

The odd one out : exploring the nature of the association between minority status and psychosis

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VALORISATION

Scientists, especially when their studies have been paid for by public funding, as is the case for most of the work collected in this dissertation, have a responsibility to make their work matter. The university rightfully encourages us to do so, yet in my opinion this should not be limited to this addendum, an obligatory afterthought not part of the scientific work itself, but integrated into the fabric of what we do. For me personally, the thought it would matter was an important motivation to start this project and carry it through to the work you hold in your hands. I vividly remember speaking to Prof. dr. Jean-Paul Selten for the first time, hearing him tell me how the risk for psychotic disorders was so much higher in Moroccan-Dutch men and other ethnic minorities, and asking myself two questions: ‘How does that happen?’ and ‘How do we remedy this?’

The preceding chapters have focused mainly on the first question, as we have expanded the scientific literature with new observations on psychotic outcomes in minority groups, possible underlying biological and behavioural mechanisms, and new ideas to be tested in follow-up studies. We know more now than we did 5 years ago, but also concluded that it is still too early to tell whether the narrative we propose on how it happens is correct. However, whether we have the underlying biology right does not necessarily matter for question 2. The current findings on dopamine release may converge with other findings and much further down the line lead to improved pharmacotherapy for people who need it, but they are by no means the lowest hanging fruit. Better treatment is important, but I hope and believe this work will be recognized as especially relevant to early detection and prevention, as from a public health perspective this is where most gains can be made.

Living through a psychotic episode, and worse, developing schizophrenia and having such a frightening experience more than once is some-

thing you do not wish upon anyone. In fact, in an elegant study where both clinicians and laypeople from communities around the globe had to make a series of choices on which of two fictitious people with different medical conditions was healthier, acute schizophrenia was weighted as representing the biggest health loss of the 220 conditions on the list, which included spinal cord lesions and terminal cancer (Salomon *et al.* 2012). We can certainly not prevent every case of schizophrenia, but I believe we can prevent more cases than we do now, and that it will turn out to be a cost-effective way to increase population health in general, and in particular for minority groups, who lag behind in many more health indicators. The idea that chronic stress and discrimination may be at the root of many of those disparities is not new (Adler & Rehkopf, 2008; Williams & Mohammed, 2008), but the case had not been made for psychotic disorders, and this dissertation will hopefully provide more ammunition to those who spread the message that social exclusion may make you sick.

This is a message that deserves to be heard by the general public, by organizations who represent the minority groups at risk, and by policy makers. The general public will probably not change any negative attitudes they may have towards minorities based on a single study, but it is important that they are informed. In the current day and age, where dissemination of opinions is cheap, people should know that if they are naming and shaming a minority group on television or the internet, it affects that group in more than a superficial way. Or, as an award-winning Moroccan-Dutch actor stated in a national newspaper, when interviewed about growing up in the context of a public debate about Moroccan immigrants and Islam with an increasingly negative tone “you need to have quite a thick skin” (Nasrdin Dchar in Trouw, 25 January 2015).

Reception in minority communities has been positive. Over the course of working on this dissertation I have stepped out of the world of conferences attended only by my scientific peers, and talked about these topics in settings of varying formality with the people it may affect. I have given a talk at a symposium on gender-nonconformity organized by an LGBT student society, spoken to social workers, minority youths and their parents and at their community centers, football clubs and mosques, and explained our studies at a camp for hard of hearing youths. For groups that feel poorly understood by the dominant majority, it can be empowering to know that people are taking an interest and are conducting studies specifically about them.

Policy makers, finally, should be aware that minority mental health lags behind that of the general population. They have the power to implement policies or fund interventions that may have preventive effects, such as anti-stigma campaigns, the legalisation of gay marriage, the installation of auditory induction loops in public buildings, or the integration of diversity education into school curricula. When I have met with policy makers during the writing of this dissertation, whether it was within the context of this work or while volunteering for organisations which promote equality, I have made such suggestions with the argument that such investments are likely to pay themselves back. After all, a healthier population means more workforce participation, and less need for care. Even if the moral argument for closing the mental health gap should be sufficient, an economic argument only strengthens the case.