identity.

Consequently, a crucial step in dealing with both ethnic and illness categories is to acknowledge that an essentialised notion of an ethnic category is not the cause of differential risk for a particular illness. Rather, the ways in which the category is racialised, and the material consequences of this, are likely to be the cause. It is on these processes of racialisation and inequality that the investigation of the causes of the correlation between ethnic and illness categories should be focused.

THE CASE OF SEVERE MENTAL ILLNESS AND ETHNICITY

We don't have to look far to see how this plays out in relation to the increased risk of receiving a diagnosis of severe mental illness for young Black Caribbean men. Explanations drawing from lay, essentialised understandings of both ethnicity and severe mental illness have been sought in relation to genetics, lone parenthood (the absence of father figures), drug use and Black inner-city cultures.

In each case, the focus has been on the nature of being Black Caribbean; the experience of severe mental illness is viewed as an inherent risk of being a Black Caribbean man, meaning the problem is essentialised. Rather, we should focus on how Black Caribbean people are racialised as threatening, dangerous, uncontrollable, etc. And how this then shapes emotions and influences their risks of exposure to racism, of experiencing illness, of being diagnosed with an illness and of being adversely treated for the illness.

HOW CAN WE CRITICALLY USE CATEGORIES?

However, a core issue is that we cannot avoid the use of categories. As already said, they are essential to how we make sense of the world. But both research and policy projects often rely on the stabilisation, or fixing, of categories and consequently run the risk of essentialising the social meanings that shape the inequalities we care about. And, to emphasise, this is also a risk of political projects that aim to celebrate and unify an identity such as Black or Muslim, but often essentialise what it is to be of that identity.

The solution, though, is not to search for a better way of categorising. Of course, we should throw away negative and oppressive forms of categorisation where we can usefully substitute them with a form of categorisation that is more progressive. But we have to live with the categories that are around us, that are used by those we interact with and who we want to influence.

Indeed, we need to find ways of using these categories in a positive and progressive way to expose the existence of inequalities and to demonstrate how these inequalities operate, rather than to box, stereotype, stigmatise and limit people and populations. Central to this is the need to critically address the ways in which categories are used in academic, policy, practice and lay contexts. To do this we need to understand the ways in which identities are constructed, experienced, acted on, and racialised; and the social, economic and health implications of this.

Our way forward is, first, framed by a focus on understanding ethnic inequalities in experience, not on ethnicity as cause. Second, it involves naming the experience of severe emotional distress as an experience of illness, so as severe mental illness – a term that is widely recognised, but one that steps back from a more objectified and biological notion of disease – and recognising that the category of severe mental illness encompasses a wide variety of experiences, just as ethnic categories do.

Third, and perhaps central, is our understanding of both ethnicity and severe mental illness as socially constructed concepts. But socially constructed concepts that reflect real underlying processes that generate inequality. In the case of ethnicity, this is about examining the ways in which having a racialised identity generates a substantial risk of adverse economic and social outcomes. And, also, that the political mobilisation and celebration of such identities might provide powerful resources, particularly if this happens in inclusive ways.

In the case of severe mental illness, this is about examining how the category is fundamentally stigmatised and the implications of that for those so categorised (or diagnosed), especially when it is attached to a racialised identity. But also that the experience of severe mental illness reflects real distress generated by adverse events and circumstances that are often profoundly threatening to the individual. We have argued elsewhere that the various ways in which racism is experienced is one of the factors that shape risk of severe mental illness (as well as a number of other inequalities).[11]

CONCLUDING COMMENTS

So, using categories always risks misclassifications and implies homogeneity within the category. Yet in practice, social classifications are a natural shorthand through which people make sense of the world - and each other. This is also how policymakers and practitioners frame their aims and objectives.

However, these categories, whether of ethnicity or illness, carry with them meanings reflecting processes of racialisation resulting from histories of oppression and violence. Therefore, understandably, there are strong beliefs – ideologies even – about the correct approach to categorisation. We always risk disagreement and divisions over the appropriate use of categories. Yet ethnic classifications, when self-ascribed, are also ways of asserting collective rights and entitlements in ways that can be recognised by those further away from the experiences of racialised groups. Thus, although there are some terms that we are not using within Synergi, indeed that we feel homogenise groups and obscure key issues, such as BME and BAME, there are others we are using to ensure our purpose is clearly signalled, including the term ethnic minority.

This purpose, or motivation, is to address ethnic inequalities and to clearly identify that we are especially focused on the inequalities faced by ethnic minority people with severe mental illnesses. The emphasis here is on illness, experience and narrative, and how this is shaped by racialised inequality, rather than disease or biology.

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ABOUT SYNERGI BRIEFINGS

Synergi Briefings provide evidence summaries, and reflect Synergi's position, approach and values, to build a fairer health care system, and to improve population health. Although embedded in the published evidence, there is much evidence in practice and in unpublished sources, or on websites, or in the memories of organisations that work with ethnic inequalities. We welcome these other sources of evidence and will place them in co-production spaces to develop shared narratives of evidence, and actions which can be taken, to prevent and reduce ethnic inequalities in the experiences and outcome of severe mental illness, and which take account of multiple disadvantage.

We welcome use of the content and discussions about progressive approaches to enhance health and social systems.

Our briefings are free to use, but please do provide the citation as suggested inside the front cover.

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