Community-initiated research: a study of psychiatrists' conceptualisations of 'cannabis psychosis'

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Concern among black and ethnic minorities with current research in 'transcultural psychiatry' entails future work taking into account their collaboration to minimise the possibility that it is prejudicial to their interests. An instance is given of a project initiated by black community groups which looks at psychiatric conceptualisations of a diagnosis commonly used locally in inner-city Birmingham: cannabis psychosis. Responsibility remains with the researcher.

The study

Black and ethnic minority groups in Britain have provided the opportunity for much psychiatric research in the area of what has become generally known as 'transcultural psychiatry'. Over 80 papers and four books have been published which have focused largely on epidemiology and on differences in the psychiatric phenomenology of patients from these groups as contrasted with the white British-born population. Little attention has been paid to service provision, or to minority patients' perceptions of mental illness and the available facilities. The theoretical perspectives chosen have usually ignored social context whilst placing particular emphasis on 'race' or 'culture' as the independent variable requiring further (but unspecified) elucidation.[1]

Over the last few years, a number of minority groups have called attention to this focus on differential pathology and to the lack of interest in those cultural factors which might contribute to lower rates of illness, such as the relative infrequency of alcohol related admissions among the Afro-Caribbean population. It has been suggested that the medical categories used in this area are less free of political context than elsewhere.[2,3] Similar points have been made in the United States where, unlike Britain, they have long been accepted as an appropriate area for research.[4] Some writers have called for a moratorium on all psychiatric research focused on minority groups, or at least for an assurance that it should involve their participation, and that it should be aimed at improving services rather than attempting to answer questions of purely academic interest. Thus, a policy document prepared by a Birmingham-based group which links mental health workers including psychiatrists, with lay members of local black and other minority groups, emphasises that research should involve such groups who might wish to initiate projects of their own: academics could either advise, offer technical assistance or carry out the project.[5]

The focus of minority groups in the area of research is likely to be very different from the conventional themes of transcultural psychiatry. In 1986 I discussed possible research needs with the Birmingham Community Relations Council, members of the Wolverhampton Rastafarian Progressive Association, a number of West Indian churches and voluntary groups, and with colleagues in the Forward Planning Group. A matter of considerable concern was the relationship between cannabis (*ganja*) use and psychiatric admission in the Afro-Caribbean community. Whilst some in the community did feel that cannabis use was likely to precipitate a psychiatric illness (a common belief in the Caribbean itself[6]), others suggested that the diagnosis of 'cannabis psychosis' was used to admit under the Mental Health Act a considerable number of young black men who had various situational crises. An epidemiological study at the time found that 27% of local male Afro-Caribbean psychiatric patients were diagnosed as having 'cannabis psychosis',[7] a diagnosis given to only 1.4 of white males (a 95-fold difference in terms of rates). Ten years previously, however, the diagnosis was seldom used locally for any group.[8] Some community members suggested that this relative prevalence did not reflect the actual differential use of cannabis in the two groups as it was extensively smoked by the local white working class.[9]

Increased prominence was given to the issue by evidence offered to the Silverman inquiry into the Handsworth riots by a local psychiatrist, who implicated cannabis ingestion as a causative factor. This view was extensively (and critically) reported in the local black press. Concern was expressed that, whatever the psychiatric consequences of cannabis might be, 'cannabis psychosis' was a particularly broad term which was being employed in situations where psychiatrists had not taken enough time to understand the social antecedents of personal crises. Because of the popular association of cannabis use

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with the black community, the use of the diagnosis had, in addition, the effect of 'pathologising' it: if West Indians used cannabis, and cannabis caused psychological difficulties, then the stresses black people in Britain experienced could be said to be, in part, a function of their own chosen way of life.

It was suggested that two questions could usefully be addressed: What were the actual psychiatric consequences of cannabis use? What was the current medical understanding of 'cannabis psychosis' and, given the serious implications, was there an accepted consensus? It was emphasised that the findings should be made accessible to the community itself. The first question is the subject of a proposal in progress, and has been addressed intermittently in the psychiatric literature without any agreement as to whether cannabis is necessary and sufficient to produce a specific reaction or whether it may serve as a non-specific stressor in those already vulnerable.[10]

The psychiatric conceptualisation of 'cannabis psychosis', the second question, was examined with a questionnaire sent to the 132 consultant psychiatrists and senior registrars in the Region, enclosed with a stamped addressed envelope for return.

The findings

One hundred and sixteen questionnaires were returned, 12 of which were not completed on the grounds of lack of experience. The remaining 104 responses are reported here question by question:

(1) Do you find *cannabis psychosis* a useful diagnosis?
Yes 40, No 64

(2) Do you use this diagnosis yourself?
Yes 33, No 71 (3 incomplete questionnaires reported 'No', none 'Yes')

(3) Is cannabis psychosis, as the term is used, a reaction which is specific to the use of cannabis or is the cannabis a non-specific precipitant?
Specific 22, Non-specific 79

(a) If cannabis psychosis is a *non-specific reaction*, which *one* of the following diagnostic categories is most commonly represented?

Schizophrenia	23
Mania	2
Depressive psychosis	1
Paranoid psychosis	21
Toxic confusional state	25
Dissociative state	5

(b) If it is a *specific reaction* which of the following items do you feel are characteristic of it?

Auditory hallucinations	12
Delusions of persecution	13
Clouded consciousness	12
Dissociation	7
First-rank symptoms of schizophrenia	3
Emotional lability	11
Grandiose delusions	9
Depressive symptomatology	3
Physical aggression	2
Visual hallucinations	9
Anxiety	5
Hypomanic affect	8
Agitation	12
Lethargy	2
Incoherent speech	10
Hypochondriasis	0
Delusional mood	9
Depersonalisation	6
Poor concentratioin	16
Suicidal ideation	0
Social withdrawal	3
Ideas of reference	8
Blunted effect	2
Flight of ideas	6
Thought disorder	7

(5) Are patients with cannabis psychosis more likely to be detained under the Mental Health Act than other patients?
Yes 26, No 55 (?20)

(6) Is cannabis psychosis a self-limiting condition?
Yes 62, No 15 (?27)

(7) The single most appropriate treatment:

Major tranquillisers	70
Reassurance	11
Benzodiazepines	0
ECT	0
None of these (please specify what)	9*

*All 9 specified symptomatic treatment or none.

(8) Do you think cannabis psychosis is more common among people of Afro-Caribbean origin (West Indians?)
Yes 59, No 23 (?22)

(9) If you answered Yes to the last question is this because:

They smoke more cannabis	45
They are more susceptible to cannabis psychosis	3
Both of these	9

(10) In general, is the smoking of cannabis a significant mental health risk?
Yes 30, No 52 (?22)

Comments

While any attempt to explain clinical procedures to our patients and their community is surely to be welcomed, in the case of a controversial diagnostic entity which has little academic standing, it is difficult to present the findings in a helpful way. To an extent this is the consequence of the short questionnaire: it is unlikely that any psychopathological consequences

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of cannabis ingestion will be neatly related to a specific syndrome as necessary and sufficient. What conclusions can be drawn from this project and usefully shared with the Afro-Caribbean community?

Firstly, most local psychiatists do not, in general, regard cannabis as a 'significant' agent of psychopathology, nor do they use the term 'cannabis psychosis' (Questions 10, 1, 2). On the general understanding of the term as used, they suggest it implies a precipitation of a non-specific illness (Question 3), and thus presumably presents no more of a characteristic phenomenological pattern than, say 'unemployment-precipitated depressive illness' or 'amphetamine-precipitated schizophrenia'. As to which reaction it is most likely to precipitate, there is an equal division of opinion between two functional psychoses (schizophrenia and paranoid psychosis) and a toxic confusional state (Question 4a). Mania was not implicated, although the only controlled prospective study conducted emphasises the 'hypomanic features'.[10] Those who favour a discrete and unitary syndrome of 'cannabis psychosis' offer a variety of clusters of symptoms from the list offered (taken from the PSE Syndrome Check List as those most frequently described locally as constituting the reaction). Of these, only five were accepted by more than half: poor concentration, delusions of persecution, auditory hallucinations, clouded consciousness and agitation. Only one, poor concentration, was accepted by more than 60%. Of interest is the salience of persecution previously reported as a common experience among black psychiatric patients.[11] What does perhaps seem a little difficult to understand is the readiness to treat 'cannabis psychosis' with major tranquillisers given its perception as a self-limiting condition (Question 6, 7). The local black perception that the diagnosis is more frequently used for the Afro-Caribbean community agrees with the medical perception (Question 8); the reason given is that Afro-Caribbeans smoke more cannabis, although a minority of respondents (which included all those who felt there was a specific reaction) considered that West Indians were more vulnerable (Question 9). Whilst the possibility of ethnic stereotypes entering into the construction of the reaction was not asked, space was provided for additional comments but only one respondent suggested this.

It may be argued that to present these results back to the black consumer will not reflect particularly favourably on the practice of psychiatry. Clearly, there is no simple pattern of responses which would suggest a generally shared set of clinical knowledge and practice. Nevertheless, the diverse response may not be uncharacteristic of other, more generally accepted, categories such as personality disorder or even schizophrenia.[4] The results are being shared with the local CRC and other groups as part of a continuing discussion on the feasibility and ethics of a prospective study on the effects of cannabis on mental health. The immediate response has been, correctly I believe, of surprise that such an inchoate category is used so frequently. A major concern is that the diagnosis is one that is used overwhelmingly for a particular minority community, already disadvantaged in numerous areas of social and medical provision, and that it implicates as pathogenic a pattern of deviant social behaviour identified, correctly or otherwise, with that community.

It should be emphasised that whilst professionals should work closely with minority groups in such areas, the ultimate ethical and political responsibility for the projects and the dissemination of results remains with the researcher. It is not acceptable for the older type of studies to continue with accountability simply transferred onto "the community".

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