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In Shortly about Affect

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Abstract

Affect is a very strong state that mostly occurs suddenly and lasts for a short time, and at one point it reaches such a strength that it almost completely takes over consciousness. It is accompanied by changes in heart function, blood pressure, respiration, work of digestive organs, endocrine glands, muscle tension. Affects also affect cognitive functioning and are therefore taken into account in the court's assessment of the perpetrator's liability, and thus possible penalties. Sometimes the term affect is also used as a synonym for feelings or moods.

Key Words: Affect, Patient, Metal Health, Criminal Responsibility

Introduction

"Affect" is a psychological term that describes the overt (observable) expression of one's emotion [1]. It describes the immediate expression of an individual's emotional state, moment-to-moment. Affect is distinctly different from mood. Affect describes the observable characteristics of the individuals' emotional state. By contrast, mood describes individuals' subjective experience of their emotional state. It would be expected that if individuals describe their mood as "happy," then their affect would match. For example, a smiling and relaxed posture (indicators of affect) is consistent with a self-report of being happy (mood). Sometimes, there is a discrepancy between a self-reported mood and the observed affect.

A number of factors are used in the description of affect. These include congruence, intensity, range, reactivity, and appropriateness of emotional expressions. Affect is useful in understanding the degree of emotional functioning of individuals and their relationship to both their inner and outer conditions at any given moment. Affect is a key element of the mental status exam.

Society

Social capital is often used in the social science literature to refer to social participation in the activities of the formal and informal networks of civil society and/or as generalized trust [2]. Social participation and trust are two aspects of social capital that mutually affect each other. In this regard, as we have seen earlier, mental health users tend to have different ties as a result of their contact with services. Their social class position and marginalization in local communities mean that they are unlikely to have the advantages of 'weak ties'.

'Strong ties' refer to kinship and peer group contacts. These are small in number and, although strong, generally have little instrumental value to the individual. 'Weak ties' refer to personal connections which are personally superficial but may be instrumentally powerful. For example, they might create employment opportunities and career progression. They may also create a general sense of safe civility and neighbourliness in a locality. Strong ties cannot easily serve larger community purposes, whereas weak ties can. This point applies to psychiatric patients in the community in particular because they are often both poor and socially avoided by non-patients. Indeed, psychiatric patients may, as a result of their primary psychological disability and the avoidance of others, lack both strong and weak ties.

Language

In an overregulated mental health care environment, there is no agreement about 'who can speak,' or from 'what position one can speak' [3]. One can say a lot about a system by studying what relations are in play between the persons who are speaking and the object of which they speak, and those who are the subjects of their speech. One might think here of a regime that, at any particular time and place, governs the enunciation of a diagnostic statement

in mental health care, a scientific explanation in biology, an interpretive statement in psychoanalysis, or an expression of passion in an erotic relation. They are not put into speech through the 'unifying function of a subject,' nor do they produce such a subject as a consequence of their effects: it is a matter here of "the various statuses, the various sites, the various positions" that must be occupied in particular regimes if something is to be sayable hearable, operable; the mental health care worker, the social worker, the scientist, the therapist, the lover.

From this perspective, language itself, even in the form of 'speech,' appears as an assemblage of 'guided' practices, from counting, listing, entering into contracts, singing, chanting of prayers, issuing orders, confessing, purchasing a commodity, making a diagnosis, planning a campaign, debating a theory, explaining a process. However, these practices do not inhabit a functionally homogeneous domain of meaning and negotiation among individuals. They are located in particular sites and procedures, and the affects and intensities that traverse them are pre-personal. They are structured into variegated relations that grant power to some and delimit the power of others, enabling some to judge and some be judged, some to be cure and some to be cured, some to speak truth and others to acknowledge its authority and embrace it, aspire to it, or submit to it. Rules of grammar concerning persons, produce or induce a moral repertoire of relatively enduring features of personhood inside the mental health care system.

Mental Health

The distinction between physical and mental health assessment is ultimately an arbitrary one; not only are people with mental health problems at increased risk of poor physical health but people with physical health problems are also more likely to develop a psychiatric illness [4]. This is reflected in the title of the government's mental health strategy document 'No Health without Mental Health', which calls for so-called parity of esteem between mental and physical health and an end to the stigmatisation and healthcare inequalities that have long dogged those experiencing psychiatric illness. It is therefore essential that healthcare professionals from all disciplines can competently assess people with mental health problems; indeed there is a growing body of evidence that the prognosis for people with mental health problems can be improved dramatically by offering them timely assessments and guiding them towards appropriate evidence-based interventions.

Mental illness and mental health care are issues that directly or indirectly affect all of us [5]. At some point in our lives, we are likely to feel depressed or be described as 'mentally disordered'. At the very least, we will know someone who has come into direct contact with the mental health care system. During such times, discussions about care and the adequacy of therapeutic options are likely to come to the fore. Such discussions are often framed in both the policy- and the personalrealm by the language of consumerism, by which the 'costs' associated with mental illness and its care are considered substantial, for affected individuals and for the community as a whole. These 'costs' include both economic expenses (e.g. medical treatment and lost income through time off work by those diagnosed as 'ill' and those who offer their unpaid assistance), social costs (disruption to relationships) and emotional costs (the resulting distress for all concerned). It is for these reasons that mental health problems have increasingly been the focus of public policy. However, although an ethos of consumerism is increasingly evident in mental health care – in the conduct and evaluation of mental health services – few policy-makers question the applicability, or acknowledge the limits of, the consumerism model.

Healthcare Providers

Healthcare providers usually begin to identify their first clinical ethics dilemmas in patients who are dying, or at the end of life [6]. In many of these situations, healthcare providers may have moral distress as well. Healthcare providers in the roles of mentoring and teaching may suffer from lingering moral residue themselves from such cases, which may affect the teaching culture and healthcare trainee expectations. Indeed, many healthcare trainees still do not get adequate training in end of life dialogues and truthful prognostication, which may not be available without skilled mentors. Finally, reducing unit moral distress that affects learners also requires formal educational forums for difficult end of life cases as well as an institutional mechanism for effective clinical ethics consultation and moral distress debriefings. Screening one of the films in this section as a unit exercise, followed by a panel discussion, may help serve that purpose if there are no other educational venues.

A further defining feature is that illness and disease or the 'breakdown' of the normal bodily state is due to 'faulty' or worn organs or systems, or changes that occur as the result of biological threats such as invading pathogens (bacteria or viruses), nutritional or chemical imbalance, injury, or simply through the ageing process [7]. In this way, the body has come to be viewed as a complex mechanism in which all of the parts must function together to ensure health. The job of medicine, therefore, is to fix the body when it breaks down through the study, diagnosis and manipulation of physical and biochemical processes. The diagnostic process usually involves physically examining the patient, and then treating him or her, which may involve repairing or controlling the affected body systems. An important feature in this system, therefore, is the role of the clinician (medical), who intervenes to limit damage and to help to resume normal functioning in the event of a bodily malfunction.

Practitioners of biomedicine are expected to remain objective and analytical, drawing on their specialist knowledge to treat the disease or injured part of the body. They hold a privileged position within society, and are generally well-educated and respected specialists who practice in settings that resemble laboratories and other scientific institutions. As one of the learned professions established in medieval times (along with law and divinity) their position is upheld in law, giving physicians the authority to treat patients, to prescribe powerful medicines and to withhold treatment if they believe this is necessary. They also have the right to detain patients in hospital if, for example, it is believed that they are suffering from a mental illness or are a danger to other people.

Evaluation

In a clinical context, the therapist and patient typically share an implicit understanding about the purpose and goals of the evaluation and treatment [8]. Both the therapist and patient understand that

the assessment will be used to develop a treatment plan, and they further understand that the goal of the relationship is, for example, reducing clinical symptoms and improving behavior and functioning. Obtaining informed consent is a recommended practice, but far from universal.

In a forensic context, however, it is critically important that the examinee understand who requested the evaluation, the purpose of the evaluation, how the results of the evaluation will be used, and the limits of confidentiality. The examinee's legal interests, including those relating to liberty and life, can be directly impacted by the results of the evaluation. An examinee's understanding of key aspects of the evaluation — that is, who requested the evaluation, the purpose of the evaluation, how the results of the evaluation will be used, and who will be able to see the resulting report — may affect the examinee's willingness to participate in the evaluation or infl uence the types information provided during the interview and psychological testing. As such, formal and explicit consent (if participation in the evaluation is voluntary) or notification of purpose (if participation in the evaluation is not voluntary) is an essential aspect of forensic mental health practice.

Criminal Resposibility

A number of diagnosable psychiatric syndromes may be seen following criminal assault [9]. Depression, anxiety, PTSD, and substance abuse are common psychological disorders found in victims of robbery, rape, and burglary, and a high proportion of panic attacks trace their onset to some traumatically stressful experience. Approximately 50% of crime-induced PTSD cases were found to persist in a chronic course after 3 months. Clinical experience suggests that such traumatic effects may persist in some form for far longer—years, decades, or a lifetime.

A criminal act can affect those not directly assaulted or killed. When a family member has been murdered, surviving family members may be plagued by intrusive images of what they imagine the scene of their loved one's death to have been, even if—perhaps especially if—they were not present at the time of the death. Criminal assault survivors may be scapegoated and blamed for their attack by friends and family members seeking to distance themselves from the contagious taint of vulnerability that crime victims are all too often imbued with.

The primary purpose of criminal law is to make the world a safe place in which all of us can go about our individual pursuits without fear of harm from others [10]. In our contemporary criminal justice system, legislative bodies enact statutes that forbid harmful conduct and authorize punishment for those convicted of violating these laws. The threat of serious sanction—loss of property, liberty, even life—is assumed to be an effective motivating force in shaping human conduct.

Although punishment is designed to deter harmful conduct and incapacitate or change those who commit crimes, it is not imposed on everyone who commits harmful acts. The moral basis of criminal law limits the use of punishment to those whom society considers truly blameworthy. Free will is the underlying premise of this system of social control. In general, any adult who intentionally commits an act forbidden by the criminal law is considered responsible for breaking the law and is subject to criminal process and sanction.

Criminal law, however, provides limited opportunities for defendants to avoid criminal responsibility for their intentional harmful acts if they can show that, through no fault of their own, they did not choose to do wrong. They may demonstrate that they lacked the knowledge essential to understand what they were doing or that they did not freely choose to act. The special excuse of insanity is based on this principle. Mentally ill offenders may avoid conviction and punishment if their mental illness was deemed serious enough at the time of the crime to impair important behavioral controls.

The assumptions embedded in this legal excuse are important ones to consider. First, there is such an entity as mental illness, which is beyond the control of any afflicted individual. Second, mental illness interferes with normal human psychological activities, such as thinking and acting. Third, the impairment of these capacities diminishes an individual's ability to understand and direct his or her conduct. In short, the insanity defense accepts a causal connection between the existence of mental illness and the individual's law-breaking behavior.

GBMI

The neoconservative revolution in criminal justice values did more than precipitate changes in the criteria of the insanity defense that were less favorable to criminal defendants [10]. Some states passed new laws creating a guilty but mentally ill (GBMI) defense.

There are two primary versions of this new defense. The first version permits a jury to find a criminal defendant who has raised the defense of insanity as either "not guilty by reason of insanity" (NGRI) or "guilty but mentally ill" (assuming, of course, that it does not convict or acquit the defendant). A defendant found NGRI cannot be sent to a regular prison for confinement; instead, he must be evaluated to see if he is presently mentally ill and dangerous. For as long as he is determined to be mentally ill and dangerous, he may be confined in a psychiatric institution; otherwise, he must be released.

The second version of the GBMI defense is even more harsh on mentally ill defendants. In this version, the verdict simply expresses the jury's collective sense that, although the defendant is guilty of committing a crime, he or she was mentally ill at the time. Once convicted and incarcerated, state penal authorities may, but need not, provide the offender with psychiatric treatment either in a prison or in a hospital. The three states that have abolished the insanity test completely have adopted this form of the GBMI defense.

Both versions of the GBMI defense have been severely criticized. Some critics object because it asks the jury to consider a fact that is essentially irrelevant to the question of guilt or innocence: that is, was the person mentally ill? Indeed, it may not be relevant to anything that has consequences for the defendant. Mental illness by itself has never excused a person charged with a crime from criminal responsibility. Only if mental illness affected specific behavioral capacities—such as cognition or volition—or prevented the defendant from having a criminal state of mind would he be excused or found not guilty. In using GBMI as an expedient com-

promise verdict, the jury may also be invited to avoid the difficult question of whether the defendant was legally insane or fully responsible.

Coercion

The distinction between what constitutes formal and informal coercion may be unclear to patients as they experience health professionals' roles simultaneously as empowering and controlling—the same people help them, persuade them, and, at times, compel them [11]. While this is also true in the hospital setting, the consequences may be more pronounced in outpatient services where professionals often are involved across different spheres of patients' lives. What is experienced as coercive might, however, depend on what the individual perceives as constituting a legitimate use of authority. Very limited research has investigated the 'personal experiences' within which perceived coercion exists or the socio-cultural meanings attached to coercion in the community setting. While leverage and informal coercion are recognized by patients, pre-defined questionnaire items may not fully account for the multiple forms and sources of pressure that influence them. For example, patients can experience considerable internalized pressure arising from socio-cultural expectations about social roles and obligations, such as being a good parent, but this is rarely reflected in research.

Family members are often identified as a source of coercion. This may be unsurprising as they have a vested interest in the patient's adherence to treatment. Mental illness can create unusual relationships between services and the families it affects, as patients can be detained against their will with or without the family's cooperation. Even when this leads to improved care, conflicting views occur. Insight into personal experiences of patients, health professionals, and family members has the potential to enhance our understanding of how community coercion unfolds. In those parts of the world where mental health services or mental health legislation is limited or absent, families, communities, and alternative service providers in particular play a prominent role.

From a human rights perspective, however, coercive laws offend human rights principles whenever they operate to usurp the entitlements of individuals to provide free and informed consent to medical treatment or to authorise treatment without appropriate regard to the subjective, contextualised experience of the person [12]. As the consumer critique of mental health laws demonstrates, coercive legal frameworks may have a significant effect on relationships of care. This is especially so in mental health and disability when cognitive ability may be called into question. While it may be argued that coerced treatment is justified on the basis that such laws address real gaps in the provision of health care, the argument suggests that the approach may compound systemic problems in health care delivery. If it is accepted that medical or psychiatric intervention may be permissible in some instances of genuine need, such intervention should be based on an engagement with the perspective of the affected person.

Connclusion

The term affect sometimes has the same meaning as the term emotion. Affect occurs suddenly and contains pronounced physical and mental changes. Examples of affect are panic fear, unbridled anger, endless joy, etc. In the affective state, intellectual processes are often disturbed, there is no self-control, reasonable behavior or respect for basic moral and legal norms. Therefore, the state of strong affect is considered in court proceedings related to serious crimes.

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