What Can We Do To Improve the Treatment of Elderly Trauma Survivors

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Dehumanization in Medicine

- “Dehumanization is endemic in medical practice.” (p. 75, Haque and Waytz, 2012)
- This results from inherent features of medical settings, the doctor-patient relationship, and routine clinical practices.
- Some of the features that cause dehumanization in medical practice are non-functional and some are functional.

Non-functional and functional causes

Nonfunctional:
- Deindividuating practices
- Impaired patient agency
- Dissimilarity

Functional:
- Mechanization
- Empathy reduction
- Moral disengagement

What is Dehumanization?

- The essence of dehumanization is the denial of a distinctively human mind to another person
- The central feature is a diminished attribution and consideration of another person’s mental states.
- Giving consideration to the other’s mental states is essential for empathy. (Haque and Waytz, 2012)
Dehumanization and empathy

• Dehumanization allows one to experience fewer moral concerns for their actions towards dehumanized others and can justify acts that otherwise would be considered harmful (Bandura, 2002; Bandura, Barbanelli, Caprara and Pastorelli, 1996).

In-group and Out-groups

• People first categorize the other as human, assuming a mind, and then differentiate among social categories (Fiske, 2009).
• People categorize their social environment into in-groups and out-groups and show in-group favoritism biases (Paladino et al, 2000).

Dehumanization and infra-humanization

• Recent work has demonstrated that people commonly attribute greater humanness to their in-group that to out-groups (Leyens et al, 2000; 2003).
• Dehumanization or Infra-humanization is a form of emotional prejudice, the denial of the human essence to outgroups. There is robust empirical evidence for the phenomenon (Haslam, 2005).

Is Dehumanization rare?

• Dehumanization is mostly discussed in the context of extreme behavior such as genocide and torture.
• However, it is a common phenomenon that is not restricted to extreme behaviors but refers to milder forms of discrimination (Leyens and Paladino, 2000).
Denying the other’s human essence

• “Outgroups are assumed to share our humanity to a lesser degree” (Schwartz and Struch, 1989). They are perceived to have less of what is “typically human”:
  • What are typical human characteristics?
    - intelligence (reasoning, thinking, etc.)
    - emotions
    - language
    - values and positive sociability.

“But WE don’t do it!”

• We would like to believe that dehumanization happens only elsewhere or at far-gone times.
• We would like to believe that those who are capable of dehumanizing others are inherently different from us.
• We would like to believe that WE would never dehumanize others, because of our commitment to professional and personal ideals.

Tuskegee syphilis experiment

• An infamous clinical study conducted between 1932 and 1972 in Tuskegee, Alabama by the US Public Health Service to study the natural progression of untreated syphilis in poor, rural black men who thought they were receiving free health care from the US Government.
  • 399 participants were recruited who had previously contracted syphilis.
  • The 40 year study was controversial primarily because researchers failed to treat patients appropriately after Penicillin was found to be an effective cure for the disease.
  • Led to the establishment of the Office for Human Research Protections.

President Clinton’s Apology for Tuskegee:
May 16, 1997 at the White House
Dehumanization here and now

• Dehumanization in a medical scientific setting in the USA is exemplified by the infamous Tuskegee experiment, which serves to remind us that we are all susceptible to the processes that make such behavior possible.

Social Psychology Research

• Social Conformity:
Asch (1956) showed that, even with regards to a simple, unambiguous stimulus, people will change their response according to the social norms.

• Compliance with Authority and diffusion of moral responsibility:
Milgram’s experiment (1963) demonstrated rather shockingly the capacity and willingness of the subjects to inflict what they believed would be painful and dangerous electrical shocks when the “researcher” instructed them to do so.

• Identification with role expectations and norms:
The Zimbardo prison experiment (1971) further demonstrated the rapid psychological adaptation to the roles of ‘guard’ and ‘prisoner’ with concomitant emergence of sadistic and depressive behaviors.

Why are we susceptible?

• We evolved as social creatures with interwoven brains.
• The human brain itself is a social organ that is built through experience and adaptation to the physical and interpersonal environment (Cozolino, 2006).

Relevance of social psychology findings to medical settings

• De-individuating treatment practices that promote the diffusion of responsibility of any single healthcare professional.
• The medical model is one based on authority of the care provider and on role-norms defining a relationship between a superior and a subordinate.
• Illness is inherently a state in which the patient has lost some power and control.
Functional features in medical settings

- Mechanization of treatment and focus on the illness and the affected organ/system/or functional problem rather than the patient as a whole.
- Necessary reduction in empathy in order to sustain the day-to-day demands of a career in healthcare and the need to inflict necessary pain, deliver bad news, lose patients (Haque and Waytz, 2012).

Social Neuroscience

- The new neuro-imaging technology allows non-intrusive study of neural networks in the brain while individuals are engaged in various tasks.
- This allows inquiry of the function of the brain with regards to emotions, cognitions and social interactions.
- The findings from social neuropsychology have great relevance to clinical work.

“Less Human than Me”

- “People do not necessarily ascribe a fully experiencing mind to the other and thus do not inevitably recognize that entity as fully human” (Fiske, 2009, pp. 31).
- Others who are perceived as either disgusting or not possessing a fully human mind can be treated as not-quite-human according to both the neural responses and the behavioral responses in the perceiver.

Social Neuroscience Findings

- Social neuroscience studies the neural foundations of social cognition.
- The accessibility of functional magnetic resonance imaging (fMRI) technology led to many new studies relevant to social cognition.
- Neuroimaging allows studying processes of dehumanized perception.
- Social cognitions are processed primarily by the medial Pre-Frontal cortex (mPFC).
- Others who have been dehumanized elicit the negative basic emotion of disgust which is correlated with reduced mPFC activation (Harris and Fiske, 2006)
- These findings suggest that individuals who elicit feelings of disgust in the perceiver, or are perceived as not having quite a human mind, are perceived as not-quite human.
Reversing dehumanization

- Processes of Dehumanization are reversible when perceivers are forced to consider the other’s mind.
- Such consideration might be as simple as asking oneself about the other’s food preferences, or imagining them.
- Perceived humanity results from differentiation and ongoing meaningful contact with people and is accompanied by increased mPFC activity.

Why patients can be perceived as “less human”

- Illness, dementia and incontinence can present experiences that are disgusting to the caretaker.
- Illness often alters appearance, behavior and basic human functioning.
- Hospitals and medical settings such as long-term care facilities have patients who are suffering from various degrees of cognitive impairment who thus have less of a “mind” (Haque and Waytz, 2012).

Group Health Discrepancies

- Group health discrepancies do exist in the US between various ethnic and racial minorities (Dovidio and Fiske, 2012).
- Such discrepancies are usually explained by differences in socio-economic status and access to health care.
- Another source for such health care discrepancies is bias among health care providers.

Social psychology and clinical work

- Implicit and explicit bias and the potential for discrimination and dehumanization in treatment of various groups does not necessarily reflect malicious intent.
- Cognitive and emotional biases in healthcare providers as in all others are due to the way the human mind evolved and how it interacts with common practices in healthcare.
Bias among healthcare providers

- Even among people committed to helping others, biases can persist.
- Despite the conscious egalitarian views of healthcare providers, implicit bias can shape what they do.
- Recognizing the potential influence of implicit responses towards specific groups can help create interventions to reduce bias.

Is bias in medical settings inevitable?

- Implicit and explicit biases can adversely affect medical decision making and clinical interactions.
- Discriminating behavior is not inevitable, but awareness of it is not sufficient.
- People need to recognize that provider discrimination contributes to discrepancies in care.

Interventions to reduce bias

- Education of staff in medical settings needs to provide tools to counter the influence of potential bias.
- Training must involve not only the development of competent skills but also develop effective self-regulation to mitigate subtle bias.
- Providers can develop new mental habits that promote self-regulation of bias.

Specific strategies for reversing dehumanizing patterns

- Focusing on common group membership rather than on differences can help reduce bias.
- Focusing on the other’s mind, even if the patient is no longer capable of thinking/communicating, activates our own mPFC and reminds us of their humanity.
# Need for change

- Many of us, as scientists, health care providers, sons and daughters of aging parents who have become patients, and patients ourselves, are recognizing the need for a change in the culture of medicine and in the culture of treatment.
- New tools are developed to make sure that the preferences, values and personhood of the patient are taken seriously.

# PTSD and Cognitive impairment

- PTSD can be seen as premature physical and cognitive aging (Yehuda, 2009).
- PTSD is associated with higher prevalence of dementia (Quereshi et al, 2010).
- Cognitive impairment is associated with delayed onset of PTSD in war veterans and in Holocaust survivors (Mittal, 2001; Grossman et al, 2004).

# Trauma Victims are at risk for distancing and dehumanization

- When encountering victims of human-inflicted, intentional suffering we are faced with human sadism and cruelty.
- We might feel horror and disgust and attempt to (mis)place them on the victim. “Blaming” the victim, distancing ourselves from them, or pitying them are common.
- Both disgust and paternalistic feelings predict social/emotional distancing from the other.

# Theconversation.org

Elderly trauma survivors are at a high risk for being dehumanized

They are:
• victims of atrocities that we might want to deny and distance ourselves from.
• They might exhibit difficult behaviors associated with PTSD which can alienate us.
• They are at higher risk for dementia, can be seen as having less of a “mind”.

Our Personal History: Benefits and Baggage

Individuals who have a history of traumatic experiences may become:
• more tolerant of others and more compassionate as a result
• hardened by their experiences, and less understanding and tolerant towards those who did not go through such hardships as they have
• yet others might be struggling internally, using distancing, avoidance and numbing to deal with their own, and others’ pain
• some ‘wounded healers’ might be over-involved and have difficulties distinguishing between their own pain and that of the patient, thus imposing their personal ‘baggage’, e.g. attitudes and judgments, on the patient or the patient’s family.
• It is particularly important for individuals in the helping professions to become aware of their own history and the manner in which they have come to deal with their past traumatic experiences.

“The past is not dead. In fact, it is not even past.” (William Faulkner)

The past is certainly not past for aging survivors of trauma, especially those who survived man-inflicted trauma.

Let us all try to make their last moments amongst us as compassionate as we can, for their humanity and our own.

Recommended Reading

Dehumanization in Medicine: Causes, Solutions and Functions
Haque, O.S. and Waytz, A., 2012
Perspectives on Psychological Science 7: 176.

Under the Radar: How Unexamined Biases in Decision Making Processes in Clinical Interactions Can Contribute to Health Care Disparities