03 - 13_Sociocultural_Psychiatry

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01 - 1. Social Classification

1. Social Classification

1. Social Classification

In Britain occupational classification forms the principal mode of social classification: The social class of a household is determined on the basis of the head of a family. Dominance and dependence are two essential underlying themes behind the categorical divisions of social classes. Most psychiatric disorders are more common in lower social classes; with controversial exceptions noted for anorexia, alcohol use and bipolar disorders. Anorexia: It is debatable whether social class affects the true prevalence of anorexia or whether the differential rates noted in various studies reflect variations in helpseeking/referral pattern. At present the growing consensus is that the social classes 1 and 2 are more prevalent in clinical (as opposed to community-based) samples but there are no differences in distribution of various clinical features across the social groups. The quality of family relationships and types of family constellations are also broadly consistent across the social classes in affected families. A prodrome of excessive diet consciousness and the actual onset of the disease itself are noted at somewhat younger ages in social classes 1/2. Community studies have shown that the degree of urbanization has a significant impact on the prevalence of anorexia, bulimia and binge eating disorder (Favaro et al., 2003). Social class, professional status, and education are not associated with an increased risk of reporting an eating disorder in such community samples. Bipolar disorder: An overrepresentation is found in the higher occupational class in bipolar probands' brothers and children. It is consistently noted that the family of origin in bipolar probands belong to a higher social class though the patients themselves might be at a lower social class. Tsuchiya et al., (2004) showed that higher social class of parents together with longer paternal education history and larger possession of wealth increased the risk of bipolar disorder in the offspring. It is speculated that ‘bipolar genes’ may offer some survival benefits such as superior creativity or productivity, which uplifts the families to higher social status. Suicide: The relationship between suicide and social class has not been conclusively established as of yet. While some authors have reported that higher social class is related to higher rates of suicide, most other studies indicate that lower social class is associated with Classes Categories Class 1: Professional, managerial and Class 2: Intermediate Class 3: Skilled, manual, clerical Class 4: semi-skilled Class 5: unskilled Class 6: unemployed

 higher rates of suicide. It is shown that among mentally ill, the higher the social class, the more the risk of suicide (Silverton et al. 2008). Alcoholism seems to defy social class boundaries. A Swedish conscript study (Hemmingson et al., 1999) reported that intergenerational social mobility that is associated with healthrelated factors, but not alcoholism itself, makes a

significant contribution to explaining variation in the rates of alcoholism among the different social classes. The class-related differences in alcoholism among young adults seem to be influenced heavily by factors that are established by adolescent years. But such adverse conditions did not seem to be well reflected by social class of origin. By far, a significant influence on the prevalence of alcoholrelated harm seems to be the public health policy regarding pricing and the sales of alcohol. In all aspects of health including life expectancy, infant and maternal mortality, there is a discrepancy between social classes, despite the existence of the NHS, which was developed to combat this. There is a question of whether the low social class has lead to poor health or if poor health leads to deterioration in social status (as suggested in the Danish bipolar study above). There is a consideration for cultural differences among social classes in terms of diet, exercise, alcohol intake and awareness of mental health problems and the treatments available.

JARMAN INDEX

A scoring system developed by the British general practitioner Brian Jarman for the level of social deprivation in a community, using census data on percentages of old people living alone, single-parent families, children younger than 5 years of age, unskilled and unemployed persons, ethnic minorities, overcrowded dwellings, changes of address in previous year, etc. Although a valid indicator, it is not generally accepted outside the United Kingdom.

02 - 2. Sick role and illness behaviour

2. Sick role and illness behaviour

© SPMM Course 2. Sick role and illness behaviour The sick role is a concept described by the American sociologist Talcott Parsons with 4 characteristics: The sick person is freed or exempted from carrying out normal social roles. The more severe the illness, the more is the freedom from normal social roles. This is granted to everyone in society irrespective of social status. People who are ‘sick’ are not directly responsible for their disease. They are not blamed or expected to take the blame, and if one takes self-blame, this is viewed as odd behaviour. It is necessary that a sick person tries to get well. The sick role is regarded as a temporary stage that should not be prolonged if at all possible. A sick person must seek competent help and cooperate with medical care to get well. This implies that a doctor is an agent of social control – one that restores people’s social roles. The concept of disease: Disease: refers to actual pathology (e.g. a process that results in illness) Illness refers to personal experience (a set of symptoms suffered by a patient) Sickness refers to social consequences (e.g. absence from work) Health behaviours are seen in healthy people who try to maintain their health – these are related to primary prevention of disease and are intended to reduce susceptibility to disease in the first place. Mechanic and Volkart, 1961, proposed the concept of illness behaviour which refers to any behaviour undertaken by an individual who feels ill to relieve that experience or to better define the meaning of the illness experience. Illness behaviour is an active process “that involves interpreting symptoms, evaluating possible responses and, finally, deciding whether to try to alleviate those symptoms or simply to ignore them”. Abnormal illness behaviour (Issy Pilowsky, 1969) is an extension of the concept of illness behaviour; it is defined as the persistence of a maladaptive mode of experiencing, perceiving, evaluating, and responding to one’s own health status, despite the fact that a doctor has provided a lucid and accurate diagnosis and management plan (if any), with opportunities for discussion, negotiation, and clarification, based on adequate assessment of all relevant bio-psycho-socio-cultural factors. These can be excessive illness affirming (e.g. somatoform or malingering) or denying behaviours (e.g. loss of insight in psychosis). Factors influencing individual response to illness Symptom visibility & their perceived importance Assessment of symptom’s significance Potential for symptoms to disrupt community Symptom denial for fear of confirmation of serious illness Deferring response to symptoms because of competing social demands Assessment of social & economic costs of responding to symptoms versus potential health-related

benefits

© SPMM Course Available information knowledge & cultural assumptions & understandings Symptom frequency & persistence Competing interpretations of symptoms International Classification of Impairments, Disabilities and Handicaps (ICIDH) provided a descriptive conceptual framework of consequences of illnesses. Impairment: interference with structural or psychological functions (that is, parts of the whole person e.g. loss of an arm's function due to fracture). Disability is interference with activities of the whole person in relation to the immediate environment (simply 'activities of daily living' e.g. not able to cook for oneself due to the fracture) Handicap is the social disadvantage resulting from disability (e.g. loss of work and inability to meet friends due to restricted driving secondary to fracture) Health Beliefs Model: The health beliefs model was developed with the observation that patients have their own beliefs about disease risks and treatment benefits. According to HBM patients' beliefs about their disease states may be more influential than medically determined disease information. The health beliefs model identifies several factors for which patients' beliefs may affect their treatment participation: (1) Patient's beliefs about the severity of their condition, (2) Patient's beliefs about their susceptibility of acquiring the disease or complications of the disease, (3) Patient's beliefs about cost of treatment adherence (including costs in inconvenience, effort, time, and money), (4) Patient's beliefs about benefits of treatment adherence, and (5) Patient's beliefs regarding the environmental and social cues to action that may assist in their treatment adherence. The Transtheoretical Model (TTM) was developed by Prochaska and DiClemente (1982). This was developed largely in response to increasing divergence in the practice of psychotherapy, and the authors attempted a (transtheoretical) synthesis among the various therapeutic systems. They identified five common processes of change that are applicable to how individuals can be motivated to change their illness-related behaviours. These processes are (1) Consciousness raising – helping the patient gather information about self and the problem (2) Choosing – increasing awareness of healthy alternatives, (3) Catharsis – emotional expression of the problem behaviour and the process of change,

© SPMM Course (4) Conditional stimuli – includes stimulus control and counterconditioning, a. Stimulus control: Avoidance of stimuli associated with the problem behaviour and the operant extinction cueing effect of the stimulus on behaviour. b. Counterconditioning: Training an alternative, healthier response to the cue stimuli. (5) Contingency control: Positive reinforcement from others and self-appraisal and improving self-efficacy by self-reinforcement. From these five processes of change, Prochaska and DiClemente identified six stages of change. These are (1) precontemplation, (2) contemplation, (3) Preparation, (4) action, (5) maintenance, and (6) relapse. In the precontemplation stage, a person is not even considering changing his or her behaviour, does not see the behaviour as a problem, minimizes and denies associated risks, and avoids information to the contrary. In the contemplation stage, the person has become aware of why the behaviour is a problem but is ambivalent about changing, and likely sees equal or more benefits than costs from the behaviour. During preparation, the person has made a decision to change, and is planning a strategy for change, but has not yet taken action. In action, the person has implemented a plan and is changing the behaviour. In maintenance, the person has been able to sustain the change and avoid reverting to problem behaviour for a significant period of time. In relapse, the person does revert to problem behaviour, 'back to square one'. These stages are not linear in sequence but rather cyclical, in that a person can relapse and reenter at a later stage

such as preparation. The stages do not operate in an invariant sequence (unlike Piaget’s models). Each stage can be moved into back and forth (reversibility). The stages are not qualitatively different. Motivational Interviewing (Miller & Rollnick, 1991) is often used together with TTM and stages of change.

03 - 3. Social role of doctors

3. Social role of doctors

© SPMM Course 3. Social role of doctors General Medical Council (UK) and other professional organisations have expounded the concept of multitude roles expected from a doctor. The RCPsych has adapted this to suit the psychiatric practice.

The Consensus Statement on the Role of the Doctor (from medschools.ac.uk) highlights the social role of the doctor: To support patients in understanding their condition and what they might expect, including in those circumstances when patients present with symptoms that could have several causes To identify and advise on appropriate treatment options or preventive measures To explain and discuss the risks, benefits and uncertainties of various tests and treatments and where possible support patients to make decisions about their own care. •Accessing, interpreting and assimilating new knowledge critically Doctors as scientists Doctors as scientists •Listening and communicating appropriately, the ability to work as part of a team, non-judgmental behaviour, compassion and integrity Doctors as health professionals Doctors as health professionals •Making day-to-day clinical decisions based on medical knowledge to assess the impact, risk and likely outcome of decisions; apply skills in the development of policy, strategy, service design, and clinical processes. Doctors as leaders Doctors as leaders •Acting as critical decision makers with responsibility for allocation of significant health resources; influence to advocate for increased resources to improve health outcomes for their patients and populations Doctors as health advocates Doctors as health advocates •Accepting duty to contribute to the education of other professionals and patients in addition to carrying a responsibility for continued personal education. Doctors as teachers Doctors as teachers •Sharing a responsibility to positively influence the culture and the environment in which they work Doctors as health sector representatives Doctors as health sector representatives

© SPMM Course All doctors have a role in the maintenance and promotion of population health, through evidence-based practice. The doctor must appreciate the needs of the patient in the context of the wider health needs of the population. For all doctors, the patient must come first but they will achieve this in different ways and in different settings. The social role of a psychiatrist includes being an appropriate role model providing effective support and guidance for those seeking treatment for psychiatric disorders and various societal dilemmas related to them. Some leaders extend this role as being a public figure in one’s community whose opinions are valued by laymen as well as other professionals and to serve as an ambassador for the profession by educating the public via various media outlets to erase misperceptions about mental illness or psychiatry (Henry Nasrallah in The model psychiatrist: 7 domains of excellence, 2011). Professionalism: There has been a great deal of interest in defining and adopting the concept of professionalism in psychiatry. American Board of Internal Medicine Foundation sets out three core

principles specific to medical professionalism that is widely adopted by doctors in the US, the EU and the UK. The 3 principles are the primacy of patient welfare (based on dedication and altruism), patient autonomy and social justice. These principles are further set out in the 10 commitments recommended for developments to promote professionalism in medical practice (from Bhugra & Gupta, 2010): 1. Professional competence 2. Honesty with patients 3. Patient confidentiality 4. Maintaining appropriate relations with patients 5. Improving quality of care 6. Improving access to care 7. Just distribution of finite resources 8. Scientific knowledge 9. Maintaining trust by managing conflicts of interest 10. Professional responsibilities (including maximising patient care, self-regulation, remediation, disciplining) Health advocacy is the process of supporting and empowering patients and carers to express their opinions, ideas and concerns and enabling them to access appropriate information and services and promote their rights. Dual loyalty: World Medical Association's Medical Ethics Manual highlights this issue when discussing professionalism. "When physicians have responsibilities and are accountable both to their patients and to a third party, and when these responsibilities and accountabilities are

 incompatible, they find themselves in a situation of 'dual loyalty'. Third parties that demand physician loyalty include governments, employers (e.g., hospitals and managed healthcare organizations), insurers, military officials, police, prison officials and family members. Although the WMA International Code of Medical Ethics states "A physician shall owe his/her patients complete loyalty," it is generally accepted that physicians may in exceptional situations have to place the interests of others above those of the patient. The ethical challenge is to decide when and how to protect the patient in the face of pressures from third parties." One such situation pertains to the issue of resource allocation. Resource allocation: In most countries governments decide the overall healthcare budget; institutions and local bodies decide the allocation to each service provided locally; doctors and healthcare professionals decide on the tests to be ordered, services to be offered and treatments to be provided. From the overall allocated budgets, the distribution of around 80% of healthcare expenditures is controlled by end-providers. Where resources are limited, all patients are entitled to a fair selection procedure for that resource. WMA recommends that this choice must be based on medical criteria and made without discrimination. In practice, physicians balance the principles of compassion and justice and are called to employ several approaches for resource allocation depending on where and when the need arises. LIBERTARIAN Resources distributed according to market principles (patient is a consumer; if he/thy have the willingness to pay, the resources will be made available to them). UTILITARIAN Resources distributed according to the principle of maximum benefit for all. EGALITARIAN Resources distributed according to the need (estimated by the provider). RESTORATIVE Resources should be distributed with a positive discrimination towards the disadvantaged (e.g. poor gets priority over the rich who can pay for private care).

WMA notes "physicians have been gradually moving away from the traditional individualism of medical ethics, which would favour the libertarian approach, towards a more social conception of their role".

04 - 4. Family life in relation to major mental il

4. Family life in relation to major mental illnesses

© SPMM Course 4. Family life in relation to major mental illnesses Family is essentially the most basic social unit and microcosm of an individual. The General Systems Model of families holds that families are systems where every action in a family produces a reaction in one or more of its members. Such a system has external boundaries and internal rules, and every member is supposed to play a relatively stable but interchangeable role. Family cycle: Stage 1: formation of the new family: 2 individuals unite - the first child is born. Tasks include formation of working dyad and restructuring relationships with families of origin. Stage 2: child rearing stage: birth of child adolescence Maintaining satisfactory marital relationship amidst the demands of childrearing is a major task. Stage 3: child launching: Children leave home. Tasks include re-establishing individual interests and reexamining the marital relationship. Stage 4: return of independence – growth and extension of family leads to the task of maintaining ties across generations Stage 5: dissolution of the family: occurs due to decline or demise of partners. Family instability can affect children to a various extent depending on sex (boys affected > girls), age (younger affected > older children), and temperament hyperactive affected > placid). This has a demonstrable effect on a child's cognitive achievements; the most common psychopathology noted is a behavioural difficulty. Family systems have been studied in detail with respect to schizophrenia especially. Lidz studied family systems in relation to schizophrenia and described two 'schizophrenogenic' family patterns: Marital schism: family is in a state of disequilibrium due to repeated threats of parental separation. Parents downgrade roles of each other and may even attempt to collude with children and exclude partners. Marital skew: family is at an equilibrium that is skewed and achieved at an expense of the distorted parental relationship. One parent may be dominant and other submissive, making the marriage 'a stable fit'. Wynne and colleagues described certain communication patterns that may relate to the later development of perceptual and thought disorders in schizophrenia. Pseudo-hostility and pseudo-mutuality refer to the disjointed or fragmented communication where the child is

© SPMM Course forced to accept and develop a pattern of communication that will negate and deny the existence of meaningless relationships in the family. Bateson described the double-bind relationship where superficial verbal communications contradict the behavioural and deeper

communications among the members of a family. These mixed messages keep a growing child in a double bind (cannot be correct either way) that can later increase the risk of psychosis. Freida Fromm-Reichmann coined the concept of schizophrenogenic-mother. These mothers were described as 'rejecting, impervious to the feelings of others, rigid in moralism concerning sex and had a significant fear of intimacy'. Causal links between the above four family functions and schizophrenia are disputed, and these models have fallen out of favour in recent times. There is no experimental evidence to support these claims and any small data regarding the above theories are poorly reproducible. Expressed emotions concept was developed by Brown & Rutter in 1966 as a part of the Camberwell Family Interview [CFI] and later modified by Vaughn & Leff in 1976. The ratings were based on content and prosodic aspects and emphasis of speech. Five measures are considered;

1. Critical comments
2. Positive remarks
3. Emotional over involvement
4. Hostility
5. Emotional warmth The final scores of emotional over-involvement, critical comments and hostility were the most predictive measures for relapse of schizophrenia. CFI is a long interview process where individual members of a family are interviewed (including the patient). If one relative is classified as high EE person, then the whole family could be classified as a high EE family. CFI ratings based on interviewing parents singly have the most predictive value. A Five Minute Speech sample (FMSS) measure was introduced as a substitute for CFI, but it tends to underestimate EE. FMSS is more useful for measuring professional or staff carers' level of EE. Studies have indicated: Worldwide the proportion of high EE in carers of patients with schizophrenia is 52%. Lowest rates are found in India and other developing nations. The strength of association between relapse and EE is identical for both genders.

  A meta-analysis of EE data reveals that for patients living in situations rated as showing high expressed emotion, the relapse rate is 50%, whereas in the 'low expressed emotion group' the rate is 21%. In a majority of the studies, high expressed emotion was predictive of relapse in symptoms of schizophrenia 9 months later for both genders. A significant amount of face-to-face contact (more than 35 hours per week) with a relative with a high expressed emotion score increased the risk of relapse, but in households with a low expressed emotion score, high levels of contact appeared to be protective. Pakistani families in the UK were more likely to be rated as high expressed emotion than White families, indicating that components such as emotional over-involvement may be cultural rather than pathogenic traits (Hashemi & Cochrane, 1999).

05 - 5. Life events

5. Life events

© SPMM Course 5. Life events (This section is best read in conjunction with the section on Stress in Basic Psychology chapter) The impact of social and family life events on mental health can be measured in two ways. a. Ranking various events according to the degree of association with mental difficulties in a sample and use this list to study other populations. This is the method followed by Holmes & Rahe (1967) Social Readjustment Rating Scale where 43 life events in the last 2 years are rated using arbitrary ‘stress’ units. The death of spouse generates 100 units of stress while divorce tops the rest of the list of stressors list with 73 units. b. Brown and Harris popularized a different method whereby life events are graded according to the inherent meaning of the events to the individual concerned – i.e. contextual rating of the social adversity. Accordingly the effect and impact of a life event is understood in light of one’s current social context and self-perspective. LEDS – Life events and Difficulties schedule was devised by Brown and Harris. Types of life events

1. Loss includes events such as death, respondent initiated separation (long-term separation) and other key losses which are rated as ‘high’ by the subject. If the lower loss is felt by the subject, these are placed at lower dimensions.
2. Humiliation includes other-initiated separation from a spouse or partner or a falling out, quarrelling, or rift in a relationship involving a close tie with a reasonable inference that the separation would be permanent or long duration event. Here the separation or estrangement is either initiated by the other person or “forced” by circumstances such as the infidelity of the subject or marked violence. The delinquent behaviour of a child or a criminal act committed by a close tie could be a humiliation. ‘Put down’ events are events such as rejection or verbal or physical attack by a close tie, or any other person if the event is highly public. This may be humiliating or threaten a core role. It includes all rapes; if the subject feels responsible in some way this might increase the humiliation felt.
3. Entrapment includes long-term sustained entrapment includes serious difficulties that can only get worse or persist according to the subject; or a failed positive event where a potential fresh start went disastrously wrong within 1-2 wk, leaving the person stuck in ‘square one’. It is recognised that the unidimensional measure of severity of life events (either loss or threat, etc.) is not sufficient to explain the effects on mental illness. Combined loss and humiliation events are more depressogenic than a threat or other individual types of events. Humiliation events induce defeat and submission responses which may be directly related to depression. In a study by Kendler et al. (2003), humiliation predicted onsets of pure major depression but not pure generalised anxiety episodes, and danger

© SPMM Course predicted pure generalised anxiety but not pure major depression episodes. But the results had only moderate strength in prediction. Depressed patients may recall more stressful life events due to cognitive bias. It is shown that the frequency of desirable or entrance life events in the depressed population is comparable to controls – so the absence of positive events cannot be the simple explanation for depression. It is demonstrated that those with a recurrent episode of depression have less preceding life events than those with the first episode of depression. This may be related to kindling phenomenon. Genes and life events: Kendler (1997) examined the relationship between genetic vulnerability to depression and the risk of experiencing stressful life events. A reverse causality effect (i.e. vulnerability to depression itself could explain the occurrence of more frequent stressful life events) was demonstrated. In a sample of over 2000 female twins, genetic liability to depression was associated with a significantly increased risk of experiencing an assault, serious marital problems, divorce/break-up, job loss, serious illness, major financial problems, and trouble getting along with relatives/friends. Similarly, the genetic liability to alcoholism impacted on the risk of being robbed and having trouble with the law. Hence, genes can probably impact on the risk for psychiatric illness by causing individuals to select themselves into high-risk environments. Therefore, life events are ‘heritable’ to some extent. Life events measures Semi-structured interviews Life events & Difficulties Scale (Brown & Harris) Interview for Recent Life Events (Paykel) Life events scales Social Readjustment Rating Scale (Holmes & Rahe) Adverse Childhood Events Scale Hassles & Uplifts Scale (Lazarus & Folkman)

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06 - 6. Social factors and mental health issues

6. Social factors and mental health issues

07 - Society as a risk factor

Society as a risk factor

© SPMM Course 6. Social factors and mental health issues Society as a risk factor Engel’s model of biopsychosocial approach is widely used in aetiological formulations in psychiatric practice, highlighting the prominence of social factors in the practice of psychiatry. Social Causation Theory: According to this concept, mental illnesses are caused by social deprivation. Most psychiatric disorders are seen in lower socio-economic class as a mental disorder is seen as directly due to the poverty and social conditions. This theory may hold for some conditions such as depression or alcohol misuse, but not for others such as bipolar disorder or schizophrenia. In a survey sampling males aged 25-34 on first admission of schizophrenia, an expected excess of social class V was noted but social class distribution of fathers of the patients was the same as the general population suggesting that schizophrenia results in a downward drift of economic status rather than poverty being a cause for schizophrenia. This Social Drift or Social Selection Theory was first suggested by Faris & Dunham on the basis of their ‘Chicago study 1922 – 1934’ that explored the relation between the spatial distribution of psychosis and social organization by applying the concentric zone model of urban organization (see the figure from university of Manitoba, Centre of Health Policy website). In this model, the social organization increased with distance from the epicenter. (Inner urban zones = most disorganized and unstable communities; outer zones = most organized and stable communities). Faris and Dunham found that the least socially organized inner urban zones had the highest rates of schizophrenia; they argued that this effect was due to the downward drift in economic status after developing the illness.

Factors mediating the effect of social class: Several factors such as lower educational levels, poverty, immigration, overcrowding, poorer physical health and nutrition influence the higher prevalence of mental illness in some social classes. For example, high parental education levels are associated with a lower risk of ADHD, especially in boys. There is no proven link with food additives but lead exposure is associated with risk. Similarly,

08 - Sociology of mental illness

Sociology of mental illness

© SPMM Course pregnancy complications such as toxaemia or eclampsia, poor maternal health, maternal age, foetal post-maturity, long duration of labour, foetal distress, antepartum haemorrhage, low birth weight and prematurity are associated with ADHD, increasing the likelihood of its prevalence among lower social classes. In fact, Rutter's landmark studies revealed six inter-related risk factors in the family environment that correlated significantly with childhood mental disturbances in general: 1. Severe marital discord 2. Low social class 3. Large family size 4. Maternal mental health disorder 5. Paternal criminality 6. Foster placement. Rutter observed that the aggregate of these adverse factors, rather than the presence of any one factor, impaired development. Poverty and psychopathology: The Great Smokey Mountains study looked at groups of white American and American Indian children grouped into 'poor', 'never-poor' and 'expoor' (ex-poor were those whose income increased annually at later times due to a casino being built on American Indian land). The results showed that before the casino opened poor and ex-poor children had more psychiatric issues, but the levels in the ex-poor fell to the same as never-poor after the casino that produced good income for the ex-poor families opened. The most prominent psychiatric issues responding to poverty were conduct and oppositional defiant disorders while the prevalence of depression and anxiety remained the same. Sociology of mental illness Mental illness as deviance: Society tends to see odd and abnormal behaviour to be against acceptable norms and values and some of these are grouped as mental illnesses. Hence, the deviance becomes an important determinant of illness concept in psychiatry. Edwin Lemert developed the idea of primary and secondary deviance as a way to explain the process of labeling. Primary deviance is any general aberration from expected normality before the person showing such an aberration is identified as a 'deviant. For example, primary deviance may refer to minor rule breaking in society such as over-speeding. With repeated instances of primary deviance, the subject gets labelled, and the institutions react to the deviant actions. This leads one to become secondary deviant. Secondary deviance refers to the actions carried out by a person identified as a 'deviant' by institutions such as the society or the justice system. This refers to the maintenance of primary deviance as a repercussion of the label given.

© SPMM Course Thus, societal reaction initiates sociological/psychological processes which sustain deviance, making it more central to the life of the "deviant." Formal deviance includes breaking a written law or code of constitution as in criminal act; informal deviance includes breaking unspoken social rules of living. Deviancy amplification spiral: Originally applied to crime reporting, the theory

identifies a spiral that starts with a ‘deviant’ act. The media report such acts as newsworthy and start regularly adding non-newsworthy items similar to this act (‘sensationalism’) setting up a bias against the so-called deviant act. As a result, minor problems look serious and rare events are perceived as common. A mounting public concern is the next stage in this spiral, forcing law enforcement to focus more resources on the particular deviancy than it actually warrants. Social construction theory explores how variations in human experience have come to be classed as illness categories; the method used for such investigation is ‘deconstruction’ or discourse analysis. According to the theory, the reality of mental illness is socially constructed and complicated by cognitive interests of social groups – doctors, lawmakers, politicians. Some examples include:

1. Agoraphobia as a concept developed around the time when the social emancipation of women occurred. The condition thus might be partly originated from problematized use of public space.
2. Sexual role stereotypes may play a role in anxiety disorder constructs and psychopathy.
3. Most major mental problems are circularly defined – e.g. a patient with schizophrenia is termed ‘psychotic’ as he hears a voice. When this patient enquires why he hears a voice, he gets told that he hears a voice because he is psychotic. Thus, most labels are circular descriptions constructed by the society. Social labelling or societal reaction theory: Labelling theory originated from the concept of symbolic interactionism. Each person plays many different social roles sanctioned by the society; in each role, interaction occurs with other people and meanings of such interactions are dependent on the role assumed. Thomas Scheff in his book Being Mentally Ill (1966) expanded labelling theory to mental illness. According to Scheff, the social routine is made of numerous, uncategorisable residual rules. These are unspoken and taken for granted often. Residual deviance occurs when these rules are broken, but often these are not noticed unless certain specific circumstances arise. Thus in certain circumstances rule breaking is accepted, ignored or normalised, but labelled deviant on other occasions.

09 - Suicide and sociology

Suicide and sociology

© SPMM Course Thus societal-labelling may occur in one-off crises situations or as a gradual shift from acceptance to labelling, depending on contingencies i.e. the effect of such deviances on others concerned. This might explain the fact that numerous voice hearers live in the community without a diagnosis of schizophrenia and the results from community surveys always showing higher prevalence compared to clinical samples for almost all mental illnesses. Once labelled as mentally ill, the labelled person takes up the role of being a mentally ill individual in the society. This new identity sanctions him certain privileges as a compensation for the loss of other privileges. Apart from the societal reaction, selflabelling will serve to strengthen beliefs with regard to the given role.

Original labelling theory is empirical without much experimental support. A modified labelling theory is now used to explain the effect of stigma on relapses of mental illnesses. Suicide and sociology Durkheim, often adored as the father of sociology, described a sociological model of suicide and described 4 types of suicides. According to him, both an unusually ‘tight’ bondage and a weak adherence to defined societal values can contribute to suicide. These are called altruistic and anomic suicides respectively. Other 2 types are described below.

The Social Origins of Depression Brown and Harris (1978) studied social & economic circumstances associated with the onset of depression in women living in inner London in 1978. They identified 4 ‘vulnerability factors’: 1. Absence of a close confiding relationship; 2. Loss of mother before age of 11; Durkheim’s model Explanation Altruistic suicide Individual is overly attached to social norms and dies for the sake of the society (i.e. for others in the society) e.g. self-molestation among Buddhist monks in Tibet Egoistic suicide Excessive individualism, but low social integration. No cohesive group attachment Fatalistic suicide Society’s control on the individual is very strong such that it interferes with moral values and personal goals Anomic suicide Individual feels that he has no guidance or regulations from the societal system; feels disillusioned

© SPMM Course 3. Lack of employment outside home; 4. Having 3 or more children under 15 living at home. Brown et al.’s further work has revealed the following factors for depression (elaborated by Morris & Morris, 2000); 1. Predisposing factors: these occur before the age of 17. a. Sexual abuse b. Parental indifference c. Parental loss d. Physical abuse (See Brown & Harris original vulnerability factors above) 2. Precipitating factors include a. Acute severe life event b. Chronic stress more than 4 weeks c. Lack of social support 3. Maintaining factors include a. Further negative life events b. Persistent poor quality social support c. Poor coping style: i.Self-blame and helplessness ii.Denial of problems iii.Inability to solve problems iv.Blaming others or external forces d. Inability to obtain adequate social support: i.Fear of intimacy ii.Denial of need for intimacy

iii.Enmeshed intimate relationship e. Low educational level 4. Relieving factors may include a. Positive life events such as i.Fresh or potential fresh start: new role, positive change ii.Removal from source of stress: e.g. separation from violent husband iii.Anchoring: role change and increased security iv.Difficulty neutralisation: ending a difficulty v.Goal attainment. b. Improved quality and consistency of support

10 - Social factors in schizophrenia

Social factors in schizophrenia

© SPMM Course Social factors in schizophrenia The significant social disadvantage (e.g. experience of racism, discrimination, economic and employment disadvantage, the perception of ‘outsider status’) is evident in populations with a higher risk of schizophrenia. According to the social defeat hypothesis, “long-term experiences of social disadvantage lead to sensitization of the... dopamine system and (or) to increased baseline activity of this system, thereby, to an increased risk for schizophrenia." Immigrant populations exemplify this link between social factors and schizophrenia. Stress and Social Adversity: Social adversity is associated with high degree of stress that can be exceptionally harmful in the context of vulnerability to psychosis. This has been demonstrated in many animal studies. Childhood Abuse and Family Dysfunction: While child abuse is not seen as a specific risk factor for schizophrenia, it is now accepted that childhood abuse may be a marker for other potential relevant risk factors, such as family dysfunction that increases the risk. Neighbourhood effect: In neighborhoods with ethnic minorities (non-white) that were at an increased risk, the risk reduced when the population of minorities increased. Similarly, natives had an increased risk in neighborhoods where minorities were larger in number, supporting the notion of social adversity in increasing the risk of schizophrenia. Urban Effect There is a large deal of evidence now to support that in most parts of the globe, children born in urban environments are at an increased risk for psychosis (OR:1.61; CI: 1.4 – 1.8). This urban-birth effect is not consistent among all countries; some Australian research has no increase in psychosis among urban areas. Marcelis et al. (1998) (Dutch National Psychiatric Register study) found that the effect of urbanicity on all psychosis was greater for men than for women. The effect of urban birth was greatest for individuals from the most recent birth cohorts and with an early-onset disease even after correcting for the length of followup. Another study noted a positive correlation between admission rates for schizophrenia and degree of urbanization. There is a consistent dose–response relationship between urbanicity and risk of schizophrenia; the larger the town of birth, the greater the risk.

© SPMM Course Immigration and schizophrenia Though the frequency of most mental illnesses are found to be higher in migrants that the natives, schizophrenia has been studied the most. Conflicting explanations have been offered to explain why migrants have more schizophrenia.

Cooper has revisited and reappraised the data available and summarised the main findings as below: a. The excess risk is not specific for African—Caribbean immigrants. It is also present among African-born Black immigrants to the UK, and to a lesser extent among immigrants from Asian countries. Hence, any explanation cannot be purely biological and not simply race specific. b. Incidence rates of schizophrenia in Caribbean countries are similar to those found in the indigenous UK population; this excludes country of origin theory which proposes that the immigrants carry such higher incidence rates from where they come from. The rate for schizophrenia in second-generation African—Caribbean people born in the UK appears to be higher than in the first generation, which is strongly suggestive of an environmental rather than a genetic effect. c. According to this notion of prepsychotic segregation, individuals who are psychosis prone find it hard to survive in the countries of birth and so immigrate to other regions. There is no evidence for selective immigration from the Caribbean as part of a pre-psychotic segregation. Also notable is the fact that apart from 1st generation immigrants having higher rates of psychosis, the 2nd generation children of immigrants also have a very high rate of psychosis (in some cases, higher than their parents), negating the probability of psychosis-induced immigration. d. The immigrants' pathways to psychiatric care are characterized by long delays in seeking professional help, a lower likelihood of psychiatric referral, and frequent involvement of the police and emergency services and high proportions of compulsory and intensive care and secure (locked) ward admissions. The long-term outcome tends to be correspondingly unfavourable for immigrants. Hospital admission rates are consistently noted to be higher among ethnic minority population as a whole but variations between groups. In UK, highest rates of hospital admissions were noted among Irish migrants followed by people born in Caribbean. The rate of mental illness among South Asian population is notably lower than UK-born white population. It is unclear if these are effects of migration or social disadvantage or organisational differences in pathways of care. Census of inpatients, 2005 showed that 9% of in-patients were black or mixed black-white ethnicity while black patients were 44% more likely to have been sectioned & 50% more likely to have been put in seclusion. Black

11 - Social factors in addictions

Social factors in addictions

© SPMM Course Caribbean men were 29% more likely to have been subject to control and restraint. It is speculated that an association with the use of substances may be a confounder. Schizophrenia and ethnicity: Aetiology & Ethnicity in Schizophrenia and other Psychoses (AESOP) study was conducted in London, Bristol and Nottingham. It reported 2-fold higher rate of incidence of psychosis in London compared to the other 2 centres. Afro-Caribbeans had a 9-fold increase in rates of psychosis. In addition, minority ethnic groups had a far higher likelihood to be detained on first presentation, accessing health often via police than GPs. Social factors in addictions Patterns of substance use across the world are strongly influenced by the sociocultural milieu of human communities. Several social factors shape the population prevalence of substance use behavior. Contextual factors such as neighborhood deprivation appear to be strong determinants of cigarette and alcohol use. Family and social network norms and social support are also important in the cessation of drug use. Factors that are consistently identified in association with substance use and alcohol are listed below (Galea et al., 2004)

Smoking Smoking •Low school achievement •Young among peer cohort •Poorer relationships with their family •Low household income Alcohol use Alcohol use •Disruption of family structure •Social networks that use alcohol •Recent immigration •Small-area deprivation Illicit substances Illicit substances •Peer drug use •Single parenting •Homelessness •Poor educational attainment •Neighborhood disadvantage •Unemployment

12 - 7. The sociology of institutions

7. The sociology of institutions

© SPMM Course 7. The sociology of institutions Goffman described a ‘total institution’ as one ‘whose character is symbolized by the barrier to social intercourse with the outside’. Total institutions share the following characteristics:

1. All aspects of life are conducted in the same premises and under the same unitary authority.
2. Each member’s daily activities are carried on in the immediate proximity of a large batch of others, who are also required to do the same set of activities.
3. All parts of a single day’s activities are strictly scheduled with one leading into the next.
4. The different enforced activities are based on a single plan whose purpose is the fulfilment of the proposed official (or statutory) aims of the institution. Goffman also described the ‘moral career’ of a mentally ill patient i.e. the process whereby a person with social ties, friends, and family in the community is institutionalized and converted into an inmate whose world is limited to his immediate hospital ambience (Peele et al. 1977). See the figure below for more details.

© SPMM Course According to Goffman although the stripping process and privilege system are offered in the disguise of being in the patient’s best interests and on therapeutic grounds, the real purpose is to break his spirit and make him more manageable. The stripping process and privilege system introduce him to a therapeutic milieu and offer him a new identity – the patient identity. Batch-living: This refers to the pattern in which all inmates did ‘the same thing’ and led a very similar life inside institutions. Binary living: Lives of the staff are in stark contrast as they have power, connection with the outside world and could change their lives in the way they choose. A binary division exists between staff and inmates. Goffman considered ‘secondary adjustments’ as a direct result of institutionalization and as a hallmark of institutionalism. Secondary adjustments refer to the habitual arrangements used by patients who now act as if their major concern is to escape the pervasive control of the institution. These were usually unauthorized activities leading to obtaining of unauthorized ends. Step 1 Step 1 •BETRAYAL FUNNEL: People we trust most – family and friends – conspire against us when we are unwell, reporting our actions to doctors and

mental health professionals (called the ‘circuit of agents’) who run the decision-making process. Step 2 Step 2 •ROLE STRIPPING: The institutionalization process begins with a series of assaults on the recruit’s self. The process of stripping inmates of their identity involves such initiation rituals as trading personal clothes and belongings for hospital issue Step 3 Step 3 •MORTIFICATION: Mortification procedures that consist of a series of assaults on the inmate's self-image. At the end of mortification one becomes a ‘full member’ of the institution. Private, personal activities go on public display; he must request permission for even the most minor activities that were purely volitional on the “outside,” such as smoking, shaving, or going to the toilet. This is termed as civil death. Step 4 Step 4 •PREVILEGE SYSTEM: The patient is then inserted into the lowest rung of an allembracing privilege system. This system is based on the house rules. The privileges are usually reductions in the institution’s control over the patient’s life. Freedom is a token of reward.

 Russell Barton (1976) described 'institutional neurosis', characterized by apathy, lack of initiative, loss of interest and submissiveness. The proposed causes of institutional neurosis include loss of contact with the outside world, enforced idleness, brutality and authoritativeness of staff, loss of friends and personal possessions, poor ward atmosphere and loss of prospects outside the institution. Social reactivity and schizophrenia: Wing & Brown explored social etiology of negative symptoms of schizophrenia. They surveyed asylums (Mapperley Hospital at Nottingham, Netherne in south London and Severalls in Essex) that existed in the late fifties and concluded that social poverty and lack of stimulation were very much related to the severity of blunted affect, poverty of speech, and social withdrawal – these were termed as ‘clinical poverty’. But such relationship was found to be weak in a reappraisal in 1990. (Curson et al., 1992). It was also feared that too much stimulation could provoke positive symptoms in these patients. Thus, social reactivity is considered to be an important phenomenon in the phenomenology of schizophrenia. Morgan (1979) coined the term malignant alienation to describe a process characterised by a progressive deterioration in the relationship between carers (staff in a ward) and a patient, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable, or overdependent. In some instances, such alienation may precede suicide / attempted suicide of the patient

13 - 8. Criminology and penology

8. Criminology and penology

© SPMM Course 8. Criminology and penology In simple terms, criminology is the study of crime, its origin and effects; in a broader sense criminology is said to include the study of: i) Attributes of a criminal. ii) Characteristics and extent of crimes. iii) Effects of crime on victims and society. iv) Methods of crime prevention. v) Types of crimes.

3 levels of explanation are often discussed with respect to the origin of criminal behaviorIndividual level (personal characteristics of the criminal), Situational or contextual level (immediate circumstances or situations), Social-structural level (social relationships, milieu and institutions). Different theories of criminology tend to construct their primary explanation for criminal behaviour at one of the above levels. Penology comes from the Latin word poena (punishment). Penology deals with the societal response and treatment of crime and criminals and thus focuses on the characteristics and workings of the Criminal Justice System. Also known as penal science, the broad goal of penology is to aid society repress criminality. In this sense, it mostly deals with the punishment of the offender but in the context of mental health issues, penology also covers medical treatment and education that aims at rehabilitation and social inclusion of the offender. Relationship between crime and mental health: It is difficult to have a clear-cut understanding of the relationship between crime and mental health. By definition, crime is understood in a social context; what is a crime in one setting may not be a crime in another time or place. So acquiring data relating crime and mental health is very difficult. Also, convictions are not same as crimes. Most data available pertains to conviction rates; nonconvicted or unregistered crimes are far too many. Also, it is not easy to study if the mental illness was directly related to an offence. A mentally ill person can commit a crime as everyone else could, but whether it is related to his mental illness is the most important but often unanswerable question.

14 - 9. Stigma and prejudice

9. Stigma and prejudice

15 - Themes of stigma

Themes of stigma

© SPMM Course 9. Stigma and prejudice Stigma is an attribute, trait or behaviour that that is considered shameful; that symbolically marks the possessor as unacceptable and inferior or dangerous. (Goffman) STIGMA TYPES Enacted stigma refers to a patient's actual experience of discrimination Felt stigma refers to a patient's fear of experiencing a discriminated act; it is more prevalent and more disabling than enacted stigma. Public stigma is the reaction that the general population has to people with mental illness. Self-stigma is the prejudice which people with mental illness hold against themselves; this internalized stigma develops from the prolonged societal response. Courtesy stigma refers to the stigmatization unaffected person experiences due to his or her relationship with a person who bears a stigma e.g. parents of children with psychiatric conditions.

Not In My Back Yard or NIMBY opposition refers to the vehement disapproval by local authorities, and social groups for localization of a community mental health facility in a geographic area due to the fear and stigma against the mentally ill. Mind (National Association for Mental health) organized a survey to measure NIMBY opposition wherein more than 2/3rd of mental health services faced such opposition in England and Wales. Fear of children's safety, falling house prices and violence were the main concerns for the opposers. Themes of stigma Hayward & Bright described 4 major recurring themes or beliefs behind the stigma against mental illness. These include: 1. Dangerousness 2. Attribution of responsibility 3. Poor prognosis 4. Disruption of social interaction These 4 themes formed the basis of an Office of National statistics survey in the UK measuring public attitudes towards mental illness. Schizophrenia and addictions were regarded most negatively; approximately 60% respondents thought addicted individuals have only themselves to blame for their problems. Most individuals knew the difference between various disorders and most felt that depression and anxiety are treatable. Little change was recorded over 10 years, with over 80% endorsing the statement that "most people are embarrassed by mentally ill people", and about 30% agreeing, "I am embarrassed by mentally ill persons" (Huxley, 1993).

© SPMM Course Surveys (e.g. Jorm et al., 1997) carried out on health professionals and the public with a case vignette show that: 1. Professionals give much higher rating than the public for the helpfulness of antidepressants for depression, and of antipsychotics and admission to a psychiatric ward for schizophrenia. 2. Public give much more favourable ratings to vitamins and minerals and special diets for both depression and schizophrenia, and to reading self-help books for schizophrenia 3. The beliefs that health practitioners hold about mental disorders differ greatly from those of the general public. Hagighat proposed a unifying theory of stigma, which states that stigma serves the selfinterest of the stigmatisers in different ways as follows: Constitutional origins: Quick and easy stereotypes at the expense of sophistication and depth. The human brain

weights negative evaluations preferentially to positive ones. Similarly, it is likely to interpret repeated episodes of violence by a few as independent episodes of violence committed by the ‘mentally ill’. It links negative (rarer than neutral or positive) events with rare objects (e.g. minority groups). Psychological origins: Human tendency uses the example of the ‘unfortunate other’ to feel happier about themselves e.g. those rewarded the same as others feel less satisfaction than those in groups with others rewards less for the same work. Those with low self-esteem derogate others to bolster their self-esteem and sense of wellbeing. These psychological dividends benefit the stigmatisers in the presence of the stigmatised. Economic origins: To increase one's access to resources, stigmatisation of rivals is used as a weapon in the socio-economic competition. Stigmatisation is likely to be more intense in more competitive, self-seeking societies. Evolutionary origins: Stigmatisation may have an evolutionary advantage in some way. A strong discrimination includes avoiding such discriminated population from being chosen as mates of sexual function. How does stigma evolve? (Link and Phelan 2001) 1. Labelling: people distinguish and label human differences. 2. Stereotyping: dominant cultural beliefs are used to group and categorise labelled persons to undesirable characteristics— to negative stereotypes. 3. Separation: the labelled persons are placed in distinct categories with an observable degree of separation of "us" from "them."

16 - Interventions against stigma

Interventions against stigma

© SPMM Course 4. Status loss and discrimination follow soon after. According to Corrigan three different stigma components can be distinguished: stereotypes (e.g. schizophrenics are violent), prejudice (endorse negative stereotypes result in emotional reactions) which lead to social discrimination (the resulting behavioural reaction). Dimensions of stigma (Jones et al., 2000)

1. Concealability - how obvious or detectable the characteristic is to others. Less concealable problems are more stigmatised.
2. Course - whether the stigmatizing condition is reversible over time, with irreversible conditions tending to elicit more negative attitudes from others.
3. Disruptiveness - the extent to which a mark strains or obstructs interpersonal interactions. The degree of stigmatisation is directly proportional to the degree of disruption in social interaction produced by the condition.
4. Aesthetics - the attractiveness or pleasing nature of a presentation to one's perceptions; A disorder that elicits an instinctive, and strong reaction of disgust will be more stigmatised.
5. Origin - one’s understanding of causal factors. A condition thought to be self-inflicted will have a higher stigma.
6. Peril - feelings of danger or threat that a condition induces. Highly threatening problems are highly stigmatised. Interventions against stigma MIND after NIMBY survey proposed 3 types of antistigma interventions: Rights based – legal methods Normalising approach – popularising the fact about how common mental illness are – e.g. 1 in 4 film from Changing Minds campaign, improving contacts between mentally ill and the neighbours, etc Educational media-based approach – highlighting the role of balanced reporting by media. Legislative intervention: Not much experimental evidence available to support that antidiscrimination legislation would or would not change public stereo-types. Legislation may reduce discriminatory acts but not the prejudice or stereotypes held. It may increase debate and self-questioning about stigma. People may change behavior to avoid legal sanctions. But there is a risk that suppressed discrimination will be shown in subtle, unpunishable forms. This may suppress but not eliminate stigma. Affective intervention: e.g. increasing contacts between local neighbourhood and the mentally ill patients living in a hostel. The generalization from a few hostel inmates in a

© SPMM Course locality to the whole category of mentally ill cannot be drawn. It is also noted that when such contacts were encouraged, the mobility of neighbours of such hostels was higher than that of people in a control street. Such measures also have the risk of reinforcing a stereotype by sub typing the better ones and differentiating them from the ‘dangerous’ ones. Public education: had mixed results, but focussed interventions can increase socially desirable responses around stigma in the post-campaign survey but no improvement in behaviour. N.B. ignorance is not the only cause of stigma. Liz Sayce (‘Psychiatric patient to citizen’) provides four different models for addressing stigma and social exclusion. These are A. Brain disease model - also known as ‘no fault’ approach – it’s an illness like any other. This has the danger of lacking credibility, is too paternalistic and may make ill-person ‘a victim of fate’. B. Individual growth model - considers a continuum or spectrum of mental health and illness. In this model, good mental health, emotional distress triggered by bereavement and enduring psychosis are related experiences (dimensional). The continuum approach has been critiqued as advocating for the status quo rather than attitude shifts involving cultural change though it is a popular approach particularly in mental health promotion. C. Libertarian model - advocates equal rights and equal criminal responsibility for mental health service users. The biggest concern is that the net result will be a series of losses for people with mental health problems rather than gains particularly in the courts and workplace. D. Disability inclusion model - the favoured approach that promotes the concept of social inclusion on civil rights grounds and not just paternalistic ‘help’. Disability is the impairment plus the effects of socially imposed barriers and prejudices faced by the individual. Changing Minds was a 5 years campaign spearheaded by Kendell and colleagues at the Royal College of Psychiatrists. In the RCPsych 1998 survey, 70% believed that people with schizophrenia are violent and unpredictable. Various anti-stigma measures were devised and popularized. 1 in 4 is a short 2-minute film aimed at young adults aged 15-25 to challenge preconceptions about mental illness. 1 in 4 refers to how common mental illnesses are. ‘Every Family in the Land’ is a book on stigma published in conjunction. Various other methods such as tube cards, press articles and videos and road shows were also conducted Labelling and stigma: A survey of nearly 5000 German nationals revealed important findings regarding the effect of diagnostic labeling on the stigma (Angermeyer et al. 2003). Labeling as mental illness has an impact on public attitudes towards people with

© SPMM Course schizophrenia. Endorsing the stereotype of dangerousness has a strong negative effect and increases the preference for social distance. By contrast, perceiving someone with schizophrenia as being in need of help evokes mixed feelings and affects people's desire for social distance both positively and negatively. Labeling has practically no effect on public attitudes towards people with major depression. Normalization is a concept that emerged in the context of the deinstitutionalization of people with developmental disabilities. It focuses on providing disabled individuals with a life in “normalized” settings in the community. It can be defined as “the utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible” (Wolfensberger 1972) Social role valorisation was formulated in 1983 by Wolf Wolfensberger to expand the scope of the principle of normalization. SRV aims to create social roles for devalued people to enhance their competencies. In other words, SRV deals with the enablement, establishment, enhancement, maintenance, and/or defense of valued social roles for people. SRV is primarily a response to the historically universal phenomenon of social devaluation and especially societal devaluation.

17 - 10. Culture and mental health

10. Culture and mental health

Comparative psychiatry refers to the study of mental illness in different sociocultural settings; Kraepelin traveled to Southeast Asia and developed the concept of comparative psychiatry. This is now referred to as transcultural psychiatry. Two perspectives of cultural studies often discussed: Emic perspective (emic view): Used to refer to the perspective of an individual from a specific cultural group about his own group. Etic perspective (etic view): Refers to the perspective of an individual outside a specific cultural group about the studied group. The etic approach, for instance, involves applying Western psychiatric concepts en bloc into a different culture and uses it for diagnosis. This approach assumes

1. Universality of illnesses
2. Invariance of core symptoms
3. Validity of diagnostic constructs

Different views in etic / emic approaches:

ETIC approach EMIC approach Diagnosis of mental illness Similar core symptoms in all cultures Linguistic and cultural variations acknowledged Classification system Common classificatory systems endorsed Locally derived systems endorsed Preferred measurement method Identical rating scales and measures across nations

Preferred research method Quantitative methods emphasizing reliability are preferred Qualitative methods emphasizing cultural validity Treatment methods Biomedically driven Local belief driven Help seeking behaviour Provision of services most important Individual health belief and explanatory models most important

Ethnicity is often defined by a set of cultural patterns (values, beliefs, roles, affective and cognitive styles, and norms), heritage, or ancestry shared by a social group of common national or

geographic origin.

© SPMM Course Term Characters Determined by Perceived as Race Physical appearance Genetic Permanent Culture Behaviour & attitudes Upbringing (enculturation) and choice Changeable (see acculturation) Ethnicity Group identity Social; pressures, psychological need for identification Partially changeable (From Seminars in Gen Adult Psych 1e. Pg. 783) Acculturation refers to the process of cultural change that takes place when an individual or a group comes in continuous contact with a culturally distinct group. Acculturation can result from immigration and can occur in either direction – hosts can get accultured; as evident in certain places in times of Colonial rule. Four types are described according to the degree of retention and adoption of the two cultures at ethnocultural group level: Berry's model of acculturation High degree of retention of culture of origin Low degree of retention of culture of origin High degree of adoption of new culture INTEGRATION ASSIMILATION Low degree of adoption of new culture SEPARATION MARGINALISATION

 Assimilation: This refers to partial adaptation of a new culture (seen in migrants or refugees) without retaining or giving up all of one's culture of origin completely. Integration refers to both high retention of one's own cultural values and high adoption of the practices of the new culture. Separation refers to high retention of one's own cultural values and low adoption of the practices of the new culture. Marginalisation refers to both low retention of one's own cultural values and low adoption of the practices of the new culture. These individuals get marginalized by members of both culture of origin and culture of adoption. When someone loses the identity of one's culture of origin voluntarily e.g. upon immigration but does not assimilate or integrate, then the risk of loss of cultural identity and subsequent increase in mental illness are noted.

© SPMM Course Enculturation refers to culture being learnt through contact with family, friends, teachers and the media. This happens to everyone irrespective of migration. At a larger societal (as opposed to small group) level, Berry's model is often mapped using the terms given below: Berry's model of acculturation High degree of retention of individual culture identities Low degree of retention of individual culture identities High degree of relationship among various cultures MULTICULTURALISM MELTING POT Low degree of relationship among various cultures in the society SEGREGATION EXCLUSION

Cultural bereavement refers to a self-limited grieving response developed by an individual on leaving his own culture. Cultural diffusion or syncretism refers to the spread of cultural traits (including psychiatric syndromes, treatment methods) through contacts across societies. This leads to creating innovations that are distinct from both groups. Sojourning refers to voluntary but brief exposure to different culture e.g. tourists, Peace Corps volunteers. Nostalgia or homesickness is common in sojourners and can be reduced by shortening length of stay, keeping in touch with family and friends at home and learning about a new culture before arrival. Segregation: This refers to removal of people from communities and placing them in an artificial community, which is more or less an institution. Goffman described 5 types of segregation:

1. Incapable harmless – orphanages and old age homes
2. Ill but threat to society – mental hospitals
3. Not ill, threat to society with malice – prisons

4. Occupation related – military barracks, boarding schools
5. Retreat from the world – monasteries, convents.

What happens when a family emigrates?

© SPMM Course 1. The elderly often find difficult to adapt and change – rejection of new culture happens 2. Complete assimilation is seen in young children 3. A bicultural pattern is seen among young adults in working age – at work they adapt to new culture, but at home they remain attached to the culture of origin.

Function of culture in psychiatric practice The five elements of cultural formulation (American Psychiatric Association, 2002)

1. The cultural identity of the individual
2. Cultural explanations of the individual's illness
3. The influence of the patient's psychosocial environment and level of functioning within it
4. Cultural elements in the patient–professional relationship (this requires the psychiatrist to be knowledgeable of her own cultural values and beliefs)
5. The use of cultural assessment in deciding diagnosis and care. The concept of explanatory models Patients' explanatory models are not fixed and are influenced by the circumstances of their symptoms, age, gender, educational attainment, time point and context of assessment and importantly their cultural beliefs. Explanatory models themselves can influence a physician's assessments. The process of exploring patient's identity and explanatory model ensures improved understanding and informs the successful negotiation of different worldviews. This exploration does not require psychiatrists to enter into another culture as a participant observer. Idioms of distress Culture as an explanatory tool: This allows description of non-pathological behaviours in the context of one's culture. Culture as a pathoplastic agent: This allows description of psychopathology that result from cultural practices. Culture as a diagnostic factor: This allows culture-specific, unique diagnostic framework e.g. culture-bound disorders Culture as a service instrument: This allows utilization of cultural knowledge in service delivery and resource distribution.

© SPMM Course Idioms are well-structured and codified way expressing thoughts via language. Idioms in one language cannot be translated as such to another – they lose their meaning out of context. In cultural psychiatry, idioms of distress refer to somatic symptoms that serve as a code for expressing one's mental distress in some cultures. Models of care in cultural psychiatry: Culturally sensitive care could be delivered using various models. Some of these include 1. Ethnic minority services: Separate services are set up for the growing minority population, but there is a risk of organizational marginalization in such models. 2. Cultural consultation model: This has been tested in Canada. It consists of a specialized multidisciplinary team which provides consultations to other clinical teams, sometimes to the families directly. They do not provide direct patient care. 3. Melting pot model: In this model, institutional factors promoting inequalities are addressed. Culture is not perceived as a problem area that needs special resources. Instead, mainstream services are commonly enriched by responding to all cultural groups' needs. This guarantees equality of access in care. (Melting pot refers to regions or countries that accommodate other cultures in huge

numbers, eventually paving way for a high degree of admixture and cultural mosaicism, e.g., United States). 4. A hedge-your-bets approach: Following both prescribed medication and ethnic, spiritual therapy may be the best hope for securing adherence. This encourages honest discussion with family and maintaining religious affiliations.

18 - 11. Culture Bound Syndromes

11. Culture-Bound Syndromes

Culture bound syndromes are identified in both ICD and DSM classification systems. Most of these syndromes are merely locally flavoured varieties of illnesses found elsewhere. Most actually occur in many unrelated cultures. More than the symptom profiles of the syndromes, the explanatory mechanisms like witchcraft or humoral imbalances are the defining features. Such illness beliefs can lead to behaviours that would seem to indicate disordered thought processes outside their cultural context, which actually make sense within the context. For example, consider the Chinese syndromes of pa-feng and pa-leng below.

 Amok (F68 disorder of personality and behaviour) Mostly dissociative not psychotic in nature. Starts with sullen period, followed by outburst of violent, sometimes homicidal behaviour; A return to premorbid state occurs after the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or an exacerbation of a chronic psychotic process. Seen in Malaysia, Laos, Philippines, Papua New Guinea, and Puerto Rico. Ataque de nervios (F45 somatoform)

An attack of distress wherein sudden shouting, crying, beating oneself on chest with dissociation and panic attacks can occur with a sense of being out of control. May have loss of consciousness or amnesia afterwards. Related to acute stress (trauma or family conflict) A sense of heat arising from chest into head may be present Mechanism: dissociative trance. Berdache North America Term for a male who has assumed female gender role Bouffee delirante Seen in French-speaking nations where a sudden outburst of agitated and aggressive behaviour, confusion resembling an episode of brief psychotic disorder. West Africa and Haiti commonly. Brain fag West Africa – seen in students with difficulties in concentrating, remembering, and thinking. A type of somatoform illness. Dhat (F48 / F45: neurotic disorder / somatoform autonomic) India/SE Asia Refers to severe anxiety and hypochondriacal concerns associated with the seminal discharge accompanied by feeling weak and exhausted. Called shenkui in China (fear of loss of yang from men: see below) According to old Hindu tradition, it takes forty drops of blood to create a drop of bone marrow and forty drops of

bone marrow to create a drop of sperm Frigophobia (Pa-Leng : fear of cold; Pa-Feng: fear of wind) (F40 specific phobias) A morbid fear of feeling cold / wind due to presumed yin-yang imbalance. Yin-yang refers to Oriental psychological notion of two opposing forces; yin is dark, female and negative force. Yang is bright, male and positive force. Excessive yin in males leads to pa-leng or pa-feng Affected men typically bundle themselves in warm clothing, avoid wind or drafts, and eat foods that are symbolically and calorically "hot' while avoiding foods that are "cold"

Koro (Turtle Head) (F48 / F45: neurotic disorder / somatoform autonomic) Malaysia, SE Asia Refers to an episode of sudden and intense anxiety that the penis (or, in women, the vulva and nipples) will recede into the body and possibly cause death. Can occur as epidemics! Latah (F48 / F44: neurotic disorder / dissociative) Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behaviour seen in middle-aged women. Malaysia and south East Asia

© SPMM Course Mal de ojo Mediterranean concept of evil eye affecting children with physical symptoms mostly. Nerfiza or Nevra Egypt, Greece and Central America Common, often chronic, episodes of extreme sorrow or anxiety, inducing a complex of somatic complaints such as head and muscle pain, diminished reactivity, nausea, appetite loss, insomnia, fatigue and agitation. The syndrome is more common in women than in men. Often treated with traditional herbal teas Piblokto (F44 dissociative) Dissociative episode with excitement often followed by seizures and coma lasting up to 12 hours. May be withdrawn before the attack and usually has amnesia for the episode; they may tear off clothing, shout obscenities, eat faeces, jump into ice cold water naked etc. Seen in Arctic Eskimo communities (Inuits) Shinkeishitsu “Nervous traits’ in Japanese A syndrome of obsessions, compulsive perfectionism, social withdrawal, extreme sensitivity and neurasthenia. Susto (F48 / F45: neurotic disorder / somatoform autonomic) Attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Tajin-kyofu-shou (F40.1 / 40.8 social phobia) Japanese psychiatric syndrome Fear of losing good will of others due to imagined shortcomings of oneself Social anxiety, tremulousness, self-consciousness and a sense of physical defect or deformity Can develop into anthropophobia (fear of people) – a severe form of social phobia four subtypes: sekimen-kyofu (the phobia of blushing – closer to social phobia), shubo-kyofu (the phobia of a deformed body- closer to body dysmorphic disorder), jikoshisen-kyofu (the phobia of eye-to-eye contact), and jikoshu-kyofu (the phobia of one’s own foul body odor). Ufufuyane, (singular), Amafufunyane, (plural), Seen in Kenya, Southern Africa; Bantu, Zulu; and affiliated groups Anxiety state attributed to the effects of magical potions (given to them by rejected lovers) or spirit possession Characteristic sobbing, repeated neologisms, paralysis, trance-like states, or loss of consciousness in young, unmarried women, who may also experience nightmares with sexual themes, and rarely episodes of temporary blindness. Windigo (F68 personality and behaviour) Involves an intense craving for human flesh and the fear that one will turn into a cannibal. Seen among Algonquian Indian cultures (Adapted from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed. Washington, DC.)

Piblokto Windigo Brain Fag Boufee delirante Mal-de-ojo, Ataque de nervios, susto © SPMM Course

Pa-leng Tajin-kyofushou, Shinkeishitsu Amok, Koro, Latah Dhat Ufufuyane 40

© SPMM Course What effect can culture have on psychopathology? Tseng described 6 different effects:

1. Pathogenic: Culture is directly causative
2. Pathoselective: tendency to select certain culturally influenced reactions (e.g. culturally sanctioned suicide of wife when husband dies prematurely)
3. Pathoplastic: Culture influences the manifestation e.g. delusional content. Acute onset of schizophrenia was seen in 40.3% in developing nations compared to 10.9% of cases in West. WHO conducted a collaborative study in 4 countries (Montreal, Tehran, Nagasaki, Tokyo and Basel) using the Schedule for Standardised Assessment of Depression – this study observed that there was a significant similarity in the core symptoms across various nations, the differences were quantitative rather than qualitative in terms of depressive symptoms.
4. Pathoelaborating: Universal behavioural reactions that are selectively reinforced by a culture
5. Pathofacilitative: cultural beliefs affect the frequency of onset by facilitating risk factors.
6. Pathoreactive: culture affects the treatment, stigma and outcome. Interestingly, the prognosis of schizophrenia seems much better in developing than developed nations. But remission was achieved by 62.7% in developing countries compared to 36.8% in the West (IPSS Data – WHO).

19 - 12. Philosophy in psychiatry

12. Philosophy in psychiatry

20 - Anti psychiatry movement

Anti-psychiatry movement

© SPMM Course 12. Philosophy in psychiatry Philosophy concerns the framework of ideas within which we consider facts presented to us rather than the facts themselves. William James asserted “philosophy is an unusually stubborn effort to think clearly”. Several streams of philosophical enquiries are often invoked to provide clarity and enquire the concept psychiatric disorders. These include the issues of

1. Illness status of mental symptoms: Consider hypomania and its relationship with a cheerful disposition. Various mental symptoms have questionable illness status that blurs the clinical distinction of disease from normality.
2. Influence of morality, legality and mental health: In general psychiatric disorders are more value-laden than physical disorders e.g. psychopathy and its relationship with delinquency, alcoholism and its relationship with drunken behaviour, etc. Societal norms regarding expected functions and roles profoundly influence the identification and treatment of psychiatric disorders.
3. The issue of ownership or agency: This is especially relevant for symptoms of psychosis.
4. Variation of symptoms: The signs and symptoms of mental disorders are diverse with the variation spanning across different dimensions e.g. organic-functional, mind-body, statetrait, etc.
5. Similarities and differences with physical disorders: This has been a crucial issue in the debate between pro-psychiatry and anti-psychiatry groups. Anti-psychiatry movement David Cooper coined the term ‘anti-psychiatry’ in 1960s. The term refers to a confederation of psychiatrists, psychologists, nurses, social and welfare workers, lay people and patients who oppose the traditional mental health practice and treatment. The central contentions of the antipsychiatry movement are about the diagnostic labels used, lack of agreement and measurability among practitioners with regard to diagnosis, stigma carried by labeling and the problems with current treatments which are seen as more damaging than being useful. Invoking various streams of philosophical enquiries (see the list above) to study the concept of psychiatric disorders, we can identify five major themes of arguments in the pro- vs. antipsychiatry debate. The psychological model: Mental disorders are learned abnormalities of behaviour; hence the disease model is inappropriate (Eysenck, 1968).

21 - Philosophical basis of psychopathology

Philosophical basis of psychopathology

© SPMM Course The labelling model: The features of ‘so called’ mental disorders are, in fact, the response of an individual labelled as deviant (see the section on sociology above). Hidden meaning model: Apparently irrational behaviours deemed as ‘symptoms‘ are indeed meaningful for the patient; thus they do not characterise a disorder at all. Unconscious mind model: Apparently irrational behaviours representing ‘symptoms’ are indeed products of an unconscious process and thus can be made comprehensible (psychoanalytic view). Political control models: The medical model of insanity is a socio-political scheme devised for the purpose of legitimizing the control of the ‘deviant, dangerous, or the undesirable’ (Also known as Foucault stance). Three major pioneers are 1. R.D. Laing, 2. Thomas Szasz and 3. Foucault. R.D.Laing wrote ‘The Divided Self’ (1959), ‘Sanity, Madness and the Family’ (1964). Thomas Szasz wrote ‘The Myth of Mental Illness’ (1961) and ‘The Manufacture of Madness’ (1971). Foucault wrote Madness and Civilization (1965). R.D. Laing famously said, “insanity need not always be a breakdown; it can also be a breakthrough”. He also said, “insanity sometimes is the sane response to an insane society.” Philosophical basis of psychopathology Human experience is varied and wide. In order to study the details of human experiences, a student of psychiatry must initially reduce such broad human experience into a simpler subject matter. Phenomenology is a method to define more clearly that which we seek to reduce, namely, the subjective essence of the given experience. (Broome, 2007) Karl Jasper: Karl Jaspers is widely considered a major figure in philosophy and psychiatry. Jaspers method of philosophical enquiry into symptoms of psychiatry has laid the foundation for descriptive psychopathology that we use today. He introduced phenomenology, a long regarded as a method of philosophic enquiry, to psychiatry. He also distinguished the difference between causal explanation (aetiology) and meaningful understanding (description) in psychiatry. In fact, he provided what Ghaemi (2007) regards as the first scientific foundation to psychiatry. The Understanding/Explanation Distinction: This dichotomy was clearly explained by Jaspers. By understanding (Verstehen), Jaspers referred to the psychological intuition that an individual could have about the meaning of a psychological state or event for another individual. By explanation (Erklären), Jaspers referred to the observable influence of one event or process on another that could be tested objectively. One can understand this distinction if one considers the

© SPMM Course fact that ‘explanation’ applies best to natural sciences (physics, chemistry, biology) and understanding applies best to human sciences (like history and art). Psychiatry requires both understanding and explanation for further study. Descriptive psychopathology differs from explanatory psychopathology in that it does not attempt to explain causality; it restricts itself to ‘understanding’ human experience through the description of what is observed. For this to be practiced, one needs a common language or terminology. By studying the glossary of psychopathology, one can prepare oneself for further enquiries in psychiatry. Hence, it is clear that there are two components in descriptive psychopathology. The initial process is one of observation of behaviour; this is accompanied by an empathic assessment of subjective experience. The latter is referred to by Jaspers as phenomenology. To describe a phenomenon, it is important to appreciate the phenomenon from the beholder’s position. This attempt to ‘feel like how your patient might feel’ is very different from feeling sorry or pitiful for your patient. The former is called empathy while the latter is called sympathy. Empathy is an essential component of learning further about the pathological processes taking place in a patient. Phenomenology purports to employ various philosophical approaches to defining the symptoms of psychiatric disorders.

1. Ostensive: illustrating a concept by clinical experience; defining by examples
2. Conventional: defining a concept using conventional description e.g. legal definitions
3. Persuasive: deliberate employment of a term to persuade users to employ it in a specific manner
4. Declarative: formal explanation of the significance of a word or its constituent parts, as used in the dictionaries
5. Contextual: defining a concept by the contexts in which it generally occurs e.g. lack of energy is related to depression
6. Essential: defining the nature of an object
7. Semantic: defining what a word means using other words

Explanatory psychopathology assumes causative factors based on theoretical constructs. Such explanations may be derived from experiments e.g. behaviourism or derived from arbitrary hypothetical theories e.g. psychoanalysis.

22 - 13. Ethics in psychiatry

13. Ethics in psychiatry

© SPMM Course 13. Ethics in psychiatry Ethics provides guidance on decisions that we make in clinical practice. The first written book on medical ethics was authored by Ishaq bin Ali Rahawi. This book called Adab al-Tabib (Conduct of a Physician), is thought to be first published in 9th century Hammurabi code is the first attempt in history to codify medical competence and legal liability for negligence. It is mostly concerned with surgical negligence and imposes eye-for-eye sentences for assaults on noblemen though slaves can be ‘replaced if accidentally damaged’! Hammurabi cannot be regarded as a code of ethics. Charaka, an ancient Indian physician, proposed what seems to be the earliest of medical ethics relevant to modern medicine. This clearly outlined four ethical principles of a doctor: Friendship Sympathy towards the sick (Caring attitude) Interest in cases according to one's capabilities and No attachment to the patient after his recovery. Charaka also emphasised the personal values central to the nobility of the profession, thus: 'Those who trade their medical skills for personal livelihood can be considered as collecting a pile of dust, leaving aside the heap of real gold'. Furthermore, 'He who regards kindness to humanity as his supreme religion and treats his patients accordingly, succeeds best in achieving his aims of life and obtains the greatest pleasures'. Charaka also advised his fellow practitioners to “always strive to acquire knowledge” (i.e. Continuous Professional Development in modern terms) and highlighted the importance of confidentiality. Present day ethical principles:

1. Higher order principles: Deontology and teleology are two alternative higher-order ethical principles concerning current medical practice. The term Deontology derives from the Greek ‘Deon’ for ‘duty’ indicating the centrality of rules in governing medical practice. Accordingly, rights and duties determine action and so it is also called as absolutism. According to Ross, some duties are right because of their very nature (such as the duty to tell the truth); these are called prima facie duties. Others are right in particular circumstances, called duty proper. Whilst this approach (duty-based approach) provides security and clarity, there may be conflicts in managing particular problems and meeting the individual patient’s wishes and needs. Examples of rules include GMC Good medical Practice and the RCPsych code of ethics.

© SPMM Course The term Teleology derives its name from the Greek ‘Teleon’, meaning ‘purpose’ and the central concept is that rather than rights, people have interests, whether these are concerns, desires or needs. Accordingly, the broad judgment of benefits and harm determine medical practice. It assumes that the right action is the one that has the best foreseeable consequences. It is also called as consequentialism or utilitarianism. Utilitarianism takes two forms: Act utilitarianism deals with a specific act only (situational ethics). Rule utilitarianism deals with general practices (for which rules can be established). Evaluation of utilitarianism: The

strengths of utilitarianism lies in its practicality and clarity. It approximates the principle of ‘beneficence’ (see below) and fits well with approaches to public policy. Two factors extraneous to psychiatry influence utilitarianism's position in psychiatric ethics. First, legislated responsibilities of psychiatrists, particularly in relation to issues of public safety (e.g., when applying Mental Health Act). Such legal imperatives are invariably utilitarian in nature and have usually emerged in the context of social and political responses to issues such as public safety especially in relation to forensic patients. The other factor promoting utilitarian thinking in psychiatric ethics has been the profound changes to healthcare systems in the face of globalization and financial pressures (managed care settings). 2. Prima facie principles: American philosophers Tom Beauchamp and James Childress and British doctor & philosopher Raanon Gillon pioneered the following prima facie principles: autonomy—respecting patients' wishes and freedom of choice beneficence—acting in patients' best interests Non-maleficence—avoiding harm – primum non nocere. Justice—treating problems equally, with equitable distribution of resources to the needy. These four principles are the main guiding aspects of current practice, and most other related ethical discussions relevant to clinical practice can be brought under these topics. 3. Models of doctor – patient interaction: The paternalistic model. It is assumed that the doctor knows best. It is an autocratic model where treatments are prescriptive. May be desirable in emergency situations. But often this approach results in a clash of values.

23 - Landmark publications relevant for critique o

Landmark publications relevant for critique on ethics

© SPMM Course The informative model. The doctor is seen as a dispenser of information. Here the choice is left wholly up to the patient. May be useful in one-off consultations, but may not work well if strictly followed on long-term professional relationship. The interpretive model. Here the doctor will be treating the patient for a long time and might know his/her patient well and understand the circumstances of their microenvironment. Here shared decision-making is established. The deliberative model. The doctor here may act as a friend or counselor to the patient, where information dispensing is coupled with advice on a course of action. This is commonly used to enable lifestyle modification and to address maladaptive coping. 4. Other terms used: Direct Ethics is about the action taken. To determine what ethical behaviour is, we should assess the act -- what has been done. Indirect Ethics is about the actor -- the nature of the individual choosing those actions. The main concern here is the formation of character by a moral agent (a person). Pragmatic ethics: Emphasis is on achieving success, on reaching a goal with relatively little concern for how that success is achieved. Humanistic ethics: Emphasis is on doing what's best for society. This dominates ethical theory overwhelmingly; according to humanism, ethics is held as a virtue, with its goal being social improvement rather than personal success. Although some actions are always wrong (murder, for instance), in most cases, ethical behaviour lies between extremes, along a range between excess and deficiency. This is the idea of the golden mean of Aristotle. Landmark publications relevant for critique on ethics Nuremberg Code 1974: Code of ethics following the Nuremberg Trials (post-World War II Trial concerning doctors experimenting on people detained in concentration camps). According to Nuremberg Code, human experimentation can be carried out only if Voluntary consent is given Research is intended for common good of the society Avoidance of unnecessary pain and suffering is guaranteed for the subjects Subject has liberty to withdraw at any point Qualified researchers undertake research Scientist must terminate a study if more harm is being caused than expected to the subjects

24 - Landmark studies relevant for critique on eth

Landmark studies relevant for critique on ethics

© SPMM Course Declaration of Geneva 1948: Reaffirmation of humanitarian aims of medicine by World Medical Association. The Declaration of Geneva is a modification of Hippocratic Oath, intended to highlight the dedication of medical profession for the cause of humanitarian goals. Declaration of Helsinki 1964: This was adopted by The 18th World Medical Association General Assembly in 1964 and has been amended five times since, most recently in 2000. Notes of clarification were added in 2002 and 2004. The current (2004) version is the only official one. The Declaration specifically addresses clinical research, reflecting changes in medical practice from the term 'Human Experimentation' used in the Nuremberg Code. Landmark studies relevant for critique on ethics Tuskegee Syphilis Study (1932-1972): Between 1932 and 1972, US public health service followed up nearly six hundred low-income African-American males, 400 of whom were infected with syphilis. All diseased subjects were periodically examined but were not informed of the disease that they were diagnosed with and the implications of such diagnosis, even after the introduction of penicillin in 1950s. In some cases, when other physicians diagnosed subjects as having syphilis, researchers intervened to prevent treatment, in order to study the natural course of syphilis. Many subjects died of syphilis during the study. The study was strongly criticized, and US government issued a public apology in 1997. As a result of this Belmont Report was produced. Important principles outlined:

1. Respect for persons i.e. Individuals should be treated as autonomous agents and those with diminished autonomy should be adequately protected for research purposes.
2. Informed consent should be obtained by providing full information, ensuring comprehension and maintaining voluntariness (can withdraw at any time).
3. During a research, beneficial effects must outweigh any harms caused, with a systematic assessment of benefits and risks carried out beforehand. Willowbrook School Study (1963 - 1966): Mentally handicapped children at Willowbrook State School were deliberately infected with hepatitis after parents gave consent for what they thought to be vaccinations. The study was looking at the course of hepatitis and effectiveness of viral inoculation. There is evidence to suggest only consenting families were admitted to the school. Jewish Chronic Disease Hospital: Studies to develop information about the nature

of human transplant rejection. Chronically ill patients who did not have cancer where unknowingly injected with cancerous human liver cells. The defense argued that the administration did not want to scare patients and expected the cells to be rejected.

© SPMM Course Tearoom Trade Study: During 1960s, a sociologist called Laud Humphries followed up many men who had anonymous sex in public places by tracing their number plates after falsely befriending them. The research was conducted without explicit informed consent and became a matter of debate, highlighting the important of ethics in scientific research in non-medical fields of enquiry.

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