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Text: Helena von Troil
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Nordic Council of Ministers
Ved Stranden 18
DK-1061 København K
Phone (+45) 33 96 02 00

www.norden.org
Foreword

The Nordic Committee on Bioethics (NCBio) was founded in 1989 with the aim to promote Nordic cooperation and exchange of information between scientists, parliamentarians, opinion leaders and public officials in the area of bioethics. NCBio works by organising workshops, conferences and by publishing reports or other publications to promote Nordic and international debate on bioethics. NCBio has two members from each of the five Nordic countries. Members are appointed by the Nordic Council of Ministers from the nominations of the Nordic countries. The committee is funded by the Nordic Council of Ministers.

In the Fall of 2011 the committee organised a conference in Helsinki on ethical aspects related to mental health. This conference summary, compiled by Helena von Troil, highlights the main challenges and issues facing researchers, policy makers and practitioners that deal with mental health issues. The committee invited a broad range of experts to talk about the psychological, historical, social, cultural, as well as biological perspectives related to mental health. For western countries, the sharp increase in the diagnoses of various mental health problems, such as depression and ADHD, and the sharp increase in the use of prescription medicines for their treatment calls for a closer ethical discussion and scrutiny of the various issues that are involved. The talks at the conference brought forth the heated debates which are taking place in various disciplines on the causes and the best ways for treating various conditions and problems. Although there are no simple answers, it is clear that mental health problems have become a pervasive issue in society and need to be addressed in a more comprehensive manner that takes into account various perspectives.

The Nordic Committee on Bioethics hopes that this summary of presentations will serve as a resource to people who are interested in the development and possible ways for tackling mental health problems in the Nordic countries, by identifying some of the key issues involved and the challenges that lay ahead in its governance.

May 2012
Aaro Tupasela
Chair (2011)
Nordic Committee on Bioethics

Förord


Hösten 2011 arrangerade kommittén en konferens i Helsingfors om etiska aspekter på psykisk hälsa. Denna konferensrapport, som är sammanställd av Helena von Troil, belyser de viktigaste frågor och utmaningar som i dag möter forskare, politiskt ansvariga och yrkesverksamma inom psykisk hälsa.


Nordisk kommitté för bioetik hoppas att denna rapport, med fokus på centrala frågor kring psykisk ohälsa i Norden, kan bli en tillgång för alla som är intresserade av utvecklingen och av möjligheterna att möta de utmaningar vi står inför.

Maj 2012
Aaro Tupasela
Ordförande (2011)
Nordisk kommitté för bioetik

Översättning: Sara Larsson
According to the World Health Organisation, mental ill health accounts for almost twenty percent of the burden of disease in Europe, and mental health problems affect one out of four persons at some time in their life. Nine of the ten countries with the highest rates of suicide in the world are European”, said Aaro Tupasela, the chairman of the Nordic committee on Bioethics, as he opened the conference.

In 2005, the Nordic countries signed WHO’s Mental Health Declaration and Mental Health Action Plan for Europe, where each state agreed to report back to the WHO on the progress it is making in addressing issues related to mental health in their respective countries. A recent report by the Nordic Expert Group on Mental Health lists six areas that deserve special attention in relation to Nordic cooperation. These areas are child and adolescent mental health, working life and mental health, mental health of older people, the primary care sector, user and carer influence and voluntariness and coercion.

What has given rise to such a surge in the development and emergence of mental health problems? What can be done to address these questions before the situation gets out of hand? “These are the main questions that are raised by these reports and declarations and many other developments in the Nordic countries and Europe”, said Tupasela.

The Nordic Committee on Bioethics felt that it is necessary and timely to organise a conference that raises and discusses some of the ethical questions related to mental health. The session on crime, society and mental health has been organised as a reaction to the recent tragic events in Norway, but the topic also addresses many other events that have taken place in other Nordic countries during the past decade.

Other session topics are psychological, social, historical and cultural perspectives of mental diseases; biological explanations for development of mental diseases; mental health problems in practice and challenges and policies.

Aaro Tupasela said that it is not possible to provide a thorough representation of the breadth and scope of the problems, but many important issues will be raised and discussed. He ended by saying: “There is a well founded need to further develop cooperation between the Nordic countries and I hope that this meeting will help to facilitate and promote the discussion about the ethical dimensions related to mental health in the Nordic countries.”

Mental Health Declaration for Europe, WHO European Ministerial Conference on Mental Health: Facing the Challenges, Building Solutions, Helsinki, Finland, 14 January 2005, EUR/04/5047810/6, 52667

I will be untrendy and approach psychiatry and mental health care as a form of social control”, began Ilpo Helén his presentation. He continued: “Mental health care, in its various forms, is an important social technology that shapes modern societies.

A profound analysis of the social dimension of mental problems and the role of psychiatry in society is marginalized in the professional discussion today although mental disorders are acknowledged to be a major public health problem. I am convinced that understanding the position, functions and impact of psychiatry in society is the basis for discussion on moral issues and ethics of mental health care.”

Psychiatry has its origins in the asylums for ‘mentally insane’ in the nineteenth century. The asylum physicians gained a role in juridical practice as experts to evaluate the mental state and dangerousness of criminals and they were given the task of isolating and managing these criminals. This became the archetype of psychiatry as social control. This control included also people with subtle ‘perversions’ and poor people and lasted until the late 1960’s.

The mental hospital institution came under heavy criticism after the Second World War. They were said to be ineffective, coercive and inhuman, similar to the prisons and they should be closed down. This led to massive dehospitalisation and today the paradigm of psychiatric practice is outpatient care. The step out of the asylums was the extension of psychiatry as a form of social control. This control included also people with subtle ‘perversions’ and poor people and lasted until the late 1960’s.

Parallel to the dehospitalisation emerged the mental health care. The psychiatric expertise was dispersed in educational institutions, social work, health care and family life. The first blockbuster psycho pharmaceuticals entered the market in the late 1950’s.

Psychotherapy was the dominant ethical technology for the masses of developed societies between the late 1950’s and 1980’s. It was a means of management of personal conduct and life, for self-understanding and self-improvement. New functions of social control evolved when psychiatry contributed to the redefinition of many forms of deviant behavior and control became increasingly individualized.

In the 1970’s and 1980’s there were attempts so modify psychiatry into a social technology. The idea was that mental health care would promote the change towards a happy, safe and equal society and, at the same time, oppose coercive and authoritarian forms of social control. Thus, mental health care was seen as an agent of social reform. In brief, the society was seen as the problem and the individual suffered. This view has now changed and today the reverse seems to be the case: the problem is an individual who harms his or her human relationships and social environment and causes economic losses and social problems. “Predominantly, mental health is seen in the light of risks, susceptibilities and pre symptomatic signs of mental illness in an individual, and the task of mental health care has become to assess and manage these probabilities and potentialities”, said Helén.

Today it is possible to see a segmentation of the psychiatric care and control into three main segments. The first being ‘everyday mood control’ to which the majority of persons with mental health problems belong. Here mental health care is essentially self-control backed up by physicians in primary care, counseling and self-help networks. This is also an extensive market for psycho pharmaceuticals and self-help literature. The second segment is what Helén called the ‘roller door psychiatry’, the specialised psychiatric care based on outpatient care. Hospital treatment is usually brief and aims at stabilizing the condition of the patient so that she or he can be discharged for ‘remission’ at home. In practice this leads, for most patients, to a circular movement in and out of the hospital ward. The third segment Ilpo Helén called ‘exclusion management’. Chronic patients are managed by maintenance treatment with drugs. This management is connected to the provision of special housing services, social assistance and social benefits and thus is, to its character, primarily social work. Thus, mental health care is transformed into management of social exclusion. The post-welfare system keeps the service users in a marginalised position that reproduces their exclusion, despite good intentions of the system.
Can the neurosciences explain mental disease and distress?

Steven Rose began with stating some important facts about the occurrence of mental disorders today. According to the World Health Organisation mental and nervous system disorders constitute thirteen percent of the global disease burden.

In rich countries depression, dementia, alcohol, drugs and schizophrenia are the most common. In any year 165 million people in Europe, almost forty percent of the population will develop mental illness. The annual cost is 800 billion Euros, one fourth of the health care budget.

One of the ‘grand challenges’ in the area of mental health care formulated by WHO is to identify root causes and risk and protective factors. Which are the modifiable social and biological factors that influence the prevalence of mental disorders? What is the impact of poverty, violence, war, migration and disaster? Which are the relevant biomarkers? “It is odd, however, that two of the three challenges are in the social domain, but most of the research efforts are in the biological domain,” said Rose. He asked: “Are we looking in the right place to solve the problem of mental disorders?”

The epidemiology and the changes over time need to be explained, he said. We have to try to explain for instance why women are disproportionately diagnosed with depression and dementia and why schizophrenia is much more common in the working and middle classes than in the population in general. Before 1990 estimates of attention deficiency hyperactivity disorder (ADHD) in children in Britain was less than one percent. In 2010 the estimate had risen to over five percent. So what has brought about the change?

The 1950–1990’s was the time of the neuroscientific approach in psychiatric research. The hypothesis was that a disordered molecule leads to a diseased mind and that the disordered molecule most likely is the result of a disordered gene. It was thought that abnormalities in the chemical neurotransmitters like acetylcholine and dopamine were the causes of disease. This lead to neuropharmacological responses where the abnormal neurotransmitter systems were targeted with different kinds of antidepressants. “Unfortunately newer antidepressants don’t seem to work much better than previous ones”, said Rose. Even in the most favourable circumstances are they not much better than placebo.

Neurogenetics today is based on animal models with modified genetic traits and gene-wide association studies drawing on the material in genetic biobanks. The hypothesis is, that if not single major genes, then a small number of genes of major effect are a cause of mental disorders. However, these studies show that anything from 14 to 650 genes are associated with schizophrenia. Many of them overlap with bipolar affective disorder.

“So maybe these are not distinct diagnostic categories?” said Rose. The conclusions for pharmacology are that the prospects for palliative treatments for frank neurological conditions like Alzheimer’s are quite good but still a long way off. But neither the hope for personalised medicine nor for single broadly effective drugs for mental distress and disorder seem likely.

Steven Rose ended by proposing that research in psychiatry should focus on the epidemiology. Why are women, poor people and ethnic minorities diagnosed with mental problems more often than others? More attention should also be given to some of WHO’s research questions: Can modifiable social factors be found, and which are they? What is the impact of poverty, violence, war, migration and disaster?
The fundamental ethical question with regard to mental disorders is whether these are just conditions that are disliked by society suiting the needs of those in power, or, if there is anything ‘real’ about mental disorders”, began Peter Jepsen. So, if the mental disorders really do exist, how should they be defined?

There are three possible answers to this question. The first answer is that disease is a biological dysfunction that gives psychiatric symptoms. In philosophy, this position could be called realism. Modern biomedicine reflects this kind of thinking. Realism regards health as absence of disease. A disease is an internal state of an organism which interferes with the performance of some natural function i.e. some species-typical contribution to survival and reproduction, and is atypical of the species. This concept of disease is considered value-neutral and purely scientific. “The problem is, however, if it makes sense in psychiatry”, said Jepsen.

According to the second main position, disease symptoms are only what we see and describe from the outside. Symptoms are, therefore, not ‘symptoms’ of anything. This position follows the philosophical position called empiricism. Modern classification systems reflect empiristic thinking which regards health and disease as manmade constructions. The conceptions are non-scientific and what is considered as mental disease is dependent of values of what should count as a normal, or non-normal, life. This makes normality relative to time and place, and religious and political opinions. There is no sharp demarcation between health and disease.

The first question is which conditions get classified as mental illnesses rather than normal conditions? The second question is: among those conditions we agree are mental illnesses, how should they be grouped together into different kinds?”

Jepsen listed four explanatory models that regard medicine as a natural science and three models that have their roots in the human sciences. The bio-medical model is a realistic approach, which regards diseases as objective realities in nature. Diseases have symptoms and pathology, course and prognosis. In a biological-psychological-social causation chain biological explanations are preferred over psychological or social explanations. The clinical-descriptive model is empiristic. Diseases are manmade constructions characterized by their symptoms. The existence of a given syndrome depends on our definition of the syndrome. Definitory syndromes, therefore, do not necessarily correspond with reality. This is a problem when descriptive diagnostic categories are used for research purposes. The bio-psycho-social model holds that in a biological-psychological-social causation chain biological, psychological, and social causes all have equal weight. This model, therefore, is useful in epidemiologic research. And the fourth, the continuum of disease model, implies that diseases are continua, spectra of expressions or stages of one and the same disease process. According to this model, there is no boundary between diseases and disease classification makes no sense. There is no sharp demarcation between health and disease and it is often unclear whether or not normality is included into a given spectrum. “This view is increasingly popular, but scientifically unproven and clinically impractical”, said Jepsen.

The first model based in the human sciences is the psychodynamic model which holds that disease is the result of unconscious inner psychic conflicts or repressed infantile sexuality. Disease symptoms can be understood or interpreted but not causally explained. Disease symptoms are thought to serve an unconscious purpose. As a scientific theory this model remains unproven.

Mental health and mental disease models

“The first question is which conditions get classified as mental illnesses rather than normal conditions? The second question is: among those conditions we agree are mental illnesses, how should they be grouped together into different kinds?”

Peter Jepsen also discussed the classification of mental illnesses, which is the subject of continued debate:
tic model considers disease as a reflection of alleged physical, mental, social or environmental ‘unbalances’. Theory as well as treatment evidence is based on observation and treatment of individual subjects. Examples are acupuncture, chiropractic, and homeopathy. Historically holistic models have their roots in pre-scientific medicine. The last model, the social-psychiatric view in its most radical form, claims that psychiatric classification depends solely on the values of those doing the classification, that there is nothing objective about it at all, and that there are no facts about what is normal.

In conclusion Peter Jepsen said that only the biomedical model offers value-neutral concepts of health and disease. All other concepts of health and disease in medicine as well as in psychiatry are more or less value-laden. This fact opens up for introduction of controversial diagnostic categories or removal of diagnostic categories after lobbying from activist groups. Mental disorders are increasingly seen as brain disorders according to the bio-medical model. It may, however, be meaningful to maintain a distinction between the psychological and the biological ways of understanding people’s illnesses, but no particular illness is purely mental or purely physical.
Neuroimaging in the study of the brain and its functions

Electroencephalography (EEG) has been used since the late 1920’s to study the function of the human brain. The possibilities of non-invasive imaging of the brain and its functions have increased dramatically during the last decades.

Now EEG has been complemented by signal source modeling and anatomical neuroimaging, and today many additional functional techniques are available. These imaging methods are extensively used in studies of both patients and healthy control subjects. “The complex network properties of brain activation has been the most evident general finding of these studies”, said Jyrki Mäkelä.

Anatomical magnetic resonance imaging (MRI) and functional MRI (fMRI) are important neuroimaging tools. In fMRI the level of blood oxygenation in the brain of the subject person is measured while he performs an experimental task. With fMRI it is, for instance, possible to predict what a person has seen by just studying the brain signals. But this is not straightforward. Different persons have different patterns of activation and usually an individual model is needed when the results are interpreted. Moreover, the relation between the signal and brain activity is clear only in some brain areas. Despite experimental complexity, the scenarios that can be studied remain relatively simple. It is a matter of guessing what you are seeing, doing or planning within a pre-defined set of possibilities.

Champagne, if you are seeking the truth, is better than a lie detector. It encourages a man to be expansive, even reckless, while lie detectors are only a challenge to tell lies successfully.”

Neuroimaging, utilizing fMRI and increasingly also magnetoencephalography (MEG) and transcranial magnetic stimulation (TMS), has been used in a multitude of psychological studies during the last two decades. The aim of using neuroimaging in this field is usually to study general brain mechanisms, but also complex questions related to, for instance, shopping preferences and voting behavior have been analyzed. In trials, individual variations are considerable, and extremes are often excluded from the study.

Prisoners and psychiatric hospital patients have been studied by anatomical neuroimaging and by positron emission tomography (PET) and fMRI, in hopes of finding indices of aggressive and violent behavior. However, these studies are targeted towards general brain mechanisms, and they often reveal a remarkable individual variation, precluding firm conclusions on individual level. The links between the imaging findings and the studied behaviors are correlative, not causal. “It is evident that much more knowledge of both properties of the measured signals as well as their relations to behavior on individual level is required before firm conclusions from behavioral traits can be obtained from brain imaging data”, said Mäkelä. “A link between, for example, terrorism or aggressive behavior and brain pathology is definitively not straightforward. “

Mäkelä also said that there are ethical problems involved in the imaging of psychopathological behavior. For instance how do we treat a situation where the person may have something she or he wants to hide? Activation of emotion-related brain areas may tell the researchers something that the person would prefer not to know about, for example, racial prejudices or sexual attitudes. However the same prejudices and attitudes can be revealed in behavioural studies. Co-operation of the subject, necessary for developing the functional brain imaging of aberrant behaviours, cannot always be guaranteed.

Jyrki Mäkelä ended his presentation with a quote from Graham Greene’s book Travels with my aunt (1969): “Champagne, if you are seeking the truth, is better than a lie detector. It encourages a man to be expansive, even reckless, while lie detectors are only a challenge to tell lies successfully.”
The biological basis of psychiatric disorders

“There is a common agreement that conditions such as depression, anxiety disorders, psychosis, attention deficiency hyperactivity disorder (ADHD) and alcoholism are the cause of considerable suffering”, said Elias Eriksson.

“But with few exceptions, no one has been able to demonstrate that any of these disorders is caused by psychological or cultural factors. Twin studies, on the other hand, indicate that all these conditions are to a great extent hereditary”, he said.

Given that all other organs in the body may be the subject of malfunctioning, it would be surprising if this could not happen also to the most complex of them all, the brain, including those parts of the brain that are of importance for emotions, cognition and behaviour.

“This is why it is reasonable to suggest that some psychiatric disorders are indeed best explained in terms of brain dysfunction of unknown origin”, said Eriksson. It is however equally reasonable to assume that some of them are not the manifestation of dysfunction, but should rather be regarded as extreme variants of a normally distributed trait. Obviously, this neither means that they do not cause significant suffering, nor that they do not have a biological basis.

Eriksson warned against mixing up aetiology (why some gets ill and some do not) with the pathophysiology of a condition. “Claiming, for example, that dopamine may be involved in the pathophysiology of psychosis does not tell us anything about why some are afflicted. Our knowledge of the aetiology of non-infectious diseases, including the psychiatric ones, is very limited. But just as we do not know why some get asthma, or Parkinson’s disease, or brain cancer, we do not know why some get schizophrenia or bipolar disorder. Claiming otherwise is to misinform the patient”, he said.

“Our understanding of how the brain works is still very limited”, said Eriksson. “This means that our insight into the mechanisms underlying psychiatric symptoms and disorders also is very limited.” Mainly thanks to a number of accidental findings of unexpected drug effects, it has, nevertheless, been possible to develop pharmacological treatments for psychiatric disorders that often are amazingly effective. These accidental findings have also given us some very preliminary insight into the possible relationship between certain neurotransmitters in the brain on the one hand, and certain psychiatric conditions on the other. These insights have enabled the development of new and, sometimes, better drugs, confirming the practical value of research along these lines.

Elias Eriksson referred to research that has shown a link between dopamine receptors in the brain and psychiatric conditions like schizophrenia and psychosis. Substances that block these receptors have been found to be effective in the treatment of these conditions. This makes it likely that dopaminergic neurons are somehow involved in the creation of psychotic symptoms and further studies on the possible role of dopamine and other neurotransmitters in schizophrenia are well motivated. However, this does not mean that psychosis is caused by an isolated disturbance in dopamine transmission. Nor does this mean that the primary biological dysfunction in schizophrenia is one of a disturbance of dopaminergic transmission.

Serotonin and depression is another example of a link between brain physiology and mental disorders. Selective serotonin reuptake inhibitors (SSRIs) have been developed, and found to be effective for depression, panic disorder and obsessive compulsive disorder. That makes further studies on the possible role of serotonin and other transmitters in depression and other SSRi-responsive conditions well motivated. But this does not mean that depression and other SSRi-responsive conditions are associated with an aberration in serotonergic neurotransmission, nor that such an aberration would have been confirmed. “The effectiveness of SSRIs does not tell us anything about why some people develop depression and others do not, but I still think it was a good thing that the SSRIs, thanks to this theory, could be developed”, said Elias Eriksson.
The ethical issues related to screening and diagnostics of attention deficiency hyperactivity disorder (ADHD) was the topic of Ingemar Engström's presentation. “The main question is: where do we draw the line between normal and abnormal?” he said. “Is the dysfunction a problem in the person’s life or is it a problem is someone else’s life?”

A shift from psychologically to biologically based diagnoses can be observed within psychiatry and especially so in child and adolescent psychiatry. This shift has given rise to considerable controversies on different logical levels in the field. These controversies may be based on ontological as well as on epistemological grounds. They may even touch upon the essence of the very concept of disease.

“Today the prevalence of ADHD in children and adolescents is said to be about five percent. But we can ask if ADHD really exists, and what do we mean with exist?” said Engström

Today the prevalence of ADHD in children and adolescents is said to be about five percent. But we can ask if ADHD really exists, and what do we mean with exist?”

He also discussed the term neuropsychiatry? Neuropsychiatric diagnoses like ADHD have been increasingly used in psychiatry during the last decades. This has been the case in child and adolescent psychiatry for quite some time and has now also made major changes in adult psychiatry and addiction care. Why is ADHD a neuropsychiatric disorder, but depression is not? “I think this term is wrong and should be abandoned”, he said.

The number of diagnoses of ADHD and other behavioural disorders in Swedish children and adolescents has increased fourfold during the last decade but with considerable regional variations. The medication has doubled over five years. Thus the key questions are: What is the true prevalence of ADHD? And what is the optimal number of children treated with pharmacological agents?

Suggestions have been made for the screening of ADHD. However, for screening to be meaningful we need valid tests that work without complex interpretations. They should be specific and sensitive and the screening should be supported by the community. “No studies have shown that prevention would have any value and my conclusion is that today it is not possible to screen for ADHD”, said Engström.

Many professionals would argue that a large group of children and adolescents finally have been given the correct diagnosis and appropriate treatment. Others would argue that the dramatic rise in neuropsychiatric diagnoses, often followed by psychopharmacological treatment, raises many scientific and ethical issues.

One fundamental ethical issue concerns the possible benefits of this diagnostic shift in relation to possible risks. Other ethical issues concern the consequences of the diagnosis with regard to self-image, psychopharmacological side effects and conceptual issues within the psychiatric field.

“We are in the midst of a sensational diagnostic shift. There are many controversies regarding the diagnosis and treatment of ADHD that need to be discussed. There are also numerous ethical problems related to the diagnosis, screening and treatment of psychiatric disorders in children and adolescents that need to be clarified and discussed”, concluded Ingemar Engström.
We are in the midst of a sensational diagnostic shift. There are many controversies regarding the diagnosis and treatment of ADHD that need to be discussed. There are also numerous ethical problems related to the diagnosis, screening and treatment of psychiatric disorders in children and adolescents that need to be clarified and discussed.”

INGEMAR ENGSTRÖM
Anders Hjern began his presentation by stating that: “Mental health is determined by a complex interaction between genetic and environmental factors.”

In the developmental ecological framework, first proposed by Bronfenbrenner, different social systems can be identified around each child, from the most intimate family, the peer group, to the neighbourhood and the society at large.

These systems are interdependent so that also risk and protective factors in the intimate family sphere are moulded in a greater social context. This explains why broad social categories of the household, such as social class, income and educational level, can be important predictors of mental health problems such as attention deficit hyperactivity disorder (ADHD), conduct disorder, depression, psychotic and addictive disorders.

The determinants of mental health in childhood are both hereditary and environmental. A life course perspective has been developed to understand the social determinants. It gives a possibility to understand that they change over time. The life course perspective looks at the situation during the prenatal stage of the child, the early childhood, the time at school and the different phases of adolescence and adulthood. The key social determinants of mental health follow the social arenas linked to each phase, mother, family, nursery school, school, neighbourhood etc. Genetic factors are activated in a similar developmental cascade in pace with the gradual maturity of the brain, and also influence the social environment to a certain degree through family and peer interaction patterns.

The importance of genetic factors for ADHD, one of the most common psychiatric disorders in childhood, has been well established in twin studies. Swedish population studies demonstrate a prevalence of ADHD in three to five percent of school children. Twin studies suggest that forty to eighty percent of the variation in the population is associated with genetic factors.

There is, however, also evidence for the importance of environmental risk factors in the development of ADHD. Prenatal exposures, social adversity and neglect in early childhood and bullying in school age have been linked to the development of the symptoms associated with ADHD. The symptoms are often more disabling in the school environment compared with the home, illustrating how social context sets the stage for mental health problems in children.

Hjern referred to several studies that have been conducted on the relation between social factors and mental health. A study concerning smoking mothers showed three times higher occurrence of ADHD in children, but a comparison between children of the same mother showed that this association to ADHD is primarily genetic. A study on Romanian adoptees in the United Kingdom showed that approximately half of the children will develop ADHD in extremely deprived institutions, the other half will not, under any circumstances. And a Swedish study showed that bullies in school more often had behavioural problems at school entry and those being bullied did not. Thus, in the first case, the ADHD symptoms may have put the children at risk for bullying, whereas in the second case victimization may have enforced the symptoms.

Anders Hjern ended by stating: “Social determinants are embedded in a complex multilayered context. They interact with genetic factors, and genetic factors shape important aspects of the social environment.”
The relation between criminality and mental illness is very sensitive, stated Sten Levander. Usually people do not want to add to the stigma of mental illness. Also, social and psychological explanations of mental illness are preferred over biological or – even worse – genetic explanations.

Levander then discussed whether persons with mental illness tend to commit more or less crimes than others. It is not a simple question so we need to start by looking at the facts: is the crime rate higher or lower? And if it is, what generative mechanisms to increased criminality can we identify?

Levander referred to a recent study which shows that former child and adolescent psychiatric (CAP) patients commit twice as many crimes than others of the same age group. Among the former CAP boys thirty eight percent had at least one entry in the crime register compared to twenty two percent for the control group. The corresponding figures for girls were twenty four and thirteen percent. It is interesting to note that the CAP over-representation was more pronounced for girls than for boys. The study also looked at the age at which the first crime was committed. In this respect there was no difference between the two groups. The median age was around fifteen for both sexes. So, do other life problems influence the rate of criminality? These possible effects seem to be small, with two exceptions: developmental problems increased violence crimes regardless of sex. Neglect increased the frequency of most crimes, but only for boys. This study was based on a data base with 3734 girl and 2321 boy former psychiatric outpatients under twenty six years old. The controls where randomly selected in the same local domicile, of the same sex and born the same year. The data on criminality was obtained from a police register which includes crimes committed by minors (from age 9).

“There seems to be a link between mental illness and suicide”, said Levander. Depression is the most common diagnosis associated with suicide, drug and/or alcohol abuse is the second most common. Schizophrenia comes in third place and is associated with fourteen percent of the completed suicides.

Schizophrenia is typically characterized by short acute episodes when the person suffers from thought disorder, hallucinations and delusions and longer periods characterized by reduced cognitive and social capacity. A Swedish study of forty eight murderers diagnosed with schizophrenia showed that almost all crimes were committed either in an acute episode or during active substance abuse.

However, acute episodes and abuse can be treated and prevented by antipsychotic drugs and psycho-social interventions. In the study a large majority of the murderers were known to the psychiatric services, but not even half were in treatment and were prescribed antipsychotic drugs.

At the time of the crime, most of them had stopped taking their medication. “This shows that if we can prevent the acute episodes and treat abuse successfully, then we have solved the problem”, said Levander.

Yes, persons with a serious mental illness do commit more crimes, particularly violent crimes against close relatives. We have created this outcome by ignoring the cumulated knowledge in the psychiatric professions. We have tried to be good and by that we have created a hell for them.”

Patients with serious mental illness often lack insight into their own illness. According to the World Health Organisation, ninety six percent of the patients do not have full insight. So the question is how do we convince such patients to accept treatment and how bad should the situation be before we introduce compulsive treatment? Is the use of good risk assessment instruments the answer? “The fact is, however, that we do not have good instruments. Another serious problem is the fact that skilled psychiatric clinicians is an endangered species, soon to become extinct”, said Levander.

He ended his presentation saying: “Yes, persons with a serious mental illness do commit more crimes, particularly violent crimes against close relatives. We have created this outcome by ignoring the cumulated knowledge in the psychiatric professions. We have tried to be good and by that we have created a hell for them.”
The ancient Egyptians described cases of suicide associated with honorable death. The Greeks and Romans were among the first to look at suicide from a philosophical or ethical perspective. Their discussions were characterized by the diversity of opinions. Each philosophical school had its own position on suicide, from the explicit opposition of the Pythagoreans to the welcoming approval of the Epicureans. The view on suicide in ancient times was much more tolerant than it has been in western societies in modern times.

A few suicides are recorded in the Old Testament. They are neutrally described without moral judgment. For example, the death of King Saul is laconically described: “After losing his sons in a battle he fell on his own sword.” The only description of suicide in the New Testament is the suicide of Judas. It is, again, a neutral description, without condemnation. There were no rules in the early Christian Church that prohibited suicide, but in the fifth century the position of the church changed. St. Augustine (354–430) called suicide a sin and said that life is a gift from God and only God can take it away.

In the twentieth century suicide began to be regarded more as a sign of mental illness than a sin. This shift occurred simultaneously with the development of psychiatry. At the same time the views of the Christian Church also became more tolerant.

Today there are many different views on suicide. The most conservative views maintain that life is sacred and not to be shortened under any circumstances. Progress in medicine has raised questions about the rights of individuals with terminal disease to decide their own time of death and to die with dignity. This debate has resulted in the concept of rational suicide, which is based on the idea that the autonomy of the individual and his ability to make rational decisions about ending his own life should be respected. A third view could be called the clinical view. It is based on the fact that underlying psychiatric illness is found in more than ninety percent of all suicides. The most common disorders are depression, bipolar disorder, schizophrenia and addiction. “It is important to realize that in the rest of the cases it is not possible to rule out a psychiatric disorder.”

This became the official and firm position of the Christian Church for many centuries to come. Suicide became a mortal sin in the thirteenth century when St. Thomas Aquinas reinforced the condemnation by proclaiming that taking one’s own life is a crime against nature, society and God.

John Donne, the English priest, lawyer and poet, was the first to defend suicide in the seventeenth century. He thought that those who committed suicide were not sinners. The view on suicide changed further in the nineteenth century when it by some was seen as a social phenomenon. For instance Emile Durkheim, who has been called the father of sociology, held the view that society, not the victim, is to blame for suicide.

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Nanna Briem ended by discussing if it is right or wrong to intervene in cases of suicide. We know that in most cases it is possible to intervene and thus reduce the frequency of suicide. Not to intervene is an irreversible and final act. It is, however, not possible to be sure whether the decision to commit suicide is rational and final or if the person would be grateful for an intervention. She ended by quoting professors Sidney Bloch and David Heyd: “It is better to err on the side of preserving life than on the side of letting it be lost.”
Coercion is used in mental health care systems every day. But is this the power of the strong, the power of the many, to suppress those who are different to conform? Or are there strong ethical underpinnings to involuntary treatment in psychiatry, he asked.

When we analyse this question we first need to define what we mean by risk and force, said Matthíasson. By risk we usually mean that the person poses a risk to himself or to others. By serious risk, we mean that there is a fair probability that someone is harmed if intervention doesn’t take place. Force is a vague term that in this context means admitting someone to a hospital or a prison and influencing his behavior using physical restraints, seclusion or medication.

Matthíasson analysed the ethics of using force in the treatment of mental illness further by comparing the views of the main stakeholders in coercion. As stakeholders he mentioned medicine/psychiatry, law, legislative bodies, public authorities, the police, accrediting bodies and lay advocacy organisations. The key questions in the discussion for and against involuntary treatment are: does mental illness exist, can treatment be beneficial, can coercion be humane and effective and can attractive treatment facilities replace the need for coercion?

“Nobody doubts that people sometimes lose their capacity for self-determination as a result of conditions like psychoses, dementias and severe mood disorders. What is not universally agreed is how best to deal with such vulnerable people”, he said. So, then the question is: under what circumstances should involuntary treatment be allowed? The first prerequisite is, of course, that there is a legal framework in place regulating the treatment and that careful scrutiny is performed.

Finally Matthíasson discussed abuses that can occur in involuntary treatment. They can be of two kinds, namely involuntary hospitalization of a person who does not meet relevant criteria and mistreatment during the period of admission. Blatant use of involuntary treatment either for moral or political reasons is rare today, although examples from the Soviet Union is a reminder that this has recently happened close to us. Mistreating people who are compulsory detained in mental hospitals is, however, a major concern. It is not always clear where the line should be drawn between treatment as control and punishment as opposed to appropriate and necessary. The use of seclusion and restraints are important in this regard. It is interesting that the use of physical restraints is prohibited in, for instance, the United Kingdom. In Iceland it has been prohibited since 1933, but it is still allowed in Denmark, Finland, Norway and Sweden. This despite repeated comments from the Council of Europe’s Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment and requests to stop this practice except in special circumstances.

Matthíasson finished by pointing out that there are differing views about the ethics of involuntary treatment. In most countries of the world coercion in mental health is accepted within a legal framework, with adequate safeguards in place. There are clear ethical arguments supporting this practice. However, the risk of abuse of power is great and careful attention is needed to monitor the practice of involuntary treatment.
“Psychiatrists must be aware of the ethical implications of being a physician, and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.”

ANNE LINDHARDT
Stigma leads to discrimination and social exclusion and also to self-stigmatisation. Anne Lindhardt emphasized that stigmatisation is common and occurs everywhere and she gave two examples. In a dinner party conversation a man in his early sixties was pronounced by a friend to be a hypoconder. Everyone laughed, and nobody was able to listen to the pain it involved. The second example was a comment by a member of staff in a psychiatric ward on a belt fixation of a young man: “We finally got him.” “We in psychiatry are working very hard on our attitudes, but there is still a lot to do to avoid the stigmatisation of patients. Health care personnel are the worst in stigmatising people, worse than lay people,” she said.

Lindhardt mentioned the ethical principles and guidelines for medical doctors and biomedicine that have been adopted in Europe in the wake of Second World War. The four main principles in these guidelines are to do good, not to harm, to preserve the autonomy of the patients and to ensure fair and just distribution of treatment. In 1996 the World Psychiatric Association adopted a code of conduct, the Madrid declaration on Ethical Standards for the Psychiatric Profession. According to the declaration “psychiatrists must be aware of the ethical implications of being a physician, and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.”

It is difficult to make a clear distinction between mental problems and mental illness, said Lindhardt. How many persons actually suffer from psychiatric problems? For instance, is stress a normal condition or a disease, or can it develop into a disease like depression? She said that a doctor’s primary task is to restore health, but he/she also has an obligation to advocate for the patients. On the individual level he/she should emphasize the importance of working with resilience and maintain the perspective and hope for recovery. On the societal level, there is today a demand to focus on health and not only illness. Prevention plays a major role often focusing on regaining working ability.

Stigmatisation is the result of the perception of individuals with mental problems as being dangerous and unpredictable. Studies of stigmatisation show that patients experience stigma at work and with family and friends. Interestingly, stigmatising is particularly pronounced among health care professionals. Stigmatisation by others usually also leads to stigmatisation by the individual herself, self-stigmatisation.

Stigma can be divided into various types according to the level in society in which it occurs. Lindhardt mentioned three types. The first, structural stigmatisation, can be identified in human rights issues and laws and in resource allocation for research and treatment. The second type is the stigmatisation among mental health professionals which reveals pessimistic attitudes and lack of compassion and involvement. The last type can be seen in the media where psychiatric patients are depicted as “bad patients” and the treatment is “bad treatment”, said Lindhardt.

Today the big ethical problem of stigma in psychiatry is being targeted in many places around the world and by a number of organisations like the World Psychiatric Association, the World Health Organisation, the European Union and several governments. Awareness of the problems is being raised. Hard core economic arguments are also used. This is because the labour force today is increasingly troubled by mental problems and disorders. Addressing the problems of stigmatisation is a long process involving not only the known facts of the phenomenon but also basic moral values and individual attitudes and beliefs. “In implementing anti stigma campaigns a lot of caution has to be exercised and possible adverse effects analysed. There is always a risk that anti stigma campaigns enhance stigma”, concluded Anne Lindhardt.
What is needed to meet the patient’s needs?

“For me mental health work is a huge solidarity project”, said Tore Gundersen when he gave the conference his views on the needs of persons with mental health problems based on his long personal experience from work in a mental health day centre.

“I have met a lot of people of all ages with depression, anxiety or being close to committing suicide, but I have never had patients”, he said. “Struggling with mental illness, the word ‘patient’ marks you with a sign, a stigma that tends to transform itself into an identity that it is difficult to get rid of. There is a tendency to become one’s own illness.”

Good and relevant treatment is a blessing, but the more special the patient is made the more distance you create between you and them. It is also a question of power in the relation between those who treat and those who are treated. When the patient is viewed as an object there is a risk of forgetting the patient’s real needs and the patient is not given the chance to feel the joy of being asked about his or her feelings.

“The persons I deal with at the mental health day centre have the same needs as I have”, said Gundersen. “To be able to cope with difficult periods in life the users of the centre first and foremost need things like proper housing, work, clothing and food, security and social networks.” Or as the Swedish author Ann Herberlein put it: the most important factors are autonomy, to feel that you are in charge of your own life, your history and even your future.

As an example of the dynamics of being a human being Gundersen took the well known story from the Bible about the prodigal son. “This story”, he said, “challenges us to acknowledge the deepest life crisis, all the losses in life, be it health, work, friends or wealth. At the same time we should acknowledge our ability to comfort, to stand up for someone, to reach out our arms. The story offers us the possibility to see our self both in the son and in the father.”

Gundersen has cooperated with a psychologist in a project aiming at further educating social workers in dealing with people with mental health problems. The social workers meet with members from the mental health day centre where Gundersen works. The person living with the problems tells about her or his life and experiences. This project offers an opportunity to confirm yourself as something else than a patient. It is a possibility to develop new ways of looking at yourself, to be curious about yourself and to dare to acknowledge that your own life story may have some significance to others. This insight really makes a difference. At the same time, the social workers also need to expand their views on those struggling with mental problems. It may be possible to adopt a new idea about those having mental problems. This could, in turn, generate new thoughts about the family, the neighbor and eventually themselves. This process is a form of empowerment that makes it more difficult to uphold the conception of ‘them and us’.

Tore Gundersen ended by telling a story about Atle, who has lived for more than fifteen years in a mental hospital. He was once asked in a radio programme: “What is your diagnosis, Atle?” His answer was: “I, I have a thousand talents.”

To be able to cope with difficult periods in life the users of the centre first and foremost need things like proper housing, work, clothing and food, security and social networks.”
Consequently, the benefits of a number of drugs have been much overrated and the harms much underrated”, said Gøtzsche. “This has been shown in comparisons of published drug trials with unpublished trials or other data available at drug regulatory agencies. Because of this, patients have unknowingly been treated with drugs that have no effect or are harmful. Society would benefit from independent drug trials”, he continued.

Selective reporting is a universal problem that has been documented for many different drug categories. The effect of antidepressants, for example, was thirty two percent larger in the published trials than in all trials that had been submitted to the US Food and Drug Administration.

A review of antidepressants revealed that, in published reports, the statistical analyses of the effects of the drugs showed considerably more favourable results compared to the data submitted as required by law to the drug regulatory agency. The published analyses were mainly ‘per protocol analyses’, where patients who drop out of the trials, e.g. because of lack of effect or adverse effects, are not accounted for. “Those required by law are ‘intention to treat analyses’, which are far more reliable, as they include these patients”, said Gøtzsche.

The United Kingdom National Institute for Health and Clinical Excellence (NICE) has drafted guidelines for the treatment of childhood depression. During the drafting the experts observed that, based on the published trials, they would recommend antidepressants, but based on all the trials, including the unpublished ones, they would not. “The effect of antidepressants is relatively small and the drugs have significant adverse effects that to a large extent have been hidden”, said Gøtzsche. Adverse events like suicidal thoughts and behaviour, and even suicide attempts, in patients taking antidepressant drugs have gone unreported. In trial reports these events have been coded as emotional lability, admissions to hospital, treatment failures, noncompliant patients, or drop-outs. Furthermore, companies have been reported to have added suicidal events to the placebo group, although they had not occurred while the patients were randomised to placebo. “Now we have access to unpublished data on antidepressants and we know they increase the risk of suicide in young people”, he said.

The majority of drug trials are planned, conducted, analysed, interpreted and written up by the pharmaceutical companies. Academic researchers very rarely have access to all the data that would enable them to perform their own analyses and interpretations. “This practice must be changed, as it is harmful to patients and expensive for our societies”, said Gøtzsche. Drug trials should be performed by independent academics and all the data, including raw anonymised patient data, should be made publicly available to allow independent assessments. In that way, society would become much better informed about the true benefits and harms of drugs. This would lead to better treatment with fewer harmful effects throughout the health care system. Transparency would be increased, making it possible for independent scrutiny of the methods and the calculations reported in the trial publication compared with the trial protocol and the raw data. This, in turn, would deter people from committing scientific misconduct and would increase the likelihood of detecting it. The efficiency of healthcare research would be improved, as many important research questions can be answered by using existing data, sparing researchers and patients from unnecessary, potentially dangerous and wasteful duplication of effort. Lastly, it would help to identify healthcare strategies and uncertainties that require research, and to set priorities for the research.

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In his presentation Peter Gøtzsche discussed the conflict between the commercial interests of the pharmaceutical industry and the common good. Selective reporting of drug trial results is common.
Transcultural psychiatry basically means psychiatry across cultures. The two professions with an interest in this field have been psychiatry and anthropology. But these two approaches have traditionally had very different approaches to the field.

Put very simply, psychiatry is interested in the universality of the psychiatric disorders, whereas anthropology is interested in the cultural particularity of different groups of people.

“We now have a large amount of literature in the field of transcultural psychiatry”, said Katrine Schepelern Johansen and gave some examples of areas that this literature deals with. One is the question of culture bound syndromes. Are there psychiatric disorders or syndromes that only exist in certain cultural settings? On the other hand, according to global research by the World Health Organisation, schizophrenia and major depression exist all over the world and therefore probably have a biological etiology. Another issue is culture and personality. Does culture form specific forms of personality and disorders. As an example she mentioned the question whether the Oedipus complex occurs in matrilineal societies.

Ethnic minority patients are overrepresented in closed and forensic psychiatry and emergency rooms and underrepresented in open wards and municipality psychiatry. But we do not know why.”

In Denmark the situation regarding transcultural psychiatry is quite similar to what is found in other European countries. Ethnic minority patients are overrepresented in closed and forensic psychiatry and emergency rooms and underrepresented in open wards and municipality psychiatry. “But we do not know why”, said Johansen. Katrine Schepelern Johansen has studied culture and psychiatry in Danish hospitals. She wanted to know how psychiatric staff members understand and work with the different cultural background of patients with another ethnic background than Danish. The results show that ethnicity is just one of many criteria for how the staff categorizes the patients. Interestingly however, ethnicity is not an objective category. For example, of two patients from the same foreign country one was considered by the staff to be “ethnic” the other was not. Usually one or more of the following characteristics needed to be present but was not enough to qualify for a categorization: skin or hair color, different clothes, different names, not speaking Danish, different religious practices. As a rule, ‘ethnic patients’ were considered by the staff to be difficult patients.

It is important to be aware of the fact that the categorization of some patients as ethnic takes place in parallel with other categorization. The primary and dominant categorization is based on diagnosis. In her study Johansen found that the staff preferred patients with schizophrenia and did not like patients with depression or personality disorders.

Another categorization of patients taking place is a division between patients with and without drug use. Patients categorized as drug users are often thought of as to blame for their problems themselves. Most staff would prefer to discharge these patients so that beds and resources can be spent on patients who really need it, and who’s disorders or problems are not self inflicted.

“From the analytical perspective some patients are more ‘right’ than others”, said Johansen. This may be because they are the norm and hence part of the majority. Patients categorized as ethnic differ from the norm of the right patient. The categorization becomes an explanation why they are not provided with the optimal treatment (e.g. it is difficult, expensive, time consuming, it is not our job to know about culture). Ethnicity becomes a possible explanation for not succeeding as well as intended.

The categorization of some patients as ethnic patients is a complicated process, drawing not only on the ethnic background of the patients but also on institutional practices within psychiatry. The solution is thus not
only to learn something about ethnic culture, but also to be aware of the culture of psychiatry itself.

Katrine Schepelern Johansen said that instead of being inspired by the large body of knowledge on transcultural psychiatry, Danish hospital psychiatry has chosen to use already existing approaches, where some patients are right and some are wrong and excluded from treatment. No major adaptations of the treatment system to these patients has taken place, instead patients have been met with the demand of adapting themselves to the system, if they want to receive treatment. This is part of a general societal process where immigrants are required to adapt to the Danish society.
Mental diseases such as schizophrenia, major depression and anxiety disorders exist all over the world and in all cultures. “What differs, however, are the cultural expressions for mental distress as well as cultural explanations and meanings given to symptoms or emotions.”

“As a result, also the understanding on the proper treatment for mental distress varies across cultures”, said Marja Tiilikainen.

Differences between migrant patients and mental health professionals have often been explained by culture. Migrant patients are seen as culturally somehow different from ordinary patients. Researchers, however, have also reminded that apart from culture also other factors such as power structures, class, gender and race have to be recognized and considered in multi-cultural mental health encounters.

In psychiatry culture-bound symptoms or syndromes refer to well-known categorizations of disease in a certain cultural area. They are localized categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences, for example susto in Latin America and arctic hysteria among Eskimos. Medical anthropologists have maintained that psychiatry itself is a cultural institution which is based on certain cultural assumptions on, for example, the individual and autonomous self.

The key question is then: what is normal or abnormal? Today biomedicine and Western psychiatry define “normal”. Moreover, behavior gets its meaning from the social and cultural context. For example, a typical Finn who is silent and socially reserved is seen as abnormal and strange in Southern Europe or Africa, whereas an African child in Finland who is energetic and lively may easily get an attention deficiency hyperactivity disorder (ADHD) diagnosis or status as a child who needs special care and guidance. Research from the United Kingdom has shown that Afro-Caribbeans are given psychosis diagnosis more easily than white patients. The high rate of psychosis among the Afro-Caribbeans has partly been explained by a tendency of Western psychiatry to pathologise ethnic and racial minorities.

In many cultures, disturbances in mood, anxiety or emotional problems are not viewed as mental health problems, but as social or moral problems that are to be solved by a family member, elder, religious leader or a traditional healer. “In most societies mental disease is stigma and to become labeled as mentally ill should be avoided – as a result, treatment and medication of mental disease may also be rejected”, said Tiilikainen.

Marja Tiilikainen has studied the views on mental health among Somali immigrants in Finland. Somalis are the largest group with refugee, African and Muslim background in Finland. According to Somali views “madness” may be caused by, for example, shocking events, strong emotions like disappointment, worry or love. Madness can also be caused by problems in social relationships (evil eye, witchcraft) or problems in relation to the spirits (jinn or saar spirits). As examples of symptoms caused by spirits are mentioned nightmares, lack of appetite, pain, paralysis, infertility and epilepsy. In the search for treatment of mental health problems Somalis turn to their families, the health center, the mosque or healers in Somalia. Mental hospital is the last resort. Sometimes the person is sent or taken back “home” to Somalia. Patients go home for treatment because they have not got help in Finland, or they do not trust the Finnish treatment. Factors contributing to the experience of becoming healed in Somalia are encounter with culturally authentic and trusted treatments and healers. The patient gets a diagnosis that can be understood and treated. Social relationships are rebuilt. The patient often has a sense of becoming mentally and physically stronger. An overall sense of being at home also seems to be an important factor.

She mentioned two ethical problems in relation to mental health and cultural minorities. The first is: What does equality in mental health care services mean? Migrants use mental health services less frequently than
the native population. How could we improve access and outcome? There are also challenges in communication. Concepts and understandings are different in different cultures. An important factor is what is discussed, or not discussed, and with whom. For instance, what can be discussed with a male or a female, who is present etc. There are often a need for both language and cultural interpretation. To overcome these problems culturally sensitive tests and tools have to be developed. The transnational health-seeking practices reveal gaps and lack of trust in multicultural healthcare encounters.

The second ethical problem is the medicalisation of social suffering and problems of life. There is an apparent need for co-operation between social and healthcare workers. “Perhaps there also is a need for co-operation between mental health professionals and traditional and religious healers”, Marja Tiilikainen ended.

“Perhaps there also is a need for co-operation between mental health professionals and traditional and religious healers.”
Elisabeth Eide discussed the role of the media and the public debate following the Utøya massacre in Norway on 22nd July 2011. Norway was not the first Nordic country where a young man committed a violent act killing many people.

In Finland frightening mass-killings, school massacres, by young men have occurred twice in the last five years, in Jokela in 2007 and in Kauhajoki in 2008. In all three cases the perpetrators have been young men and they have all posted their messages on the internet, before the terror act, where it has spread rapidly. The difference however, is the massiveness of the crime in Norway. Furthermore, in his message Anders Behring Breivik explicitly expressed his hatred towards what he called ‘Cultural Marxists’ and Muslims.

“Soon after the violent acts on Utøya, Norway became a nation in mourning with a sense of collective grief and of a ‘larger we’, said Eide. Prime Minister Jens Stoltenberg and the royal family showed their grief and pain publicly and set an example for their fellow Norwegians. They also advocated for more openness in society and more democracy. As a result, many Muslims said they felt more at home, more accommodated. But in some media, very different tendencies could be seen.

“Research has shown that in Norway the integration of immigrants is a relatively large success. But there are individuals and groups who oppose immigration and reject these research results”, said Eide. “There is a need for a fundamental debate”, she said. “Some claim that views critical to Islam and Muslims have been marginalized in Norway and that this perhaps contributed to Anders Behring Breivik’s acts of terror. On the other hand, did Anders Behring Breivik feel that he had support for his views, and thereby also, maybe for his deeds, through negative expressions towards immigrants in the media, particularly social media?”, she asked.

Elisabeth Eide has analysed the media and the public debate following the Utøya events. She finds three different trends or positions in relation to the ensuing debate.

According to the first position Breivik’s acts were wrong, but his views, or at least some of them, make sense. This view can be seen now in the opinion pages of the mainstream media. Some also claim that the government got what it asked for. Others, although very few, even portray Breivik as a hero doing the right thing, the latter two mainly through social media.

The second position that can be seen in the public debate is portraying Breivik as the only one that can be blamed for the terror and assassinations. He may have felt that he had support in society for his views and acts. “Today racism and hostility to Muslims can be seen both in the media and elsewhere”, said Eide.

The third position blamed the Muslims. This occurred mainly during the first few precarious hours before the events in Utøya and the perpetrator’s ethnic Norwegian background became public knowledge. Some immigrants faced a lot of hatred, they became victims of the collective guilt syndrome and some were even physically attacked. One reaction against this tendency was Sophia Adampour who wrote on the web page of the Norwegian Public Broadcasting on 25th July: “Hi, I am thirteen years old and a Norwegian Muslim and I feel that this is my fault. He says he killed everybody since I am here. Should I move away to protect Norwegian children in the future? This is how I feel. Greetings from Sophia.” She was then invited to a TV talk show to meet the Minister for Integration.

An early analysis of the media some months after the events on Utøya show that now compassion and victim positions have come into focus. The compassion for the victims became large and global. But there were also expressions of compassion for the right wing extremists. Some claimed that they have become partly marginalized; and some of the most critical to Islam have positioned themselves as victims. And lastly there is compassion for the first to be blamed, the Muslims and partly marginalized minorities that have often been targets of hate speech.

Elisabeth Eide concluded by discussing what she called the psychiatry and ethics of the social media. “Is there a new climate for debate?” she asked and continued: “While I fight for the right to free expression I’ll also fight for a media atmosphere where anonymity is a rare exception and for the right of the ones talked about to be free of discrimination and for decency and humanity.”
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ELISABETH EIDE
Ethical aspects of mental health

Ethical aspects related to mental health was the topic of a conference organised by the Nordic Committee on Bioethics in Helsinki in the fall of 2011. This conference summary highlights the main challenges and issues facing researchers, policy makers and practitioners who deal with mental health issues. The committee invited a broad range of experts to talk about the psychological, historical, social, cultural and biological perspectives related to mental health.

The heated debates which are taking place in various disciplines on the causes and the best ways for treating various conditions and problems were brought forth in the presentations. The Committee hopes that this summary will serve as a resource to people who are interested in the development of possible ways for tackling mental health problems in the Nordic countries, by identifying some of the key issues involved and the challenges that lay ahead.