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Are British Psychiatrists Racist?

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Out of a sample of 220 British psychiatrists, 139 completed a questionnaire regarding a case vignette of a psychotic illness. The sex and 'race' of the vignette were varied and the responses compared. The Afro-Caribbean case was regarded as that of an illness of shorter duration, and requiring less neuroleptics than the white case. Respondents judged the Afro-Caribbean case as potentially more violent and thought criminal proceedings were more appropriate. The female vignette was perceived as less violent, less criminal, and less likely to need neuroleptics. Cannabis psychosis and acute reactive psychosis tended to be diagnosed more often and schizophrenia less often in Afro-Caribbean cases, refuting the claim that psychiatrists tend to overdiagnose schizophrenia in this group. Such 'race thinking' (a form of stereotyping which is distinct from ideological racism) could lead to inappropriate management.

'Race' is "a socially constructed categorisation which specifies rules for the identification of members. Racism is the application of 'race' categories in social contexts" (Husband, 1982). Fernando (1986) provides a more elaborate definition of racism: "behaviour that arises from a belief that people can be differentiated from one another mainly or entirely on the basis of their ancestral lineage . . . some physical characteristic, . . . sometimes by a behavioural characteristic, and that groups of people so characterised are to be treated as different . . . with one or more groups being inferior to others." This definition introduces the idea of inferiority as an integral part of racism. The difficulty surrounding this area has led to the distinction between ideological racism and everyday beliefs about 'race', sometimes called 'race-thinking' (or 'common-sense racism') (Husband, 1982). Race-thinking wrongly assumes that 'race' is an objective fact which explains differences between people, rather than an artificial, socially constructed label. However, unlike ideological racism, race-thinking does not refer to any socio-biological theory. Furthermore, the difficulties in defining inferiority, a debatable value judgement inherent in ideological racism, are avoided.

In the last decade there has been concern over the apparent increase in the rates of compulsory treatment, police involvement, and prescription of long-acting neuroleptics among Afro-Caribbean immigrants and their descendants with psychotic illness (Littlewood & Cross, 1980; Ineichen *et al*, 1984; McGovern & Cope, 1987; Fahy *et al*, 1987). One explanation for these worrying statistics is that psychiatrists and the police are not exempt from the racist beliefs and attitudes prevalent in British society (Burke, 1984), and that these attitudes could bias psychiatric diagnosis and treatment. Littlewood & Lipsedge (1981) suggested that psychotic reactions in British Afro-Caribbeans are more likely to be misdiagnosed as schizophrenia. In addition, Littlewood (1988) noted that the diagnosis of cannabis psychosis is applied more frequently in this population despite the lack of convincing evidence supporting a major aetiological role for cannabis in severe psychosis (Onyango, 1986). In short, it has been argued that mentally ill British Afro-Caribbeans are treated more punitively and more likely to be 'labelled' with the stigmatising diagnoses of schizophrenia or cannabis psychosis because of racist attitudes among psychiatrists (Littlewood & Lipsedge, 1981; Mercer, 1984; Cox, 1986; Littlewood, 1988).

Evidence has also emerged suggesting an increased incidence of schizophrenia among British Afro-Caribbeans (Rwegellera, 1977; Dean *et al*, 1981; Cochrane & Bal, 1989), despite using standardised assessment intended to minimise diagnostic bias (Harrison *et al*, 1988). This increased incidence has been used to explain differences in the rates of compulsory treatment (McGovern & Cope, 1987; Fahy, 1989), as such treatment and the use of biological therapies are appropriate given a diagnosis of schizophrenia. Some authors still implicate societal racism as a possible cause of the increased risk of schizophrenia (Littlewood & Lipsedge, 1988).

The purpose of the present study was to examine race-thinking in psychiatrists working in Britain. One approach to a psychological understanding of this phenomenon is the concept of stereotypes: "oversimplified, rigid and generalised beliefs about groups of people in which all individuals from the group are labelled with the perceived characteristics of the group" (Harré & Lambe, 1983). Stereotypes can be studied using the case-vignette method, in which subjects are randomly allocated short case descriptions and asked to complete questions on management, clinical features, and attitudes (e.g.

Lewis & Appleby, 1988). The information presented is kept sparse deliberately, to force the respondents to call upon their beliefs, attitudes, and prejudices; stereotypes are needed to complete the questionnaire. The experimental nature of this method is another important advantage. Critical variables in the 'cases' can be manipulated independently of all potential confounders and the respondents can be randomly allocated to the different conditions.

The case-vignette method has been used to study diagnostic bias according to 'race'. Loring & Powell (1988) in a sample of US psychiatrists found that diagnosis, using DSM-III (American Psychiatric Association, 1980), was influenced by the 'race' (and sex) of case vignettes, despite warnings that the reliability of their diagnoses would be examined. Ford & Widiger's (1989) study, using the same methodology, showed a sex bias in the diagnosis of DSM-III histrionic and antisocial personality disorders.

The attitudes, proposed management, and diagnoses of practising psychiatrists were studied using the case-vignette method. The aim was to examine how psychiatrists' responses differed when presented with Afro-Caribbean and white psychotic 'patients'.

Method

The names of 220 psychiatrists who lived in England, Wales or Scotland were randomly selected from the 1985 Membership List of the Royal College of Psychiatrists (approximately 10% of total – Department of Health and Social Security (1987)). Those who were described as registrars and senior registrars, those who were retired and those listed as being child psychiatrists were excluded. The survey was carried out in early 1989. Subjects were randomly allocated one of four brief case histories, which they were asked to read before completing and returning an accompanying questionnaire. They were told that we were interested in attitudes to community care. The real purpose of the study was not explained.

The four case histories differed from each other in one particular detail. The amount of information was deliberately restricted. The first case history was as follows.

> A 23-year-old woman has recently become unemployed. Her family called the police because she had damaged furniture, been acting in a threatening manner, and been verbally aggressive. She has no past psychiatric history but the family noted that she had spent more time in her room alone, reading religious books, which seemed to follow the death of a close friend. They also suspect that she had been smoking cannabis. Her father is a British Rail ticket clerk and her mother a housewife. There are two younger sisters and an elder brother. The only family history of mental illness is in an aunt who spent several years in a mental hospital. She drinks two units of alcohol per week and denies drug abuse.
>
> She is a fit white woman who appears agitated and paces around. She does not complain of depressed mood but says she heard a voice telling her that the world was ending. She also believes that the neighbours are plotting to kill her and that they are poisoning the milk. There are no other mental-state abnormalities.

This case was modified slightly in the following ways: case 2, the patient is an Afro-Caribbean female; case 3, the patient is a white male; case 4, the patient is an Afro-Caribbean male.

Subjects were asked to give their sex and age and provide details about previous experience, medical school of graduation, and main clinical setting (community, mental hospital, or general hospital). They were asked to record their views of mental illness on a biological–social continuum and their position on community care.

The questionnaire also included 23 semantic differentials with a six-point scale, designed to elicit one aspect of the assessment or management of the case. Most of the items placed emphasis on management and included statements designed to examine the hypothesis that racist attitudes would lead to a more custodial, less psychotherapeutic, less sympathetic plan of management (Table I). The semantic differentials were scored so that a higher score represented agreement with the statements listed in Table I. For instance, a response at the end of the scale 'Risk of violence to staff' scored five, and a response at the end 'No risk of violence to staff' was scored zero. It is difficult to know how the absolute values of the semantic differential scores would correspond to actual attitudes or practice. For this reason the analysis will concentrate on the *relative* differences between groups.

Each subject was asked to complete the questionnaire and then choose the three most likely diagnoses in order of preference from the following: schizophrenia, affective psychosis, cannabis psychosis, acute reactive psychosis, schizotypal personality disorder, and pathological grief reaction. The diagnoses were restricted in this way to simplify the analysis.

Results

Twenty-nine of the 220 psychiatrists were either retired or deceased. Of the remaining 191, 139 (73%) completed the questionnaire; a further 10 replied refusing to participate. There were 118 (85%) men and 21 (15%) women in the final sample. Mean age was 49 years (s.d. 9) and mean years of experience in psychiatry was 21 years (s.d. 7). There were 107 (79%) UK graduates, 16 (12%) had graduated from medical schools in less developed countries, and 13 (9%) graduated from other foreign medical schools (the other three had data missing). Sixty-three (47%) of the final sample worked mainly in mental hospitals, 43 (32%) in general hospitals, and 9 (7%) in the community. The remaining 19 (14%) for whom data was available worked in other settings, including the private sector.

There was no significant difference between the characteristics of the respondents on the four versions of the case vignette on age, medical school, or years of experience. However, there was a systematic distribution of sex of respondent ($\chi^2 = 9.2$, d.f. 3; $P = 0.03$). This is accounted for by the lack of female psychiatrists examining case 2 (black female), which occurred by chance, despite a correct randomisation procedure. Hence analyses which include the sex of respondent are not presented. We

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TABLE I
Means (s.e.m.) scores for semantic differentials[1], by race of vignette

Statement about patient	*Race*		*Significance*		
			parametric:		*non-parametric:*
	white	*black*	*t*	P	*Wilcoxon*
Admission as an in-patient is indicated	3.79 (0.14)	3.68 (0.16)	0.53	0.60	0.60
Admission as a day patient is indicated	2.72 (0.19)	3.27 (0.22)	1.87	0.06	0.07
Section 2 indicated	3.01 (0.20)	3.13 (0.21)	0.39	0.69	0.70
Not a suicide risk	2.81 (0.15)	3.00 (0.16)	0.85	0.40	0.33
Risk of violence to staff	2.41 (0.15)	2.87 (0.13)	2.29	0.02[2]	0.03[2]
Risk of violence to family	2.86 (0.14)	3.08 (0.12)	1.12	0.27	0.39
Suitable for proposed community treatment order	2.62 (0.19)	2.69 (0.21)	0.24	0.81	0.85
Neuroleptic treatment indicated	4.26 (0.12)	3.71 (0.18)	2.57	0.01[2]	0.02[2]
Duration of illness likely to exceed three months	2.61 (0.20)	1.94 (0.19)	2.36	0.02[2]	0.03[2]
Cannot be managed in the community	2.92 (0.18)	2.77 (0.18)	0.57	0.57	0.53
Cannabis a major contributor to mental state	1.96 (0.15)	2.13 (0.16)	0.78	0.43	0.35
Locked environment needed	0.74 (0.13)	0.96 (0.14)	1.10	0.27	0.11
Police involvement appropriate	1.74 (0.23)	2.05 (0.22)	0.97	0.33	0.26
Attendance at job centre might be unhelpful	3.71 (0.17)	3.48 (0.17)	0.97	0.33	0.19
Bereavement counselling not indicated	2.55 (0.20)	2.46 (0.18)	0.32	0.75	0.82
Should be charged with criminal damage	0.33 (0.11)	0.43 (0.09)	0.69	0.49	0.02[2]
Should be remanded in custody	1.14 (0.23)	1.68 (0.27)	1.55	0.12	0.07
Difficult to establish rapport	3.10 (0.13)	2.85 (0.14)	1.33	0.19	0.26
Unlikely to comply	3.38 (0.14)	3.28 (0.12)	0.56	0.58	0.42
Family counselling not indicated	1.61 (0.18)	1.71 (0.18)	0.41	0.69	0.50
Do not refer to community self-help group	1.43 (0.18)	1.93 (0.21)	1.79	0.08	0.07
Offer genetic counselling	0.50 (0.12)	0.57 (0.12)	0.42	0.67	0.29
Antidepressant treatment not indicated	3.23 (0.18)	3.21 (0.20)	0.07	0.95	0.99

1. Scored 0–5, higher scores indicating agreement with statement about patient.
2. 'Significant' results.

adjusted for the possible confounding effects of sex of respondent using multiple-regression methods, and this did not alter materially the results presented below.

'Race'

The overall effect of the 'race' of the 'case' was found to be statistically significant when assessed irrespective of sex, by multivariate analysis of variance (MANOVA) with all 23 semantic differentials as the dependent variables ($F_{23,90}=1.71$; $P=0.04$). The full results for each semantic differential are shown in Table I. Tests of significance of the difference between scores were calculated by both parametric (*t*-test) and non-parametric methods (Wilcoxon's rank test) since some of the distributions of scores are skewed. Multivariate analysis of variance was used because the possibility of a type 1 error was increased by multiple hypothesis testing.

Sex

The overall effect of sex of the vignette, irrespective of race, was assessed using a MANOVA ($F_{23,90}=1.63$; $P=0.05$). Four of the items differed significantly at the 5% level (Table II). Although it was felt more appropriate to charge men with criminal damage, the responses indicated that this was not regarded as appropriate overall.

Interaction between sex and 'race'

As response to some items appeared to be influenced by the sex of the vignette *and* by race (Tables I, II), it might

TABLE II
Influence of sex of vignette on mean (s.e.m.) scores for semantic differentials

Statement about patient	*Male*	*Female*	t	P	*Wilcoxon*
Risk of violence to staff	2.83 (0.14)	2.40 (0.15)	2.14	0.03	0.05
Risk of violence to family	3.24 (0.12)	2.67 (0.14)	3.07	0.003	0.004
Neuroleptic treatment indicated	4.22 (0.12)	3.79 (0.18)	1.99	0.05	0.04
Should be charged with criminal damage	0.54 (0.13)	0.21 (0.06)	2.30	0.02	0.04

be reasonable, *a priori*, to suggest that black men might be subject to racial stereotypes more readily than black women. It is therefore necessary to examine the data for an interaction between sex and 'race'.

This hypothesis was examined using MANOVA. There was no statistical support for an interaction using all 23 items ($F_{23,88} = 1.04$; $P = 0.4$), although there was support for independent effects of race ($F =_{23,88} = 1.66$, $P = 0.05$) and sex ($F_{23,88} = 1.58$; $P = 0.07$). This result indicates that the effect of 'race' cannot be explained by the sex difference.

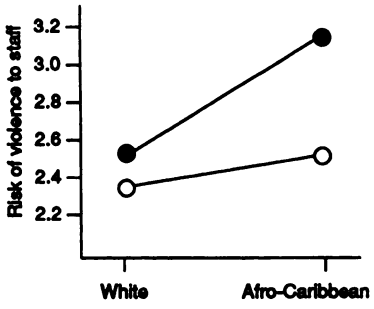

FIG. 1 The interaction between sex (●—● male, ○—○ female) and 'race' on increasing risk of violence to staff.

There was some indication, however, after thorough scrutiny of the data, that one item, 'Risk of violence to staff', illustrated an interaction (Fig. 1), with black males being regarded as potentially more violent. This could not be demonstrated statistically using an interaction term ($P = 0.25$), although this could have resulted from a lack of statistical power.

Diagnosis

Respondents were asked to give their three most likely diagnoses in order of preference. Schizophrenia was more commonly diagnosed when the hypothetical patient was white (Table III; $z = 1.54$; $P = 0.06$, one-tailed t-test) and there was a slight excess of acute reactive psychosis in the Afro-Caribbean group. When each diagnosis was considered in turn, the only group difference that reached significance was for cannabis psychosis (Wilcoxon's rank test, $P = 0.04$). Although cannabis psychosis was rarely chosen as a primary diagnosis in either group (Table III), it was more commonly given second or third place in the Afro-Caribbean group.

Table III also gives results for the item 'Risk of violence to staff' stratified by diagnosis. It can be seen that the Afro-Caribbean group still show higher scores within each diagnostic category. Although the small numbers prevent statistical analysis, the group difference illustrated here cannot be explained in terms of diagnostic preference.

There was no indication that the sex of the vignette influenced diagnosis.

Experience and 'race' of psychiatrist

The sample was divided into three groups according to the number of years' experience in psychiatry. We examined the following six items: risk of violence to staff and family, neuroleptic treatment indicated, duration of illness, and need for criminal proceedings including remand. A MANOVA showed that more experienced psychiatrists gave significantly and consistently lower scores ($F_{6,123} = 3.47$; $P = 0.003$). To examine whether the 'race' of the psychiatrists influenced their attitudes to the patient we asked them to state where they obtained their qualifications in medicine. It was felt that a straightforward question about ethnicity would prime the respondents to be more conscious of their attitudes towards different 'racial' groups and so this question was not asked. There was no statistical evidence to support any difference between the attitudes of foreign-trained and British-trained graduates.

Discussion

The results support the notion that the 'race' of a patient influences clinical predictions and attitudes of practising psychiatrists. Furthermore, it is possible to extrapolate a stereotype of a black person presenting with a psychosis. This stereotype consists of an illness of short duration, more likely to lead to violence, in which criminal proceedings are slightly more appropriate, and in which neuroleptic medication is less likely to be necessary. It most easily fits the rubric of brief/acute reactive psychosis and may be especially strong in a male patient. The

TABLE III
Frequency of most favoured diagnosis and perceived risk of violence, by race of case vignette

Diagnosis	*Frequency of diagnoses*		*Risk of violence to staff*[1]	
	Afro-Caribbean	*white*	*Afro-Caribbean*	*white*
Schizophrenia	20 (38.5%)	32 (49.2%)	2.75 (0.24)	2.66 (0.24)
Affective disorder	11 (21.2%)	12 (18.5%)	3.28 (0.24)	2.77 (0.33)
Cannabis psychosis	4 (7.7%)	5 (7.7%)	3.00 (0.41)	2.80 (0.80)
Acute reactive psychosis	16 (30.8%)	13 (20.0%)	2.87 (0.30)	2.15 (0.32)
Pathological grief reaction	1 (1.9%)	3 (4.6%)	-	-
Schizotypal personality	0	0		
Total	52	65		

1. Mean score (s.e.m.) on semantic differential.

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diagnosis of cannabis psychosis was considered more often in the Afro-Caribbean group, although it was infrequently applied. More importantly there was a suggestion that schizophrenia was *less* likely to be diagnosed in the Afro-Caribbean group. This was unexpected considering claims that schizophrenia is overdiagnosed in blacks in the USA (Loring & Powell, 1988). The 'race' of the vignette did not appear to determine whether treatment should be community or hospital orientated, nor did it lead to unequal estimates of depression.

The study sample was intended to be representative of consultant psychiatrists working in Britain today and the response rate was 73%. The group were very experienced (mean 21 years) and this may limit the generalisability of the data; junior psychiatrists will also have an influence on diagnostic and management decisions. In addition, older psychiatrists appeared to predict less violence and a better outcome. A further limitation on the generalisability is the use of a single case description, as particular facets of the case could have elicited (or concealed) the psychiatrists' racial stereotype.

The main aim was to examine the differences between scores which can be attributed to the 'race' of the vignette. This was interpreted as evidence for a racial stereotype. The mean responses on neuroleptic treatment, for instance, showed that on average the psychiatrists thought that neuroleptics were indicated for both black and white vignettes. The same argument applies to the criminal damage item, as few psychiatrists thought legal proceedings were justified. We stress that it is the presence of a difference between the scores, irrespective of its size or absolute value, which supports the notion of a racial stereotype.

It should be emphasised that the current study examined attitudes to a hypothetical case and may not be a true reflection of actual practice. Respondents may also have been aware that attitudes to 'race' were under study and so racist views would be modified in the direction of social desirability. However, this would not explain the increased likelihood of violence and charging with criminal damage in the black group. Moreover, gender of the case vignette produced an effect in a predictable direction (i.e. women less violent, less in need of custodial care), lending indirect support for the validity of the method.

Among the aims of the study was to examine interactions between 'race' and other variables including sex of vignette. Unfortunately, the low statistical power of the small sample size will increase the chance of type II errors (false negative). For example, the effect of 'race' on perceived violence was approximately five times greater in the male compared with the female vignette (Fig. 1) but failed to reach conventional levels of statistical significance. We were even more restricted in examining interactions between black psychiatrists and black cases, as we chose not to ask subjects a question on ethnicity, and there were few psychiatrists who trained abroad and none who trained in the Caribbean. On this point, Loring & Powell (1988) found that both black and white psychiatrists in the US were biased similarly by the 'race' of a case vignette.

Racism and psychiatry

Commentators who have emphasised the importance of racist attitudes in psychiatry (Burke, 1984) have presumed a somewhat different racial stereotype to that described here. While sharing some features in the above, it also includes overdiagnosis of schizophrenia, increased use of custodial care, and heavy doses of neuroleptic drugs (Littlewood & Cross, 1980; Littlewood & Lipsedge, 1981). However, in this study there was no indication of a greater readiness to detain patients compulsorily or to manage them on a locked ward merely on the grounds of 'race'. Also, the results suggest that the increased prevalence of schizophrenic disorders recorded in a number of studies (McGovern & Cope, 1987; Harrison *et al*, 1988) cannot readily be ascribed to tendencies among British psychiatrists to overdiagnose schizophrenia in black people: a trend in the opposite direction was noted. The stereotype elicited here is consistent with the influential early descriptions in the literature of psychotic reactions in Afro-Caribbeans (Littlewood & Lipsedge, 1981).

At first glance, some aspects of the stereotype such as diagnostic preference may seem reassuring. However, we believe that any racial stereotype has harmful consequences, especially where it interferes with clinical judgement. For example, the duration of psychosis in Afro-Caribbeans is no shorter than in whites (Harrison *et al*, 1988), and failure to acknowledge the true prognosis may lead to inappropriate management. Finally, a tendency to ascribe psychotic reactions to cannabis may also deflect from proper management (Pilowsky & Moodley, 1989). The criteria for the diagnosis of 'cannabis psychosis' are poorly defined and at present, the best conducted study in this field pointed to a possible role of cannabis in increasing the risk of schizophrenia (Andréasson *et al*, 1987).

Conclusion

The racial stereotype elicited here contains some aspects that most people would regard as implying

inferiority; for instance, the attribution of increased violence and the appropriateness of criminal proceedings in Afro-Caribbeans. However, the other aspects are not so clearly pejorative. The evidence for a racial stereotype provided here, irrespective of any implied inferiority, supports the view that race-thinking is prevalent among British psychiatrists. Race-thinking distorts all social interactions, including the psychiatric assessment, and thus undermines the 'objectivity' of psychiatric diagnosis and management. There is no indication that interpersonal aspects of care such as ability to establish a rapport, counselling and predicted compliance are prejudiced on grounds of race. Rather there is a tendency to expect brief, perhaps cannabis-influenced, violent psychotic reactions of limited duration and in less need of neuroleptic medication.

Although some commentators have argued that racism in psychiatrists merely reflects racism in British society, the content of the stereotype may be more influenced by professional literature and training. We hope that by highlighting the nature of this stereotype its unwitting use may be prevented.

The term 'racism' may be applied to some British psychiatrists, but such accusations seldom change beliefs or behaviour for the better. We suggest that race-thinking is a wider problem, and though less obvious and obnoxious than outright ideological racism, it is still an unseen and damaging influence.

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