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Comparison of Group CBT with Memory Specificity Training (MEST) and Self-distancing & Group CBT with MEST among Depressed Outpatients

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Abstract
Memory specificity training (MEST) or self-distancing (SD) has been associated with improving symptoms of depression. The aim was to compare the efficacy of group CBT with MEST and SD (group A) with group CBT with MEST (group B) in depressed adults and establish the relationships between memory specificity improvement and changes in low mood (BDI-II), rumination (RRS), problem solving (PSI) and suppression (WBSI). Method was to recruit participants from advertisements, 120 fulfilled the inclusion criteria, consented and block randomised to either group. Fifty-five participants from each group (N=110) completed treatment. Results from parametric tests showed group A was statistically significant on all dependent variables, memory specificity (AMS), BDI-II, RRS, PSI, WBSI compared to group B at post-treatment and three month follow-up. Group A was clinically significant on the BDI-II score at post-treatment. Test of association at three months follow-up showed AMS improvements was independent of improvements in all the other dependent variables A multiple regression analysis confirmed that only RRS had a significant mediating effect on AMS changes. Discussion, group A was more effective for depression than group B, indicating that SD enhanced both MEST and CBT. That AMS may improve mood partly by directly improving rumination. Limitations, not fully blind, no independent therapists, low frequency of supervision checking manual adherence, no SCID, follow-up period short and reduced generalis ability. Future research could repeat this study by recruiting participants from mental health clinics, improve blinding, use SCID, frequent supervision and independent therapists.

Keywords: Cognitive Behavioural Therapy, Memory Specificity Training, Self-Distancing.

Contemporary standard cognitive behavioural therapy (CBT) appears to be less effective for depression than classical CBT conducted decades ago [1-2]. It may also be no more effective than other types of psychological therapies for depression [3] including third wave CBT therapies [4]. It is imperative to continue to explore other psychological options that could enhance CBT, such as using memory specificity training (MEST) and self-distancing (SD) as adjuncts to group CBT.

Literature review
Promising results have been achieved from studies using four to five sessions of MEST that targets over general memory (OGM) by increasing memory specificity (AMS) may or can improve mood [5-7], including rumination, experiential avoidance and problem-solving skills [5]. Over general autobiographical memories (OGM) are strongly associated with making the depression more severe, delays recovery and is a vulnerability factor for subsequent depression [8]. They are defined as a summary of several similar events or a memory of a general time period, spanning more than one day [9]. Memory specificity is a memory for a specific occasion, event that occurred at least one week or longer at a particular place and time within a 24 hour period [5-6].

Theoretically, OGM may be a failure to progress down a memory hierarchy to lower more specific levels of memory during memory retrieval and remain at the general level. The capture of memory brings together OGM’s that causes or keeps the depression in place. This
may occur in rumination [10]. Studies that have induced a reduction in rumination led to an increase in AMS, indicating an association between rumination and OGM [11-12] which may be bi-directional [13] but a recent study found no such relationship between rumination and OGM [14].

Access to previously successful problem solving strategies stored in memory to deal with current problems could be captured at the intermediate level of the hierarchy, or at the OGM level [9], poor problem solving is associated with depression and OGM [15].

Increases in OGM are made worse by functional avoidance of specific details of distressing memory events [10] such as suppression. Recalling OGM’s is considered as a way to avoid unwanted vivid mental images and strong negative affect that accompanies AMS [16] as seen in depression [17]. Suppression is defined as the effort not to think a specific thought [18], feeling, emotion, urge, sensations or memories, increasing them instead. It increases the risk of depression and makes it more severe [19].

Interesting results have also been reported in self-distancing (SD) induction studies that involved both distancing and reconstruing. Those who were induced to SD felt less distress than those who self-immersed. They focused less on recounting, rumination and more on reconstruing, problem solving that promoted new insights, meanings, improved mood and sense of closure [20-25].

A self-distanced perspective is grounded in social and cognitive psychology theories, including construal level theory and psychological distance. The more distant an object is from the individual, the more abstract, conceptual, non-specific it will be thought of, while the closer the object is, the more precise, concrete it will be thought of [26].

Self-distancing involves taking a mental step back, recalling or retrieving past experiences from the perspective of a distanced observer, a stance that permits a broader context to be observed, allowing and facilitating reconstruing to take place, that may lead to the development of adaptive explanation, understanding, meaning and insight that can reduce current and future distress [20-25; 27]. It is a balance between less recounting and more reconstruing that may account for the emotional regulatory effects of SD [21] especially when using non-first-person pronouns and one’s own name than first person pronouns that were associated with self-immersion [25].

Recent studies have proposed expanding the use of MEST, for example in the study by Neshat-Doost et al, 2013, p 7 [6], suggested to use MEST as an ‘…adjunct to CBT…’ and Dalgleish et al, 2014, p 8 [28], stated that ‘…MEST may be used as an adjunct…to more comprehensive therapies such as CBT’.

Building on the MEST studies, a larger sample would increase the power of this research, trauma would remain as an exclusion criteria to reduce a possible confounding variable, a balanced group to be randomised, measures to be used to cover not only low mood but also rumination, experiential avoidance and problem solving that was measured in the study by Raes et al [5] but not used in the other two MEST studies [6-7]. There was a need to not only look for difference between groups but also the relationship between AMS changes and other dependent variables, this was attempted in Raes et al study [5] that needs to be repeated and expanded on due to the small sample size and high drop-out rates and non-significant result for experiential avoidance.

This research had a follow up period of three months with strict criteria that participants could only stay in the treatment group if they were not receiving treatment elsewhere. This was required so as to avoid confounding results at three month follow up as occurred in Eigenhuis study [7]. Another novel aspect was the participants were from the United Kingdom (UK) not as I am aware done before.

Self-distancing research mainly covered induction studies using relatively young non-clinically depressed participants [20-25]. Only one study that I was aware of induced SD on a depressed group from San Francisco area in America. There was no extended follow up period, no control group or active comparative group treatment [24], limiting generalisability. In Kross and Ayduk, 2011, p 189 [23], they suggested further research using SD in depressed
adults. Kross et al, 2012, p566 [24], gave more direction by suggesting whether the benefits of SD studies as above can generalise to depressed adults under a “variety of conditions”, that could be extended to cover using SD as an adjunct in an active treatment, such as with group CBT and MEST.

Self-Distancing could enhance a main component of CBT called cognitive reframing, increasing the ability to challenge unhelpful distressing thoughts and then reframe them [29]. It was hypothesised that cognitive distancing (CD) is required to allow engagement with the reframing process [29]. A recent study [30] implied that a key factor to facilitate appraisal and interpretation of one’s experience was the use of distancing as found in decentering that can reduce depression [31], similar to the distancing component in SD.

Memory specificity training may be enhanced by facilitating the ability to tolerate, through distancing, strong negative affect [20-25]) associated with the recall of AMS [5-7]. The use of SD may have the effect of increasing AMS more than could be achieved by MEST alone. It may also be able to enhance improvements in mood, rumination and problem solving as seen in Raes et al study [5] and SD studies [20-25].

The purpose of this study was to compare the efficacy of seven sessions with a three month follow up of group CBT with MEST and SD compared to CBT with MEST, building on the need for research using MEST as an adjunct to CBT (Dalgleish et al., 2014, p.8 [28]; Neshat-Doost et al., 2013, p.7 [6], and built on the need to incorporate SD with a substantive therapy, group CBT with MEST to see if it could enhance them (Kross and Ayduk, 2011, p 189 [23]; Kross et al, 2012, p 566 [24]. Also it was important to establish any mediating factor(s) between AMS and other dependent variables.

[a] Hypothesis one: There would be a difference in effect between group A and group B on the amount of change of AMS recalled by moderately depressed adults by post- treatment and three month follow up conditions.

[b] Hypothesis two: There would be a difference in effect between group A and group B on mood change in moderately depressed adults by post-treatment and three month follow up

[c] Hypothesis three: There would be a difference in effect between group A and group B on amount of change of rumination in moderately depressed adults by post- treatment and three month follow up

[d] Hypothesis four: There would be a difference in effect between group A and group B on amount of change of problem solving in moderately depressed adults by post-treatment and three month follow up conditions.

[e] Hypothesis five: There would be a difference in effect between group A and group B on amount of change of suppression in moderately depressed adults by post- treatment and three month follow-up.

[f] Hypothesis six: There is a relationship of association and mediation between changes in memory specificity and changes in one or more other variables, BDI-II, RRS, PSI and WBSI at three months follow-up.

Method

A mixed group design, $2 \times 3$ was selected to compare differences in the dependent variables, AMT, RSS, PSI, WBSI between and within group A and group B at each time point from pre-treatment, post-treatment and three month follow-up. A correlational design, followed by a repeated ANOVA with covariates and multiple regression was used, alpha set at 0.05 to test the relationship between improved memory specificity and improved mood, rumination, problem solving and suppression at three month follow up. A randomised controlled trial (RCT) was used as it is a powerful method when comparing the effectiveness of interventions [32] and helps to minimise allocation and confounding variable bias [33].

Data from Raes study [5] suggested a sample size of 22 (11 per group) would provide 80% power, with a directional alpha of .05 to detect a similar improvement in AMS. The sample size had to be larger than 11 per group as a requirement of 36 or more for each treatment group was needed to achieve medium effect sizes averaging $d= 0.51$ in previous research on self-distancing [20-21].
Two treatment manuals was developed, one for group A and one for group B, ethical approval was obtained then the research was advertised in two London boroughs. Prospective participants responded by e-mail to leaflets posted through the letterbox of people’s homes, flyers posted on the advertisement boards in supermarkets, health clubs, local libraries, community centres, religious places of worship, several newsagents and charity shops. For each cohort there was a screening process, participants who scored moderately or high on each questionnaire got interviewed to ensure they fulfilled the DSM 5 criteria for depression [34], met the inclusion and exclusion criteria and gave written consent.

They were then cluster randomised using a stratified randomisation procedure [35]. Sixty participants for each group were initially recruited, 55 for each group started and completed the treatment. The confidentiality of participants was protected by storing all data on an assigned participant number rather than their name or other identifying data. The participants were made aware that involvement in the study was voluntary and withdrawal from the study was acceptable without repercussions.

Inclusion criteria included, aged between 20-60, Beck depression inventory (BDI-II) score of 20 or more but less than 29 [36] and fulfil DSM-5 criteria for depression. Has an AMS of less than 0.70 as assessed on the autobiographical memory test[37]. Exclusion criteria, high levels of suicidality or harm to self, primary bipolar, or psychotic, anxiety, personality disorder; current drug, alcohol abuse, dependence, presence of head trauma or organic brain damage, history of childhood abuse; trauma symptoms, chronic pain, adjustment problem, primary problem is anxiety, receiving treatment for depression elsewhere, poor grasp of the English language, reading, writing, unwilling or unable to give written consent.

The autobiographical memory test (AMT) was developed by Williams & Broadbent, (1986) measures both OGM and AMS and has good validity and reliability [37]. In this research, two parallel sets of 18 cue-words, nine positive and nine negative, similar to a previous MEST study [6], were matched for familiarity and emotionality using three independent raters [38] for pre-test, post and follow up.

Beck’s depression inventory (BDI-II) is a 21-item self-report questionnaire used for measuring the severity of depression that has high reliability and validity [36, 39]. Ruminative responses scale (RRS) measures how participants tend to focus on the self, symptoms and reasons, causes for low mood, shows good reliability and validity [40]. Problem-solving inventory (PSI) (Heppner, 1988) is a measure of self-appraised problem solving ability, style [41] that has high reliability [42]. The white bear suppression inventory (WBSI) measures thought suppression, has good internal consistency and stability with a one week test-retest correlation of .92, and a three week to three month test-retest correlation of .69 [43].

The CBT components consisted of behavioural activation and cognitive reframing that followed the Beckian cognitive model and Lewholm behavioural model [44,29]. MEST guidelines was followed [5,6] but spread over seven sessions instead of five due to having to accommodate the CBT content and self-distancing technique [20-25]. For group B it had exactly the same content, format as for group A except no SD was done, each session lasted 90 minutes that was carried out in a community private health centre on the same day. Both manuals where scrutinised by other professionals to ensure they were the same except for SD in group A and that the CBT components were typical of what was used for depression in the UK.

Changes in the dependent variables are the measurement scores on the AMT, BDI-II, RRS, PSI, WBSI, interval data at the various time conditions, pre, post treatment and follow up. The continuous variables all met the normality test and met the conditions necessary for the specific parametric tests described below to test hypotheses one to six.

Significance level for the hypothesis tests was set at .01 with a confidence level of 99% for all statistical tests. Effect sizes are indicated in terms of both Cohen’s d and partial $\eta^2$, the former has effect sizes of 0.2, 0.5, and 0.8 that are considered small, medium, and large [47]. To treat with caution, for partial $\eta^2$ it was suggested that the effect size in a one way ANOVA may be 0.01, 0.06 and 0.06, respectively small, medium and large. For repeated measurement
such as repeated ANOVA’s, partial $\eta^2$ could be 0.01, 0.09 and 0.25, corresponding to small, medium and large effects [45]. All effect sizes are reported as significant at $p<.01$.

Differences in categorical variables such as gender, marital status, education, occupation status, ethnicity and religion was tested with the chi square test. Continuous variables such as age, was tested using a univariate ANOVA. Using SPSS 22 software, repeated MANOVA, univariate ANOVA with Bonferroni correction, independent t-tests answered hypotheses one to five. Hypothesis six was tested using the Pearson product-moment correlation coefficient, partial correlations, repeated ANOVA and multiple regression analysis. To help guarantee the integrity of each treatment, two random audio recordings and two random in situ observations were made between session two to seven by an independent clinical psychologist. This was to check for manual adherence and bias in non-verbal presentation, none was found.

Results

Missing data was low for both groups (i.e., 8.3% at post-treatment and one-month follow-up), the decision was made to not utilize multiple imputation strategies to replace missing values. SPSS 22 listwise output was relied on as the percentage of 8.3% does not compromise statistical analysis [46]. At pre-treatment a chi-square test of demographic categorical variables for both groups and univariate ANOVA for age range showed no statistical difference. All dependent variable scores between the two groups at pre-treatment also had no statistical significant differences.

For group A and group B pre-treatment data was normal with no outliers. Multicollinearity was met; the box’s test of equality of covariance matrices (p = .024) indicated that the assumption of homogeneity of variance-covariances matrices was also met. Levene test for the equality of variances for each group at each time points were largely met. A repeated within and between groups multivariate analysis of variance (RMANOVA) was performed to investigate the differences between group A (N=55) and group B (N=55). The combined dependent variables used, AMS, BDI-II, RRS, PSI and WBSI. The independent variables was treatment and time, 2 x 3 design, pre-treatment, post-treatment and three month follow up. Preliminary assumption testing was conducted to check for normality, univariate and multivariate outliers, homogeneity of variance matrices, and multicollinearity, with no serious violations noted.

There was a statistically significant differences between both groups on the combined dependent variables at post-treatment, $F (5, 104) = 161.458, p = .0001; \text{Pillai trace }=.886$; partial eta squared = .886; and also at three month follow up, $F (5, 104) = 427.719, p = .0001$, Pillai Trace$=.954$, partial eta squared $.954$. A statistical significant difference within groups was found at each time point by post treatment, $F (5, 104) = 243.474, p = .0001$, Pillai Trace$=.921$, partial eta squared $.921$; and also at three month follow up, $F (4, 104)= 148.157, p= .0001$; Pillai Trace$=.954$; partial eta squared = .954. The results for the dependent variables AMS, BDI-II, RRS, PSI and WBSI was considered separately using a univariate ANOVA with a Bonferroni adjustment alpha level of .001. There was statistical significance found between both groups at post-treatment and three month follow up with large effect sizes- see tables 1 and 2.

Table 1 Univariate ANOVA: between group results for each dependent variable at post-treatment

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>DV</th>
<th>df = F</th>
<th>p</th>
<th>$\text{partial } \eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>AMS</td>
<td>(1, 108) = 16.251,</td>
<td>&lt;.0001</td>
<td>.131</td>
</tr>
<tr>
<td>Two</td>
<td>BDI-II</td>
<td>(1, 108) = 406.635</td>
<td>&lt;.0001</td>
<td>.790</td>
</tr>
<tr>
<td>Three</td>
<td>RRS</td>
<td>(1, 108) = 167.380</td>
<td>&lt;.0001</td>
<td>.608</td>
</tr>
<tr>
<td>Four</td>
<td>PSI</td>
<td>(1, 108) = 258.547</td>
<td>&lt;.0001</td>
<td>.705</td>
</tr>
<tr>
<td>Five</td>
<td>WBSI</td>
<td>(1, 108) = 280.693</td>
<td>&lt;.0001</td>
<td>.722</td>
</tr>
</tbody>
</table>

DV=dependent variable; df= degrees of freedom; F= distribution; p = significance level
Table 2 Univariate ANOVA: between group results for each dependent variable at three month FU

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>DV</th>
<th>df = F</th>
<th>p</th>
<th>partial η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>AMS</td>
<td>(1, 108) = 44.619</td>
<td>&lt; .0001</td>
<td>.292</td>
</tr>
<tr>
<td>Two</td>
<td>BDI-II</td>
<td>(1, 108) = 472.582</td>
<td>&lt; .0001</td>
<td>.879</td>
</tr>
<tr>
<td>Three</td>
<td>RRS</td>
<td>(1, 108) = 516.389</td>
<td>&lt; .0001</td>
<td>.789</td>
</tr>
<tr>
<td>Four</td>
<td>PSI</td>
<td>(1, 108) = 1101.846</td>
<td>&lt; .0001</td>
<td>.911</td>
</tr>
<tr>
<td>Five</td>
<td>WBSI</td>
<td>(1, 108) = 617.685</td>
<td>&lt; .0001</td>
<td>.851</td>
</tr>
</tbody>
</table>

DV=dependent variable; df= degrees of freedom; F= distribution; p = significance level

An independent t-test was conducted to determine were the differences in AMS, BDI-II, RRS, PSI and WBSI scores lay between group A and group B.

Hypothesis one was answered by showing that group A had greater improvement on the AMS scores (M=91.22, SD=2.28) than group B (M=88.05, SD=3.3), a statistically significant mean difference of 3.17 (99% CI, 1.70 to 4.63), t(108) = 5.675, p =.0001, d = 1.09 at post-treatment. Group A had greater improvement on the AMS scores (M=96.58, SD=2.41) than group B (M=92.54, SD=2.55), a statistically significant mean difference of 4.02 (99% CI, 2.80 to 5.28), t (107.65)=8.550, p =.0001, d = 1.64 at three month follow up.

Hypothesis two was answered by showing that group A had greater improvement on the BDI-II scores (M=8.18, SD= 1.15) than group B, (M=14.04, SD=0.77), a statistically significant mean difference of -5.86 (99% CI: -6.33 to -5.37), t (95.48)= -31.889, p =.0001, d= 6.10 at post-treatment. Group A had greater improvement on the BDI-II scores (M=3.75, SD=1.72) than group B (M=10.60, SD= 1.42), a statistically significant mean difference of -6.85 (99% CI, -7.65 to -6.06), t (108)= -22.249, p =.0001, d=4.34 at three month follow up.

Hypothesis three was answered by showing that group A had greater improvement on the RRS (M=25.20, SD= 1.21) than group B (M=32.51, SD= 1.44), a statistically significant mean difference of -7.31 (99% CI, -7.97 to -6.65), t (108)= -28.856, p =.0001, d=5.50 at post-treatment. Group A had greater improvement on the RRS (M=23.34, SD=1.07) than group B (M=29.07, SD= 0.99), a statistically significant difference of -5.73 (99% CI: -6.35 to -5.32), t (108)= -29.587, p =.0001, d=5.61 at three month follow up.

Hypothesis four was answered by showing that group A had greater improvement on the PSI (M=74.89, SD= 1.81) than group B(M=86.78, SD= 1.99), a statistically significant mean difference of -11.89 (99% CI, -12.84 to -10.94), t (108)=-32.700, p =.0001, d=6.25 at post-treatment. Group B had greater improvement on the PSI (M=55.58, SD=2.32) than group B (M=75.56, SD= 2.96), a statistically significant mean difference of -19.38 (99% CI, -21.31 to -18.65), t (108)=-39.425, p =.0001, d=7.51 at three month follow up.

Hypothesis five was answered by showing that group A had greater improvement on the WBSI (M=23.27, SD= 1.25) than group B (M=32.33, SD= 1.23), a statistically significant difference of -9.06 (99% CI, 9.68 to -8.43), t (108)= -38.182, p =.0001, d = 7.31 at post-treatment. Group A had greater improvement on the WBSI (M=19.38, SD=1.10) than group B (M=27.00, SD= 1.12), a statistically significant difference of -7.62 (99% CI:-8.17 to -7.06 t (108)= -36.003, p =.0001, d= 7.62 at three month follow up.

Hypothesis six was answered through tests of association, repeated ANOVA and mediational analysis. There was moderate to large correlations that were statistically significant found between all variables at three month follow up. A partial correlation was run to determine the relationship between AMS and RRS at three months follow-up, while controlling for BDI-II scores. There was a small to moderate negative partial correlation between AMS (94.56 ± 3.20) and RRS (26.15 ± 3.10), whilst controlling for BDI-II (7.17 ± 3.78), that was statistically significant, (r(107) = -.289, N = 110, p < .002. However, zero-order correlations showed a statistically significant, large, negative correlation between AMS and RRS (r(108) = -.612, n=110, p < .001), indicating that the BDI-II changes had a significant influence in controlling the relationship between AMS and RRS.
A partial correlation was run to determine the relationship between AMS and PSI at three months follow-up whilst controlling for BDI-II scores. There was a small to moderate negative partial correlation between AMS (94.56 ± 3.20) and PSI (65.57 ± 10.37), whilst controlling for BDI-II (7.17 ± 3.78), that was statistically significant, (r(107) = -.255, N = 110, p < .007). However, zero-order correlations showed a statistically significant, large, negative correlation between AMS and PSI (r(108) = -.603, N=110, p < .001), indicating that the BDI-II changes had a significant influence in controlling the relationship between AMS and PSI.

A partial correlation was run to determine the relationship between AMS and WBSI at three months follow-up whilst controlling for BDI-II scores. There was a small to moderate, negative partial correlation between AMS (94.56 ± 3.20) and WBSI (23.19 ± 3.98), whilst controlling for BDI-II (7.17 ± 3.78), that was statistically significant, (r(107) = -.276, N = 110, p <.004). However, zero-order correlations showed a statistically significant, large, negative correlation between AMS and WBSI (r(108) = -.613, N=110, p < .001), indicating that the BDI-II changes had a significant influence in controlling the relationship between AMS and WBSI.

A repeated ANOVA was run on the changes in AMS from pre-treatment to three months follow-up, the within-subject factor. The covariates used were BDI-II, RRS, PSI, and WBSI to find out if improved changes in these variables had an effect on improved changes on the AMS variable or not. A repeated ANOVA was run to establish the baseline statistic for the AMS at three months follow up before doing the covariates. There was a statistically significant AMS score change, with improvement from pre-treatment to three months follow-up, F(1,109)= 8439.424, p < .001, partial η 2 =.987. Running the same test using the BDI-II as the covariate, the AMS remained significant and the effect size large but substantially reduced, F(1, 107)= 21.012, p < .0001, partial η 2 =.164. The RRS was then run as the covariate, and the AMS remained statistically significant with a reduced but still large effect size, F(1, 107)= 33.456, p < .0001, partial η 2 =.238. The PSI was run as the covariate, and the AMS remained statistically significant with a reduced but still large effect size, F(1, 107)= 17.218, p <.0001, partial η 2 =.139. The WBSI was run as the covariate, and the AMS remained statistically significant with a reduced but still large effect size, F(1, 107)= 53.777, p < .0001, partial η 2 =.334.

The repeated ANOVA results established that improved changes in AMS remained statistically significant after controlling for improved change scores on the BDI-II, RRS, PSI, and WBSI that indicates the changes in these covariates do not explain how the changes in AMS occur.

A multiple linear regression was calculated to determine the amount of variance of the dependent variable AMS that is explained by each predictor variable individually. The predictors included BDI-II, RRS and PSI. There was reasonable linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.325. There was reasonable homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for cook's distance above 1. There assumption of normality was met, as assessed by Q-Q Plot. Tolerance for the RRS was .181, PSI .144 and BDI-II .210. The overall model was significant, F (3, 106) = 22.139, p < .001, R² = .385, accounting for 38.5% of the variance. The results indicated that RSS was the only significant predictor of increased AMS scores and the BDI-II and PSI were not significant predictors of change in AMS scores.

A multiple linear regression was calculated to determine the amount of variance of the dependent variable WBSI that is explained by each predictor variable individually. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.014 and reasonable homoscedasticity, as assessed by visual inspection of a plot of studentized residuals, versus unstandardized predicted values. There were no studentized deleted residuals greater than ±3
standard deviations. There assumption of normality was met, as assessed by Q-Q Plot. Tolerance for the AMS was .610, BDI-II .221, RRS .159 and PSI .136.

Table 4 Multiple Regression Analyses of BDI-II, RRS and PSI on AMS scores (N=110)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE_b</th>
<th>β</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>107.303</td>
<td>5.786</td>
<td>-0.205</td>
<td></td>
</tr>
<tr>
<td>BDI-II</td>
<td>-0.173</td>
<td>0.140</td>
<td>-0.205</td>
<td></td>
</tr>
<tr>
<td>RRS</td>
<td>-0.466</td>
<td>0.184</td>
<td>-0.453</td>
<td>0.013*</td>
</tr>
<tr>
<td>PSI</td>
<td>-0.009</td>
<td>0.102</td>
<td>0.017</td>
<td>0.934</td>
</tr>
</tbody>
</table>

Note: *p < .05; B= unstandardized regression coefficient; SE_b = Standard error of the coefficient; β = standardized coefficient;

Table 5 Multiple Regression Analyses of AMS, BDI-II, RRS and PSI on WBSI scores (N=110)

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE_b</th>
<th>T</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>3.541</td>
<td>4.978</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMS</td>
<td>-0.036</td>
<td>0.044</td>
<td>-0.029</td>
<td>-0.822</td>
</tr>
<tr>
<td>BDI-II</td>
<td>0.208</td>
<td>0.062</td>
<td>3.368</td>
<td>0.001*</td>
</tr>
<tr>
<td>RRS</td>
<td>0.312</td>
<td>0.089</td>
<td>3.512</td>
<td>0.001*</td>
</tr>
<tr>
<td>PSI</td>
<td>0.205</td>
<td>0.029</td>
<td>7.106</td>
<td>0.001*</td>
</tr>
</tbody>
</table>

Note: *p < .05; B= unstandardized regression coefficient; SE_b = Standard error of the coefficient; β = standardized coefficient

The predictors included AMS, BDI-II, RRS and PSI. The overall model as significant, F (4, 105) = 301.059, p < .001, R² = .920, accounting for 92% of the variance. The results indicated that BDI-II, RRS and PSI were significant predictors of decreased WBSI scores. The AMS was not a significant predictor of decreased WBSI scores. The result in table 5suggests that WBSI is not a significant predictor of change in AMS scores but was for the BDI-II, RRS and PSI.

Table 6 shows reliable clinical significant change on BDI-II scores for group A compared to group B.

Table 6 Reliable clinical change on the BDI-II at post-treatment and three months follow-up

<table>
<thead>
<tr>
<th>Group</th>
<th>Pre: BDI-II</th>
<th>Post: BDI-II</th>
<th>3mth FU</th>
<th>Change</th>
<th>99%CI: Clinical Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>26.3</td>
<td>8.2</td>
<td>3.7</td>
<td>18.1</td>
<td>13.59 (achieved)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>26</td>
<td>14</td>
<td>10.6</td>
<td>12</td>
<td>13.59 (not achieved)</td>
</tr>
</tbody>
</table>

Note: input used- SD=11.8, test-retest=0.90 (Steer et al., 1999); (Devilly, 2004).

http://www.swin.edu.au/victims

Discussion

Results for hypothesis one to six rejected the null hypothesis and accepted the alternative hypothesis with group A showing greater improvement in all the dependent variables, AMS, BDI-II, RRS, PSI and WBSI at post-treatment and three month follow-up compared to group B. The results here supported Raes et al [5] findings that AMS improvements occurred independently of improvements in BDI-II, PSI and WBSI scores only but not for RRS. The multiple regression analysis suggested that the BDI-II, RRS, PSI and WBSI together could account for up to 40% of the variance in change in the AMS scores but only the RRS could account for almost half that improvement making the RRS a significant predictor of AMS score changes.

This result clarifies the assertions in previous MEST studies that AMS gains increase improvements in depression, namely improved mood [5-7]). Group A may have enhanced AMS improvement by increasing improvement in RRS, a mediating factor for AMS, confirming previous experimental studies [11-12]. Alternatively, improvement in RRS score
may have been due to a possible bi-directional relationship with AMS improvement [13], more so than group B.

Self-distancing as an adjunct as in group A did improve the outcomes of CBT more so than MEST which restricted itself to improving AMS that was not associated with mediating improvements in the other dependent variables, except possibly having a small reciprocal mediating effect in improving rumination and in turn improving mood.

The addition of SD to group CBT and MEST enhanced both their outcomes and would be a more clinically useful tool as an adjunct with CBT and MEST to use to treat moderate depression within the National Health Service in the United Kingdom and elsewhere than just group CBT with MEST.

Limitations included, study was not fully blind, no independent therapists used to run groups, no SCID used. All participants were highly motivated as evidenced by voluntary participation, high attendance rate, high homework compliance between both groups, factors not typical of clinically depressed adults that attend out-patient clinics for CBT. There is limited generalisability due to participants being primarily depressed, co clinical co-morbidity and not on anti-depressant medication. The researcher running both group interventions did not receive training to use the treatment manuals for group A and group B, compiled though by the researcher. This researcher also did not receive weekly supervision to check manual adherence when running the groups. This was limited to a few random audio recordings and direct observations by an independent experienced clinician.

Conclusion

The findings of this study addressed the stagnation in outcomes for moderate depression [1-2] and expanded the work of previous researchers in the area of MEST for depression [5-7] and SD [20-25]. Both groups can improve depression symptomatology such as low mood, rumination, problem solving and suppression but only group A compared to group B on all dependent variables at all time points was more efficacious, not only statistically but clinically significant as well for moderate depression.

The research helped to clarify that improvement in AMS was mediated by improvement in rumination which in turn could improve mood which could explain why in the previous MEST studies [5-7] they found an association between improvement AMS and mood. This research can be repeated with modifications, by having a larger sample size, better blinding, using SCID, regular independent supervision for each deliverer of group intervention; using independent and different therapists to run each group intervention. Participants can be recruited from typical mental health out-patient clinics with co-morbidity.

References


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**Conflict of Interest**

There are no conflicts of interest for the author.
Perception and Feedback of Undergraduate Medical Students on Medical Humanities

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Introduction

Medical humanities (MH) has been defined as “an interdisciplinary and increasingly international endeavor that draws on the creative and intellectual strengths of diverse disciplines including literature, art, creative writing, drama, film, music, philosophy, ethical decision making, anthropology, and history in pursuit of medical educational goals” [1] There is a great need of a “humane” doctor, with the understanding, assisted by interpretative ability and insight, and governed by ethical sensitivity, to apply this scientific evidence and skills to the individual patient.[2]. Empathy is a term difficult to define and it is said that in encompasses ethics, professionalism, communication skills and is much more and beyond these. Empathy describes the ability of the doctor to visualize and understand the patient’s suffering, pain and perspective and then communicate back to him with the aim of healing him [3,4]. Empathy is a better understanding of and alleviation of human suffering and therefore it has cognitive, psychomotor as well as an affective component. It is essentially a quality which helps doctors gain an insight into the quality of pain being experienced by the patient and doing something active to allay his pain and solve his problem.

The good doctor must also develop sensitivity in his/her dealing with patients, which is based on knowledge of oneself and their own values and insight into the problems and contexts of patients’ lives. Doctors need to be able to assimilate the scientific knowledge of disease and treatments with the understanding of the individual patient and to have good clinical judgment as to what might be of benefit to this patient with this particular problem at this point in his life [5]. This is the core problem for medical education to take on. In the last century the focus was largely on giving students the scientific knowledge and skills required of a doctor, but this is just not enough. In 1993 The General Medical Council (GMC) recognized that medical education needed a radical change, humane doctor, rethink, and in their document, Tomorrow’s Doctors,[6] recommended a greater focus on education, as opposed to training, in the undergraduate degree. The good doctor, as the GMC suggest, must be an educated doctor and this is one of the major areas where arts and humanities subjects might make a contribution.

Developing and maintaining an empathetic attitude towards patient is one of the important goals of medical education aiming at producing healers rather than mere physicians. The American Association of Medical Colleges has identified the development and enhancement of empathy in medical students as a key goal [7]. In recognition of its importance, many universities and medical colleges have awakened to the need of teaching empathy to medical students. Many medical schools offer a number of elective MH courses and students can select a particular one according to their interest and aptitude. However, the idea of MH is still relatively new in Asia. Studies have been conducted at Nepal and the authors found a positive approach of students towards the modules [8, 9]. Inadequate and miscommunication are the gaps in communication, while the problem of lack of communication between the doctors and the patients has long been recognized in India as well, still not much has been done remedial measures. MH is largely untouched in most of the medical schools and institutions in India. Also, we are not aware of any teaching modules or programmes on MH in the country.
The study was therefore undertaken as a pilot project at Era’s Lucknow Medical College when we tried to introduce sixth semester students to medical humanities. Among the specific objectives of the project were to understand empathy and its importance in medical care, know the effect of disease and sickness of a loved one on the family, be aware of the doctor-patient relationship. Paintings and photographs as visuals play an important role in the project. Detailed participant feedback about the paintings used, the activities carried out using the paintings, problems with using visuals made available and their role future was also asked. Hence the present study was done to obtain detailed feedback about the use of photographs and paintings from the six semester student participants.

Aim of the study
1. To introduce sixth semester year medical student to the subject of empathy through Medical Humanities
2. To assess their receptivity to the subject
3. To obtain detailed feedback about the use of photographs and paintings
4. To sensitize them towards the role it plays in improving patient care.

Methods
The study in MH was used undertaken as a pilot project at Department of Medical Education at Era’s Lucknow Medical College.

The following steps were followed.
1. In the first session, students were explained the definition, meaning, scope and purpose of MH. This was followed by describing the scope of the present session.
2. Photographs and paintings were of artists, obtained from the Literature, Arts and Medicine database. The activities undertaken by students were; ‘What do you see’ and ‘what do you feel’ about the painting or the photograph, in approximately 50 words.
3. We asked the students to analyze the negative perceptions about medical care givers among general public. The next step was to ask the students to reflect and explore the reasons for this negative image.
4. The session ended by asking for commitment on their part to behave in a more ethical and professional manner and develop good communication skills once they start practicing medicine.
5. Feedback was obtained about the activity. We requested the students to participate in a confidential, post discussion questionnaire. The participation was voluntary. The questionnaire comprised of 15 questions, which were both open ended as well as close ended questions.
6. Participants were asked to rate on a Likert’s scale of 1 to 5 their enjoyment of the use of paintings in the project, their perception regarding the usefulness of the paintings and photographs and how useful they felt.

The median score was calculated for each statement and compared among male and female students using appropriate nonparametric tests (p < 0.05).
7. Four batches of 15 students posted in emergency medicine for 2 weeks were subjected to participate in the pilot project after obtaining consent. The time was between 2pm to 4 pm. Annexure 1 presents the visuals with brief description.

Results. (Annexure 2)
Fifty-eight students participated. Eighteen students (31%) were male and forty were female.
The anatomy dissection painting was easily identified; it was eye catching and dark nature of painting. 67.4 respondents were correct. 50% students observed the dead mother and child not ready to believe in great depth. The terrorist attack on Taj was perceived as a message of hatredness, loss of peace, people and property by 52%. (Table 1 shows observation of all visuals) The most common overall comments about the use of paintings were “I could feel what I saw” (18 respondents), “enjoyed the sessions” (18 respondents), “some paintings were hard to interpret” (12 respondents). Suggestions to make annotations about paintings more useful were to make them shorter and more precise. Twenty-one students (36%) had difficulty with the exercise ‘what do you feel’. 56% (33 students) enjoyed the session on Likert’s scale of 4 to 5. (Table 2). 39 students (67.24%) found it a useful way of monitoring visual skills or observational power of an individual as it helped them to explore creativity, improve imagination and thinking, express their feeling, heightens emotions and a way of expression (Table 3). Advantages expressed in learning through painting is depicted in Rabble 4. Median Scores as per gender were not relevant.

Discussion

The project and the activity was a new experience to the students. Overall opinion about the visuals – photographs and paintings was positive. The paintings aroused and helped them to see and feel and were generally understandable and enjoyable. Students identified the photographs and paintings but expressing “what you feel” was at times difficult to express. Expression was not easy. Drawing and arts and Humanities in general do not get the attention they deserve in school. Also the top performers in school usually opt for the science Stream and the ‘arts’ stream are look down upon as students with a weaker academic performance. Imagination will be useful in putting oneself in the position of another person and indirectly improving empathy. Creative thinking may help developing skills of understanding in the patient perspective of illness. Later a better doctor-patient relationship may develop. Art has been used to improve empathy and identifying with and improving compassion towards the sufferer in the west [5]. The effectiveness of arts-based interventions in medical education is well documented in the west but the development of medical humanities in Southeast Asia is a relatively recent phenomenon [10]. In Table 4 the stated advantages of pictures were: alleviating empathy and feelings, the activity was creative and increased thinking capacity. Our observations were in accordance to Asian study at Nepal [8].

The questionnaire focused on many aspects of use of photographs and paintings in the pilot project with objectives of only as a small but important portion. Confidential student feedback was taken at the end of session. Feedback suggested that to some extent the objectives were met. The students will be followed through clinical postings and internship to see the impact longitudinally.

Conclusions

Instilling and percolating Medical humanities in medical students as a part of curriculum has already started in the Asian region. Participant response was positive and they were satisfied with use of photographs and paintings in the study. These are easily available. Use of more paintings from Asia and India can be considered. Free imagination, critical thinking, observational skills, expression of thought, non verbal as well as verbal communication are all needed from time to time. Further larger group and longitudinal follow up studies may be required to understand whether use of these visuals succeeded in fulfilling study objectives.

Key words: Medical humanities, visuals, and feedback.

References

[1]. American Society for Bioethics and Humanities. Purpose of the ASBH. Available at: www.asbh.org/about/purpose.htm


[7]. NunesP, Williams S, Sa B, Stevenson K. A study of empathy decline in students from five health disciplines during their first year of training. International Journal of Medical Education. 2011; 2:12-17. http://creativecommons.org/licenses/by/3.0


ANNEXURE 1

Fig.1 Post disaster earthquake primary health care
Fig 2. Visual arts – anatomy dissection

Fig 3. Dead Mother and child refusing to believe.
Fig. 4 “Hug,” the clasping patient and caregiver

Fig. 5 Sick and fear of loosing
Fig 6. Goya with Dr Arrieta

Fig 7. Fire at AMRI Hospital Kolkata
Annexure 2

Results

Table 1. Paintings with which students identified the most N-58

<table>
<thead>
<tr>
<th>Painting</th>
<th>Number of respondents</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy lesson</td>
<td>39(67.24%)</td>
<td>Eye catching, dark nature of painting, pain of the patient</td>
</tr>
<tr>
<td>Mother and child</td>
<td>29(50%)</td>
<td>Child not ready to hear loss of mother</td>
</tr>
<tr>
<td>Taj on terrorist attack</td>
<td>30(51.74%)</td>
<td>Loss of peace, people, property. Message of hatredness</td>
</tr>
<tr>
<td>Patient in ICU</td>
<td>41(70.68%)</td>
<td>Fear of loosing all</td>
</tr>
<tr>
<td>School students terrorist attack</td>
<td>25 (43.10)</td>
<td>These are painful situation</td>
</tr>
<tr>
<td>Earthquake and firstaid</td>
<td>32 (55.17)</td>
<td>Preparedness required</td>
</tr>
</tbody>
</table>

Table 2. On Likert’s scale liking N-58

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you enjoy the use of paintings</td>
<td>-</td>
<td>12</td>
<td>13</td>
<td>27</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>in the session</td>
<td>(20.68%)</td>
<td>(22.41%)</td>
<td>(46.55%)</td>
<td>(10.34%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the use of</td>
<td>-</td>
<td>8</td>
<td>10</td>
<td>23</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>paintings in the module</td>
<td>(13.79)</td>
<td>(17.24)</td>
<td>(39.65)</td>
<td>(15.51)</td>
<td>(13.79)</td>
<td></td>
</tr>
</tbody>
</table>
Table 3. Respondents’ perception about the activity create a story of 50 words and feeling of usefulness N-58

<table>
<thead>
<tr>
<th>Perception</th>
<th>Number of respondents (percentage)</th>
<th>Reasons (in decreasing order of frequency)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Useful</td>
<td>39 (67.24%)</td>
<td>analyzing humanity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helps in creatively exploring one’s talents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improves thinking &amp; imagination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>heightens emotions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nice way to express feelings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interesting way of learning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aroused professionalism</td>
</tr>
<tr>
<td>Not useful</td>
<td>9 (15.51%)</td>
<td></td>
</tr>
<tr>
<td>No response</td>
<td>10 (17.24)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4. Advantages of learning using paintings for medical students

<table>
<thead>
<tr>
<th>Stated Advantage</th>
<th>Number of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotes empathy &amp; feelings</td>
<td>23</td>
</tr>
<tr>
<td>Creative &amp; enjoyable activity</td>
<td>17</td>
</tr>
<tr>
<td>Increases thinking capacity</td>
<td>10</td>
</tr>
<tr>
<td>Provides opportunity to share ideas with group</td>
<td>7</td>
</tr>
<tr>
<td>Sensitizes students to future scenarios</td>
<td>7</td>
</tr>
<tr>
<td>Underlines importance of doctor-patient relationship</td>
<td>6</td>
</tr>
<tr>
<td>Improves power of imagination</td>
<td>6</td>
</tr>
<tr>
<td>Refreshing break from theory classes</td>
<td>6</td>
</tr>
<tr>
<td>Promotes lateral thinking</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 5. Median scores of specific parameters according to gender

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Male</th>
<th>Female</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyment of paintings</td>
<td>4</td>
<td>4</td>
<td>0.916</td>
</tr>
<tr>
<td>Usefulness of annotations</td>
<td>4</td>
<td>4</td>
<td>0.148</td>
</tr>
<tr>
<td>Usefulness of paintings</td>
<td>4</td>
<td>4</td>
<td>0.493</td>
</tr>
</tbody>
</table>
Socioeconomic Inequalities in Common Mental Disorders: A Systematic Review

Article by Edna Chirwa Simwinga
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Abstract

Low socioeconomic status (SES) is generally associated with high medical morbidity, and poorer access to health care. A number of studies have investigated the relationship between SES and common mental disorders with differing results. Therefore, the author conducted a systemic review to evaluate such an association. The review included 17 studies. Socioeconomic inequality in common mental disorders is mixed and varies according to the approach mental disorder is accessed, to the definition and measurement scales of SES, and to background characteristics such as region and time. However, the analysis found convincing evidence for socioeconomic inequality in common mental disorders. Policies for tackling inequality in common mental disorders are necessary, particularly in relationship with the course of the disorders.

Keywords: Mental disorders, SES, depression, anxiety, level of education

Introduction

Low socioeconomic status (SES) is generally associated with high medical morbidity and poor access to health care. This situation extends to mental disorder as well. In countries where epidemiologic studies have been conducted and compared, the group in the lowest level of education had a higher prevalence of mental disorder morbidity (Andrade et al. 2000). Lower SES group have higher risk factors such as poorer coping styles, stress exposure, ongoing life events, and weaker social support among others compared to groups in higher SES (Turner and Lloyd, 1999). Even in cases where both groups suffer mental disorder also it has been found to be unequally spread. For example, even with the same severity level, lower SES groups tend to suffer more impairment (Bebbington, et al. 2000) and have a poorer prognosis (Weich & Lewis, 1998). In places where the government does not provide sufficient welfare support, people in lower SES groups tend to have lower access to health care in general (Katz, et al 1997) and they are were less expected to have access to expert mental care (Algeria et al. 2000).

Strong empirically based studies show a link between social conditions and disease and based on these studies, the theory holds that disease risk at the individual level should be studied in the context of the wider social conditions that leaves individuals to health compromising circumstances. Therefore, well-being is hypothesized to be a consequence of access to social as well as material resources.

In a study review by Dohrenwend & Dohrenwend (1969) that included all types of mental disorders, 17 studies of 20 studies evaluated all types showed higher rates of global medical disorder among the lowest SES group. However, upon examination of the early psychopathologic epidemiologic studies Dohrenwend (1998) found that most studies had three main methodological weaknesses. Firstly, most studies only enrolled participants who were patients, consequently making research results vulnerable to variations in the help-seeking behavior and referral process (Holzer, et. al.1986). Then secondly, most studies conceptualized mental disorder with poor classification and criteria that were inadequate for setting the threshold of mental disorders (Dohrenwend 1998; Anthony, Eaton & Henderson (1995). And thirdly, they employed symptom-screening tools that were unsatisfactorily specific, because they mixed a wide range of psycho-physiologic disorders as well as true
psychopathological disorders (Algeria, et al. 2007). Since the early 1980s, significant psychiatric epidemiologic surveys have been conducted on a broader geographic area. Most of the studies have employed structured diagnostic criteria and more specific psychopathological classifications like the ones in the Third or Fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III or -IV). Nonetheless, they have not generated consistent results for the monotonicity strength, or direction of the relationship between SES and mental disorder (Andrade et al. 2000).

We chose to carry out a systematic review so as assess the actual relationship between SES and mental disorder. Considering the methodological and geographic diversity of previous studies, we furthermore sought to illuminate on the methodological and contextual issues which might elucidate the variability of the results related to the SES-mental disorder.

**Methods**

A systematic review was employed in the analysis. The studies employed in this systematic review were chosen with a mix of processes to select the appropriate articles on the study.

**Search**

Search procedures involved keyword and search for particular authors by use the internet and a review of citations comprised in reviewed articles.

Keywords used were: Common mental disorders, depression, anxiety, education, income, deprivation, SES, socio-demographic, social correlates, socio-economic, socioeconomic, social class, psychiatric, psychopathology and mental.

The method in this systematic review encompassed correlational studies, SES studies and/or psychopathological studies. Being a comprehensive field, only research studies that investigated the relationship between SES and mental disorder were included.

Studies addressing common mental disorders (a mix of depression, mood disorders, anxiety) were included. Regarding SES, we retained studies providing a continuous individual level of stratification related to income, education, occupation, social class, or wealth (Krieger, Williams, & Moss, 1997).

Three selection criteria were defined relative to date, setting, and population. Studies published after 1980 (consistent to the publication of the DSM-III) were selected. Selection was limited to works in which a community sample was used. These exclusion criteria prevented the biases related to referral or help-seeking behavior (Andrews, Henderson and Hall, 2001). The study was restricted the review to studies of adults (aged ≥15 years); studies devoted to children or the elderly was excluded, mainly to reduce the confounding bias of poor physical well-being.

Interdisciplinary sources (psychology, psychiatry, medicine, sociology, and economics) were included. The search also followed up with a snowball search (Davis, 1997), as well as references from some papers relating to this topic.

The studies show that the SES-psychopathology relationship may be affected by numerous features associated to measurement and analysis. There are many tools in existence for the assessment of the psychiatric status of adults, and they can be divided into two main groups namely: psychiatric scales and diagnostic schedules (Murphy, 1995). Also, the strength of the relationship might differ based on the clinical category. Including all neurotic disorders, the way it was done in Kessler, McGonagle & Zhao (1994), might result in stronger relationship because the definitions of substance disorder and anxiety, factors that might result in sharper socioeconomic slopes than mood disorders (Regier & Farmer, 1993). On the other hand, the incorporation of all mood disorders might reduce the slope, since dysthymia might be distributed more equally among the socioeconomic strata than other mood disorders such as major depression (Wohforth, 1997). Then, the period of reference was also seen as a possible explanatory factor since the prevalence rate might be influenced more by the length of the episode for shorter reference periods.
Studies reviewed

There have been two competing hypotheses in sociological inquiry that have delivered interpretations of the documented relationship between low socioeconomic status and common mental disorders. The selection hypothesis holds that common mental disorders hinders attainment, while the causation hypothesis holds that conditions of life related with low socioeconomic status distinctly hikes the risk of mental disorders. Using data from the longitudinal Dunedin Multidisciplinary Health and Development Study, Miech, Caspi, Moffitt, Wright and Silva (1999) examined selection and causation courses through the transition to early adulthood by way of exploring the reciprocal influence of mental disorders and educational attainment, a fundamental component of socioeconomic status. The Dunedin Study follows a group of people from 0 to 21 years of age and included psychiatric diagnoses for study participants at ages 15 and 21 employing the DSM criteria. Miech, Caspi, Moffitt, Wright and Silva (1999) focused on the four common mental disorders namely: anxiety, depression, attention deficit disorder, and anti-social disorder, and find a distinctive relationship with socioeconomic status for each of these disorders.

The study found that mental disorders among adolescents were more probably to be found among the youth in families with low socioeconomic status than would be predicted by chance alone. Furthermore, there were differences in the relationship between socioeconomic status and mental disorders when mental disorders were considered individually. Among common mental disorders, anxiety and depression, there were different associations with family’s socioeconomic status. Anxiety was found to be disproportionately in families with lower SES as expected, however, depression was not. These findings are consistent with Kessler’s (1994) findings that showed that SES is more strongly associated to anxiety than depression in the general population ages 15-54 (Kessler et al. 1994).

In another study by Arriola et. al. (2015), the study sought to examine the association between social support and physical and mental health among inmates and the probability that housing stability mediates this relationship among inmate living with HIV. The study included a cohort of HIV-infected inmates from 10 grantees funded, the study participants were needed to have been at the collaborating jails who were aged 18 years or above.

In a cross-sectional study data was obtained from 438 clients who participated in structured interviews. This study found a significant positive association between social support and both mental and physical well-being; while homelessness was related to lower mental well-being. Nevertheless, the study did not find any evidence of moderation. Additionally, the study demonstrated how important social support and economic considerations in the understanding well-being among HIV positive detainees (Arriola et al, 2015).

These studies show that accessible options to maintain health and wellbeing are limited in conditions of poverty and housing instability (Kushel et al., 2006; Weiser et al., 2009). Housing insecurity has been defined as “having difficulty paying rent, having frequent moves, living in overcrowded conditions, or doubling up with friends and relatives” (Kushel et al., 2006). To the point that housing uncertainty is an indicator of socioeconomic status, the Theory of Fundamental Causes elucidates why housing and health may be correlated (Link and Phelan, 1995; Phelan et al., 2004). This theory postulates that social factors such as social support and socioeconomic status presents access to essential resources such as money, electricity, prestige, and social connectedness) and thus have the possibility to serve as “fundamental causes” of a number of physical and mental health disorders.

Hudson (2005) study tested several hypotheses about the causal structure of the correlation between SES and mental disorder. He did this by analysis of a longitudinal statewide database on acute psychiatric hospitalization in Massachusetts between 1994 –2000 and census data. The modeling strategy employed techniques of structural equation modeling. This study found that SES impacted directly on levels of mental disorder and indirectly through the effect of economic hardship amongst the low and middle income groups (Hudson, 2005).

Agerbo, Nordenfot and Mortensen (2002) in attempting to estimate the risk of suicide among youths related to family as well as individual psychiatric and socioeconomic factors
used a design population based nested case-control study. Data was collected from longitudinal Danish registers. It included 496 cases of youths aged 10-21 years who committed suicide in the period between 1981 and 1997 in Denmark and 24,800 controls matched for age, age, and time. The main outcome measures all suicides in Denmark compared with controls; parents and siblings from population based registers; in-patient data from discharge registers of national hospitals; as well as socioeconomic data. The study found that parental factors related to an increased risk of suicide in youths were suicide hospitalization for a mental disorder, unemployment, low income, low level education and divorce, as well as mental disorder in siblings and mental disorder and low level education among the youths. The biggest risk factor was mental disorder among the youths. The impact of the parents’ SES factors decreased after adjusting for a family history of mental disorder and of suicide (Agerbo, Nordentoft and Mortensen, 2002).

In another study (Weich and Lewis, 1998) to investigate whether poverty and unemployment increase the probability of or delayed recovery from common mental disorders as well as whether these relations could be explained by subjective financial stress. The study employed a prospective cohort study design in England, Wales, and Scotland with 7726 participants aged 16-75 residing in private households. The common mental disorders were evaluated by using the general health questionnaire (a self-assessed questionnaire of psychiatric morbidity). The study found that poverty and unemployment were linked with the maintenance yet not the onset of episodes of common mental disorders. The links between poverty and employment and maintenance of common mental disorders, were much smaller than those found in cross sectional studies. Furthermore, financial stress at baseline was independently linked with both onset and maintenance even after adjusting for objective indices of standard of living. Finally, both poverty and unemployment were found to increase the duration of episodes of common mental disorders however, not the probability of their onset. Then financial stress was found to be a better predictor of future mental disorder (Weich and Lewis, 1998).

In an attempt to test the hypothesis that persons in regions of Britain with the highest income inequality have higher prevalence levels of the common mental disorders, Weich, Lewis, and Jenkins (2001) employed a cross-sectional survey. The study recruited 8191 adults aged 16-75 living in private households based in England, Wales and Scotland. The prevalence of common mental disorders was measured by employing the General Health Questionnaire. The relationship between income inequality as well as prevalence of the common mental disorders were varied with individual income level. Amid individuals with the highest income levels, common mental disorders were more frequent in regions with higher income inequality. Furthermore, the reverse was true for those with the lowest income levels. Income inequality was linked to worse mental health amongst the most prosperous individuals (Weich, Lewis, and Jenkins, 2001).

To analyze the association between geographical income inequalities and common chronic medical conditions and mental disorders prevalence, and to match it with the association between family income and these health disorders (Roland and Roan, 2002). The study employed national household telephone survey between 1997-1998 among 60 metropolitan areas or economic areas in the United States. 9585 adults were recruited in the study and participated in the community tracking.

The study found a strong continuous association between health and family income or education. However, there was no relation found between income inequality and depressive disorders and anxiety disorders or chronic medical problems prevalence, either in the whole population or among lower SES group. However, self-reported general health was significantly correlated with inequality at the level of the population, however, after adjustment this correlation disappeared for individual features. This study offers no evidence that income inequality poses as a major risk factor to common physical or mental disorders (Roland and Roan, 2002).
In another study (Kahn, Wise, Kennedy, and Kawachi, 2000) to analyze the relationship of state income inequality and family income with the mental and physical health of women with young children. A cross-sectional study design was employed. Individual family level data outcomes included income, and other sociodemographic covariates from a 1991 follow-up survey of a birth cohort set in 1988 and income inequality at state level were calculated from the 1990 US census of each state income. Participants included nationally representative stratified random sample of 8060 women who had their babies in 1988 and contacted in 1991. The study results show that 19% women had depressive symptoms, and 7.5% had fair to poor health. Furthermore, women in the lowest fifth were more expected to report depressive symptoms and fair to poor health in contrast to women in the highest fifth of distribution of family income.

In comparison with low income women in low income inequality states, low income women in states from high income inequality showed a higher risk of depressive symptoms and fair to poor health. Overall, this study shows that high income inequality gives an increased risk of poor mental and physical health, predominantly among the poorest of women. Income inequality as well as family income are important for health among women (Kahn, Wise, Kennedy and Kawachi, 2000).

Araya, Rojas, Fritsch, Acuña and Lewis (2001) sought to determine the prevalence of common mental disorders including socio-demographic correlates among the adult population in Santiago, Chile. A cross-sectional survey in private households was conducted and a probabilistic sampling design was employed. Common mental disorders were assessed by means of the Clinical Interview Schedule-Revised (CIS-R). They found that of the 3870 participants interviewed 25% were CIS-R cases while 13% met criteria for an ICD-10 diagnosis. Low education, low social status, unemployment, female gender, separation and lone parenthood were associated with a higher common mental disorders prevalence (Araya, Rojas, Fritsch, Acuña and Lewis, 2001).

When determining the prevalence of psychiatric disorder, alternative diagnostic criteria were applied to a random sample of 576 women in an Edinburgh community (Surtees, Dean, Ingham, Kreitman, Millerand Sashidhara, 1983). Any diagnostic system was employed, resulted in significantly higher rates of disorder were among were divorced, widowed, cohabiting or separated women, working class and the unemployed; in the subgroup of women who met above conditions, up to 50% were found to satisfy the diagnostic criteria. The study shows that the prevalence rates can be explained as the factors effects of each demographic factor acting independently, no interaction effects being needed. Our results are discussed in relation to the findings of others, and in terms of the statistical issues involved (Surtees, Dean, Ingham, Kreitman, Millerand Sashidhara, 1983).

In a study in Australia, Korten and Henderson (2000) aimed at examining the distribution of common psychological symptoms as well as associated impairment in the Australian population. This arose from the fact that the mental health of populations can be denoted either by case prevalence rates or by symptom scales. Korten and Henderson (2000) hold that scales are advantageous in that they can be employed to identify sub-syndromal distress levels. The study employed a household representative sample of 10 641 participants from the Australian population. They underwent the Composite International Diagnostic Interview. The study found that the Symptom scales demonstrated similar relationship with socio-economic variables just as did diagnoses. Substantial impairment was related to symptom levels showing distress however, not reaching formal diagnoses levels of anxiety or depression (Korten and Henderson, 2000).

While most studies show that people at highest risk of suicide including those who are socially and economically underprivileged, are equally at high risk of being hospitalized with a mental disorders. In certain cases it seems that mental disorder is a determining factor on social position and suicide (Agerbo, Mortensen, Eriksson, Qin and Westergaard-Nielse, 2001). However, their study indicated that the significance of socioeconomic factors as risk factors for suicide was attenuated after adjustment for a history of mental disorder. They
presented findings from 811 cases of suicide as well as 80787 matched control subjects from a population based study whose aim to gain further insight into the relationship between social position and mental disorder (Agerbo, Mortensen, Eriksson, Qin and Westergaard-Nielse, 2001).

With regard to comparing groups in two group from economically different country, Hollifield, Katon, Spain and Pule (1990) compared data from adults in a village in Lesotho, and data from a large epidemiological study in the United States. Participants were interviewed utilizing the same research instrument to find out the community prevalence of panic disorder, major depression, and generalized anxiety disorder. The prevalence data of the two were then compared with data. They found a significantly higher prevalence rates of all three diagnoses in Lesotho in comparison to the United States. Data from the two populations showed that women were at an increased risk of the three disorders, even though statistical significance was not established for depression. The majority of participants (77%) who had panic attack episodes reported that they had sought help for these symptoms, with the majority seeking help from Western-trained doctors. The association between explanatory models and help-seeking behavior were explored among people who had had panic attacks. 40% Less than participants with generalized anxiety disorder reported having sought help. The findings were attributed to difference in SES (Hollifield, Katon, Spain and Pule, 1990).

In another study investigating the association between SES and common mental disorder Stewart-Brown, Samaraweera, Taggart, Kandala and Stranges (2015) studied whether the socioeconomic correlates of mental well-being match those for mental disorder. The study was conducted among 13983 participants of the 2010 and 2011 Health Surveys for England. The study found that low mental well-being matched those for mental disorder, however, not those of high mental well-being, demonstrating that the SES factors linked with positive mental health are different from those linked with mental illness (Stewart-Brown, Samaraweera, Taggart, Kandala and Stranges, 2015).

**Discussion**

The above reviewed studies have found a relationship between SES, income inequality, educational level, gender and mental health or disorder. Furthermore, ongoing efforts to understand the causal issues involved in the correlation between socioeconomic status and mental disorder show that the hypothesis of a recursive or interactive association might be the most plausible, at least with the mental disorder. Some of the factor involved in this relationship could include mental health costs of economic policies, allocation mental health resources, and the employment of this knowledge-base in service planning and delivery.

It is apparent that there is a strong social gradient in health, as measured by the prevalence of general medical conditions and common mental health disorders, by income and education. Decades after the Dohrenwend and Dohrenwend (1969) milestone review, SES seems continue to correlate with common disorder. Low SES does seem to increase the risk of episode onset as well as the risk for persistence of common mental disorders. This association is not restricted to the lower SES group but continues throughout the whole social stratum.

The king of this relationship is not straightforward. Concerning the direction of this association for common mental disorders, the studies more consistently show the argument that causation i.e. low SES increases risk of common mental disorders - has the edge over selection i.e. depression hinders social movement (Dohrenwend, et al 1992; Kessler, 1995; Johnson, 1999).

The processes associating SES and common mental disorders can be divide roughly into two groups: stress and strain (Thoits, 1999). The stress theory posits that personal resources, including coping style, mastery, self-esteem and locus of control, cushion the effect of stress on common mental disorders and that people in higher-SES groups are gifted with such resources (Brown, 1984 & Wheaton, 1980). The strain theory addresses the influence of community features such as social welfare, values, social cohesion, public health policy and infrastructure (Thoits, 1999; Lomas, 1998; Robert and House, 2000). This outline is based on
between-country differences in socioeconomic health inequalities observed for subjective health (Van Doorslaer, 1997; Hollifield, Katon, Spain and Pule, 1990) or cause-specific mortality (Kunst, Groenhof and Mackenbach, 1998). However, the evidence for such contextual effects on mental disorders is inconsistent (Duncan, Jones and Moon, 1995; Driessen, Gunther and Van Os, 1999). Studies have shown that individual income and regional inequalities in income are interlinked in influencing the level of mental disorder (Weich, Lewis and Jenkins, 2001; Roland and Roan, 2002; Kahn, Kennedy and Kawachi, 2000). Furthermore, the relationship between socioeconomic inequalities and common mental disorder differs in different regions and nations.

This review could have been affected by limitations related to confounding bias, and publication bias. For example, gender and age could be confounding factors in the SES-common mental disorder relationship. For instance it is well known that women have a higher prevalence of some common mental disorders such as depression and lower SES, and younger people have a higher risk of being lower SES groups, therefore, ignoring gender will intensify the SES gradient. In addition, ignoring age is likely to suppress the gradient.

Physical disease might also provide another possible confounding factor that is rarely considered in mental health epidemiology (Dohrenwend, 1998). Very few of the studies reviewed included analysis of physical health. However, studies (Hippisley-Cox, Fielding, Pringl, 1998) show that a relationship exists between mental disorder and physical diseases such as cancer as well as cardiovascular disorders and another relationship between SES and physical diseases exists. However, a study by Lynch, Kaplan and Shema (1997) proposes that the general effect of physical disease on the SES-common mental disorder relationship is small.

Furthermore, certain significant mental health epidemiologic studies did not consider the problem of the SES distribution of common mental disorder (Offord, Boyle and Campbell, 1996; Wittchen, Essau and von Zerssen, 1992). A later cross-national review showed that education was associated to mental health status in Ontario however, not in Munich (Andrade, et al. 2000). Also an availability bias is present, predominantly in to developing countries. Studies like these may not even be published in peer-reviewed English-language journals. Taking a recent cross-national review of seven countries as an example (Andrade, et al. 2000), some studies from developing countries were not published in peer-reviewed journals.

**Conclusion**

Regardless of these, there is convincing evidence of inequalities in common mental disorders favoring the higher SES groups. This should lead to informing planning and implementation of health programs. The review show that one strategy would be to put emphasis on reducing the chronicity of depression among people in the lower socioeconomic strata.

**References**


To Explore the Experiences of Mothers Losing Biological Sons to Death through Alcoholism in Njatha-ini Village - Sagana - Kirinyaga County

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Abstract

American Psychological Association defines alcoholism as: -
“an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead to usually to intoxication if drinking is begun; by chronic to intoxication if drinking is begun; by chronicity, progression; and by tendency towards relapse” (Hoffman, 1975).

The aim of the study was to explore the experiences of mothers losing biological sons to death through alcoholism in njatha-ini village sagana - kirinyaga west county, Kenya. The target population was mothers with adult sons that have died through alcoholism. in Njatha-ini village Sagana area – Kirinyaga County. The study design was qualitative and non-probability design was used utilizing snow-ball sampling. According to Orodho and Kombo (2002) sampling is the procedure a researcher uses to gather people, places and things to study. It is a set of respondents from a larger population for the purpose of a study. Seven mothers from the Ndia ethnic community located in Njatha-Ini Village, Kirinyaga West County in Kenya, were interviewed through the Focus group discussion. A chunk of written notes audio taped were then transcribed, read and re-read then grouped items together. The information was placed into emerging themes; responses coded and conceptualized, attributed and searched for meanings from the data segmentation.

The mothers bio-data was based on four key descriptions, the age of the mothers, age of sons at time of dying, duration since the death of the son and the circumstances under which the son died through alcoholism. The mothers aged between 52 and 78 years old, the dying sons aged between 17 and 38 years, the sons were dead between 8 months and 10 years and although death causative was alcoholism, the circumstances of dying for the seven sons ranged from one poisoned while drunk, two sons from alcohol induced accidents, one suicide, two overdosed, and one murdered whilst drunk.

Keywords: Mother, Son, Death, alcoholism

Introduction to background information

Njatha-ini Village - Sagana - Kirinyaga County, is one of the forty seven counties in Kenya. Kirinyaga County is Located in Central Kenya, it borders Meru to the North, Embu to the North East, East and South, Murang’a to the South West, and Nyeri to the West. The County has four wards, i.e., Mwea Ward, Gichugu Ward, Ndia Ward (which is the host of the study) and Kirinyaga Central Ward Sagana, which is central to this study, is one of the county’s local Authorities. According to the County’s Strategic Plan (2005-2010), Kirinyaga County is one of the poorest counties in Central region and it accounts for 1.5% of the national poverty. The main problems concerning population and development in the county include high rate and early marriages, HIV pandemic, increased numbers of single parenthood, increased orphans as well as consumption of illicit brews among the youth which translates to lack of employment, high mortality/morbidity and declining family incomes.

Problem statement

The cry of generations of mothers losing sons to Alcoholism is getting louder day after day across the world and the number of mothers falling in this experience keeps swelling day by day. Evidently there is little thought on these experiences of mothers especially in the rural areas where counselling
support is negligible and little has been done on mothers to analyse the impact of losing sons to death specifically through alcoholism.

This is dissimilar to other scourges such as HIV/AIDS, Tuberculosis and malaria whose vulnerable communities have been documented and supported to cope. The experiences call for sober rethinking taking into consideration the many challenging effects the experiences subject mothers to which can compromise their health, even though this is not the only depressing experience that mothers go through. The situation increases mothers’ vulnerability not considering other factors such as maternal mortality. In Kenya, part of the Vision 2030 is Health which is an element of the Social Pillar, and good health is expected to play an important role in boosting economic growth and poverty reduction. Mothers therefore have a role to play in the realization of Vision 2030. It is of utmost importance that we assist the bereaved family to avoid irreparable trauma and endless suffering. Too many people not given enough help either go through years of unresolved grief or require psychiatric help later (Kubler-Ross, 1974).

**Justification**

Most of alcoholism fatal cases, the casualty is the male gender and majority are young, compared to female. Mothers ruminate a lot about the death of a significant other more than other family members. Even prior to death, more often than not, it is the mother who worries about the alcoholism trend and will accompany the child to seek professional help, if at all, hence avid motivation to recollect the mothers’ experiences over own sons’ death.

**Broad objective**

To explore the experiences of mothers losing biological sons to death through alcoholism in **Njatha-ini Village - Sagana - Kirinyaga County**

**Knowledge**

Losing a child to death through alcoholism has emerged as one of the crushing and potentially destructive pains in mothers’ lives. However, researches focusing on mothers that have lost sons to death through alcoholism are scarce. This study was quite limiting in that there are no past studies specifically to mothers’ experiences of losing sons to death through alcoholism done in this locality.

**Methodology**

The study was done in Njatha-ii-village in Kirinyaga County and the target population were mothers that have lost sons through alcoholism. One of the key features of qualitative research is to give a voice to participants, focusing on enabling participants ‘voices to be heard’ by providing deep descriptions of phenomena being investigated (McLeod, 2001). The study explored human phenomenon perspective and considered the qualitative method, otherwise referred to by Kumar (1996) as naturalistic or subjective. The main objective of qualitative study is to describe the variations in a phenomenon, situation or attitude whereas the quantitative research in addition helps you to quantify that variation (Kumar, 1996). The study is rooted in the phenomenological paradigm being one of the traditions underpinning the qualitative research whereby it is concerned with questions about the nature of the object itself, but with the human subjective experience of perceiving and relating to the object. This is qualified by the fact that mothers’ experiences touch on their feelings, thoughts and emotions and the study seeks to understand the mothers subjective experiences of having their sons die through alcoholism. Further qualitative research is rich in uncovering peoples’ experiences looking at why situations are the way they are. Coolican (1990) argues strongly that some qualitative proponents the qualitative research method do not necessarily invoke greater subjectivity at all. The experiences can be written objectively and can be checked with them for accuracy and true reflection of earlier lived experiences, thus qualitative studies are almost always naturalistic and are conducted in more natural every day circumstances.
According to Orodho and Kombo (2002) sampling is the procedure a researcher uses to gather people, places and things to study. It is a set of respondents from a larger population for the purpose of a study. A sample size of seven respondents as sample size requires minimal time and resource investment and this was small enough to give everyone the opportunity to express their opinion. The 7 were picked using snow-balling sampling out of 20 mothers that were willing. The following criterion was to work with the respondents:-

- Willingness for inclusion in the Focus Group discussion and answering corresponding questions
- Willingness to allow the interview be tape recorded
- Consent if the research is considered for the publication of the study.
- Mothers that have experienced the phenomenon of losing their biological sons to death through alcoholism.
- Adult mothers
- Volunteering

Results

Focus group participants bio-data information
<table>
<thead>
<tr>
<th>Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age of mother</td>
<td>58</td>
<td>70</td>
<td>70</td>
<td>52</td>
<td>58</td>
<td>64</td>
<td>78</td>
</tr>
<tr>
<td>Age of son at the time of death</td>
<td>38</td>
<td>30</td>
<td>25</td>
<td>25</td>
<td>17</td>
<td>27</td>
<td>23</td>
</tr>
<tr>
<td>Duration since death</td>
<td>04 years</td>
<td>03 years</td>
<td>10 years</td>
<td>08 months</td>
<td>18 years</td>
<td>05 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Death Circumstances</td>
<td>Poisoned while drunk</td>
<td>Accident occasioned by alcoholism</td>
<td>Suicide</td>
<td>Overdosed</td>
<td>Overdosed</td>
<td>Murdered drunk</td>
<td>Accident while drunk</td>
</tr>
</tbody>
</table>
Some notable characteristics of the respondents that emerged that out of the seven respondents who had lost sons to death through alcoholism, only one respondent was not a widow. The respondent’s ages ranged between ages 58 and 78 years. The sons of the respondents had died between 8 months and 18 years ago. The deaths through alcoholism had happened through means of alcohol intoxication, poisoning, road accidents, suicide and murder. At the time the sons died, they were aged between 17 and 38 years. Twelve main themes emerged from the data analysis:

- **Positive recollections on the dead sons**
  
  The mothers of the dead sons had positive memories. It was clear that no matter what circumstances death occurred, there were fond memories and good deeds cherished over the years.

- **Feelings that come with loss**
  
  Several forms of feelings were expressed in the experience that ranged from fear, bad pain, sadness; unhappiness, disturbed, being looked down upon, shame, depression, loneliness, guilt, betrayal of parenting by the dead, emotional pain and insomnia associated with the loss is evident for the mothers in general.

- **Helplessness**
  
  Helplessness was expressed especially in the effort of trying to heed the addicted stop drinking but the concerned would not stop even with the doctor’s intervention and the medical warnings but again and due to compulsives of the alcoholism disease, the affected son was unable to stop and finally death strikes.

- **Traumatic & untimely death**
  
  Untimely death has been depicted as sudden, at any age, murders or even suicide, the unpredictability of accidents, and the death of young people has been proven as profoundly distressing.

- **Birth Order**
  
  The birth position of the child within the family as well as the atmosphere of the family has been shown as playing a significant role in the family constellation and a major influence as to how a mother views death of same. First and last born have featured comparatively.

- **Stigma from the surrounding community**
  
  The community has been shown as one of the put downs and reproach for the mothers in their experiences.

- **Grandmother’s parenting inevitably**
  
  With the son’s dead and having left children and wives the mothers bury the sons and embark on active care of their grandchildren within their homes. They have spent all their strength and effort in bring up the children, educating them and giving them a sense of belonging. The process has been shown as draining as they handle their grandchildren and on the other hand they are mourning.

- **Cognizance of the effects of alcohol to families**
  
  The effects of alcoholism are indeed in the awareness of the mothers and some worry if the other sons in the family just turn out to be like the deceased.

- **Coping with the loss**
  
  Every other manner of coping was seen. Some respondents turned to their Higher Power, getting saved, others went to their fellow women and together they formed a fellowship, uniting with the church, others replaced the death memories with work, just working with their hands to make the
mind feel calm, placing a telephone call to woman friend, prayer requests and women groups. These sustained the mothers in the absence of any formal settings in dealing with the loss of sons to death through alcoholism.

- **The act of letting go**
  
  Some respondents moved to acceptance
  
  Ones grief depends on one’s personality, back-ground, religious believes , relationship with the deceased, and cultural environment. Even though the mourner may never recover completely, from the loss, most people return to a state of productivity and this process of normal grief is what Collins (1994) refers to as ‘uncomplicated mourning’.

- **Suicidal ideation & death**
  
  Feeling grief, which naturally takes a surprising amount of physical energy, coupled with exhaustion my increase thoughts of suicide. These powerful suicidal thoughts are potentially very destructive and should be given the proper attention and care immediately.
  
  The idea of the mothers coming together after experiencing the death of their husbands had naturally staffed the suicidal thoughts *hanging themselves, they would die, they would get sick and get a heart failure,*
  
  Collins (1994) acknowledges that for some, there could be hyperactivity, giving up attitude of helplessness and hopelessness, intense guilt, a strong self-condemnation, extreme social withdrawal

- **12. Self-concept**
  
  Some mothers experienced poor relationships with the late sons’ children and the left behind daughter in law. It is normal for human beings to experience poor inter-personal relationships especially when they are managing stress, undergoing a crisis or dealing with negative feelings.

**Discussion**

**Sudden trauma & post traumatic stress**

When death or loss of any kind is sudden, it is hard and brings an overall sense that life is unfair and to put the immediate horror to rest is not easy. Such sudden traumatic deaths my come in form of murder, alcoholism overdose, accidents or even suicide which feels like a true nightmare. This is because life has given you no time to get used to the idea of having to say good bye. Feelings were expressed by the mothers as a result of the sudden death of their sons in terms of fear, bad pain, sadness; unhappiness, disturbed, depression, loneliness, guilt, betrayal, emotional pain and insomnia which is associated with the loss. There was anger, pain, rage, disbelief and regret which further complicate the grief. The pain for the survivors is complicated because the experience is sudden, typically unexpected and this may mean sometimes many years of working through the grief. Going by the experiences, some of the mothers are still struggling with disquiet which can be described as post-traumatic stress disorder or PTSD which is an anxiety disorder resultant from a traumatic experience such as losing a loved one. Indeed, Macin (2009) suggests that deaths that people think should not have happened produce highly visible grief.

**Community response**

African cultural tradition prescribes that when a child dies, the family and community rally around the mother for a few weeks, sitting with her, bringing food, cleaning her house, in addition to talking about the pain of the loss. And supposedly by the time of the funeral, family members have talked enough about the death and are ready to let go of the deceased child”. This helped mothers to move on after death. Times have changed and from the study and own experience confirms that communities are no longer tightly knit and community members often do not know one another. Each family therefore struggles with their own grief unless very close family members are willing to share the
burden and even for them, they soon retreat back to their own lives without ever returning to the
grieving family.

No man is an island’ It is not good and healthy to exist in isolation when death strikes and
irrespective the causative factors, we need each other. Despite the western culture where people tend
to value independence and individualism, locally we talk about co-operation and mutual support. But
we rarely remember this and sometimes the assumption that personal problems are best handled alone,
reigns. Ideally, the community should be giving acceptance, support and fellowship but more often
than not, the mothers were faced with contempt and neither psychological support nor professional
help was forthcoming for mothers who had lost sons to death through alcoholism. In America, groups
such as Gay Bereavement Project, Jewish Bereavement Counselling Services are there to provide
freely individual support and making public statement about overlooked losses. In this study it was
revealed that it has fallen to individual grieving to draw attention to their own particular loss and grief
experience. Many bereaved also point out that the behaviours of the people around them also change.
People don’t know what to say. They want to help in times of grief but do not know how. They may
try to over-control in an attempt to be helpful.

Changes

Faith can be the source of great comfort at a time of loss. Most respondents affirmed their
knowledge that their Higher Power is in control and took care of them during these difficult periods.
They found praying, fellowshipping and working as a provider of special and needed comfort in their
lives at this time. There were others whose changes happened behaviourally and could not sleep all
the time. There are no rights or wrongs here and each respondent made a personal choice their pattern
of change. Commenting on such changes, Peck (1994) underscored that often people who have had
such experiences were not previously spiritual, but became so afterwards and invariably, they have
come to believe in life after death and have a much diminished fear of death.

Coping

Whilst coming to terms with the fact that death of a loved one has occurred, more often than not
this means getting help from others. Another way is to find support groups of people who have had
similar experiences. In here, one can find the reassurance that they are not alone anymore and that you
are not the only one who has undergone this kind of loss. It however remains the task of the bereaved
to find out whom to include in their own circle of support from family and friends, congregation and
community as well as support groups.

Resilience

There was evidence of repressive coping, but it is unclear to what extent this was natural emotional
response and to what extent it was the only way these mothers could cope in light of the absence of
support and the need to address more urgent daily needs of survival.

Support groups can offer important human contacts to those who are experiencing high levels of
loneliness. Sensitivity is called for in counselling to the possible ways in which different cultures
express themselves in their outer and inner worlds. However, realistically, the counsellor need not
become an expert in different cultural orientations. Corey (2000) says that both self-help groups and
therapy groups have a contribution to make in our society. Self – help groups are quite common with
mothers especially even in circumstances that are not related to los of relatives through death. It
improves on the resilience of mothers who seem quite strong even in the face of challenges of caring
the young and the old.

Conclusion and recommendation

The study revealed that the experiences of mothers that have lost sons to death through alcoholism
are the most universal of all losses and one of the crushing and potentially destructive pain in mothers.
Their lonely life struggles to soldier on with their grief and their meagre Self Support Group to cope is
That even though the loss of the sons may never get easier, it might be comforting to know that they are not alone on grieving their sons but may not feel so alone if they gather with other mothers who are equally mourning their lost children. Communities were unrealistic in shouldering their pain. Their healing path can be emulated and their learnt lessons can be supportive to mothers entering the loss for the first time.

Appropriate support would equip the mothers in the future in the event the loss re-emerges. In the meantime, the needs of these mothers and the deceased’s significant others (wife and children where applicable) deserve top priority and medical treatment needs to be combined with appropriate psychosocial support. Their experiences call for a National intervention.

Further and in conclusion, it was realized that although the mothers’ hearts are broken and they cannot become so absorbed in their own loss that they fail to continue to be a light of those who have no hope. This may not be helpful just for the mothers that have lost sons just to alcoholism, but grief in general. From the discussion, it came out that to a larger extent most of the mothers struggled to move forward on their own in working on their emotions.

Recommendations

- This piece of study should in future be used as pilot study while developing future researches on the area.
- Such mothers should be supported by the government Agencies such as National Authority for Campaign Against Drugs (NACAADA) in Prevention.
- The County Government should endeavour to partner with Addiction Professionals to form Al-Anon and Alcoholic Anonymous Support Groups.
- The Kirinyaga County Administration should assist the group with meeting venue once a week.
- The emotional and physical burden on these bereaved mothers warrants further investigation, especially in light of associated health issues such as depression and post-Traumatic Stress.
- Replication of the study in future involving bigger samples and diverse groups, such as researches into the plight of losing a young husband and father of your children to alcoholism.
- It would be useful for future studies to measure the extent of resilience among these mothers and, more importantly, to examine which factors promote resilience. Community counselling to help build social support by promoting increased co-operation, communication to counter isolation amongst community members.
- Sensitization and awareness creation on bereavement to such mothers.
- National Augmenting of trained Counsellors and Psychologists
- Formulation of National Suicide Prevention Strategy by the Government.
- Cultural bereavement methods need to be revived in the community in order to help those who have buried their sons.
- This study is further recommended as a learning point to General Public, Government Agencies, individuals, Addiction and General Counsellors, bereaved communities; spiritual and lay leaders, prisons and Workplace can grasp the world of mothers that have lost sons to death through alcoholism as they bump into them in their midst. It is a lonely and a road without much understanding.

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References


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