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## **Do clinicians and clinical researchers do enough to foster social inclusion?**

In this article I discuss three research papers that highlight the issue of social conditions and how clinicians and clinical researchers might need to consider these more in their practice, their research and the way they write about them.

## **Is depression caused by being defeated and trapped?**

### **Theories of evolution suggest why adversity can lead to feeling defeated, trapped and depressed**

Griffiths, Wood, Maltby, Taylor and Tai (2014) begin their article by explaining a theory of depression that places it in the context of evolution. Humans have evolved to have a way of coping with defeat. It is similar to what happens in other animals when they compete for a mate or resources. The one that loses withdraws and may lose sleep and be on hyper-alert for further danger. This is good because it helps them avoid injury, and it passes off in a while. However, if escape is blocked, the animal may behave submissively to cope with feelings of threat, and this resembles depression in humans. Furthermore, people in this situation feel not just defeated, but trapped.

However, Sloman (2008) suggests that this 'entrapped' state is only a problem when it persists over a long period. One of the causes of it persisting is through growing up in circumstances of stress: Mothers, both animal and human (and presumably human fathers too), find it harder to give adequate care to their offspring when they themselves are stressed. This results in the youngster growing up with heightened alertness to danger and less ability to form alliances with others. Thinking about this in humans, it means that if

people meet further stresses, they may feel defeated and trapped more easily, and therefore become depressed.

### **Testing whether feeling defeated and trapped leads to depression**

Griffiths et al. (2014) wanted to test this defeat-entrapment theory of depression. For their study, they recruited a sample of people living in a deprived area of Northern England. They reasoned that people living in this area would be in social conditions likely to make them feel defeated and trapped, such as poverty, unemployment and lack of opportunities. The authors tested whether feeling defeated and trapped predicted feeling depressed or anxious a year later. However, they also tested the opposite prediction - whether depression and anxiety predicted feeling defeated and trapped a year later.

There were 195 people in the sample initially and only 22 dropped out in the following 12 months. About two thirds of the 195 were women. Most were employed, over a third had studied up to A-Level but only 12% had a university or higher degree. At the first measurement, 63% of the sample scored above the clinical cut-off for depression, and 55% were above the cut-off for anxiety on standardised self-report questionnaires.

Feeling defeated and trapped were measured using the Defeat Scale and the Entrapment Scale, both produced by Gilbert and Allan (1998). An example of feeling trapped is given as "I am in a situation I feel trapped in" and an example of feeling defeated is given as "I feel defeated by life" (Griffiths et al., 2014, p. 54).

### **Were people who felt defeated and trapped more depressed a year later?**

At the beginning (Time 1) the researchers found that feeling defeated and trapped were very strongly linked with each other. If people felt defeated they also felt trapped. Because of this the scores on defeat and entrapment were combined into one score as a predictor in the regression analyses (statistical analysis used to test predictions). Defeat-entrapment at Time 1 significantly predicted both anxiety and depression at Time 2 a year later. There were also many people reporting anxiety and depression at Time 1, and Griffiths et al. (2014) found that each significantly predicted defeat-entrapment at Time 2.

### **Did the researchers answer the question whether depression is due to feeling defeated and trapped?**

Griffiths et al. (2014) suggest that their finding that defeat and entrapment seemed to be part of the same psychological state supports the theory that people get stuck in their defeat reaction when they cannot escape from their situation. They continue to feel defeated and trapped. The finding that these feelings predicted increases in both anxiety and depression supports the theory that both depression and anxiety can be the result of people feeling trapped in circumstances that are difficult to escape from, such as poverty and situations of scarce opportunities.

However, the authors also suggest that their results point to a two-way process: Depression and anxiety also led to feeling more defeated and trapped a year later. The authors say this supports the idea of a vicious cycle of defeat and entrapment leading to depression and anxiety, which in turn lead to more defeat and entrapment.

Griffiths et al. (2014) concede that there is a need for research on shorter timescales, however. Given that they started with a sample of people already in difficult circumstances, it may be that defeat and entrapment are more likely to be experienced together in such circumstances. If everyone had been free of depression initially, and questionnaires had been given at several times points over the following year or longer, then perhaps the researchers would have seen people going through difficult events such as redundancy or not getting a hoped-for pay rise, and other stresses. Some people then may have felt defeated, and if things did not improved or had got worse, they may later have felt trapped, and then depressed.

Others may have initially felt defeated but later been able to improve their circumstances, and not felt trapped, and not become depressed. The authors concede this point, and suggest that perhaps another variable caused people to report depression, anxiety, defeat and entrapment. An obvious possibility is the actual difficulties they may have faced, such as low paid employment, poor housing and so on (which were not included in the analysis). Such circumstances could cause all of these feelings if they led to constant financial challenges and health problems.

### **What will help when people feel trapped and depressed?**

I felt a bit disappointed by the solutions Griffiths et al. (2014) put forward. They suggested that cognitive behaviour therapy (CBT) could help people to notice their defeat reactions and think differently about their situation. They do recognise that people in more deprived settings are more likely to feel defeated and trapped, and they point out that

people in these circumstances are more than twice as likely to get a mental health diagnosis. But they do not consider how we can make it less likely that people experience defeating social conditions. It might be helpful for clinicians to recognize social inequalities and exclusion, and to combat the common belief that people in poor conditions only have to make more effort to improve their lot. It may require concerted social action to reduce inequality and social exclusion.

In their defence, Griffiths et al. (2014) are not simply suggesting that people pretend a bad situation is a good one. They suggest that it is helpful for people to be aware that when they feel defeated, trapped and depressed, it does not mean they have failed in life, although it may feel like this. It may also feel frustrating and angering, something that clinicians perhaps also need to take into account, since they may be unprepared for the natural hostility that can go with persistent exclusion. Clinicians may be blind to the inequalities in society that lead people to be excluded. Nevertheless, people usually have some experiences in life that have felt successful, and they can be reminded of these to help build resilience, say Griffiths et al. (2014).

## **A medical view can add to the social exclusion of women**

### **A medical view of domestic abuse may increase 'victim-blaming'**

Paige Sweet's (2014) article is about how medical researchers write about women who have suffered domestic violence. The way people think, talk and write about health and illness has consequences.

Sweet's (2014) article looks at medical articles written over the past forty years. She suggests that the medical focus on the woman who has been abused rather than her wider social context has made 'victim-blaming' more likely. As Sweet reminds us, others have discussed the 'medicalisation' of social problems. For example, much human distress has come to be seen as psychiatric illness. Distress can then appear to be like other medical conditions such as infections. But mental distress often happens because of social conditions, such as child abuse and neglect, exploitation at work or persistent lack of opportunities. These social causes of mental distress are made much less visible when there is too much focus on biological causes, Sweet (2014) suggests.

Sweet (2014) tells us that over the years, medicalisation has now turned into 'biomedicalisation'. This relates to the increase in discoveries about the biology of our bodies and brains. All this knowledge about biology seems to give medical articles more weight when they use diagnostic terms, Sweet suggests. A diagnosis, whatever it is, comes to be seen as a 'thing' that the person has inside them. For example, people believe they 'have' depression. This makes it appear like 'having' a cold, but we don't actually 'have' depression in the same way. There is no physical sign that people 'have' depression. There can be signs of an altered brain state or physiological markers of stress, but there are similar signs in people who are grieving. Yet we don't say someone 'has' bereavement. We see it as a state, not something that has got inside the person.

Sweet (2014) suggests that the biomedical view also tends to make us all think more about our future health. Biomedical research focuses on risk of future ill health. Whilst this

is a good thing if it reduces illness, there can be a sense that people have more responsibility to ensure that they do not become ill, by living healthy lives. However, our circumstances can make it harder for some of us to do this.

### **The problem of seeing domestic abuse as a ‘women’s problem’**

Sweet (2014) studied 53 articles published between 1970 and 2013. She focused mainly on “review articles on the health effects of domestic violence” (p. 46). Her aim was to look at medical views of domestic violence. These views are not the only ones, but they are influential. Back in 1979, Sweet recounts, clinical psychologist Lenore Walker wrote a book suggesting reasons why women often stay in abusive relationships. Her theory about this was drawn upon in court cases in defence of women who killed their abusers. Walker (1979; 2009) suggests that women in abusive relationships come to believe they cannot escape. In some ways this seems a helpful idea: If we think that a woman cannot see any alternative to staying in the relationship, we may be more sympathetic to her, rather than thinking of her as weak. However, to many clinicians and researchers, ‘battered woman syndrome’ did start to be seen as the woman’s weakness, and a personality defect.

Sweet (2014) suggests that women’s injuries came to be seen in the medical literature as part of the diagnosis of ‘battered woman syndrome’. Women would claim that the injury or the danger they faced was minor. This went alongside staying in the relationship and therefore being injured again. This was seen as part of the woman’s illness and personality problem. No attention was given to men who suffered violence from partners. This was a ‘women’s problem’.



From around the 1980s and 1990s, feminists and others began to shift the focus onto the perpetrator and to highlight the problem of male violence against women. Whilst Sweet (2014) suggests that this was helpful in some ways, she also takes the view that biomedical literature, even when written by feminist clinicians, sees the battered woman as ill and vulnerable over a longer time. Sweet (2014) quotes from an article (Kramer et al., 2004) that suggests women coming into hospital emergency units following domestic violence should be viewed as having “chronic illness” (i.e. long-term). This is because the women are likely to suffer long-term consequences of the abuse, including weakened immune systems leading to more physical illness and infections, more mental health problems, and they are likely to use more services. Sweet (2014) suggests this makes it more likely that women themselves will be blamed for their difficulties. Even where they have escaped an abusive relationship, they are seen as a continuing burden on society because of numerous problems.

Sweet (2014) makes a convincing case that even well-meaning medical writing about women who experience domestic violence can increase our view of them as the problem. However, she does not offer any suggestions for changing this view.

## **Enabling clinicians to notice social exclusion and perhaps change things**

### **Training in cultural competency is not enough**

Metzl and Hansen (2014) seem to offer a way of addressing both the concerns raised by Sweet (2014) and the lack of any mention of social action in Griffiths et al. (2014). They start by pointing out problems with the training given to student clinicians on ‘cultural

competency'. This training is meant to enable students to become more aware of how the differences between their own experience of life and that of a patient from a different background or ethnicity may lead to misunderstandings and contribute to stigmatisation of the patient. Students are given stories about different patients who may come to see them, mentioning the patient's ethnicity and how the encounter begins. The student has to decide how best to approach the patient, who may arrive late and seem to be ignoring medical advice, for example.

Metzl and Hansen (2014) suggest that the problems that can arise go beyond the specific doctor-patient encounter: Students need to be aware of how wider society affects the way a patient interacts with them or how the patient understands advice given. They point to institutional stigma, that is, stigmatising attitudes that pervade our institutions. They mention some training initiatives in different places, but only a few of these are embedded in professional healthcare training. They argue that trainee clinicians need to be able to understand about the social conditions that contribute to health and illness, including inequality and economic and political factors.

Although medicine has advanced in understanding how circumstances such as deprivation and stress affect people, Metzl and Hansen (2014) suggest that the USA probably has worse conditions than ever for people growing up in some geographical areas: Living in a certain neighbourhood can predict life expectancy. Yet, knowing about these things does not help clinicians to know what to do when seeing a patient. They are not trained to deal with these larger social issues.

### **How should clinicians be trained?**

Metzl and Hansen (2014) offer a solution: They suggest training people in 'structural competency'. This means enabling them to understand how decisions made at a society or community level, and prevalent social conditions, i.e. 'structures', affect both individuals and how their difficulties are viewed and treated. These structures could be provision of transport to a specific area, or parks and other amenities. They can also be the long-established practices of doctors around diagnosis and the accompanying bureaucracies. Structures can also mean the taken-for-granted ideas that groups of people hold about themselves or others, including about the causes of illnesses. Metzl and Hansen (2014) recognize that individual doctors may not be able to change things, but awareness of social issues can help them to have a better understanding of their patients and their wider context.

Metzl and Hansen (2014) suggest five competencies:

1. Awareness of societal issues that affect clinicians' encounters with patients
2. Being able to talk about these issues
3. Moving beyond culture to the wider social issues affecting people's lives
4. Understanding possibilities for changing things
5. Understanding the limits of possible change

### **Awareness of social issues**

When using scenarios of clinical encounters in training, instead of the student clinicians thinking only about the doctor and patient, they are encouraged to think about

the wider issues around why, for example, the patient is late for their appointment or is apparently refusing to take advice about healthy eating. Metzl and Hansen (2014) allude to the difficulty of easily finding fruit and vegetables in some neighbourhoods. Students might also be encouraged to think about the implications of time pressure that may prevent sufficient understanding of the patient's circumstances. This has an effect on both patient and doctor.

### **Being able to talk about social issues**

Metzl and Hansen (2014) use ideas from medical sociology to help create the ability to talk about the effects of social issues on health and illness. This could include things like institutional racism, crumbling roads and communication infrastructures affecting health in certain neighbourhoods, assumptions about what good health means and how they can stigmatize those who do not fit the ideal.

### **Moving beyond culture**

Whilst Metzl and Hansen (2014) suggest that it is important to be aware of the values of people who belong to different cultures, it is also important to be aware of how social structures can reduce their inclusion or access to resources. Thus, there may be barriers that make it hard for a patient to get to a clinic appointment on time, but patients might have, or develop strategies, perhaps shared with others locally, for overcoming barriers.

## **Changing society**

Structures can be changed. Students might study previous interventions, or work in teams to develop their own. Metzl and Hansen (2014) suggest students gain experience by being placed in projects such as those promoting recovery in mental health, and where staff work collaboratively with service users to help them towards goals they decide for themselves.

## **Understanding the limits of possible change**

Metzl and Hansen (2014) remind us that the issues are complex, and it is important that student clinicians do not forget this. They may have good knowledge of the constraints on their patients but should not assume they therefore completely understand the issues, which are complex and ever-changing.

## **Conclusions**

The paper on depression highlights how depression may be closely linked to the social conditions people live in. However, its authors (Griffiths et al., 2014), in their suggested solutions, focus only on the individual person. It can be good to reduce negative thoughts and self-blame, and in my own experience of managing depression, a CBT approach is helpful in this regard. However, it also seems important that a clinician be open to the real-life pressures and stresses that people have had to cope with. If a stressful and defeating situation is ongoing and therapy is not going well, it may be too easy for the therapist to believe their client is not trying hard enough or that it is due to character

defects. Sometimes a simple acknowledgement of someone's ongoing situation and how difficult it is can help motivate them to do what they can to improve it. If they can change it even a little bit, this also reduces negative thoughts, self-blame and depression.

Sweet's (2014) analysis of medical writing about domestic abuse indicates how a narrow focus on biology or the individual person as having the problem can reduce our ability to see women who are abused as survivors and to see the wider causes of domestic abuse and what to do about it. It becomes seen as a 'women's problem', and an illness women have and a personality defect of women. Instead we need to highlight both abused and abuser and the wider social context in which abuse comes about.

Metzl and Hansen (2014) point to one of the possible solutions to the problems highlighted by the other two papers. If we train clinicians to recognize and care about the social conditions of the people they serve, this may enable clinicians to help change things, and at least understand why apparent non-compliance with medical advice is usually a lot more complicated than people just being difficult or 'treatment-resistant'.

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