Sociology of Mental Health RC49 Newsletter

Volume 12, Issue 1: Summer 2011

Notes from the President

Welcome from your new president. I look forward to serving you for the next four years. I consider that my role is to help the group to communicate and be in touch with each other, so if there is an article you would like to draw attention to, or a professional activity that would interest RC 49 members, please email me at blichten@ua.edu. The current issue features J. Gary Linn's work in global health and community engagement and Silvia Krum's research on desire for children and parenthood among people with mental illness. I look forward to receiving similar items from members who have been working in the sociology of mental health and whose perspectives and experience could enlighten us all.

XVII World Congress of Sociology Conference, Gothenburg, July 11-17, 2010

The World Congress meeting was a great success for RC49. The weather was warm, the sessions were well-attended, and conferees had the opportunity to catch up with far-flung colleagues and to enjoy the food and sights of Gothenburg. RC49 held eight sessions on mental health topics ranging from methodological developments to research on social stigma, adolescence, and social disparities in mental health services. Thank you to everyone who contributed to these sessions. Thanks also to Reinhold Kilian for his leadership as President of RC49 from 2006-2012.

Second ISA Forum, Buenos Aires, Argentina, August 1-4, 2012

The 2nd Forum promises to be another successful conference for RC49. We have a total of 8 sessions that include new sessions on gender and mental health, disaster and mental health, and institutionalization as an instrument of oppression. The capstone session for RC49 will be a panel of distinguished speakers who will address emerging issues in the sociology of mental health. These innovative sessions are an exciting development for the committee.

Future Directions

Future RC49 activities will include recruiting new members and organizing sessions for the ISA Forum in Buenos Aires, Argentina, August 1-4, 2011. Members should encourage colleagues who study or work in mental health to join RC49. Membership forms will be made available at all RC49 sessions for the ISA Forum in 2012. Remember: Committee membership is $40 for four years - ISA membership is preferable but NOT a prerequisite. Travel grants will be available for junior sociologists who meet the criteria of being untenured and/or 5 years post-doctoral. Anyone who is interested in applying for a grant should email Silvia Krumm at silvia.krumm@bkh-guenzburg.edu.

I look forward to seeing everyone in Buenos Aires.

Bronwen Lichtenstein, University of Alabama, USA

Research Committee on Mental Health and Illness, RC49

Programme coordinator

Bronwen LICHTENSTEIN, University of Alabama, USA, blichten@ua.edu
Number of allocated sessions including Business meeting: 8.

Deadlines

- On-line abstract submission **from August 25 to December 15, 2011.**
- All Forum participants (presenters, chairs, discussants, etc.) need to pay the early registration fee by **April 10, 2012,** in order to be included in the programme. If not registered, their names will not appear in the Programme or Abstracts Book.
- On-line registration will open **August 25, 2011.**

Call for papers

The Research Committee on Mental Health and Illness, RC49, had eight sessions at the Gothenburg meeting, and would like to build on this success by holding another eight sessions for the Buenos Aires meeting in 20

Only abstracts submitted through ISA websi platform will be considered.

Proposed sessions for the ISA Forum, Buenos Aires, Argentina, August 1-4, 2012

Session A
Involuntary psychiatric treatment and the misuse of psychiatric institutions as instruments of political oppression

Organizer
Reinhold KILIAN, University of Ulm, Germany, reinhold.kilian@bkh-guenzburg.de

Beyond its role in treating mental disorders it had always been the role of psychiatry to protect the public against the potential dangerousness of mentally ill persons and to protect mentally ill persons from self-harm. In modern democratic societies it is generally expected that involuntary psychiatric admissions and involuntary treatment takes place only on the basis of legal and human rights principles and that such activities be reduced to an absolute necessary minimum. Nevertheless, international studies indicate large differences in the legal principles, the practice and the figures of involuntary psychiatric measures. In addition, in some countries psychiatric institutions will still be misused as measures against political opposition and insubordination against the authorities. In this session current research on the various aspects of involuntary psychiatric treatment should be presented.

Papers can include the following research topics:

- Studies which analyze the frequencies and rates of involuntary treatment and/or the relationships between changes in the frequency of involuntary treatment and changes in other social, political or economic variables.

- Studies which investigate the written legal or ethical principles of involuntary treatment or the application of these rules in the practice of compulsory measures.
- Studies which examine the situation of involuntary treated patients and/or their subjective experience of involuntary treatment.
- Case studies which provide examples for the typical practice of involuntary psychiatric treatment in particular countries

Session B
Gender, social justice, and mental health

Organizer

Sylvia KRUMM, University of Ulm, Germany, silvia.krumm@bkh-guenzburg.de

Over the last decades, many efforts have been made to strengthen the social position of people with mental illnesses in order to enhance social equity and social justice. It is evident that gender equality is an essential criterion within the idea of social justice. Yet, despite some tremendous changes in gender roles in many societies, several gender based inequalities still exist due to different socioeconomic as well as sociocultural positions. Accordingly, there is a substantial knowledge of gender as a significant determinant of mental health and illness.

This session aims at the various links between gender, social justice, and mental health and encourages papers which deal with issues that include but are not exclusive to:

- Gender, social status, and mental health and illness
- Gender based violence and mental health and illness
- Gender bias in diagnosis and treatment
- Different access to mental health services for women and men
- Gender related stigmatization

Session C
Disaster, society, and mental health

Organizer

Takashi ASAKURA, Tokyo Gakugei University, Japan, asakurat@u-gakugei.ac.jp

Disaster struck on March 11, 2011 when Japan was struck by a massive earthquake and tsunami, followed by a meltdown of nuclear reactors in Fukusima. Japanese people and society will struggle with this natural and technological disaster for the foreseeable future. Up to now, about 27,500 died or are missing; private and public properties, as well as communities vanished along Sanriku Coast; 100,000 people are refugees; and more than 88,000 people were forced to evacuate because of serious radioactive contamination. Despite this severe disruption, the social order was maintained, and sufferers and victims alike experienced solidarity and reciprocity amid a chaotic aftermath. It is surprising that not only despair or fragileness, but also hope or resilience emerged simultaneously among people who were affected by the disaster. The Japanese example is only one of many that occurred in recent years.

We invite papers related to mental health and society following all types of disaster. These papers could address natural disasters such as earthquakes, tsunamis, tornadoes, flood, drought and famine, disease outbreaks or epidemics of E. coli cholera or HIV/AIDS, or sociopolitical disasters related to terrorism, war, social upheaval, and human displacement. Papers that address the sociology of disaster - especially mental health effects - are not only timely but will advance our understandings of the sociology of mental health during periods of social and existential crisis.

Session D
HIV/AIDS, social change, and social justice

Organizer
J. Gary LINN, Optimal Solutions in Healthcare and International Development, USA, jlinn87844@aol.com

Approximately 30 million individuals have died from AIDS since the first identified cases were treated in 1981. The majority of these deaths were in poor countries with limited healthcare systems and access to life saving medications. Currently, there are about 34 million persons infected worldwide with HIV/AIDS; most of these in resource limited Sub-Saharan Africa. About two thirds of the more than 1.1million persons living with HIV in the U.S. are Blacks or Hispanics. Globally, social movements formed around AIDS changed attitudes of citizens and policy makers regarding the illness. These change agents pushed through legislation for more research, better health services, protection of rights and greater advocacy. Changes in the social organization of healthcare delivery made treatment available in Africa and in other developing areas. More effective behavioral science based prevention enhanced with medications offer the promise of reduced infection and a diminishing epidemic.

We welcome abstracts dealing with the theme of HIV/AIDS, social change and social justice in varied settings from developing or industrialized countries.

Session E
New challenges in mental health policies

Organizer
Breno FONTES, Federal University of Pernambuco, Brazil, brenofontes@gmail.com

This session will discuss new trends and challenges in the policies of mental health care, comparing groups, populations or countries with different realities in structuring socio-cultural processes. An underlying assumption is that there are differences in levels of engagement between civil society and rules on how people should be dealt with in relation to mental illness. The practices of care would thus be consequences of different levels of institutionalization, with greater or lesser presence of the state or civil society. The comparison of these realities could give us excellent examples of how different societies face the problem of mental health, and how socio-institutional arrangements are produced within or independently of standardizing policies across the globe.

Papers should address new challenges in mental health policies that include but are not limited to:
- government’s role in treating mental illness
- insurance policies that limit mental health care, deinstitutionalization
- mental health care during economic recession
- changing patterns in who is considered mentally ill (e.g. sex offenders)
- criminalization of the mentally ill

Session F
Distinguished speaker panel: emerging issues in the sociology of mental health

Organizer
Bronwen LICHTENSTEIN, University of Alabama, USA, blichten@ua.edu

The panel brings together four distinguished speakers from three countries– Professor William C. Cockerham of the United States, Professor Victoria Grace of New Zealand, Professor Breno Fontes of Brazil, and Dr. Anne Scott of New Zealand. Each speaker has engaged in developing a body of work that advances our understanding of the theoretical intersections and practical applications of research on mental health and society. Session and speaker details will be posted by December 2011.

Session G
Mental health and illness in modern societies

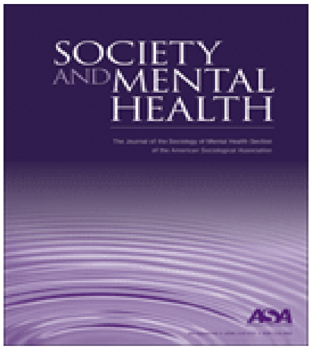
Organizer
Dirk RICHTER, Bern University of Applied Sciences, Switzerland, dirk.richter@bfh.ch

Although the current discourse on the etiology of mental disorders is mainly triggered by genetic and neurobiological research, it is becoming more evident that there is some renaissance for social factors and societal developments. This session invites contributions which cover empirical research and theoretical ideas on social patterns and questions such as:
- Are mental disorders on the increase?
- Does modern society lead to individual sickness?
- How are discourses on mental health and illness culturally and socially constructed?

Session H
RC49 Business meeting

New Journal

NEW!



FEATURED FIELDWORK

James. G. Linn, Ph.D.

Field Notes of a Sociological Odyssey; Observations and Lessons Learned From a Quarter of a Century of Health Projects in Africa and Latin America

Optimal Solutions in Healthcare and Economic Development

For almost 25 years, I have studied the behavioral and mental health dimensions of HIV/AIDS as they relate to public health initiatives in Africa and Latin America. As the epidemic has evolved and institutional responses to it expanded and become more effective, the role of the sociologist in project planning, implementation and assessment has also grown and become more important for program success. In Botswana in the late 1980s we evaluated a government nursing program which reoriented nurses from a traditional hospital model to a new community based clinic approach. While we found that nurses had successfully adopted the new primary care nursing practices, they were reporting higher levels of occupational stress due to the appearance of mothers and their infants with HIV in their clinics. They feared that they might contract the illness and they were stressed by the additional time and effort required by these patients who took them away from their mandated duties. These findings and additional evidence were used as rationales for new nurse trainings in HIV/AIDS education and treatment protocols.

The Ghana Ministry of Health and foreign donors in the mid 1990s wanted to reach young rural to urban migrants with an effective HIV prevention program. As University of Ghana Professor, Kwabena Poku observed, "in rural Ghana people believe that sex equals life, now we must convince them that unprotected sex equals death." Recent experience with STD prevention education in the capital, Accra, suggested that behavior change messages delivered by respected peers in workers associations were more likely to be heard and acted on than those delivered by the mass media or official health educators. Taking into account these local STD program histories, and utilizing culturally adapted peer education methods obtained from foreign donors, we developed and implemented an HIV prevention education program with condom distribution. It targeted young recently arrived rural migrant males living around Accra. Over a three year period several thousand participants received HIV prevention education and supplies of condoms. The locally selected and expertly trained peer educators continued to work in their informed urban communities delivering prevention education and condoms after the funded program was completed.

In Brazil the largest concentration of indigenous people is located in the remote Upper Rio Negro region of the northern state of Amazonas. This is a highly vulnerable population with substantial rates of tuberculosis, STDs, and parasitic infections. The first medically confirmed case of AIDS in this group was recorded around 1997. Health experts were concerned about the development of an HIV epidemic that would rapidly expand among concentrated indigenous communities. Existing Brazilian Ministry of Health programs of HIV prevention education were limited by language (Portuguese), location (metropolitan and peri-urban areas) and method of delivery (formal and didactic). To reach the indigenous communities of the Upper Rio Negro region with a systematic HIV/STD prevention education program, in the early 2000s we partnered with a group of healthcare professionals from the State of Amazonas who had been doing clinical outreach in the area for several years. They could speak and write the local languages and knew the tribal cosmologies. With domestic and foreign donor assistance, they developed culturally appropriate HIV prevention education materials. Using a train-the-trainer approach, health agents or designates were prepared to be HIV/STD prevention educators for their indigenous villages. Pamphlets and posters written in Tukano and other local languages were given to them to be distributed to adults in their communities. Health agents took advantage of local community meetings to provide prevention education and distribute pamphlets. A process evaluation of this successful program was presented to Health Ministry and foreign donors to obtain sustaining resources.

Mozambique, like its neighbors in the southern cone of Africa has a high rate of HIV infection (16 to 26 percent) and a generalized epidemic. By 2006, the Mozambican Ministry of Health was making a country-wide effort to roll out anti-retroviral therapy for the affected urban and rural population. Zambezia province in North Central Mozambique with approximately 3 million inhabitants has the largest population of any of the provinces in the country. Yet, it is a rural area with many dense settlements. In 2006 about 20 percent of its population was infected with HIV. We partnered with the Ministry of Health and an NGO already delivering HIV/AIDS care in Zambezia to help scale-up the delivery of anti-retroviral therapy through several rural government clinics. Previous work completed by psychologists at

Mozambican anti-retroviral clinics run by ICAP, an affiliate of Columbia University, found that patients experienced substantial psycho-social stress which could be successfully addressed by counseling and the sharing of patient experience. Published case reports from clinicians working with Doctors-Without-Borders recommended employment of "Expert Patients" in clinics to facilitate counseling and support for new patients to ensure good treatment adherence. After our initial site visits to the four public clinics in Zambezia where we had been authorized to expand anti-retroviral therapy, we developed community plans to address potential treatment adherence and other patient-care issues. We drew upon case reports of other anti-retroviral providers and our own clinic observations. Our recommendations to employ expert patients and social workers in patient support, counseling, and case finding were followed and later proved effective in improving treatment adherence.

My field experience related to HIV prevention and treatment in Africa and Latin America over the past several decades has provided me with several "lessons learned". First, take a holistic approach in the development and implementation of HIV prevention education and treatment programs. Sexual risk behavior change programs will not be effective unless they account for unique community, cultural, and attitudinal factors which are observed through qualitative research. Similarly, anti-retroviral treatment adherence requires mentoring, counseling, social support and typically active community searching for persons lost to follow-up. In rural catchment areas where patients are primarily subsistence farmers, their nutritional requirements may have to be met through food supplements, special gardens and/or the introduction of new low labor agricultural practices and plant varieties.

Second, effective HIV/AIDS prevention and treatment programs must be maintained over several years and then institutionalized to yield maximum primary and secondary benefits. Ghana, Uganda and Brazil for decades have invested in nationwide HIV/AIDS education and have been able to confine the disease to high risk groups. While the verdict is still out on the long-term effects of the Presidents Emergency Plan for AIDS Relief (PEPFAR) anti-retroviral treatment program, the first 5 years showed millions of new people treated, thousands of healthcare workers trained and a noticeable decline in new infections in Africa.

Third, perfection is the enemy of the good or uncompromising adherence to bureaucratic procedures and/or scientific methodologies can undermine program success and achievement of humanitarian goals. The effective utilization of workers associations in informal urban communities of Accra Ghana, or traditional village meetings in indigenous communities of Northern Brazil to provide HIV/STD prevention programs, or traditional healers in Mozambique to support patients' recovery and anti-retroviral therapy probably cannot be replicated in a controlled community experiment. Yet there is compelling evidence that these methods work and will work again in similar settings in the developing world. Evidenced based interventions should include programs documented using qualitative methods.

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FEATURED RESEARCH

Silvia Krumm, PhD.
Ulm University, Germany

Psychiatric discourse on desire for children and parenthood among people with mental illnesses

Up until the midst of the 20th century people with mental illnesses were kept from reproduction through sterilisation and sex-segregated hospitalisation. Nowadays, affected people are – at least formally - free to decide for or against parenthood. Since there are substantial reproductive risks for the affected person as well as for the (unborn) child, one might assume that professionals find themselves within an area of tension between respecting reproductive autonomy of their patients while feeling the need for protecting the patient or the (unborn) child from severe harm. This problem is even more complicated by the lack of sufficient knowledge of the effects of reproduction on the illness course and the effects of medication during pregnancy on the unborn child. We assume that mental health care is affected by professionals' collective and individual perceptions of reproductive issues.

Aims

This new research investigates the psychiatric discourse as well as subjective attitudes of mental health professionals in regard to desire for children and parenthood (in a broader sense family planning, contraception, genetic counselling etc). In collaboration with the Institute of the History, Philosophy and Ethics of Medicine, the study will also analyze the ethics of psychiatric discourse. The main question of the study is if and to what extend professionals perceive ethical conflicts in regard to reproductive issues among their patients and how they cope with them within their action orientation. Also, the study will examine differences between the members of four professional groups (psychiatrists, nurses, psychologists, social workers) and on the specific motives that play a role in the implementation of discursive practices (which may also include tabooing). Finally, the research will assess the need for support in dealing with reproductive issues of mentally ill patients.

Methods/Instruments:

In a first step, existing data regarding professional dealing with reproductive issues or ethical conflicts will be analysed by a document analysis as well as analysed from a discourse analytical perspective. The central aim here is to reconstruct normative argumentations due to reproductive issues since the psychiatric reform movement. In a second step, group discussions will be conducted with mental health professionals in clinical settings. The central aim is to analyse the collective meaning of professionals' dealing with reproductive issues of psychiatric patients as well as conflicts, coping strategies, and a need for support in dealing with these issues. Finally, problem-focusing interviews with members of each professional group will be conducted to assess subjective perceptions, attitudes, valuations, and coping strategies in regard to dealing with reproductive issues of the mentally ill patients.

For questions and comments on the project please contact: Dr. Phil. Silvia Krumm, Department of Psychiatry and Psychotherapy II, Ulm University, Bezirkskrankenhaus Günzburg, Ludwig-Heilmeyer-Str.89312 Guenzburg, DE.
Phone: 08221/96-2876
Fax: 08221/96-28160
Email: silvia.krumm@bkh-guenzburg.de

BRIEFS

1. **Gary Linn** and his Canadian collaborator, Debra Wilson, had a chapter titled "The Globalization of Health: Current Challenges and Future Attainments" accepted for publication in the *Encyclopedia of Globalization*, a forthcoming book from Elsevier*.*

2. **Judy Gordon** is a Member-at-Large of the NGO Committee on Mental Health at the United Nations. Judy spoke at a side event at the UN Commission on Women in February, 2011.The Commission focused on the priority area of Women, Science and Technology. Judy is also an author of a target paper published in the *American Journal of Bioethics.*

3. In 2011**, Esteban Calvo** together with Christopher Tamborini and Natalia Sarkisian at the Universidad Diego Portales, Santiago, Chile, wrote a Working Paper #17 titled "Causal Effects of Retirement Timing on Subjective Well-being: The Role of Culture Norms and Institutional Policies." Available at: http://www.udp.cl/descargas/faculades_carreras/economia/pdf/documentos_Investigacion/wp17_Calvo_Sarkisian_Tamborini.pdf

   Esteban Calvo and Natalia Sarkisian also wrote Working Paper #2 titled "Retirement and Well-being: Examining Characteristics of Life Course Transitions." Available at: http://www.politicaspublicas.udp.cl/wp-content/uploads/doc/ipp_udp_dt_2_retirement_well.pdf

4. **Bronwen Lichtenstein** was a visiting scholar at the Centre for Global Health, Population, Poverty and Policy at the University of Southampton, United Kingdom, in the Fall semester of 2010. During this time, she wrote a book titled: *Colonizing Stigma: Race, Gender, and Social Power in the Sexual Epidemics* which will be published in 2012 (Lynne Rienner Publishers).

RC49 Members dine at the ISA World Congress Meeting in Gothenburg, 2010

Reinhold Kilian and Herbert Mattschinger

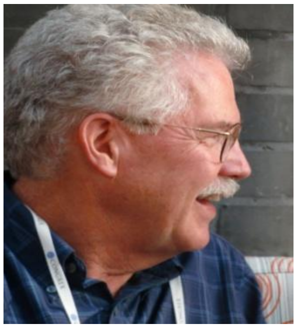
Stanley Brodsky and Takashi Asakura

L-R: J. Gary Linn, Bronwen Lichtenstein, Silvia Krumm, Reinhold Kilian, Herbert Mattschinger, Takashi Asakura

L-R: J. Gary Linn, Bronwen Lichtenstein, Silvia Krumm

Silvia Krumm

Stan Brodsky & Takashi Asakura



J. Gary Linn

Office Holders 2010-2014

President
Bronwen LICHTENSTEIN
blichten@ua.edu

Vice President
Takashi ASAKURAT
asakurat@u-gakugei.ac.jp

Treasurer
Silvia KRUMM
silvia.krumm@bkh-guenzburg.de

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