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The social responsibility of psychiatry*

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Playwright George Bernard Shaw and British Prime Minister Winston Churchill had a somewhat friendly rivalry. In a famous exchange Shaw wrote: "Dear Churchill, I am enclosing two tickets for the first night of my new play, trust you will come and bring a friend… if you find one," to which Sir Winston replied: "Dear Shaw, I cannot possibly attend the first performance, but will try to attend the second… if there is one." Although this is not a play, it is indeed the second time my country has been honored to host this world summit. It is quite a distinction! As some of you may recall, in 1971 Mexico hosted the V Congress of the World Psychiatric Association (WPA).

Needless to say, since that time, many things have changed in our field. The world has experienced radical transformations and it is precisely for that reason, that the social responsibilities of psychiatry are perhaps more relevant than ever before. However, at the opening of that Congress, forty-seven years ago, when Mexico City had less than half of today's population and it was easier for visitors to get around, the President of the Congress, made a clear-cut statement about our social responsibility concerning the potential abuses of psychiatry at those times. After visiting the Soviet Union with a group of world leaders and members of the Executive Committee of the WPA, in response to claims that psychiatry was being used to silence political dissidents, and as there were reasonable doubts to believe that it may had occurred, he thought someone had to denounce it as such a practice was absolutely unacceptable. I am proud to say that that man was my father. He certainly received a standing ovation but most important, the WPA reaffirmed its leadership for standing on the side not only of knowledge and science, but also of ethics and social values. We know that such commitments have prevailed and that they are part of the strength of the WPA. As I recall my father's brave statement on that occasion, I also praise all of those colleagues that have contributed to foster such a laudable code.

Let us move now to briefly review a few examples of today's life to illustrate some circumstances in which psychiatry's social responsibility is or has been of vital importance in restoring dignity to the lives of many people, bringing compassion to decisions that can affect individual or global mental health and equally important: enhancing social trust in our field.

Policies and attitudes toward migrant children and families have largely ignored the long-lasting effects that stem from detention and deportations. Certainly, psychiatrists and other professionals have documented many of the problems experienced by these most vulnerable persons. They range from low-birthweight babies as well as delayed growth and development, to all sorts of identity-based stressors, neuroendocrine unbalances, anxiety, depression, PTSD, addictive behaviors, suicidal risk, etc. And yet, we are still searching for a better way to make our recommendations more influential in the multiple contexts (social, economic, and political), where policies are formulated and enforced. I believe that international forums such as this still have an important role to play in shaping such policies provided a firm, collegiate voice is taken on the matter.

Recently, we were shocked by the wrenching story of over twenty-five hundred migrant children being separated from their parents at the U.S.-Mexico border. What was done is a dreadful stain on any country's moral integrity. That the American Psychiatric Association (APA) and hundreds of other mental health professional organizations raised

their voices and signed a petition to the President of the United States to end that inhumane policy, was an encouraging sign for millions of people from several countries below that border that felt deeply aggrieved – not to mention the relatives and friends of those families involved.

The APA statement was clear-cut: "…We oppose any policy that separates children from their parents… any forced separation can cause lifelong trauma and increases risk of other mental illness, and also results in serious medical and health consequences… We recommend an immediate halt to the policy of separating children from their parents."

Once again, it was science, the knowledge that stems from our universities and research centers that allowed us to argue that what happens to children when they are forcibly separated from their parents can be catastrophic. Their heart rate goes up, their body releases a flood of stress hormones which can in turn start killing off dendrites and, especially in young children, wreaking serious long-term damage both, psychologically and to the structure of the brain. As another of the above-mentioned petitions of our colleagues read: "To pretend that separated children do not grow up with the shrapnel of this traumatic experience embedded in their minds is to disregard everything we know about child development, the brain and trauma." Had the policy makers known this? There is so much published research on the subject that is hard to believe they didn't. In any case, the point is that the most fundamental and critical bond in human biology was under attack by an erratic policy, and someone had to speak out and be the voice for the children who don't have a voice because they belong to a historical precariousness.

Images of the detention centers; the cages, the tents, the obstinate officials who came off as cold blooded and tone deaf, made the scandal grow. An audio clip repeated over and over on television and social media, allowing us to hear the wails of the detained, sobbing children triggered indignation around the world. Yes, some may argue, border separations were legal. The legality is under debate but what is not in question is that the separations were not moral. If we ignore and excuse the forced separation of the most vulnerable, if we agree to punish children for the sake of politics, then all manner of horrible things can be permitted in the name of the law. And, while this border story is not over, the impact of the sound arguments and the collective voices of psychiatrists and other mental health professionals made a difference and that should be kept in mind as we move forward.

Another example of our social responsibility is even closer to home. It would be impossible for me not to address the severe impact of collective violence on mental health. The UN estimates that Latin America and the Caribbean, with just 8% of the world's population, account for roughly one third of global murders. Between 2000 and 2017, approximately 2.5 million people were murdered in our region. According to UN figures that compares with 900 000 killed in the armed conflicts of Syria, Iraq, and Afghanistan combined. During that same period, according to the Global Terrorism Database accounts, all of the world's terrorist attacks killed 245 000 people. At current murder rates, for instance, it has been estimated that if you live in cities such as Acapulco, Caracas, or San Salvador for 70 years, there is a roughly 1 in 10 chance you will be murdered. Of course, not all Latin American and Caribbean countries have this problem and there are states within each country with violence rates well below that. That, in itself, is a phenomenon worth exploring further.

According to some scholars, Mexico has become an extremely violent society. It appears to meet most of the generally accepted criteria: there are various victim groups, there is a broad participation (including some agents of the state), there are multiple casualties and there is a great amount of physical violence. The high levels of violence in Mexico are largely caused by organized crime, which, in turn, flourishes as we continue to lose the absurd war on drugs undertaken by our governments for the last 12 years. Beyond subjective interpretations, the UN Office on Drugs and Crime has found that homicide rates and unsolved homicide rates are reasonable indicators of the levels of security within states and of organized crime activity. Homicide rates in Mexico have grown as never before, to almost 25 per 100 000 inhabitants. This dramatic figure corresponds in time with actions carried out by the government to combat organized crime, as well as that of criminal gangs battling to control territories and markets.

Mexico is particularly vulnerable to these dynamics because of the global geography of drug consumption and shifts in controlling routes of access to large markets. Drug trafficking is, in turn, linked to weapons trafficking and thus even minor disputes amongst gangs are stained by violence. Sadly, to our horror, we have become a nation of unmarked graves, a society where the bodies of the victims can be dissolved in acid or where corpses can be stored on trucks for weeks or months because local morgues are too full. We must acknowledge that Mexico's policies in this regard have been unsuccessful and simultaneously ineffective in addressing the social dimensions of violence. Organized crime is winning this war. Treating violence with violence only leads to more of it. We need to stop it. As has been suggested, on drug policy, we must move from prohibition to regulation. But we also need to call upon science to design better policies to deal with illicit drugs' damage, to reduce consumption and to avert violence and revert its consequences. We need to create better life conditions for all citizens and to redefine the ethical understanding of what we are as a society. We are not autonomous individuals: the biopolitical inequality of today is our collective responsibility.

The price tag for crime is huge. Crime affects everyday life, but not enough attention has been paid to its effects on

mental health. What are we doing about that? How deep have we delved into it? It would be helpful if, when designing public policies, violence could be conceived as a public mental health problem, as well as a criminal one. I don't mean psychiatry should assume the primary responsibility for violence, but I believe it can play a larger role than it has done so far to advice society in a stronger documented way.

Certainly, some significant work has been done in that area, here and elsewhere. But we need to do more research, to learn more about the psychological triggers for violence, in order to discover new approaches and more efficient ways to combat it. Let me briefly mention that over the past three years, our group at the Universidad Nacional Autónoma de México and colleagues from the Instituto Nacional de Psiquiatría Ramón de la Fuente Muñiz, have been studying the effects of violence on mental health in a community in the state of Guerrero. It is a place where violence has created a dystopia. Social norms have been broken down, children have dropped out of schools, people are afraid to go to church, medical services are frequently interrupted, drug and alcohol abuse has increased, and sexual violence, especially against women, has intensified. We have developed a model for a relatively low cost intervention which is being tested. Preliminary results are promising and hopefully it soon can be reproduced elsewhere. Mental health cannot remain as the forgotten consequence of the kind of violence that is affecting us. It is a too great a cost.

While reviewing the field reports of scholars working in other communities severely affected by the violence and discussing their findings at various seminars and workshops, it also became quite clear to us that many people maintain the capacity to function in a relatively normal way, both psychologically and physically, despite exposure to high levels of social disruption, violence, and distress. It would appear that resilience indeed does play an active and adaptive role beyond its attributed properties of avoiding more serious mental illness.

Of course, providing mental health aid to these communities should be the highest priority, but these efforts also represent an opportunity to expand research to more deeply understand why and how some people can successfully cope with extremely stressful conditions such as the ones they are facing. I want to praise my brave colleagues that work in those communities. Sometimes it becomes risky. I firmly believe that further studies on the psychobiology of resilience are likely to provide new insights to thoroughly understand successful individuals' responses to adverse life events and the fundamentals of stress-related disorders.

Another look at our field from a social perspective allows us to convene that despite significant advances of psychiatry, there is no doubt that the burden of mental illness and related problems in our societies keeps growing. The sociocultural dimensions of individual experiences have somehow lost their place in clinical practice despite the fact we have known for years that social interventions are crucial for the prevention of psychiatric disorders. We need more clinicians to lead on the agenda of public mental health. Psychiatry has a responsibility to speak for its patients and their needs and to highlight both: the impact of social inequalities on mental health and the resulting inequalities of mental illness.

As I finished a presentation on Psychiatry and Society last year, at a meeting of the Mexican Psychiatric Association, a young colleague asked me: do you think psychiatry is a social science? My reply was: I believe part of it may be. Of course –I continued– as a branch of medicine it is mostly a natural science, but, at least for some research, it borrows methods from social sciences.

Of course, it seems to be more accurate to say that there is a social scientific dimension of psychiatry. As it is impossible to exclude social conditions in the process of understanding any patient with a psychiatric disorder, it is equally impossible to dissociate the psychological factors of any given patient. That is not to say that the causal origins of a disorder are social in nature. However, social context does affect diagnosis and treatment. How would you explain otherwise that poor children with attention deficit hyperactivity disorder (ADHD), anxiety disorders, or depression are more likely to be medicated? Of course, they have fewer educational opportunities, less healthy food, less-safe neighborhoods, and get less attention for their problems but more drugs for their treatment. It would appear that in countries where medications are available, too often poverty is treated with pills, whereas in many poor countries there may be no medications at all.

As any other physician, psychiatrists must be devoted to the best interest of each individual patient. But I believe it is also our responsibility to respond to the mental health care needs of society, especially the needs of our most vulnerable and underserved populations. It is our responsibility to be socially engaged and accountable. We, together with other mental health professionals, should champion social efforts aimed at addressing all known determinants of mental health, and strive to be involved in public advocacy (which is not the same as activism) directed at improving conditions that positively impact the well-being of patients. We need to act and react not only to decrease the burden of mental illness but also to enable a future in which the most vulnerable groups may have access to services.

As expected, there has been an ongoing debate as to whether or not some of these are indeed our responsibilities, and the contextual references to them differ from country to country. But I believe that the task of working towards mental health awareness must be seen as an integral part of our job. In addition, we need to be aware of how society views our profession and the many changing trends in it. A wise balance is much needed: a view not too restricted to limit our scope but neither too loose to forget our primary

purpose as mental health professionals. There is also a need for balancing idealism with pragmatism: to determine how much is feasible and how much should be attempted.

Faith in the capacity of science and technology to resolve human and social problems is diminishing and psychiatry is not an exception to this. Medicalization of life problems has not been successful and has, in many instances, backfired. But if we want to keep up with the social expectations of solutions to both mental health problems and psychiatric disorders, we might advance more if we place ethics before technology and recognize the uncertainties of our clinical practice.

I cannot conclude this discussion without mentioning a most critical issue that has to do with ethics, legal responsibilities, and mental health: I am referring to the pervasiveness of sexual harassment, assault, and related misconduct within our own profession and elsewhere. I believe it demands our most serious attention as it represents a violation of the fundamental expectations of respect, equality, and dignity.

Sound policies against harassment must be mandatory at all psychiatric and mental health institutions to ensure that all procedures for raising complaints and reviewing them are fair and effective. Personal support, counseling, and guidance about options for reporting must be available to all of those who have experienced sexual misconduct. We need to increase the awareness of the problem as many cultures still consider talking about sexual harassment, coercion, and assault as a taboo. Because most harassers are men, we must play a critical role in leading and driving the necessary initiatives to remove these practices from our culture once and for all. We cannot denounce social injustice with virulence while indulging male domination and abuse.

Although it is clear that the ethical questions raised by Professor Ramón de la Fuente at the V World Congress of Psychiatry in Mexico City back in l971 were different from the ones I raised today, our goal remains largely the same: to treat our patients with a holistic perspective as individuals, while at the same time recognizing that social conditions do affect mental health and that we have a responsibility as psychiatrists to speak out against conditions and situations that threaten the mental stability not just of our own patients but of society at large.

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