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[Social Science & Medicine](#)

[Rural gerontological health: Emergent questions for research, policy and practice](#)

Laura I.L.Poulina, Mark W.Skinnera, NeilHanlon

This article explores what can be learned from the evolution of rural gerontology as a field of study to inform a more critical approach to the health of rural older adults. To counter the prevailing essentialism of highlighting the rural health disparities faced by older adults, there is a need to expand rural gerontological health research beyond deficit and medicalized understandings of health in rural communities. We argue that appreciating the interplay between unique health experiences, the complexity of the rural context and the continuum of older adult care is an important next step to foster advances in the field. Emergent questions for research, policy and practice are discussed and new directions for rural gerontological health are proposed.

[Considerations for employing intersectionality in qualitative health research](#)

Jasmine A. Abrams, Ariella Tabaac, Sarah Jung, Nicole M. Else-Quest

Intersectionality theory has recently emerged in the health sciences as a critical theoretical and methodical approach. Though some scholars have outlined explicit guidelines for applying intersectionality in research using quantitative methods, others have cited epistemological concerns and additive thinking to advocate for the analysis of intersectionality with qualitative methods. Thus, there remains a need for additional guidance and support for utilizing and applying intersectionality theory throughout the qualitative research process. With the goal of demystifying the process of utilizing intersectionality as a methodological approach in qualitative research in the health sciences, this paper provides researchers with recommendations, specific examples, and important considerations for incorporating intersectional approaches into study conceptualization, participant recruitment, data collection, and data analysis. Additionally, this

paper reviews challenges that researchers may experience in conducting research using intersectional approaches and offers suggestions for overcoming challenges. This paper offers timely and relevant information that can be used to strengthen the theoretical and methodological rigor of qualitative health research, especially studies that seek to advance health equity.

[Cross-sectional associations of neighborhood third places with social health among community-dwelling older adults](#)

Anna P. Lane, Yuting Hou, Chek Hooi Wong, Belinda Yuen

Social health is a key aspect of active ageing. The objectives of this study are to investigate whether and what type of neighborhood third places are associated with positive social health among community dwelling older adults, and explore whether the associations vary by gender. Neighborhood third places are those spaces that have a social function and are located within a neighborhood, but outside the home (first place) and work (second place). Cross-sectional data were from 981 adults aged 55 years and older who responded to a survey conducted in 2018 in three Singapore neighborhoods. The neighborhoods were selected because they have a high percentage of older residents, different housing typologies, and heterogeneity of built environment qualities. Social health was measured using the six-item Lubben Social Network Scale. Attributes of participants' physical environment included residential density, pedestrian-friendly street design, access to public transport, and were objectively assessed using geographic information systems data. Covariates included age, sex, ethnic group, highest educational qualification, marital status, number of people living in dwelling, years living at current address, dwelling unit type, and number of diagnosed medical conditions and IADLs. Regression analysis was performed using Stata version 15 and indicated that female respondents who live in closer proximity to a wet market were more likely to have higher levels of social health independently of individual demographic and physical health characteristics, physical environment qualities, and other destination types. In a time of heightened concern about social isolation and loneliness among older age groups, this study contributes evidence that older people, particularly females, who live in closer proximity to a wet market self-reported better social health. Wet markets are spaces where people can mingle while purchasing or bargaining for fresh produce and household necessities. The mechanisms via which neighborhood third places may contribute to social health requires examination.

[Patient resistance towards clinicians' diagnostic test-taking advice and its](#)

[management in Chinese outpatient clinic interaction](#)

Chunjuan Zhao, Wen Ma

Performing diagnostic tests is a fundamental information-gathering activity in diagnostic process. However, little attention has been paid to the interactional process where a diagnostic test is advised and received, especially in Chinese medical settings. Decision making over prescribing diagnostic tests consists of clinicians' advice and patients' acceptance or resistance/rejection. Drawing on audio-recordings of clinician-patient encounters in Chinese outpatient clinics as data and conversation analysis as a method, we discuss how patient resistance to clinicians' diagnostic test-taking advice is displayed and managed over sequences of interaction. Two types of advice deliveries have been identified: advice either with no diagnostic utterances or with indeterminate diagnostic utterances. We find that patients demonstrate their resistance towards the former type of advice in two ways: questioning clinicians' decisions and proposing an alternative plan. Displaying resistance to the latter type of advice, patients have been found to recurrently resort to one way: proffering additional information about personal experience. Confronted with resistance, clinicians generally proceed to justify decisions by either asserting their epistemic primacy in determining a test or lowering certainty in the original speculative diagnosis. Towards persistent resistance, clinicians mainly employ two techniques to impose acceptance onto patients: repeating the initial advice and terminating forcefully current sequence. This study adds to a growing body of research on resistance in medical settings and contributes to our understanding of the decision making over medical investigations in Chinese outpatient clinic interaction.

[Relationship between costs and clinical benefits of new cancer medicines in Australia, France, the UK, and the US \(open access\)](#)

Sebastian Salas-Vega, Emily Shearer, Elias Mossialos

As cancer drug prices rise, it remains unclear whether the cost of new interventions is related to their beneficial impact for patients at a societal-level. Using data for 2003–2015 from the IQVIA MIDAS® dataset, the relationship between cancer drug costs and drug clinical benefits was studied in four countries with different approaches to drug pricing. Summary measures of drug clinical effects on overall survival, quality of life, and safety were obtained from a review of health technology assessments. Mean total drug costs for a full course of treatment were estimated using standard posology for each medicine and in each country. Regression analysis was used to test whether, at a societal-level, the cost of recently licensed drugs is related to their beneficial impact for patients. Across all eligible medicines, average treatment costs were lowest in

France and Australia and highest in the UK and US. Compared with Australia, France, and the UK, cancer medicines were on average between 1.2 and 1.9 times more expensive in the US, where the average total per patient cost for treatment was \$68,255.17. Costs for new cancer medicines are high and, at best, only weakly associated with drug clinical benefits. The strength of this relationship nevertheless varied across countries. Some new cancer drugs—particularly in the US—may be neither affordable nor clinically beneficial over existing treatments. While all countries can benefit from strategies that more robustly align price with therapeutic benefit in cancer drugs, the US stands out in its opportunity to improve both affordability and value in cancer drug treatment.

[Challenges to medical ethics in the context of detention and deportation: Insights from a French postcolonial department in the Indian Ocean](#) (*open access*)

Nina Sahraoui

Owing to a growing policing of borders, healthcare professionals become increasingly involved in the biopolitical management of migrants' mobility. While their presence on sites of migration control and detention is necessary to ensure migrants' access to healthcare, their role risks being instrumentalized to ensure the sustainability of detention and swiftness of deportations. This article analyses the practice and ethics of midwives' medical expertise in processes of migration control in the French overseas department of Mayotte in the Indian Ocean. Midwives in this setting are required to assess the health of pregnant women intercepted at sea by the police in order to determine whether they can be detained. The article traces how midwives come to be invested with a power to police patients' mobility. In the face of such unwelcome responsibilities, midwives resorted to emotional distancing while suspicion on both sides impeded the possibility of genuine relations of care. The article analyses how midwives framed the ethical dilemmas at hand and examines how they perceived their decision-making responsibility. I argue that midwives are socialized into the logics of border enforcement and gradually brought to implement a minimal version of care as a result of migration control's inroads into care. The article thus questions the function and meaning of biopolitics within migration control and aims at initiating a conversation around the necessary conditions for ensuring medical personnel's independence in these extraordinary care settings. The article draws on a three-months fieldwork completed in Mayotte between mid-April and mid-July 2017 during which I conducted 40 interviews with healthcare professionals in perinatal health services and 15 interviews with officers from stakeholder organizations, from local and international NGOs to health institutions. This article draws in particular on interviews with the medical team that was required to attend to migrant women intercepted at sea by the police.

[A crack in the wall: Chronic pain management in integrative group medical visits](#)

Ariana Thompson-Lastad, Sara Rubin

Amidst a national crisis of opioid overdose, substantial uncertainty remains over how to safely and effectively address chronic pain. In response to this crisis, safety-net primary care clinics are instituting integrative group medical visits (IGMVs) for chronic pain management. Through two qualitative studies of IGMVs, we found that these groups acted as workarounds implemented by clinicians seeking to innovate upon standard pain management protocols. While clinical uncertainty is often framed as a problem to be managed, in this instance, overlapping uncertainties provided an opportunity through which enterprising clinicians could generate reform at the local level. However, these clinician-led changes were incremental, situational, and partial, and occurred outside of broader systemic reform. In the following article, we draw on 46 interviews with clinicians and staff associated with IGMVs and observations of 34 sessions of 22 distinct IGMVs. We begin by describing the structure of the IGMVs we observed. We analyze the multiple uncertainties surrounding chronic pain and its treatment at the time of our data collection, just before the opioid crisis was declared a national public health emergency. We then demonstrate how clinicians tinkered with existing pain management protocols via their involvement with IGMVs. Lastly, we discuss the conditions of possibility that allowed for the existence of IGMVs at our study sites, as well as the conditions of limitation that restricted the expansion of these groups. Our research points to the potential of IGMVs for treating chronic pain, while showing that IGMVs continue as an innovation by individual clinicians, not as a result of broader reforms.

[The wazan janch: The body-mass index and the socio-spatial politics of health promotion in rural India](#)

Carly E. Nichols

The body mass index (BMI), which measures body mass divided by height squared (kg/m^2), has become a popular technology for quickly measuring and assessing individuals' health and disease risk. However, the BMI has also been widely criticized by health professionals who argue that it's a poor measure of health. Feminist scholars are also critical, arguing BMI is a technology of neoliberal health promotion that pathologizes body size, and produces responsabilized subjects invested in maintaining "proper" weights, while often ignoring the social and environmental conditions that result in differently sized bodies. In this paper, I look at a series of BMI "camps" held across rural North India in 2017 and put forth two central arguments. First, BMI is not an a priori technology of neoliberal

governmentality, but can be also be a means to highlight social marginalization and create relations of care. I find the spaces of BMI deployment are tightly linked to the types of responsibility and care it produces. Second, while the intended goal of these BMI camps is to propel people, mostly women, to change their behavior to be more healthful, this behavior change was often stymied by the everyday business of surviving in India's current political economic climate. Despite that women were unable to implement much of the nutrition advice (and sometimes reported additional stress due to attendance at such camps), women continued to attend health-related camps. This paper draws on the notion of cruel optimism, which argues that the objects of our attachments, such as ideas of "the good life" can be self-detrimental, as a way to unpack the paradox of women who continue to show up for health camps despite not taking anyway many useful skill and sometimes causing them anxiety.

[Examining associations of food insecurity with major depression among older adults in the wake of the Great Recession](#)

Rachel S. Bergmans, Riley Wegryn-Jones

As a psychosocial stressor, the degree to which food insecurity impacts major depression may be dependent on macro-level context, which can be examined in the wake of the Great Recession. The objective of this study was to determine (1) whether food insecurity transition status (i.e. initially food insecure, becoming food insecure, and remaining food insecure vs. not food insecure) was associated with major depression in older adults and; (2) whether this association was moderated by macro-level context. Data came from the United States Health and Retirement Study, 2008–2016. Multivariable logistic regression across all years revealed that major depression was associated with any exposure to food insecurity, however; this association was moderated by time period. Remaining food insecure was associated with major depression during all time periods. In contrast, becoming food insecure was associated with major depression in the years during and immediately following the Recession, but not in later time periods. Findings suggest that associations of food insecurity with major depression among older adults are moderated by macro-level context, consistent with theories of social comparison and relative disadvantage. Food insecurity may represent an important risk factor for major depression and mental health disparities across socioeconomic strata in old age. Thus, policies that increase access to food assistance programs or improve the quality of local food environments may buffer against the impact of food insecurity on depression and associated complications among older adults.

["I'm not a freshi": Culture shock, puberty and growing up as](#)

[British-Bangladeshi girls](#) (open access)

*Lauren C. Houghton, Rebecca Troisi, Marni Sommer, Hormuzd A. Katki, ...
Kate R. Hampshire*

Early puberty is a risk factor for adult diseases and biomedical and psychosocial research implicate growth (in height and weight) and stress as modifiable drivers of early puberty. Seldom have studies examined these drivers simultaneously or concurrently using quantitative and qualitative methods. Within the context of migration, we used mixed-methods to compare growth, stress and puberty in a study of 488 girls, aged 5–16, who were either Bangladeshi, first-generation migrant to the UK, second-generation migrant, or white British (conducted between 2009 and 2011). Using a biocultural framework, we asked the questions: 1) Does migration accelerate pubertal processes? 2) What biocultural markers are associated with migration? 3) What biocultural markers are associated with puberty? Girls self-reported pubertal stage, recalled 24-h dietary intake, and answered questions relating to dress, food, and ethnic identity. We collected anthropometrics and assayed saliva specimens for dehydroepiandrosterone-sulfate (DHEA-S) to assess adrenarcheal status. Our findings demonstrate that first-generation migrants had earlier puberty than second-generation migrants and Bangladeshi girls. British style of dress did not increase with migration, while dietary choices did, which were reflected in increasing body mass index. However, the widely-used phrase, “I’m proud of my religion, but not my culture” demonstrated that ethnic identity was aligned more with Islamic religion than ‘Bangladeshi culture.’ This was epitomized by wearing the hijab, but denial of eating rice. The social correlates of puberty, such as ‘practicing’ wearing the hijab and becoming ‘dedicated to the scarf,’ occurred at the same ages as adrenarche and menarche, respectively, among first-generation girls. We suggest that the rejection of ‘Bangladeshi culture’ might be a source of psychosocial stress for first-generation girls, and this may explain elevated DHEA-S levels and early puberty compared to their second-generation counterparts. Our results support a biocultural model of adolescence, a period for biological embedding of culture, when biological and psychosocial factors adjust developmental timing with potential positive and negative implications for long-term health.

[Forced migration experiences, mental well-being, and nail cortisol among recently settled refugees in Serbia](#)

Jelena Jankovic-Rankovic, Rahul C. Oka, Jerrold S. Meyer, Lee T. Gettler

Refugees are exposed to a wide breadth of traumatic and psychosocially stressful experiences that have long-term implications for their health and resilience. Most prior research on this topic has focused on long-settled

refugee populations, as opposed to those who find themselves in more intermittent transitional stages of the forced migration process. Specifically, few studies have explored how refugees' experiences during their recently completed journeys correlate with their mental well-being or physiological profiles that are responsive to psychosocial stress and trauma. Using data from recently settled refugees in Serbia ($n = 111$), our study helps address this existing gap by examining the associations between refugees' experiences during their arduous journeys, fingernail cortisol concentrations (CORT), and self-reports of psychosocial stress and PTSD symptomology. We found that refugees who reported experiencing longer journeys had higher recent perceived stress as well as poorer well-being and physical health. Refugees who experienced trauma during their journeys also reported higher recent perceived stress and tended to have higher CORT than those who did not experience trauma. In addition, we also observed sex differences in mental health and CORT profiles. Women tended to report poorer mental well-being and physical health and also had lower CORT compared to men. While longitudinal research is needed, our correlative findings are consistent with the notion that reducing exposure to extreme trauma and stress by establishing safe migration pathways for people fleeing hardship could potentially help attenuate forced relocation-related illnesses and improve health outcomes among refugees as they await resettlement.

[Children's perspectives on health-promoting living environments: The significance of social capital](#) (*open access*)

Malin Eriksson, Kjerstin Dahlblom

This article discusses the usefulness of social capital as a conceptual tool to design neighbourhoods promoting children's health. The aim was to explore children's perspectives of health promoting environments, and we used a combination of photovoice and grounded theory. Children from two neighbourhoods in a Swedish municipality were invited to photograph and discuss places of importance for their well-being. They presented places facilitating togetherness, enjoyable activities and positive emotions, mostly found in their immediate environments: at home, at school and in their neighbourhoods, but the access to these places was unequally distributed between the areas. The results highlight a need for ensuring all children's access to health promoting places and to include children's views in policy and planning. Investments in the physical environment need to be combined with efforts to influence norms and collective efficacy to secure local ownership and use of these investments. We found that the concept of social capital is a relevant conceptual tool for understanding what constitutes health-promoting places from children's perspectives and contributes to a deeper understanding on how physical and social environments are interlinked.

[‘I am the master key that opens and locks’: Presentation and application of a conceptual framework for women’s and girls’ empowerment in reproductive health](#) (*open access*)

Celia Karp, Shannon N. Wood, Hadiza Galadanci, Simon Peter Sebina Kibira, ... Caroline Moreau

Rationale: A renewed focus on women’s and girls’ empowerment in the era of Sustainable Development Goals reflects the belief that empowerment is central to health and development. Sexual and reproductive health (SRH) outcomes, including pregnancy and contraceptive use, may contribute to and result from empowerment. However, enhanced understanding of how women become empowered for SRH requires clear conceptualization of empowerment. Objective: We aimed to assess the applicability of a proposed framework for women’s and girls’ SRH empowerment (WGE-SRH) in sub-Saharan Africa. We sought to understand what shapes and motivates preferences for childbearing and contraception, exploring how women and girls navigate external pressures or rewards to exercise and achieve their reproductive goals. Methods: Grounded in the WGE-SRH framework, we conducted a qualitative study in four distinct contexts (Ethiopia, Kano and Anambra States in Nigeria, and Uganda). We implemented and analyzed 120 in-depth interviews and 38 focus group discussions with 440 women and men and translated results to refine the WGE-SRH framework. Results: Findings demonstrate the salience of women’s internal motivations, including the social value and joys of motherhood, in shaping existence of reproductive choices. However, existence of choice was limited by couples’ economic situations, pressures from providers, partners, and family members, and women’s fears of contraceptive side effects or relationship dissolution. Despite these constraints, many found ways to exercise their reproductive choices through negotiation with partners, third party involvement in reproductive discussions, non-verbal communication, and covert use of contraception. Conclusions: The WGE-SRH framework is useful for exploring SRH empowerment, embracing the multilevel, dynamic nature of empowerment, as a process transitioning from existence of choice (autonomy) to exercise of choice (self-efficacy, decision-making, negotiation), and, ultimately, to achievement of choice. Future research and programs related to SRH empowerment should distinguish between existence and exercise of choices to promote the health and well-being of women and girls.

[How do pregnant women and new mothers navigate and respond to challenges in accessing health care? Perspectives from rural South Africa](#)

Christina A. Laurenzi, Sarah Skeen, Bronwyne J. Coetzee, Sarah Gordon, ... Mark Tomlinson

Women in low- and middle-income countries and in contexts characterized by inequality face various interpersonal and structural barriers when accessing formal maternal and child health (MCH) services. These barriers persist even in contexts where programs to increase access to services, such as community health worker (CHW) interventions, have been implemented. However, while barriers to accessing care have been extensively documented, less is known about the diverse ways that women respond to, and navigate, these situations. This study explores strategies pregnant women and new mothers use to navigate and respond to health care barriers in a rural district in the Eastern Cape, South Africa. Twenty-six pregnant or recently delivered clients of the Enable Mentor Mother program were interviewed about their experiences of accessing formal MCH services. Interviews were conducted between February-March 2018 by an experienced isiXhosa-speaking research assistant, translated and transcribed into English, with transcripts coded and organized by themes using ATLAS.ti software. Facing resource shortages, inconsistent communication, and long travel times to clinics, participants employed diverse, innovative strategies to navigate interpersonal and structural barriers to care. While some participants chose to respond to barriers more passively—citing endurance and acceptance as practices of health system engagement—those participants who focused more on active responses tended to leverage their education, existing relationships, and available community resources to overcome barriers. Nevertheless, most participants described feelings of frustration and dejection. While CHW interventions may alleviate some of the burdens facing fragile health care systems in these contexts, these programs still rely on an underlying infrastructure of care that primary health care clinics and hospitals should be providing. Future programming should work in tandem with formal health systems and should support staff to improve quality of care provided to pregnant women, new mothers, and their infants to prioritize their health at a time of vulnerability.

[“Talk about it:” changing masculinities and mental health in rural places?](#)

Rachel V. Herron, Mairo Ahmadu, Jonathan A. Allan, Candice M. Waddell, Kerstin Roger

Rural men’s mental health has been described by some scholars as a “silent crisis.” Rural men report lower levels of stress and depression and, paradoxically, much higher rates of suicide and substance use. Research has linked rural men’s silence to dominant forms of masculinity with limited consideration of how masculinities are changing within and across rural places. In this article, we draw together literature on changing masculinities, rural places, and rural men’s mental health to explore how, where, and with whom rural men talk about mental health; as well as their perspectives of what it means to be a healthy man. To collect in-depth

information about men's perceptions and experiences of mental health and masculinity, the study employed semi-structured interviews with 23 adult male participants (aged 20-79 years) in Manitoba, Canada. Men in the study described the complex dynamics of talking about mental health with spouses, other family members, friends, and in the community. Many men wanted to talk about their mental health and some men actively developed relationships to support "talking about it;" however, they also identified competition, gossip, and stigma in relation to talking about mental health in the community. Most men in the study resisted hegemonic masculinities and some men aspired to more balanced, relational, and caring ideals. Men in the study identified community and environmental challenges to talking about mental health and changing masculinities in rural places. We argue that addressing the so-called silent crisis of rural men's mental health requires greater attention to community change and rural development to support relationships and places to talk about mental health.

[A qualitative enquiry into the meaning and experiences of wellbeing among young people living with and without HIV in KwaZulu-Natal, South Africa \(open access\)](#)

Darshini Govindasamy, Giulia Ferrari, Kealeboga Maruping, Paidamoyo Bodzo, ... Janet Seeley

Young people in sub-Saharan Africa encounter health and livelihood challenges which may compromise their wellbeing. Understanding how young people's wellbeing is defined could strengthen wellbeing policies. We investigated perceptions and experiences of young people's wellbeing, and whether these aligned with Ryff's psychological wellbeing (PWB) model.

Data were collected between January–August 2018 through focus-group discussions (n = 12) and in-depth interviews (n = 16) with young people living with and without HIV, selected purposively from South African healthcare facilities. Key informant interviews (n = 14) were conducted with healthcare workers and subject-matter experts. Using a framework approach, we situated our analysis around dimensions of Ryff's PWB model: autonomy, self-acceptance, purpose in life, environmental mastery, positive relationships, personal growth.

Young people's wellbeing was rooted in family and peer relationships. Acceptance and belongingness received from these networks fostered social integration. HIV-related stigma, crime and violence reduced their perceived control and social trust. For males, fulfilling gendered roles made them feel socially valued. Self-perceived failure to uphold sexual norms undermined women's social contribution and autonomy.

Social integration and contribution framed young people's wellbeing. However, these dimensions were not fully captured by Ryff's PWB model. Models that consider relationality across socio-ecological levels may be relevant for understanding young people's wellbeing.

[Projected diagnosis, anticipatory medicine, and uncertainty: How medical providers 'rule out' potential pregnancy in contraceptive counseling](#)

Eliza Brown

This article builds on theories of anticipatory medicine and diagnostic uncertainty using the critical case of ruling out pregnancy. Through discourse analysis of 224 patient visits from the Patient-Provider Communication about Contraception Study in which medical providers assess the probability of pregnancy, this article compares cases with and without material evidence and reliable tests. This article demonstrates that in cases in which providers do not currently have access to the tests and tools to which they are accustomed, they continue to reach for additional versions of the potential pregnancy. As part of this, providers may mobilize a version of potential pregnancy using unseen or anticipated events inside the patient's body. Thus, the practice of diagnosis not only involves oscillating between observed material and known categories, but also between habituated practices and projected possibilities. This article expands our understanding of anticipatory medicine, diagnostic uncertainty, and medical authority by considering the role of the missing and unseen.

[The trouble with IVF and randomised control trials: Professional legitimisation narratives on time-lapse imaging and evidence-informed care \(open access\)](#)

Manuela Perrotta, Alina Geampana

Focusing on the case of time-lapse imaging (TLI), this paper analyses how medical professionals negotiate the use of new 'add-on' fertility treatments in light of the limited evidence available. The data produced by TLI technologies is meant to help professionals identify the best embryo to be implanted. Embryo selection is essential in IVF practice for increasing pregnancy rates and reducing the negative effects of repeated failures. More than 5 years after the introduction of TLI in IVF labs, however, there has been no conclusive randomised control trial (RCT) evidence to show that the tools do indeed have a significant impact on pregnancy rates. Nonetheless, many public clinics in the UK have adopted such technologies. Consequently, our research asks: How is the use of TLI tools legitimised by professionals, in light of contradictory evidence? Focusing on 25 semi-structured staff interviews, we argue that

professionals use several strategies to legitimise the use of TLI in the clinic without, however, challenging the tenets of evidence-based medicine (EBM) and the value it places on RCTs. Rather, professionals emphasise various advantages that TLI offers, including its use as a lab tool, its potential for knowledge production in embryology, and the role it plays in the management of patient expectations and course of treatment. This paper contributes to debates on the role of EBM in modern medicine and fertility care specifically – an area where this inter-relationship has been underexplored. We conclude by suggesting avenues towards a more nuanced understanding of EBM as it relates to IVF treatment and a rapidly changing biotechnology context.

[Managing patient preferences and clinical responses in acute pathophysiological deterioration: What do clinicians think treatment escalation plans do? \(open access\)](#)

Carl May, Michelle Myall, Susi Lund, Natasha Campling, ... Alison Richardson

Treatment Escalation Plans (TEPs) are paper and electronic components of patients' clinical record that are intended to encourage patients and caregivers to contribute in advance to decisions about treatment escalation and de-escalation at times of loss of capacity. There is now a voluminous literature on patient decision-making, but in this qualitative study of British clinicians preparing to implement a new TEP, we focus on the ways that they understood it as much more than a device to promote patient awareness of the potential for pathophysiological deterioration and to elicit their preferences about care. Working through the lens of Callon's notion of agencements, and elements of May and Finch's Normalisation Process Theory, we show how clinicians saw the TEP as an organising device that enabled translation work to elicit individual preferences and so mitigate risks associated with decision-making under stress; and transportation work to make possible procedures that would transport agreed patterns of collective action around organisations and across their boundaries and to mitigate risks that resulted from relational and informational fragmentation. The TEP promoted these shifts by making possible the restructuring of negotiated obligations between patients, caregivers, and professionals, and by restructuring practice governance through promoting rules and resources that would form expectations of professional behaviour and organisational activity.

[Doctors are seen as Godlike: Moral typecasting in medicine](#)

Amelia Goranson, Paschal Sheeran, Julia Katz, Kurt Gray

Objective

Doctors are generally thought of as very intelligent and capable. This perception has upsides—doctors are afforded respect and esteem—but it may also have downsides, such as neglecting the mental and physical health of physicians. Two studies examine how Americans “typecast” doctors as Godlike “thinkers” who help others, rather than as vulnerable “feelers” who might themselves need help.

Method and results

Study 1 examines how a representative sample of Americans (N = 681) view the mental capacities of doctors compared to other targets (including patients, other workers, and God). Results show that people see physicians as highly capable of the thinking-related capacities of thinking, remembering, self-control, and planning (equal to that of God), but less capable of the feeling-related capacities of experiencing fear, pain, embarrassment, and hunger. Study 2 (N = 451) examines whether physician typecasting impacts other domains. People believe that, relative to the average working professional, physicians are better able to ignore physical and mental health issues, and physician job performance is less impacted by bodily and emotional limitations.

Discussion

We discuss implications for medical practice, especially the growing epidemic of physician burnout.

[“You have to find a caring man, like your father!” gendering sickle cell and refashioning women’s moral boundaries in Sierra Leone](#)

M. Berghs, S.M. Dyson, A. Gabba, S.E. Nyandemo, ... G. Deen

Most research on sickle cell disorders has tended to be gender-blind. This qualitative study undertaken in 2018, explores if and how sickle cell disorders become gendered in Sierra Leone through the analytical framework of a feminist ethics of care. It argues that women have to navigate moral blame when they have children with the condition. At the same time women refashion moral boundaries so that gendered norms around childhood and parenting for such children become suspended, in favour of creation of careful spaces. Parental fears of physical and sexual violence mean that gendered sexual norms are enforced for teenage boys as they are encouraged into early adulthood. In contrast, girls are kept in enforced ignorance about the consequences of sickle cell for reproduction and are encouraged to delay motherhood. This is because, as women relate, relationships and giving birth are fraught with embodied dangers and risks of violence.

[Does community-level social capital mitigate the impact of widowhood & living alone on depressive symptoms?: A prospective, multi-level study](#)

Atsushi Nakagomi, Koichiro Shiba, Masamichi Hanazato, Katsunori Kondo, Ichiro Kawachi

Widowhood and living alone are linked to increased risk of depression. We examined prospectively whether community-level social capital can mitigate the adverse impact of widowhood and living alone on depressive symptoms. We used data of the Japan Gerontological Evaluation Study of functionally independent adults aged 65 years or older. Three waves of surveys were collected in 2010, 2013 and 2016. We conducted gender-stratified multilevel linear regression to examine the moderating effects of community-level social capital on depressive symptoms (as assessed by the 15-point Geriatric Depression Scale) associated with widowhood and living alone. Widowhood in the past 12 months in combination with living alone was associated with a marked worsening in depressive symptoms among men (beta coefficient = 1.67; 95% confidence interval: 1.38, 1.95). Community-level civic participation, but not social cohesion or reciprocity, was associated with lower depressive symptoms in men and women. In addition, community-level civic participation moderated the association between depressive symptoms and recent widowhood/living alone among men (coefficient per 1 standard deviation = ?0.30; 95% confidence interval: ?0.59, ?0.02). We found no significant effect modification of community-level social capital on depressive symptoms associated with widowhood and living alone among women. Communities with greater civic participation appear to mitigate the onset of depressive symptoms among recently widowed men living alone. Promotion of community activities might be an effective community-level intervention to promote mental health in this vulnerable group.

[Social Studies of Science](#)

['Nothing to do with the science': How an elite sociotechnical imaginary cements policy resistance to public perspectives on science and technology through the machinery of government](#)

Melanie Smallman

That policymakers adopt technoscientific viewpoints and lack reflexivity is a common criticism of scientific decision-making, particularly in response to moves to democratize science. Drawing on interviews with UK-based national policymakers, I argue that an elite sociotechnical imaginary of 'science to the rescue' shapes how public perspectives are heard and distinguishes what is considered to be legitimate expertise. The machinery

of policy-making has become shaped around this imaginary – particularly its focus on science as a problem-solver and on social and ethical issues as ‘nothing to do with the science’ – and this gives this viewpoint its power, persistence and endurance. With this imaginary at the heart of policy-making machinery, regardless of the perspectives of the policymakers, alternative views of science are either forced to take the form of the elite imaginary in order to be processed, or they simply cannot be accounted for within the policy-making processes. In this way, the elite sociotechnical imaginary (and technoscientific viewpoint) is enacted, but also elicited and perpetuated, without the need for policymakers to engage with or even be aware of the imaginary underpinning their actions.

[Transcultural Psychiatry](#)

[The Cultural Formulation Interview since DSM-5: Prospects for training, research, and clinical practice](#)

Neil Krishan Aggarwal, G. Eric Jarvis, Ana Gómez-Carrillo, Laurence J. Kirmayer, Roberto Lewis-Fernández

While social science research has demonstrated the importance of culture in shaping psychiatric illness, clinical methods for assessing the cultural dimensions of illness have not been adopted as part of routine care. Reasons for limited integration include the impression that attention to culture requires specialized skills, is only relevant to a subset of patients from unfamiliar backgrounds, and takes too much time to be useful. The DSM-5 Cultural Formulation Interview (CFI), published in 2013, was developed to provide a simplified approach to collecting information needed for cultural assessment. It offers a 16-question interview protocol that has been field tested at sites around the world. However, little is known about how CFI implementation has affected training, health services, and clinical outcomes. This article offers a comprehensive narrative review that synthesizes peer-reviewed, published studies on CFI use. A total of 25 studies were identified, with sample sizes ranging from 1 to 460 participants. In all pilot CFI studies 960 unique subjects were enrolled, and in final CFI studies 739 were enrolled. Studies focused on how the CFI affects clinical practice; explored the CFI through research paradigms in medical communication, implementation science, and family psychiatry; and examined clinician training. In most studies, patients and clinicians reported that using the CFI improved clinical rapport. This evidence base offers an opportunity to consider implications for training, research, and clinical practice and to identify crucial areas for further research.

[Cultural Context in DSM Diagnosis: An American Indian Case Illustration](#)

[of Contradictory Trends](#)

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Recent revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) increasingly acknowledge the importance of cultural context for the diagnosis of mental illness. However, these same revisions include evolving diagnostic criteria that simultaneously decontextualize particular disorders such as Major Depressive Disorder (MDD) and Posttraumatic Stress Disorder (PTSD). As a result, the DSM reflects a contradictory role for context in psychiatric diagnosis. The case analysis presented here frames the consequences of this contradictory trend for an American Indian woman with a history of DSM-IV MDD and PTSD, whose diagnostic portrait is substantively altered in light of more recent DSM-5 criteria. Specifically, consideration of this respondent's bereavement-related illness experience suggests that a sociocentric cultural frame of reference, which places high value on interdependent personal relationships, is not well-captured by DSM-5's revised MDD or PTSD criteria, or the newly proposed categories of traumatic bereavement or Persistent Complex Bereavement Disorder. The respondent's illness experience argues for greater recognition of this contradictory diagnostic trend, suggesting a need for future resolution of this tension toward more valid diagnosis for culturally diverse populations.

[Interdisciplinary case discussions as a training modality to teach cultural formulation in child mental health](#)

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The DSM-5 Cultural Formulation Interview (CFI) may become an important tool to help operationalize culture in the clinical realm. However, challenges exist in teaching its use to avoid the risk of stereotyping and oversimplification, which could result in misunderstanding and stigma. The aim of this article is to document whether the CFI can be taught using regular Interdisciplinary Case Discussion Seminars (ICDSs), proposed as continuing education in child mental health and as part of clinical rotations for new trainees. During a two-year evaluative research project, ICDSs were held monthly in three different primary care settings servicing recent immigrants in Montreal, Canada. ICDSs were recorded and analyzed to examine their effect on the cultural formulation process and focus groups were conducted to explore the subjective experience of the participant trainees and professionals. Results suggest that ICDSs are a helpful way to teach the use of the CFI. The group discussions helped participants to better capture the complexity of the cultural and social experience of the child and family by moving away from simple identity assignments,

supporting an inquiry into structural dimensions, and considering stigma and inequality in their formulation. The multiple levels of diversity (individual, disciplinary, and interinstitutional) represented in the discussion groups helped clinicians to understand the cultural formulation as situated in a specific relational context and a particular moment and, in so doing, helped trainees to avoid cultural formulations that essentialize culture.

[Defining and assessing key behavioral indicators of the Shifting Cultural Lenses model of cultural competence](#)

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Models of cultural competence highlight the importance of the sociocultural world that is inhabited by patients, and the question of how best to integrate sociocultural factors into clinical assessment and intervention. However, one significant limitation of such approaches is that they leave unclear what type of in-session therapist behaviors actually reflect cultural competence. We draw on the Shifting Cultural Lenses model to operationalize culturally competent in-session behaviors. We argue that a key component of cultural competence is the collaborative relationship between therapists and patients, in which therapists shift between their own cultural lenses and those of their clients, as they co-construct shared narratives together. Accordingly, we propose that culturally competent therapist behaviors include accessing the client's views, explicitly presenting their own views as mental health care professionals, and working towards a shared understanding. We further specify the latter set of behaviors as including the practitioner's integration of the patient's view, their encouragement of the patient to consider their professional view, and the negotiation of a shared view. We developed a coding system to identify these therapist behaviors and examined the reliability of raters across 11 couple and 4 individual therapy sessions. We assessed whether the behavioral codes varied in expected ways over the first 3 sessions of 2 therapists' couple therapy as well. Operationalizing the behavioral indicators of the Shifting Cultural Lenses model opens the door to the integration of both process- and content-oriented approaches to cultural competence.

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