I|J|S|P

International Journal of
Social Psychiatry
2017, Vol. 63(3) 179–180

DOI: 10.1177/0020764017691552
journals.sagepub.com/home/isp
SAGE

Social media and social psychiatry

Antonio Ventriglio[1,2] and Dinesh Bhugra[3,4]

Human beings are social animals. However, with many cultures in transition around the globe, the structures of society at large and those of the family at a more personal level are beginning to shift towards a more ego-centric norm. This is further compounded by complex patterns of communication of which increased use and indeed reliance is changing the modes through which we correspond with our friends and others. Within the new social media, the definitions of friendship are beginning to change.

The millennials and younger generations have very different attitudes towards communication and a very different degree of comfort with technology. Bernstein and Bhugra (2011) pointed out that different generations also have varying attitudes towards work and social interactions. Coiera (2013) reminds us that social processes underpin not only our lifestyle but also the decisions we make about our health. It has always been the case that when someone falls ill, they try to deal with their experiences either by themselves or through the folk or social sectors before going to the professional sector.

Social networks embedded in social media provide an element of connectedness but also of perceived support. There is a problem in that such support may be superficial. The more connected we are, the more lonely we can be. These networks can be seen as faux friends and families. In the social context, these can provide a sense of belonging, and these networks can enable individuals to influence others and be influenced by them, no matter how weak the networks and links are. Social networks have been seen as links in the chain between individuals and the impact these links can have on shared or individual behaviours. Coiera (2013) points out that people have friends who are similar to them (and share their values), a phenomenon called homophily (also see Rogers, 1995). Coiera (2013) raises the question of whether homophily represents simply people with similar attitudes coming together or people altering their behaviours to fit in others, a phenomenon described as social contagion. Social contagion means that individuals are trying to change their behaviours to match those of their peers (Christakis & Fowler, 2013). This illustrates a type of communicability of symptoms too (as suggested by Ventriglio & Bhugra, 2017). SoMe (social media) using different technologies – such as Facebook or Twitter – will have varying influences not only on the individuals or their backgrounds.

Lafferty and Manca (2015) draw our attention to the fact that SoMe tools can provide new opportunities for contact as well as communication through which information – new or old – can be gathered and shared. There is no doubt that these can provide better ways of conducting research and sharing data. Social media can be used in collecting data as well as sharing the findings.

Another aspect in the use of social media in healthcare is through its development of and usage for health education and interventions. In psychiatry, there is an increasing trend to develop and use phone apps for behaviour therapies and cognitive behavioural therapies (see Fox, 2011). DeCamp (2015) quite rightly raises concerns about the ethical dimensions of such approaches. These ethical dimensions can be applied to research, mobile health applications and public health.

Public mental health can use similar strategies. Coiera (2013) criticises public health messages which use social media mainly for one-way broadcasting of messages, though not surprisingly social media does have the potential to reach more diverse audiences with new ways of engagement and partnerships aimed at (mental) health promotion (Neiger et al., 2012). Network interventions can influence changes in behaviour. Coiera (2013) emphasises that social networks can be manipulated in different ways, depending on the state of the existing network and the goal of the interventions (Valente, 2012) by influencing individuals as well as targeted groups. These online support groups can be self-help groups and provide peer support. The online support groups have proliferated in the past few years and can be oriented, operated and governed by groups of patients and their partners (Mehta & Atreja, 2015). These authors highlight that the ideal online social group or support network will be patient oriented and patient powered, with clear goal direction and mobile

[1]Department of Mental Health, ASL Foggia, Foggia, Italy
[2]Department of Clinical and Experimental Medicine, University of Foggia, Foggia, Italy
[3]World Psychiatric Association, Geneva, Switzerland
[4]Mental Health & Cultural Diversity, Institute of Psychiatry, Psychology & Neuroscience, King's College London, London, UK

Corresponding author:
Antonio Ventriglio, Department of Mental Health, Ospedali Riuniti, Viale Pinto – 71100 Foggia, Italy.
Email: a.ventriglio@libero.it

access with data sharing. They also suggest that clear outcomes should be outlined and measured.

Obviously, care needs to be taken to ensure that confidentiality, privacy and professional values on the part of clinicians and health professionals are maintained. Chretien and Tuck (2015) propose that there is a need for online professionalism which must include ethical values and the wide sway of the SoMe also needs to take into account individual variations in need and response. There needs to be a clear and careful evaluation of professionalism but, equally importantly, there must be a fuller account of ethical implications of such groups and such support.

The pathogenesis or spread of a disease may be mediated by social networks, and these networks are accessible to manipulation (Coiera, 2013). The challenge for psychiatry in particular is how these are utilised in public education. Coiera (2013) draws our attention to the fact that smoking cessation may succeed in social network manipulations. He illustrates the idea that as Alcoholics Anonymous (AA) offers support and mentors for those who are recovering, social media may well offer a perfect platform for this.

For the public health agenda, there needs to be a clear understanding of the goals of the intervention (DeCamp, 2015). Furthermore, the efficacy of such programmes and barriers must be identified before any plans are put in place. The actual implementation of such plans must be clear and fair, taking targets into clear account. For mental health promotion, SoMe can be extremely useful. Sharing knowledge is the first step. Whether an increase in knowledge can lead to changes in behaviour or changes in attitudes is a different matter. Advising an individual who is anxious about their symptoms may not be helpful, but helping them identify stress points and trigger or tipping points can be extremely valuable.

There remain ethical issues. Chisholm (2015) reminds us that healthcare professionals and learners, as well as providers, are involved in using social media (much more than many other professions). She argues that social media can enable an immediate exchange of information and ideas around shared areas of interest. This sharing, therefore, can improve communication and foster collaboration, not only between individuals and their clinicians but also among researchers and clinicians. Social media can be used effectively in medical education as well as continuing professional development. Using SoMe for expanding educational opportunities has not happened universally but indeed there is major scope to do exactly that.

Social media and its indiscriminate use can also create problems. Being trolled on Twitter can be stressful and harmful to one's self-image and self-esteem. However, social media can provide opportunities for networking, leading to peer support, and can also provide platforms for education and learning at various stages of medical training. Ethical implications and professionalism are important aspects of the use of social media and need careful attention and further debate.

Social psychiatry can learn from social media about the use of social contagion and communicability of symptoms. It can develop social support online networks which can help share knowledge and provide information, but more importantly for public mental health plans and interventions.

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