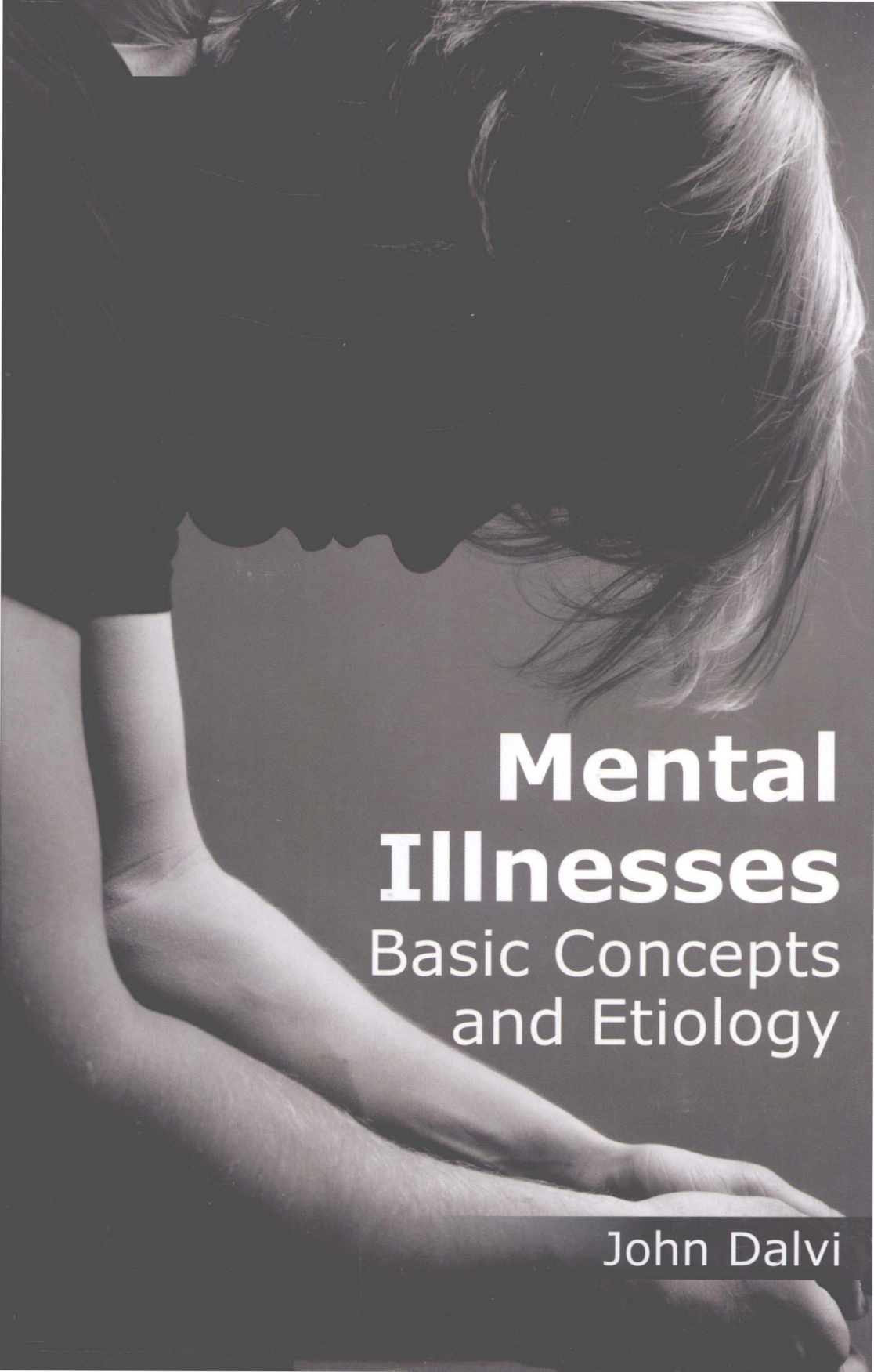
Mental
Illnesses
Basic Concepts
and Etiology
John Dalvi

Mental Illnesses: Basic Concepts and Etiology

Edited by **John Dalvi**

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Preface

In my initial years as a student, I used to run to the library at every possible instance to grab a book and learn something new. Books were my primary source of knowledge and I would not have come such a long way without all that I learnt from them. Thus, when I was approached to edit this book; I became understandably nostalgic. It was an absolute honor to be considered worthy of guiding the current generation as well as those to come. I put all my knowledge and hard work into making this book most beneficial for its readers.

Major concepts and discoveries in the treatment of mental illnesses are discussed in this book. In this book, the main focus is on the various background factors that govern the understanding of public attitudes, immigration, stigma, and competencies surrounding mental illness. Many etiological and pathogenic factors, commencing from adhesion molecules on one side, and concluding with abuse and maltreatment in children and youth on the other, are linked with mental illnesses, inclusive of personality disorders that lie between mental health and illness. The book makes an attempt to integrate theory and research data in understanding particular ways to deal with mental illness.

I wish to thank my publisher for supporting me at every step. I would also like to thank all the authors who have contributed their researches in this book. I hope this book will be a valuable contribution to the progress of the field.

Editor

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Part 1

Introduction – General Background

1

Stigma and Mental Disorders

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1. Introduction

Stigma is recognised as a major obstacle to recovery and integration of people with mental health problems. In this chapter the definitions of cognitive, emotional and social aspects of stigma will be presented, as well as origins, main representations and coping strategies. The research on stigma is presented, beginning with Gofmann's work (Chapter History) and followed by contemporary research and critical overview. This work follows the International Study of Discrimination and Stigma Outcomes (INDIGO) led by professor Graham Thornicroft (UK), which was a cross-sectional survey in 27 countries, in centres affiliated to the INDIGO Research Network, by use of face-to-face interviews with 732 participants with schizophrenia. This research was followed by the creation of Antistigma European Network, with further research goals and a strong mission to overcome or at least reduce the consequences of mental disorder stigma in Europe. Each country participated in this projects produced additionally locally specific answers and solutions. Some of them are listed below-these are comments on stigma made by patients with schizophrenia in Slovenia. Each country involved in these research projects also produced locally specific answers and solutions to the stigmatization and particularly to discrimination problems.
The intent of this publication is, besides giving an overview of stigma research, to provide some additional insight into real life experience of people with severe mental illness.

2. Definitions

2.1 Stigma

Stigma is a term that applies to labelling certain people as different and inferior. It is a mark of shame, a sign of worthlessness applied to the stigmatized. Its consequence is avoidance and even expulsion from society. It can be described as a form of social monitoring or omission of minorities from certain competitive areas, working as a form of intangible control over groups of people with mental disorders (Goffman, 1963).
Its influence is in proportion to social, economic and political forces that make possible the creation of stereotypes, destruction of reputation, and other forms of discrimination (Link & Phelan, 2001). Stigma is obviously a wide concept, one that binds aspects of labelling, stereotyping, cognitive rejection, emotional reactions and discrimination - therefore, it has cognitive, emotional and social components, whose final result is the loss of social status for the person affected. Social status here refers to an individual's position in society and to an individual's reputation and influence. A high social status guarantees material goods,

freedom, space, comfort, time and the feeling that one is appreciated. The fight for status is a fight to expose our inner wealth.

2.2 Stereotypes

Stereotypes are knowledge acquired by the majority of a social group so that knowledge of other social groups can be categorized. A stereotype is a collective agreement, needed for quick orientation as far as expectations and impressions are concerned. They are dynamic constructs, dependent on social judgment. Having a stereotypical opinion of a patient with metal health disorder would be thinking of him as dangerous and severely behaviourally disturbed. These stereotypes do not fit the facts. A typical patient lives in the community, his behaviour socially managed. A typical person with mental disorder has far less trouble in social adaptation than the usual hospitalised patient. Patients who must be treated regularly throughout their lives are a minority in the mentally ill fringe group. They function according to the severity of the illness, associated disabilities, the level and quality of available support and treatment capabilities. Patients who have recovered are usually invisible to professionals and public, as they generally hide their illness from others, because of stigma. They avoid institutions and social services so that they can pursue their careers, education or other personal goals. A diagnosis only describes the part of a person that the symptoms fit. A person with schizophrenic symptoms is not a schizophrenic, as these symptoms are only a part of his personality at the moment of diagnosis. A diagnosis is used to set treatment goals and methods and to estimate the illness' course. It is only to be referenced correctly in medical classification and professional assessment. Any other use of a psychiatrist's diagnostic terminology is considered to be stereotyping, aimed at discriminating against people with mental health disorders. Psychiatric diagnoses are often carelessly used to discredit political or other opponents, which is hurtful to people who have been diagnosed and have to live with illness and disability.
People do not always agree with stereotypes. Belief in them forms prejudice.

2.3 Prejudice

Prejudice is a wrong conviction, an ideological construct based on stereotyping and oversimplification. It motivates an authoritative bearing, hate and exclusion. In Nastran Ule's (1999) opinion, prejudice is simply a set of evaluations passed by privileged groups. Their main trait is helping repression. She defines repression as dominion of the strong over the weak, with the strong never allowing the weak to question the fairness of this arrangement. People are always very interested in learning how to have more power than others. If prejudice is collective, as those surrounding people with mental disorders are, people adapt to it. The general opinion is that people with mental disorders are less capable and that they require constant monitoring and care, which is followed by disdain and patronizing.
Almost every paper on stigmatization mentions prejudice as hard to change, relatively stable and spontaneous, affecting us no matter our will. This thesis introduced a certain amount of pessimism in all attempts to reduce stigmatization and rationalised poor results of anti-stigmatization campaigns. Social and psychological research, on the other hand, refuses this conclusion and proves that stigmatization is easily manipulated and very changeable in nature, as seen in Jew and women discrimination history (Henriquez et al., 1984) and the quick minimalisation of racial prejudice in the last few decades. It therefore

follows historical experience that prejudice can be changed swiftly and successfully, if appropriate social circumstance and political goodwill exist. Politics can achieve position changes and improve tolerance through media access. But prejudice can not be created or stopped only with conviction. A complex social movement is required, one that provides both moral and financial consequences for those that break the rules. It has been proven repeatedly that the behaviour of people with mental illness even when completely normal is considered »weird« because of prejudice (Link & Cullen, 1986; Link et al., 1987, Link et al., 1999). Their behaviour is not incorrectly interpreted only by the general public, but also by professionals. In 1974 Langer and Abelson made an experiment in which two groups of analytic psychotherapists were shown s video interview with a young man. One group was told that this was a job interview, whereas the other was told that the man was a psychiatric patient. Despite watching the same tape the second group described his behaviour as abnormal, whereas those in the first group didn't see many problems at all (in Corrigan, 2005).
Prejudice means a poor life quality for the affected. It generates strong emotional responses, of which fear is the most important.

2.4 Fear

Most people are afraid of people suffering from mental illness. They fear »infection« despite it being general knowledge that mental illness can't be transmitted. For example, a common effect of fear are complaints from mental health staff about how hard it is to work with psychiatric patients, not because of the workload, but rather because they fear projective identification that could influence a staff member's mental health. This fear originates in prejudice of danger and unpredictability. People with mental health disorders may be dangerous, but only very rarely and always under foreseeable circumstances. Studies show that the percentage of patients with an affinity for violence is less than 10% in men and significantly less among women. Even this small percentage is not dangerous constantly, but only when they're under influence of psychoactive substances like alcohol and alternatively, when their psychotic symptoms are left untreated or poorly treated. Less severe mental disorders like depression and anxiety are not connected to violent behaviour. Research shows that 75% of the population believes that the mentally ill are dangerous, the number of people with this belief doubling over the last 40 years (Corrigan, 2005: 165). The rise of the danger myth can be explained by deinstitutionalization, meaning less access to hospitals and other social institutions; and primarily by media reports (Wahl, 1995). There was a series of papers published in the USA that "proved" psychiatric patients were dangerous. This research is methodologically dubious and its results were interpreted haphazardly at best. It was best refuted by the following statement: Mental illness has little connection to violence. This connection is used for discrimination of people with mental disorders and their families. People with mental disorders must be guaranteed quality treatment. The occurrence rate of criminal acts done with full awareness is much higher than of those who are motivated by illness.
Today, 6% to 15% of the American prison population are people with mental disorders. This number saw a 150% increase over the last 10 years. The reasons for this fact can be found in poor service accessibility, public fear, legislation that prevents hospitalization and lack of education. In the USA, officers of the law seem to have a role of doormen to the medical system, for which they are not educated. Furthermore, in the US, the number of psychiatric hospital beds is evidently over reduced.

Any behaviour that is caused by prejudice is discrimination (Corrigan & Watson, 2002, Corrigan et al., 2003).

2.5 Discrimination

The behavioural manifestation of "applied prejudice" is discrimination. Affected people are discriminated against by being marginalised, avoided and being victims of violence. Even though discrimination can be an upfront protest against the mentally ill, it more often takes the form of avoidance. Openly ridiculing patients is no longer acceptable due to rising awareness. Hostility or (at least) ambivalence is nowadays expressed more subtly.

But, many patients report feeling lonely, losing friends, not being in contact with their families, losing their jobs and being delegated to lower positions in their workplace. Discrimination is not authoritarian and directly aggressive anymore (Corrigan et al., 2001), most likely due to anti-stigmatization movements, which managed to influence the way discrimination is exhibited, but not what it's about. An Australian study researching nurses' relationships with their patients (Happel et al., 2002) showed that most of nurses agree with anti-stigmatization programs, yet wouldn't allow a mentally ill individual to be part of a job screening procedure in their workplace. 40% of them were found to believe that even though a users' view on mental illness is important, lectures on this topics should be given by nurses.

Social distance raises the levels of disability amongst the mentally ill and significantly worsens the illness. Stereotyping, prejudice and discrimination can thus stop people from realising their ambitions and life goals.

3. History of stigma

Any discussion of mental illness is accompanied by strong emotion. Psychiatrists are still considered to be modern witches, capable of both help and harm. The general population's view of psychiatry and psychiatrists is coloured by emotions such as fear, shame, guilt, hostility, admiration and ultimately, confusion. It is for this reason that most mental health disorders are only discussed and treated in a close circle of friends, family and acquaintances and professional help only being sought in extreme circumstances.

Throughout history, society constantly changed its treatment of people with mental disorders. Rejection, punishment and avoidance was replaced, in certain times, by relative tolerance and attempts at integration, but this trend was never exclusive, as different viewpoints coexisted, sometimes obviously in mutual opposition. The general consensus is that the more the group was removed into specific institutions and the edge of society, the more negative society's attitudes were. In Europe, the relationship between marginalised groups and public opinion had been primarily defined by the church, its own attitudes subject to change from acceptance to rejection. For instance, when the predominant belief was that people with mental disorders were possessed by demons, they were either jailed or banished from society, whereas when mental illness was seen as a gift from god, they were protected and respected. In 1486, the book Malleus Maleficarum (The hammer of the witches) was published, ushering in 150 years of persecution of people with mental illness. Women with hysterical or psychotic symptoms were labelled as witches and torture was used for making them admit their guilt. The subsequent executions and other extreme violence were not put to a stop until 1656, when, under the influence of more tolerant ideas, asylums were first opened in the French monarchy. During the next century, people with

mental illness were joined in these buildings by orphans, prostitutes, homosexuals, the chronically ill and the elderly. The same century saw the first attempts to classify mental illnesses and understand them as medical disorders. There were attempts to improve the quality of care by the reformists Vincenzo Chiarugi (1759-1820) in Firenze, William Tuke (1732-1822) in York, and finally Jean Baptiste Pussin (1745-1826) and Philippe Pinel (1745-1826) in France. The removal of shackles from the Parisian hospital Bicètre marks the start of moral treatment. Pinel classified mental illnesses as being melancholy, mania, idiocy or dementia and claimed they were caused by both environmental and hereditary factors. He used education and persuasion as his methods and provided a comfortable environment for patients to heal in, but it wasn't until the 19th century that psychiatry became a branch of medicine, which brought about significant advances. In England, Tuke influenced the removal of restraints from hospitals. America saw a reform of psychiatric institutions, initiated by Benjamin Rush. The Kraepelin classification of mental disorders provided an accurate enough description of psychiatric symptoms. In 1920 electroconvulsive therapy was introduced.

Sigmund Freud (1856-1939), the founder of psychological interpretation of mental disorders, initiated the development of psychotherapeutic treatment through his personality, dream interpretation, sexuality and other theories. Social psychiatry began to evolve, using as it's tools both clinical and social theory knowledge. It dealt with the problems of poverty, racial prejudice, war and mass migration, even if it was apparent that no profession can solve them. The anti-psychiatry movement originated within social psychiatry, explaining mental disorders through social and family influences.

From 1954 to 1956, Ervin Goffman, the author of the famous Asylums(1961), was doing research in psychiatric hospitals and other institutions, precisely describing life in these »total institutions« (hospitals, prisons, homes for the elderly etc.) meant to hold patients away from society. He reasoned that any »total institution« has the same characteristics: the presence of a large number of people, group management and a clear structure of activities meant to institutionalise. In its essence a »total institution« was about controlling a large population with a bureaucratic institutional organisation, in which obedience was expected from both the population and the staff that oversaw it. A rift between the staff managing the asylum and the patients using it became apparent. The social distance between the superior, displeased staff and the weak, inferior patients was immense, with most of the staff's energy being directed at stopping patient to doctor (or any other staff member with more responsibility) communication. The simple effect of this was that patients were excluded from deciding their own fate. The secondary effects ranged from extreme boredom, the cause of which was that the patients were not trusted with anything, to post-treatment social exclusion. Upon leaving the hospital most patients had no established contacts with the outside world, as being institutionalized severed their bonds with the world. The mere entry into a psychiatric hospital was highly indicative of permanent loss: washing, disinfection, hair cut off, a personal search, listing of personal belongings and receiving instructions. In this way, a patient's life story became nothing more than property of a group of experts treating him, his actions only seen and evaluated through his diagnosis. The whole admission process could, in this light, be termed »programming« for an institutionalised life. A patient thus had no right to personal possessions and could have no space that could not be searched by anyone. Electroshocks were administered to patients in plain view of the rest of the patient population. Patients were only allowed spoons to eat their meals with. One way of ensuring obedience in the patient population was to demand humility, in any

way deemed important by the staff, mainly by acknowledging the staff's superiority. The patients were talked about in their presence, and constantly asked to participate in sessions that forced them to acknowledge that their situation was their fault. These »mea culpa« sessions were but one form of mental torture, another example being that they were forced to discuss the conflicts within the patient population. In the name of behavioural therapy, patients were accorded material possessions that were part of normal life in the outside world: clothes, cigarettes, etc. Physical examinations were performed in common rooms, forcing the patients to be exposed to everyone. The hygienic standards were non-existent. Any and every action that was not in accordance with hospital regime was strictly sanctioned, no matter the triviality. Patients lived in a state of constant fear, starting to accept their "moral" careers as psychiatric patients, living their role as social outcasts.

The year 1952 brought about the first antipsychotic medication, which made a significant difference in severe mental disorder prognosis. Public opinion shifted, and under its influence many hospitals were closed. The deinstitutionalisation process and anti-psychiatrist movement were present in every country that had some form of institutional care, leading to thousands of patients ending up on the streets.

There is no clear answer to the question of choosing institutional or not-institutional care. Should the patients be treated in institutions or outside is not even a valid question, as they need versatile care. There seem to be two prevailing types of public opinion concerning this - the public should be protected from the mentally ill and on the other hand, they need to be liberated of any institutional control. Both viewpoints are stigmatizing as they take away both the power to decide one's own treatment and disregard the patient's specific needs. We need to note, however, that Goffman's Asylums and the subsequent debates about stigma brought about significant changes in psychiatry. Hospitals were renovated, the number of the personnel employed increased and their education was improved. Patient's human rights are now vigorously protected, through legislation, certain in-hospital rules and advocates and lawyers who take part in the treatment process.

The World Health Organisation and the World Psychiatric Association began a far reaching public campaign in 1996 aimed at reducing stigmatization. Interest in stigmatization prevention reached it's zenith in 2001 when the media actively advertised stopping any kind of biased behaviour toward the mentally ill. This message appeared in every important document in the international mental health community. Yet, the perceivable effect was low. There is no evident decrease of stigmatization of people with mental disorders. The prejudice against people with severe mental illness can even be, according to some authors, proven to be rising, mostly because of mass media (Stier & Hinshaw, 2007).

4. Causes of stigma

Stigmatization is grounded in a narcissistic emotional satisfaction that crosses the boundaries of rational self-criticism. One who stigmatizes others finds validation in discrediting another. This discreditation enables him to join the majority; he finds himself stronger and agreed with. Regardless of whether this is the real majority or simply a privileged group, the stigmatised represent a "problem" which needs to be solved. For Jews, this was the »final solution of the Jewish question«, for African Americans it was open disdain and disrespect of their basic human rights. The mentally ill face the same sort of persecution, in the form of avoidance and isolation. In the 1950's, Adorno's study showed that any kind of hate directed towards the different is rooted in early childhood repression