Lecture 8: Mental Health across the Lifespan

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Introduction

- Norms of behaviour primarily based around behaviour expected for middle-aged adults.
- There are some specific differences when it comes to criteria for childhood (less so for old age), but tricky…these are periods of immense change.
- Both children and older adults are described as facing unique challenges related to mental health.
- Some unique features about child and older adult mental health, e.g. emphasis on 3rd party reporting.

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Emergence of Childhood Mental Health

- In 19th c., childhood "invented" as period of leisure and play. New interest in "proper development" of the child.
- Emergence of psy-ences helped transform "bad kids" into "problem children."
- Growth of psychoanalysis prompted increased interest in children and relationships to family.
- 1950s cult of the "ideal family" – the "broken home" as threat to children and society.
  - Refrigerator mothers, divorcées, widowers cited as incubators of poor mental health.

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Emergence II

- Mental hygiene movement promoted preventation – school as surveillance site.
  - 1960s: move to identify "pre-delinquent" children – those that had minor behavioural issues that might be amplified later. "Early intervention" as strategy.
  - Increasing use of school staff w/ responsibility to identify deviant children "in need of intervention."
  - Distinction between 'healthy' and 'unhealthy' children hardened…moving from a spectrum to a binary of normal/abnormal.
  - New diagnoses emerge to capture these "disturbed" children.

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Case Study: Conduct Disorder

- "A repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal norms or rules are violated."
- Signs: excessive levels of fighting, bullying, cruelty to people or animals, destructiveness to property, fire setting, stealing, lying, being truant, running away from home, temper tantrums, playing pranks, being sexually active at a young age, disobedience.
- Linked to inconsistent parenting, parental mental health problems, poverty, low educational achievement. Other speculated causes linked to genetics and other biological features.
- Found in 2-16% of US pediatric pop.

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Explosion of Childhood Mental Disorder

- Since mid-1990s:
  - Rates of ADHD have tripled.
  - Autism diagnoses up by 2000%.
  - Childhood B.D. rates increased by 4000%.
- Childhood mental health redefined as absolutely critical period for intervention, why?
  - Biological explanations: neural plasticity, connections being forged within brain.
  - Psychological explanations: learned behaviours, patterns, self-concept formed.
  - Social explanations: learn relationships with others, connected to community.

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Explaining The Rise - Criteria

- Expanding criteria:
  - ADHD now includes daydreamers who do not display hyperactivity, age threshold increased to 12 years.
  - Autism originally emphasized communication issues, social struggles, and intellectual deficits.
    - Many children who wouldn't have met original criteria for diagnosis now do.
  - ODD, antisocial and disruptive behaviours, resisting authority.
    - Since introduced in DSM-III, criteria has loosened so greater number of behaviours understood as symptoms.
- Childification: new "childhood" symptoms created for disorders previously associated only w/ adults.
  - B.D: in adults, psychiatrists look for cycling in terms of moods that last weeks or months…in children, expected that moods might change multiple times in a single day.
- Creation of new illness categories (DMDD).

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Explaining the Rise – Family and Parenting Change

- Parents have gotten busier - behaviours that are irritating, disruptive, or demand attention more likely to be understood as problematic.
- Fewer blended families, fewer "parents" around. Increasing reliance on professionals for child rearing advice.
- Shifts in parenting styles -> from authoritarian to emphasis on promotion of individual rights of children.
  - Growth of "me" culture.
  - Positive mental health qualities prevented from developing (autonomy, independence, resilience).
  - Parenting out "the good reasons for feeling bad."

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Explaining the Rise – Third Party Reporters

- Symptom reporting does not necessarily come from the child, but other people.
  - Many disorders (ADHD, autism) tend be diagnosed exactly when child begins school.
  - Specialist teachers demonstrated to be much more tolerant and less likely to report behaviour as deviant or mentally unhealthy than general class teachers.
  - Parents were more likely than physicians to identify children's behaviour as meeting criteria for DMDD.

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Explaining the Rise - Others

- Lobby groups (such as CHAAD)
- Pharma
- More family physicians and pediatricians, less psychiatric involvement.
- More corollary materials: *Brandon and the Bipolar Bear*
- Increased expectations and stress
- Dietary changes

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Impact of Childhood Diagnosis

- What does it mean to be diagnosed?
  - Access to treatments, care, accommodations.
  - Impacts identity & self-concept (could be legitimizing).
  - Changes how others treat the person (stigmatized, feared, given 'free pass').
  - Changes how parents are perceived (to blame/relieved of blame).
  - May result in treatment (drugs/ABA, etc.) that some might see as harmful.
    - Stimulant prescriptions have increased 700% since 1990.

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Older Adults

- Despite lack of focus on the mental health of older adults, challenges to wellbeing and good mental health:
  - End of typical roles, loss of independence.
  - Deaths of partner/friends, loneliness.
  - Cult of youth and beauty.
  - Discrimination that prevents development of situations protective to good mental health (e.g. employment)
  - Challenges related to institutions (depression, etc.)

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Dementia

- Medical view: set of symptoms related to progressive cognitive decline: memory, communication, judgment, attention, depth perception, emotional regulation, time awareness.
- Social view:
  - Like any other mental health issue, involves exclusion, silencing, removal of autonomy.

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Dementia History

- Prior to late 19th c. senility and old age conflated. Little negative connotation.
- Senility then medicalized, reconceptualized as age-specific deterioration of cognitive ability. Acquires negative stigma.
- Until mid-20th c., understood as problem with social adjustment for men who transitioned from labour force to retirees. Women "shielded" by domestic role.
  - Conclusion: need more social/recreational activities to help individuals find meaning in post-retirement lives.
- 1960s onwards: reemergence of organic theories, dementia as disease.
  - Conclusion: need more drugs, genetic screening, prevention.

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Epidemic?

- From 1980s, warnings of "dementia tsunami."
  - As pop. above 80 yrs increases, more people living to develop dementia.
- *NEJM (2016)* – actually see 20% decline! Although absolute number increasing, dementia rate falling across most age groups.
- Regardless, the "societal burden" of dementia a major focus for gov't, researchers, etc. Widespread fear.
  - Does this focus on "ticking time bomb of dementia burden" obscure discussion of rights of those w/ dementia?

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Harms and Other Phenomena

- Tendency to see individuals as lacking willpower, preferences, desires, reason. Total conflation with impairments. Cut out of policy discussions.
- Writing off emotional responses as symptoms.
- (Premature) institutionalization
  - Isolation, silencing, dependency-creating.
- Language: "Living death," "burden of dementia"
- "Psycho-emotional disablism" – how caregivers, medical staff, family speak may prompt feelings of worthlessness, burdensome, incapacity.
- Professional pessimism: 2/3 GPs saw "no point" in taking action once person diagnosed w/dementia.
  - Inappropriate medical treatments (e.g. heavy sedation).

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Why So Much Discrimination?

- Materialist: capitalist economies have no use for these doubly-discriminated individuals who are both impaired *and* old.
  - As unproductive and "useless" individuals, they must consume minimal resources: warehoused, fed using minimal resources (i.e. less choice), minimal expenditure on care).
- Poststructuralist: as a society that values beauty and youth, the bodies of those with dementia become seen as undesirable, alien, and disgusting.
  - Those with power (e.g. medical profession) shape wider discourse by defining dementia in terms of deficit.

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Addressing the Mental Health of "Special Populations"

- Psychological approach: psychotherapy.
- Biomedical model: medications to solve problem behaviour and manage symptoms.
- Technological solutions: smart homes (e.g. stovetops), surveillance equipment, day/night calendar).
  - Critics: reifies particular notions of what it means to be human: defined solely by ability to *do* certain tasks, ignorance of other human aspects such as vulnerability, dependency.
  - Reduce levels of human contact/intimacy.
- Social approach: change policies (e.g. school system, age-friendly cities).

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Conclusions

- Childhood and elder mental health relatively new fields, understood as “special” populations.
- Critics: both children and elderly present challenges to overworked, overstressed individuals “responsible” for their wellbeing.
- Treating or simply managing?

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Death and Dying

- Unlike all other animals, humans foresee our own deaths.
- Erikson proposed spectrum of two extremes: those generally content with the life they have live/those who feel that it has all been meaningless.
- While we have long strived for the good life, increased emphasis on a good death. In terms of mental health, it typically involves:
  - Familiarity of surroundings (at home vs hospital).
  - Less pain.
  - More autonomy and control.

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