

Mental Distress in Context: Gender, Race and Diagnosis at Valkenberg Hospital

PSY4000W Research Project

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ABSTRACT

The extent, to which the gender and race of a representative sample of Western Cape psychiatric patients can be shown to statistically relate to the frequency of specific clinical and personality disorder diagnoses in that sample, was examined. A randomly selected sample of (N = 167) patients from Valkenberg Hospital was drawn from the population of 1670 patients discharged between 2006 and 2007. Patients' records were accessed and their key demographic and diagnosis variables were recorded. Explorative Chi-square analyses were run and specific significant relationships between patients' gender, race and diagnoses were identified. The results illustrate the significant role played by patients' gender and sometimes significant role played by patients' race in the development of mental distress.

Key words: gender; race; socio-economic position; clinical disorder; personality disorder; Valkenberg Hospital.

This epidemiological and archival study explores the existence of a relationship between psychiatric patients' social position and their clinical and personality diagnoses. A sample of 167 randomly selected patient records from Valkenberg Hospital was collected and patients' gender, race and diagnosis variables were statistically analysed for significant patterns of association. Explorative Chi-square analyses revealed both significant and insignificant associations between patients' gender, race, clinical diagnosis and personality diagnosis. It can, however, be argued that the results generally illustrate the continuing salience of factors like gender and race in the post-Apartheid South African context. Consequentially it is important that this association between socially related factors like gender and race groupings and patients' mental health outcomes be taken into serious consideration in clinical contexts. This study offers a discussion and description of the dimensions of this association.

While the Diagnostic and Statistical Manual of Mental Disorders-TR (American Psychiatric Association, 2000) includes contextual socio-economic factors in its multi-axial diagnosis system, the extent to which such contextual factors are associated with axis one and axis two diagnoses in South Africa today remains unclear. Both gender and race have been selected as key demographic variables of interest in this study because, it can be argued both continue to be indicative of the majority of South Africans' social, economic, political and power positions.

Towards a contextual view

Although in many ways an obvious observation to make, it remains important to properly appreciate that a person's socio-economic, cultural and political position will often influence their lives pervasively, including their mental health outcomes. Vygotsky (1978) has written on the subject of social context and human development and has argued that a person's level of functioning will depend to a large degree on the kinds of opportunities and upbringing they receive in their lives. Such opportunities as a good education for example are for the most part dependent on socio-economic status. For Vygotsky, the influence of such socio-economic contexts is crucially important to bring to bear in psychological assessment or debate on the mentally distressed individual.

Peterson (1998, p. 8) remarks that the critical approach to psychology regards mental health issues as being impacted upon by politico-economic structures that "pattern interpersonal

relationships, shape social behaviour, generate social meanings and condition collective experience”. Thus in contrast to psychodynamic and interpretive perspectives of psychology, the critical and post-structuralist view places the onus of psychological understanding and intervention on societal factors. Indeed Collins (2004, p. 3) argues that the very notion of the individual as separate from society is a “social construct, specific to recent western culture”.

This contextual approach to psychiatry and psychology has significant relevance in South Africa where the majority of the population live in or come from a collectivist and community-based culture and ideology but where for perhaps too long predominantly individualist and western norms of psychology have been used to treat them. It is also crucially important to consider individuals’ societal contexts in South Africa because of the high degree of economic inequality and historical political oppression suffered by African, coloured and Indian groups. It can be argued that the effects of Apartheids’ directed under-development or so called ‘separate development’ for the most part continue to be felt today in those same racially-defined communities. Indeed Strebel and Msomi (1999, p. 59) conclude from their extensive epidemiological study that “the demographic profile of the sample reflects clearly the history of racial and gender inequalities in SA (as well as the specific socio-economic dynamics of the region), which might contribute to particular psychological vulnerabilities.” Indeed it was found that significant differences remain with regard to psychiatric diagnosis and management across gender and race categories.

This present study attempts to address what is seen as a general over-emphasis on the individual in mental health care by considering the possible and often reported influence of societal context on individual mental health outcomes. Indeed Long and Zietkiewicz (2002, p. 164) argue that “in spite of a massive accumulation of data regarding culture and mental health, Western psychiatry has, for the large part, continued to ignore the articulation of socio-cultural factors in its theoretical and applied approaches to the problem.”

Race in context

According to Pillay and Peterson (1996) mental health care in South Africa has historically been directed towards the needs of the white and wealthy population, while being both beyond the reach of and supposedly inappropriate for the majority of South Africa’s population. The fact that Apartheid systematically under-developed African, coloured and

Indian population groups underlines the importance of addressing contextual factors like race in this study. Indeed when considering for example that the sharp gap between the rich minority and poor majority in South Africa has remained, well past 1994, it is clear that this history is pervasive, with aspects of it still relevant to and influencing the present.

The humanist psychologist Abraham Maslow is famous for his characterisation of human motives as a hierarchy of needs, arranged by fundamental priority, culminating in the need for self-actualisation (Maslow, 1970). This hierarchy is useful in order to illustrate the South African context. In South Africa, contextual factors like poverty, unemployment, HIV/AIDS and crime relate to the basic physiological and security needs of the population and according to Maslow, would need to be adequately dealt with in order for people to progress towards prosperity, mental health and self-actualisation. Thus considering factors like race and its possible association with diagnosis is particularly relevant in South Africa, where race can be said to remain closely associated with socio-economic position.

Spangenberg and Pieterse (1995) explored the impact of adverse socio-political conditions on the mental well-being of black South African women. Stress caused by socio-economic factors, especially low incomes was found to have a stronger negative effect on well being than stressful events of a more personal nature generally would. Indeed van Eeden and de Beer (2001) have noted how evidence of a narrowing gap between race groups in cognitive ability tests could be indicative of a broader lessening of socio-economic and cultural differences. Political and social contexts clearly can be very influential on a person's mental state and should be adequately appreciated in clinical contexts.

Swartz and Ismail (2001) have plotted the historical emergence of the antisocial personality disorder in the early twentieth century in South Africa. They note that white men of the time in particular were far more likely to be diagnosed with 'psychopathic personality', the forebear of antisocial personality disorder, than African or 'coloured' men were. This is, according to Swartz and Ismail, because the category was used selectively on the basis of race, with white men more likely to be seen as mentally ill and African and 'coloured' men more likely to be seen as criminals and directly incarcerated. This historical social background is useful to consider in relation to the present research findings regarding race and anti-social personality disorder specifically.

It has also been argued that dysfunctional homes and inappropriate socialisation and parenting styles can increase the likelihood of children from such deprived contexts becoming antisocial (Sutker, Bugg & West, 1993). Indeed Lahey et al. (1998) found that people with antisocial personality disorder typically came from homes where discipline is erratic, inconsistent and abusive and where one or both parents has antisocial traits.

Interestingly the risk factors that are associated with an increased likelihood of abuse for an individual include poverty and parents' poor working models of the self and self-other relationships (Engeland, Jacobvitz & Sroufe, 1988). Thus having economically disadvantaged and inadequately educated or socialised parents might increase the risk of abuse for children. This again underlines the sometimes central role of socio-economic context in determining individuals' environment, upbringing and mental or emotional development.

Dohrenwend (1974) previously postulated that the association seen between low social class and high rates of schizophrenia was either the result of a higher level of stress amongst poorer classes or a result of more inferior genes in the poorer populations. Indeed vulnerability to schizophrenia is according to Byerley and Coon, (1995) generally agreed to be largely genetically determined. Zubin and Spring, (1977) however, concluded that schizophrenia probably results from a combination of genetic predisposition and adverse environmental context. Greenwald (1992, p. 145) reports "numerous studies have found that schizophrenics are more common in the lower social classes." The nature of this association has, however, "long been the subject of controversy" (1992, p. 163). Interestingly she goes on to argue that the "dominant research trend of looking for the biological underpinnings of schizophrenia may well reinforce the neglect of social-class, stress, and gender factors" (p. 163).

Brown's (1999) 'neurodevelopmental hypothesis' of schizophrenia contends that schizophrenia is caused by disruptions in the normal maturation of the brain during pregnancy. According to this model, malnutrition during pregnancy for example will cause subtle but permanent brain damage that will increase peoples' vulnerability to schizophrenia later in life. Precipitating stress is also generally assumed to play a central role in the manifestation of schizophrenic disorders (Fowles, 1992). Thus socio-economic factors which affect peoples' access to quality food and their stress levels can be included as relevant to understanding the etiology of schizophrenia.

The legitimacy and validity of modern diagnostic psychiatric categories themselves have also been questioned (Foucault, 1967; Szasz, 1979). Foucault has contested the very use of precise diagnosis at all, because as he sees it, 'madness' is a fluid concept constituted by culturally and socially relative categories, the boundaries and meanings of which shift over time due to changes in academic debate and practice. The dominant individual and medical model of psychiatry and psychology today then might be characterised as a product of modern Western society and its pervasive individualist ideology. Ultimately it would seem then that a thoroughly contextual approach, which includes factors like race and political history is key to appreciating an individual accurately and fairly.

More specifically it has recently been noted that few studies adequately examine the effects of culture and tradition in dealing with schizophrenia (Peterson, 1998; Swartz, 1998). Peterson explains that in Zulu culture mental illness or distress is traditionally understood as being an invasion of the person by an evil spirit. Therefore the subject's perhaps more understandable problem garners more sympathy, support and less ostracising by their community than it might in a western culture. It could be expected then that Zulu people would be less likely to find schizophrenia especially maladaptive and this would then translate in fewer diagnoses of schizophrenia in such a group. Peterson maintains that a culturally sensitive approach is especially important to maintain in the South African context.

Franklin-Jackson and Carter (2007) elucidate the sometimes subtle influence of context on mental health in a study on racial identity, stress and mental health outcomes. They found that both participants' racial identity and level of perceived race-related stress had a significant negative impact on their mental health scores. They contend that "a person's racial identity must be considered when understanding race-related stress and mental health" (p. 5).

Gender in context

It can be said that gender remains an especially value-laden social category that exerts influence in many spheres of peoples' lives. Indeed "most of the mental disorders diagnosed within the DSM-IV do appear to have significant differential sex prevalence rates" (Hartung & Widiger, 1998, p. 271). Meehl (1967) has, however, argued that finding equal or similar diagnosis rates between the genders would be extremely unlikely, because some natural, random variation should always be expected. Many theorists do, however, maintain that it is

important to consider the possible influence of sex bias and the many other factors that might play a role in the generation of such perhaps expected gender differences (Desjarlis, Eisenberg, Good & Kleinman, 1995; Hartung & Widiger, 1998; Wesely, 2006). Indeed Wesely (2006) argues that women are far more likely to experience “sexual, emotional, and physical violence; degradation; social exclusion; and economic vulnerability” than men are. She goes on to say that women’s unequal social position and their associated accumulated victimisations “set them up for social, emotional, and behavioural deficits” (2006, p. 325).

Indeed it has been argued that psychiatric hospitals in the Western Cape have a long history of institutionalised sexism, evident in gender-biased diagnoses for example (Durrbaum, 1998). Shelmerdine (2001) examined records at Valkenberg hospital from between 1930 and 1935 and found that female patients were more frequently diagnosed in the ‘manic-depressive’ category than male patients were and that male patients were more frequently diagnosed in the schizophrenia-like ‘dementia praecox and paranoia’ category. Shelmerdine argues that “these findings are probably explainable in terms of the prevailing stereotypes of women as more emotional than men, and of the fact that women were, through these stereotypes, socialized into being more emotional” (p. 11) at that time. She also found that doctors’ constructions and written descriptions of their patients in the case records were often gender-biased and patriarchal. Although this study dealt with data from seventy years ago it is pertinent to this present research because it highlights the apparently sexist background of psychiatric assessment in the Western Cape. Indeed, the present research endeavours to establish whether similar indications of gender over-representation or gender bias survive in the same institutions today.

Although many psychiatric hospitals like Valkenberg have a gender-biased and generally bigoted histories, it is necessary to discuss more recent and general findings on the relationship between sex and diagnoses. The American Psychiatric Association has stated that “it has long been held that males and females are affected in roughly equal numbers” (APA, 1994, p. 281). Hartung and Widiger (1998, p. 267) have, however noted that “sex differences in schizophrenia have always been of substantial theoretical and clinical interest.” They argue that it is this interest that has led to the widespread “recognition of differences” in the development and prognosis of the disorder across genders (p. 267). Indeed Greenwald (1992, p. 168) has argued that “it is vital that data on schizophrenics be examined separately by gender, so that any differences can emerge clearly.” She argues that rates of diagnosis

generally show significant gender-related differences with regard to “onset, premorbid functioning and personality, precipitating stress, symptoms and prognosis” of schizophrenia (p. 168). Szymanski et al. (1995) found that males diagnosed with schizophrenia had significantly higher numbers of hospitalisations and relapses than females diagnosed with schizophrenia did. This was also seen in extensive meta-analytic studies by Wahl (1977) and Wahl and Hunter (1992).

Widiger and Samuel (2005) note that many of the personality disorders have especially pronounced differences in their diagnosis rates between the sexes. Establishing the reason for this has “been among the more difficult and heated diagnostic issues” in mental health professions (p. 283). In addition to an actual biological difference between the sexes, researchers have offered a number of alternate explanations for these gender differences, including allegations of sex-bias in DSM diagnostic definitions and criteria, as well as gender-biased attitudes in clinicians. The present study includes the social-constructionist explanation that patients themselves may internalise sex and gender norms present in society and that this may indirectly result in, for example, more women presenting borderline or histrionic symptoms and men presenting more anti-social traits.

Indeed such gender differences could be interpreted as being evidence of the influence of a wider societal patriarchal ideology which may have shaped participants and influenced their development of specific psychological pathologies according to constructed norms of sex and gender. Feminist and social-constructionist critical theory generally has problematised the notion of distinct binaries between sex and gender categories (Butler, 1993, 1997; Fuss, 1989). Thus essential sex differences that might exist in the sample are very difficult to separate from the influence of life-long sex and gender role socialisation that both patients and diagnosticians undeniably undergo. It is hoped that by considering traditional gender categories in this study the very real ways these categories are influential will be better understood, despite their highly socially constructed nature. However, it must also be appreciated that there is still considerable debate about how such gender-related diagnosis patterns emerge (Nolen-Hoeksema & Girgus, 1994).

The degree to which the DSM is biased in terms of gender is important to consider in this study as any such bias would influence and confound results. Becker and Lamb (1994) have argued that “sex biases in diagnosis persist” (p. 59) and are evident in the DSM classification

systems of borderline personality disorder and posttraumatic stress disorder as well as in the often biased attitudes of diagnosticians generally. Indeed Garb (1995, 1997) argues that clear sex bias in general diagnostic criteria commonly used by diagnosticians is largely responsible for the disproportionate number of women diagnosed with histrionic personality disorder, for example. Funtowicz and Widiger, (1999) however, found no evidence of sex bias at all in the DSM-IV. More recently Jane, Oltmanns, South, and Turkheimer (2007, p. 166) conducted an experiment to ascertain whether “difficulty parameters for all items (in the DSM-IV) were gender dependent”. By testing mentally healthy men and women the researchers found that there were some significantly biased items, with men generally scoring higher in antisocial and paranoid personality disorders rating criteria. In similar research Boggs et al. (2005) evaluated 668 individuals according to the DSM-IV, but found relatively little evidence of gender bias in their critical analysis except for the borderline category which seemed to be more directed at women. Indeed Shaw and Proctor (2005, p. 483) conclude from their review of the literature that “the diagnosis of borderline personality disorder is applied predominately to women”. Histrionic personality disorder has also historically been applied almost exclusively to women and as a result its criteria have frequently been criticised as sex-biased (Brown, 1992; Landrine, 1989).

In an extensive review of international diagnosis data Culbertson (1997) found that general depression rates are twice as high in female populations. Simpson, Nee, and Endicott (1997, p. 633) similarly conclude from their review of relevant literature that “there is a sex difference in the prevalence of unipolar major depression.” However, in their 15-year longitudinal study of 197 patients they found that there were no significant differences in the progression and prognosis of the illness between men or women. Thus while diagnosis rates do appear to differ between genders, both men and women seem to deal with depression in similar ways. Indeed Costello, Erkanli, Federman, and Angold (1999) found in a study of 1420 children, that boys and girls showed more similarities than differences in the course of early psychopathology. Myers and Durvasula (1999) found that 20% of both males and females experienced major depression, again signalling some commonality between the sexes.

Indeed in a 1995 study Tohen and Goodwin found that bipolar mood disorder is seen equally often in men as it is in women. However, Myers and Durvasula (1999) reported that anxiety related disorders are more commonly seen in males and that symptoms of posttraumatic stress

disorder are more common in females. Indeed a number of studies have shown evidence of such a difference (Breslau, Davis, Andreaski, & Peterson, 1991; Yonkers & Gurguis, 1995).

The possible aetiologies of such mood disorders are thus important to take into consideration. In a study on fraternal and identical twins Dubovsky & Buzan (1999) found that genetic factors appear to play a significant role in the development of major depression and bipolar disorder. Dubovsky and Buzan do also note though that environmental influences will often influence whether such genetic predispositions to certain mental illnesses manifest themselves.

Research aims

The influence of social, economic and political contexts on individuals' mental health outcomes is generally well-evidenced in the literature. This evidence is, however, sometimes inconsistent as well as being the subject of ongoing theoretical debate. Although there has been a fair amount of work done on the unequal access to mental health services for different races in South Africa's Apartheid history (Louw & Foster, 2004; Nicholas, 1993) it has been noted that "to date very little has been documented about the role of race and gender in psychiatric diagnosis and management in South Africa" today (Strebel & Msomi, 1999, p. 53). This research then attempts to address the lack of recent epidemiological psychiatric data in South Africa as well as the lack of consensus regarding how to interpret the possible association between gender, race and diagnoses.

Indeed Hartung and Widiger (1998, p. 271) write that in relation to the possible influence of context on mental health "the most informative findings will be provided by epidemiological studies involving representative samples of respective populations."

This research project aims to identify whether the gender and race of a representative sample of Western Cape psychiatric patients is statistically related to their specific clinical and personality diagnoses. Indeed presenting the frequencies of certain race or gender groups is in itself meaningful, considering the sample is randomly-selected and thus fairly representative of Western Cape psychiatric patients. The research hypothesis was that significant relationships between gender, race and diagnoses would be found. It was expected that patients' gender and race would be significantly related to higher or lower frequencies of

specific clinical and personality diagnoses, namely schizophrenia, depression, bipolar mood disorder as well as antisocial, histrionic and borderline personality disorders. Although thought to be unlikely, it was decided that if the frequency of clinical and personality disorders were found to be very similar across gender and race categories, it would be understood as overwhelming evidence of an absence of such contexts' influence.

The key variables of interest are the gender and race of psychiatric patients, the diagnosis of clinical disorders (including deferred diagnoses, diagnoses of dementia, substance-related disorders, schizophrenia, depression, bipolar disorder, anxiety states and posttraumatic stress disorder) and the diagnosis of personality disorders (including anti-social, borderline, histrionic and dependent disorders as well as mental handicap).

Recently discharged psychiatric patients from the local public Valkenberg Hospital constitute the research population and as such the research can be said to offer original and locally relevant data on the research question.

The persistent salience of race and gender-related issues in post-Apartheid South Africa is abundantly apparent, with controversy continuing to surround national affirmative action policies like Black Economic Empowerment as well as policies designed to uplift women's position in the workplace. This political national context has to some extent served as a catalyst for this research. Indeed it remains important to determine whether the long-standing effects of Apartheid's racist policies and the insidious effects of a patriarchal society continue to be seen in mental health outcomes in this country.

METHOD

Design

This research is descriptive in nature because a broad range of possibly interrelated variables, including gender, race, clinical disorder diagnosis and personality disorder diagnosis are examined and described. These variables were analysed in an exploratory and open-ended fashion, in order to avoid neglecting possible unforeseen relationships between them. This design is seen as being particularly appropriate because the nature of the possible relationships between the variables is uncertain. However, certain specific associations were

looked out for, including those relating to schizophrenia, depression and antisocial personality disorder specifically.

Sample

The research sample is made up of 167 discharged patients of Valkenberg Hospital. They were all admitted between January 2006 and December 2006 and were all discharged between January 2006 and July 2007. Due to the fact that a randomly selected sample of ten percent of the total population of 1670 patients discharged was drawn, it can be said that 167 cases appears to be an adequately sized sample from which to draw statistical inferences about the population. Indeed each participant was randomly selected using a random selection computer software program. It is essential for the sample to be statistically representative because inferences about the broader Western Cape psychiatric population are made based on this sample. Access to participants' records was gained through correspondence with the relevant authorities and ethics committees at Valkenberg Hospital and at the University of Cape Town.

Apparatus

A data schedule form was constructed specifically for this study. It outlines all the possible relevant variables and arranges them under subheadings referring to their general nature. Each variable is designated a coded number to facilitate easier computer analysis. Assigning a coded number to the variables is appropriate because the data under analysis is categorical in nature. Although the data in the records reflects the results of a number of complex diagnostic procedures, the data itself is fairly straight-forward and categorical and thus was collected fairly simply.

Procedure

Data was collected over numerous visits to the administration and out-patients department of Valkenberg Hospital. Data was accessed directly in the hospitals' patient discharge files. All the relevant variables that were available in the files were recorded using the data schedule form already outlined. Each patient's case number and coded variables were recorded in a single dataset using a laptop computer. A confidentiality agreement was undertaken with Valkenberg Hospital prior to commencement, due to the very private nature of the data.

Data analysis

The raw data that was gathered from the hospital was coded and entered into a Statistica spreadsheet. Each case included the patients' coded characteristics for the variables already outlined. Because the data is categorical and certain paired associations were expected, a series of Chi-square analyses were run. This statistical procedure was thought to be the most appropriate to use as it provides comparable scores regarding the statistical significance of the possible paired associations between patients' sex, clinical diagnosis and personality diagnosis.

RESULTS

Once the dataset had been collected it was possible to consider the frequencies of gender groups, race groups and diagnoses critically. Gender was found to be unequally represented with more male (60.48 %) than female (39.52%) patients seen (Fig. 1). Race also appeared to be unequally represented, with coloured patients being the most common (58.08%), African patients the second most common (24.55%), whites the third most common (16.17%) and Indian patients being the most uncommon (1.2%) (Fig 2).

In terms of clinical diagnoses, the most common was schizophrenia (45.51%) and the second most common was bipolar mood disorder (19.16%). Substance-related disorders were seen third most commonly, in 16.17% of the cases. The fourth most common disorder was depression (9.58%) and the fifth most common was a deferred diagnosis (3.59%). Anxiety states were seen in 2.99% of patients. Dementia, posttraumatic stress disorder and other disorders were the most infrequent, seen in 0.60%, 0.60% and 1.8% of the sample respectively (Fig. 3).

The most common personality disorder variable was 'other', which included deferred diagnoses (63.47%). Antisocial personality disorder was the next most frequently diagnosed (29.15%), with borderline personality disorder being the third most common (5.39%). Histrionic and dependent personality diagnoses were made in 1.2% and 2.4% of the cases respectively. In 2.4% of the sample patients were identified as having a mental handicap (Fig. 4).

Chi-square analyses were conducted to test the possible relationship between patients' race and clinical diagnoses, between patients' race and personality diagnoses, between patients' gender and clinical diagnoses and between patients' gender and personality diagnoses. In all four Chi-square tests the null hypothesis was that no significant association would be found.

For the association between gender and clinical diagnosis the Pearson's Chi-square statistic was found to be 28.137 ($p < 0.0005$). Thus a significant association was found. Indeed the effect size, measured with Cramer's V was 0.41, which is substantial. For the association between race and clinical diagnosis a Pearson's Chi-square statistic of 12.193 ($p > 0.05$) was found. Thus this association was found to be statistically insignificant. Cramer's V was found to be 0.15 for this association, which is insubstantial.

The association between gender and personality diagnosis resulted in a Pearson's Chi-square statistic of 26.338 ($p < 0.0005$). Thus a significant association was found. Indeed Cramer's V was 0.39, which indicates a fairly strong effect. For the association between race and personality diagnosis a Pearson's Chi-square statistic of 33.989 ($p < 0.005$) was found. In this case Cramer's V was 0.26. Thus personality diagnosis and race were significantly associated, but the association was fairly weak.

DISCUSSION

This research is based on data from a clinical psychiatric context and as such interpreting results in a research-orientate and academic context needs to be done with consideration of the limitations of such assessment data (Flaskerud & Hu, 1992). Indeed although the diagnosis data has been carefully collected, those diagnoses themselves should not be considered completely valid representations of the patients or completely free of bias. The quantification of psychological distress is notoriously problematic (Parry & Swartz, 1997; Szasz, 1979). Indeed "it is important to recognise debates which approach such hospital records not as documents of factual reality, but as social constructions, embedded in and reflective of particular histories of discursive psychiatric practice" (Strebel & Msomi, 1999, p. 60). Although patients diagnoses were considered to be dependent on a multitude of factors, special consideration was given to the possible influence of race-related socio-economic contexts of patients' development as well to the politically and socially-related gender positions patients occupy. Moreover by isolating race and gender as possible contributing

factors to mental health outcomes, an interesting comparison between the effects of the two could be made.

Contrary to expectations and to much of the extensive literature on the subject, race and its associated socio-economic context in South Africa, was not found to be significantly associated with clinical diagnoses. Personality diagnoses were, however, significantly associated with race. Interestingly gender was found to be significantly associated with both clinical and personality diagnoses.

The frequencies of clinical and personality diagnoses that were found in relation to race, do, however, remain important and significant to consider. Although race was not significantly associated with mental health outcomes, the fact that the majority of patients were coloured for example should not be ignored. Indeed the Chi-square analysis of race and clinical diagnosis was probably insignificant because patients from all race groups had similar distributions or ratios of clinical diagnoses, with schizophrenia for example being the largest grouping and bipolar disorder the second largest, across the board. The fact that coloured people with schizophrenia are the most common grouping of patients at Valkenberg can still, however, be considered highly significant information. Indeed the fact that African patients with schizophrenia are the second most common grouping is also significant information, especially when considering that both groups for the most part continue to live in under-developed and economically deprived contexts. The fact that substance-related disorders were the second most common disorders is also important to note, considering the high levels of drug use and associated violent gangsterism in poorer communities, especially in the coloured communities of the Western Cape.

The significant association seen between antisocial personality disorder and race is important to consider as possibly especially indicative of the influence of patients social contexts on their mental health. Indeed the highest levels of antisocial personality disorder (17.37% of patients) and of substance-related disorders (9.58% of patients) were found in coloured patients. This evidence then would be in line with notion that violent and economically deprived communities will foster antisocial personalities and fuel substance abuse. Indeed such personalities and behaviour may be somewhat adaptive for those individuals in disadvantaged and hostile socio-economic contexts.

The fact that gender was significantly associated with clinical and personality diagnoses is also important to take into consideration, given the generally subjugated position of women in society. Perhaps entrenched gender norms are responsible for the greater numbers of women diagnosed with depression (7.19% of patients) compared to men (2.4% of patients). This apparent gender disparity was also seen in the difference between rates of substance related disorders in male patients (14.37% of patients) compared to female patients (1.8% of patients). Schizophrenia, however, is the diagnosis category where the difference between the genders is most clear. Indeed males accounted for almost double the number of schizophrenia diagnoses in the sample (29.94%) compared to females (15.57%). Interestingly rates of bipolar disorder were fairly similar across genders, with females diagnosed with bipolar amounting to 7.78% of patients in the sample and males diagnosed with bipolar amounting to 11.38% of patients, which is in line with previous research findings.

Although these findings corroborate the results of a number of international and local studies into the link between social context and diagnosis, further research into the complex associations between gender, race and diagnoses is needed, especially in regard to the aetiology of mental distress in South Africa.

Conclusion

According to this sample, gender can clearly be said to have a significant association with peoples' mental health outcomes. Whether this is indicative of the influence of patriarchal gender roles and norms in society is unclear but such an explanation seems probable. Although race is not significantly associated with mental health outcomes, the very clear over-representation of coloured and African race groups in diagnostic categories has been said to be a meaningful finding. It can be concluded then that both individuals' gender and race groupings should be taken into serious consideration as possibly influential factors in the aetiology or manifestation of mental distress.

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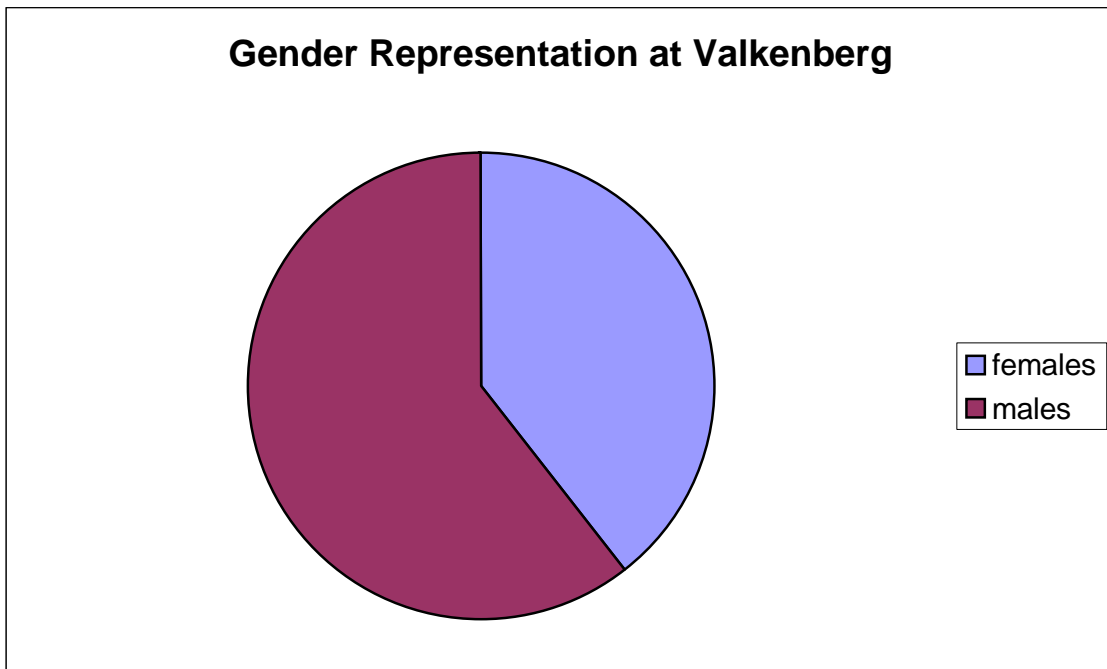
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FIGURES

**Figure 1**

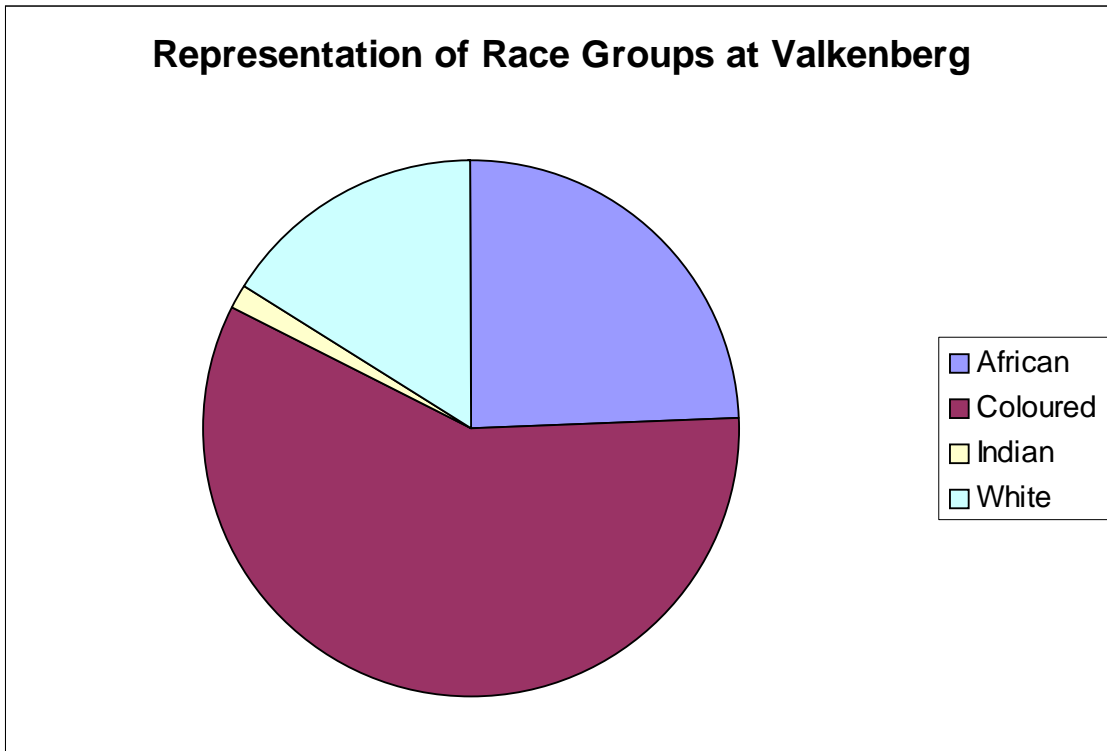


Figure 2.

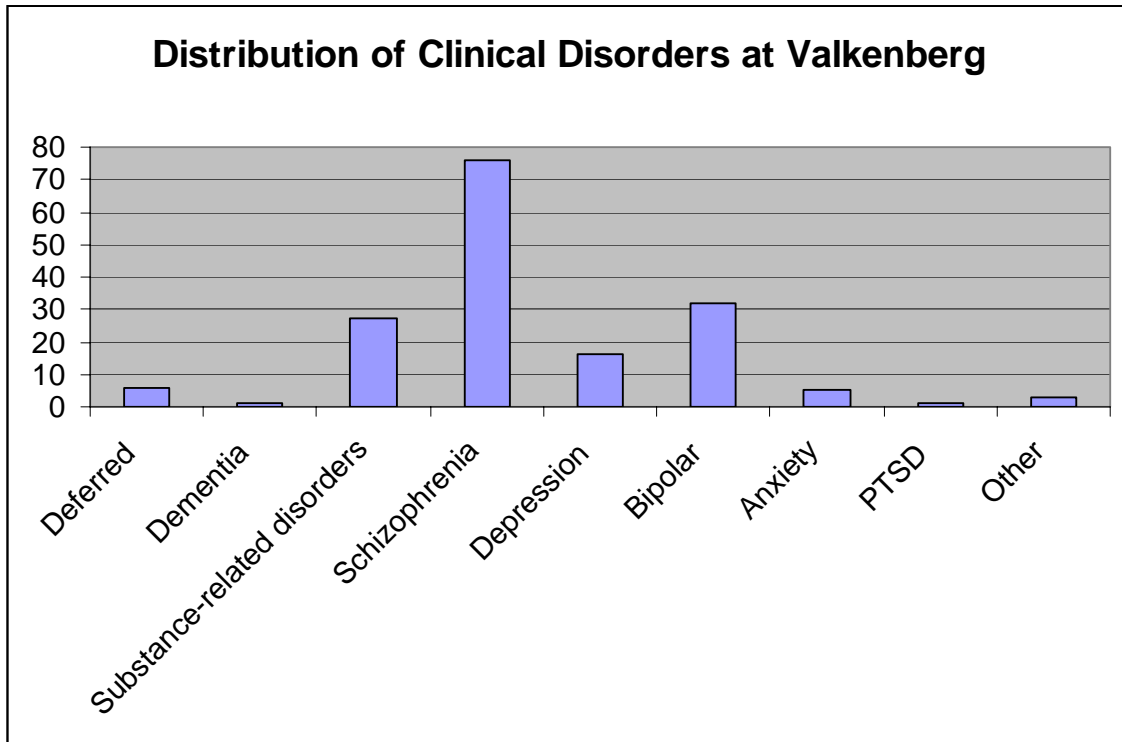


Figure 3

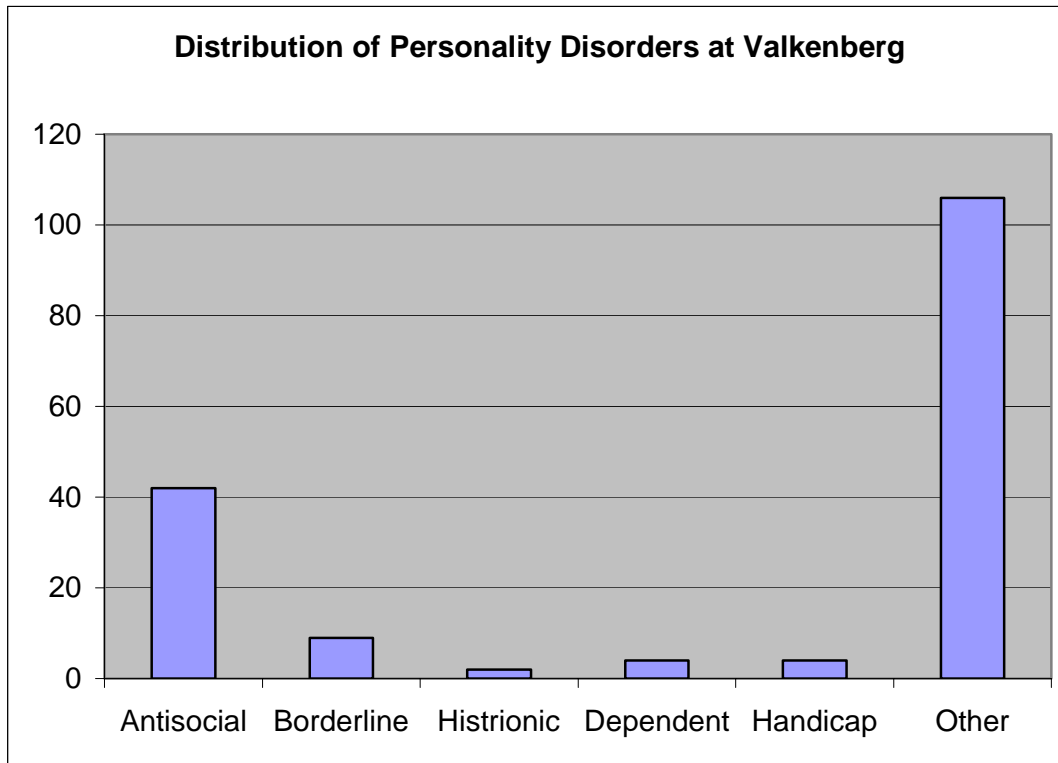


Figure 4.