

Psychiatry and the Mental Patient: An Uneasy Relationship

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ABSTRACT. *The second half of the 20th century has witnessed major changes in the way mental health care in the Western countries has been organized and provided for people suffering from mental illness. Deinstitutionalization and community care became common terms used to define a policy that aims to shift the locus of psychiatric care from large mental hospitals and custodial institutions into community.*

Deinstitutionalization of psychiatric care requires an empowering approach towards the mentally ill individuals and their capabilities to lead a self-dependent life in the community. Such an approach implies accepting the mentally ill health-care service users as credible individuals capable of taking responsibility for their actions and life.

The aim of this article is to examine psychiatric conception of mental illness, treatment and the psychiatric encounter. The presentation largely draws upon analysis of Lithuanian psychiatric texts, although some foreign psychiatric literature is also used. The article starts with an introduction of a changing situation of the mental patient and proceeds to the analysis of the psychiatric discourse. The author argues that by conceptualizing mental illness as pathology located within the functioning of the individual body that affects the ability of a sick individual to apprehend the reality and to retain critical insight towards one's health problem, psychiatric discourse may reproduce paternalistic approach towards the mentally ill individuals even in the deinstitutionalized settings. Such an approach may have certain implications for the individuals' ability to lead an independent life in the community.

KEYWORDS: *psychiatry, mental illness, mental patient, paternalism, empowerment.*

RAKTAŽODŽIAI: *psichiatrija, psichikos liga, psichikos liga sergantis pacientas, paternalizmas, įgalinimas.*

During the second half of the 20th century certain changes occurred within health care policy affecting the organization and delivery of medical (and psychiatric) care. As a result of the proliferating chronic disease that is largely incurable in traditional sense modern medicine had to develop a new approach towards health and illness. This led to a certain shift in the medical paradigms: the narrow biomedical model that dominated medical practice over a century became broadened by the so-called biopsychosocial perspective that integrated biological, psychological and social factors in the aetiology and treatment of

illness and that was based on prevention and primary health care (Richter 1999).

In line with these changes there was also a need to reconsider the traditional roles once played by the doctor and the patient in a medical encounter¹ since prevention and management of chronic illness required a more active collaboration between the two. Within the biopsychosocial perspective, patient came to be regarded as a unique personality whose health problems required holistic, individualized approach and he/she was thought of as an active participant of the medical encounter whose subjective experience and meaning of illness were important in both establishing the diagnosis and designing the treatment (Mead and Bower 2000). Since then a “patient centered medicine” has been developed that emphasized patients’ participation in health care related decision-making and orientation of health care towards the fulfillment of patient’s needs and expectations.

Along with this shift and also partly shaping it and being shaped by it in the medical paradigms, the social movements of the 1960s and 1970s set the tone for the emergence of an emphasis on patients’ autonomy and rights first in the USA and later in other Western European countries. The patients’ rights movement reflected increasing distrust of medical authority and it was critical of paternalism that was deeply entrenched within the medical encounters. Various patients’ organizations called for the necessity to let the patients speak for themselves and define their own needs. This resulted in a subsequent shift within the legal discourse from the more paternalistic “best interests” argument to the institutionalization of patients’ rights, autonomy and informed consent (McClelland and Szmukler 2000).

All these developments made the patient’s perspective and role in the medical encounters and decision making more prominent, legitimate and accepted by the health professionals and policy makers.

What about the Mental Patient?

While there has been a steady increase in focus on patients’ perspective in health care in general, the mental patient’s subjective experience of illness and the medical encounter has lacked, until quite recently, more comprehensive analysis and attention. Thorne et al. (2002), for example, have analyzed reports published between 1980 and 1996 in any health and social science field of the qualitative studies that dealt with some aspect of what it was like to live with a chronic disease from the perspective of an individual involved. They noted that whereas studies have typically focused on individuals with rheumatic, cardiovascular, or endocrine disorders, “rarely were persons with chronic psycho-

¹ I.e., those of a dominating doctor and a submissive patient.

logical or psychiatric disorders related to the physical illness included in these kinds of studies” (Thorne et al. 2002, 443).

Nonetheless, the need to incorporate mental patients’ views into evaluation of psychiatric services is being recognized following the general trend of involving patients into the assessment of their health care. The changing situation of the mental patient is marked by the diversification of ways in which the user of mental health services defines oneself and in which he or she is portrayed in contemporary psychiatric, legal and health policy discourses as well as in the sociological literature. Pilgrim and Rogers (1999, 192) outline four common ways to refer to the user of the mental services:

- the user as a patient;
- the user as a consumer;
- the user as a survivor;
- the user as a provider.

Here the user as a patient implicates traditional medical discourse within which the mentally ill individual is primarily seen as affected by illness and in need of professional help. The notion of the user as a consumer emanates from the consumerist discourse, which emphasizes the need to make the health service accountable and satisfactory to the consumer (Lupton 1997).² The notion of the user as a survivor was introduced by the social movement of users of psychiatric services that emerged in 1970s in various European countries and in the US (Hölling 2001). This discourse distinguishes itself by an antipsychiatric attitude and is radically critical of psychiatry and the psychiatric services.³ Finally, the notion of the user as provider is based on a view that people who have experienced mental illness and mental health care should become providers of mental health services for other people with mental problems as they know best what it means to be mentally ill (Pilgrim and Rogers 1999).

Crossley and Crossley (2001) noted that the voice of a mental patient became more prominent and publicly accepted following such social movements as antipsychiatry, feminism and black liberation movements that have questioned the taken-for-granted assumptions maintained by various professional, social and other discourses. These movements and the general atmosphere of the counter-culture of the 1960s paved the way for the mental health users’ movement that was further strengthened by the rise of an ethos of consumerism. These transformations have created a space for establishing the voice of a mental patient and have been crucial in preparing the audiences to listen to that voice (Crossley and Crossley 2001).

The reorganization of the psychiatric care has itself affected the situation

² Pilgrim and Rogers (1999) point out that the term “consumer” is problematic in psychiatric setting where various practices of denying patient’s autonomy still prevail.

³ The very term “survivor” points to an interesting phenomenon: no other branch of medicine faces such juxtaposition between the patient and the professional as psychiatry.

of mentally ill individuals. Today a majority of people living with a psychiatric disorder receives mental health care services in the community rather than behind the hospital walls. Their experiences of illness, health care and living in a community have been analyzed in various sociological and other studies (see, e.g., Schulze and Angermeyer 2002; Onken and Slaten 2000; Topor 2001). This kind of research often argues for the importance of incorporating a mental patient's perspective into designing treatment and care for the mentally ill people. At the same time, the first-person accounts of the psychiatric treatment begin to appear in some professional journals or as autobiographies, revealing personal experience of illness.⁴

Mental patients' experiences often diverge from the psychiatric conception of illness and its treatment. Pečiulis, himself a mental patient, in his book *10 Secrets of a Successful Life for Persons with Mental Health Problems* (2002) called for a greater self-worth of people suffering from mental illness by emphasizing the value of extraordinary experiences these people go through. According to him, psychiatry fails to understand the mental patient and the illness itself, since it does not look for the subjective meaning of illness for a mentally ill individual. Pathology starts when it increases human suffering or becomes dangerous to the sufferer and others around him or her. All other, even if apparently irrational experiences, beliefs and perceptions should not, according to the author, be considered abnormal as they could be "harmonized, developed and creatively used" (Pečiulis 2002, 75). Pečiulis has distinguished between the positive (productive) and negative (destructive) symptoms in mental illness and has called for accepting the former as a unique manifestation of human creativity that did not require treatment.⁵

In the health professional discourses, discussions are still continuing on the credibility of the mentally ill individual's judgments and views (see, e.g., Alexius et al. 2000; Barker and Orrell 1999; Shipley et al. 2000). Mental patients are often regarded as not capable of making rational choice and as lacking insight (Lowry 1998). In Lithuania, like in other Eastern European countries, mentally ill individuals still remain passive recipients of psychiatric services: their various needs are often defined by the policy makers, health and other professionals, institutions or the family members rather than by themselves (Slušnys 2000; Pūras 2000). This suggests that some professionals, policy makers and society in general consider mental patients as not capable to define

⁴ According to Schulze and Angermeyer (2002), first-person accounts of mental illness were first given room in scientific discourse of psychiatry itself when such journals as *Schizophrenia Bulletin* or *Psychiatric Services* started to publish patients experiences of stigma and discrimination. However, as the authors point out, access to this forum is limited, as journals require keeping to some standards of writing and as people with mental illness experience are not always aware of such possibilities.

⁵ According to him, mental patients can learn to manage a part of their illness by reflecting upon their illness experiences and learning from them.

their needs and interests; moreover, the mentally ill individuals do not feel able to change their situation.

This situation might be reinforced by the very psychiatric discourse that tends to portray mental illness as inhibiting an individual's capacity to appreciate the nature and scope of the health problem and that fosters the belief that the mental patient's views need to be validated by more "objective" accounts.

The Psychiatric Conception of Mental Illness

Contemporary Western psychiatry is not an internally consistent body of professional knowledge and practice. It covers many different and manifestly contradictory ways of viewing and treating mental illness. Despite the variety of conceptual approaches, contemporary psychiatry is inclined to look for a physical evidence of mental illness⁶ and to apply somatic treatment (Busfield 2000).⁷ This approach is based on what, in general medicine, has come to be called as a medical model.⁸

Adoption of the medical model in psychiatry has important implications for the way psychiatrists address the phenomenon of mental illness: regardless of its aetiology, illness is understood as located within the individual body. This means that it is primarily the individual and not the social environment that is problematized and dealt with. Also, as Sarbin and Keen (1998) point out, by relegating mental illness to the realm of neurotransmitters, brain damages or psychological processes, the medical model in psychiatry leaves no room for the sick individual as an agent capable of intentional action. As a result, it

⁶ Psychiatry does not generally deny the interplay between the biological, psychological and social factors in the onset and course at least of some mental disorders. Indeed, the so-called biopsychosocial model has been a background paradigm in community based psychiatry. However, as Richter (1999) points out, at least in severe mental illness as, e.g., schizophrenia and other psychoses, the causation of social factors has not been proved. Social factors are seen only as contributing but not determining the course of such disorders.

⁷ European psychiatry has been much more biological in its orientation compared to American psychiatry that has relied, for a long time, on the psychodynamic perspective (Mechanic 1978).

⁸ In some literature a synonymous term "biomedical model" is used. The medical model envisages modern medicine as a scientific and technologically oriented social institution that applies scientific knowledge and methods to diagnose and treat illness (Turner 1987; Mechanic 1978). Disease within this model is presented as: 1) malfunction located within the functioning of the individual body; 2) being a discrete and discernible entity; 3) having specific causation that can be objectively identified and treated primarily with the help of medicines and medical technologies (Busfield 1989). Thus, patients are approached as passive objects of a "medical gaze" that examines and treats the body with emotional neutrality.

challenges the validity of individual's actions and reactions (Ingleby 1981) and reinforces patient's dependency on psychiatric care.

Although psychiatry has largely adopted the medical model in its theory and practice, some differences between the general medicine and psychiatry exist in the way they identify illness. In general medicine health or illness is defined by reference to certain physical and biochemical parameters, such as weight, haemoglobin or cholesterol level, blood pressure, etc. Each of these parameters has their "normal" values. Deviation from these values indicates pathology. Psychiatry instead largely relies on communication with the patient and patient's observation in collecting the anamnesis and drawing the diagnosis since many types of mental illness cannot be identified by laboratory tests (Bagdonas 2005). In the absence of clear physical and laboratory tests, the psychiatrists are more dependent on their clinical experience, judgments and training, which may increase a risk that some psychiatrists would "manufacture" patients – "thrust their psychopathology into the standards of one or another known disease" (Dembinskas 2003, 101).

Rosenhan (1991) aroused considerable controversy about the psychiatric diagnosis when, in his study, eight researchers with no histories of mental illness or obvious psychiatric problems gained admission to different psychiatric hospitals by complaining that they "heard voices." Once admitted to the hospital, these pseudo-patients ceased simulating symptoms. With the exception of one case, all "patients" were diagnosed with schizophrenia and later released with a diagnosis of "schizophrenia in remission." All of them were administered drug treatment. This study demonstrated that psychiatrists might apply drug treatment even if they were uncertain about the nature of the mental problem. Also, Rosenhan's study showed how readily psychiatric hospitalization could be achieved, particularly if the patient voluntarily agreed to hospital admission. On the basis of his study Rosenhan argued that it was not possible to distinguish the sane from the insane and that psychiatric diagnoses were not reliable.⁹

Mechanic (1978) notes that personal disturbance can be alternatively viewed as organic in nature, as a result of developmental failures, as a moral crisis, or as a consequence of socio-economic, social or structural constraints. Although all of these elements may be present in the same individual situation, the one that the psychiatrist emphasizes has both moral and practical

⁹ The reliability of the psychiatric diagnosis is one of the major issues raised in sociological literature on mental illness. Allen (1998) notes, e.g., that the diagnostic classifications of mental illness used by psychiatrists in diagnosing are frequently revised. This, according to him, indicates that what constitutes psychiatric knowledge is always under negotiation. Psychiatric diagnostic classifications are criticized for their inability to deal with the question of whether categories of mental illness exist apart from the social constructions and normative judgements of the authors of diagnostic manuals (Sarbin and Keen 1998). The proponents of the antipsychiatric movement have even asked how "real" the diagnosis of mental illness is (see, e.g., Szasz 1974).

implications for the individual patient. Diagnostic and therapeutic decisions are not completely value free judgments.¹⁰ They affect people's behavior, their attitudes towards themselves and the way others look upon them.¹¹

As it was already noted, the psychiatric diagnosis may lead to a long lasting dependency of the individual on the psychiatric care. This is also because psychiatry is rather cautious in its approach towards the possibility of total recovery from mental illness (at least when it comes to such major mental illnesses as schizophrenia or depression). In Lithuanian psychiatric texts, for example, mental illness is conceptualized as largely chronic and difficult to prognosticate; hence, a common term used by psychiatrists to refer to a symptom free condition is not "recovery" but "remission" (see, e.g., Dembinskas and Goštautaitė-Midttun 2003; Navickas 2003).

Reluctance to use the term "recovery" relates to the fluctuating nature of mental illness as the very term "remission" denotes. In case of depression, for example, the possibility of recovery is seen as diminishing with every consequent relapse. According to Navickas (2003), there is more and more evidence that after one episode of depression this disorder might be present for the whole life, reappearing from time to time and with no complete recovery. Thus, as he maintains, "if no symptoms of depression appear during a period of six months the patient is considered to be *recovered* from *this* episode of depression" (Navickas 2003, 301, my emphasis).

Even if an individual is symptom free for a longer period of time and has regained usual level of social functioning, this is regarded as possibly a short-term condition that needs to be further observed (see, e.g., Navickas 2003). According to the literature (Navickas 2003), if there have been several relapses, a patient in remission should undergo a prophylactic treatment that actually implies taking medications for an indefinite period of time.

The concept of remission, hence, has no clear boundaries that allow separating between health and illness. Whereas in general medicine the absence of symptoms often allows withdrawing the diagnosis, the psychiatric concept of remission locates an individual who has once suffered from mental illness in a more or less permanent sick role, making his or her condition chronic and subject to a long-lasting treatment.

¹⁰ Some of the diagnostic categories of mental illness are based on criteria that can be seen as primarily drawing on the infraction of moral norms. This was the case with homosexuality which was later demedicalised, and it is still the case with the diagnosis of some personality disorders. E.g., the diagnostic criteria used to characterise "antisocial personality" refer to such behavior on the part of an individual as "disregard of social norms and rules" and "irresponsibility in relations with other people" (see Milašiūnas 2003, 436); the "histrionic personality" is pathologised for "inappropriate bent for flirting" (Milašiūnas 2003, 438).

¹¹ A common consequence of the psychiatric diagnosis is stigma and social exclusion (Gefenas 2003).

Psychiatric Treatment and the “Misbehaving” Patient

As a branch of modern scientific medicine, psychiatry has always occupied an uneasy position: while general medicine has been quite successful in the elaboration of specific biological causes for various types of illness, psychiatry for the long time could not provide any clear evidence of what caused mental illness and how to treat it effectively (Pressman 1993). It was only with the advance of psychotropic medications in the mid 20th century that psychiatry could finally demonstrate some more or less successful management of mental disorder.¹²

Today medications are considered to be a primary remedy for many mental illnesses. However, together with the expected relief psychotropic medications often produce side effects that may result in new symptoms. Dembinskas and Goštautaitė-Midttun (2003), for example, admit that poverty of emotions and speech, apathy, social withdrawal common to schizophrenia might be both a symptom of disease and a side effect of anti-psychotic medications. Other side effects may include tremors, protuberance of tongue, grimaces, problems of digestion and sight, also disturbances in heart rhythm, increase in weight and allergic reactions and such dangerous conditions like malignant neuroleptic syndrome, which can result in death in up to 10% of cases (see Radavičius 2003).

Application of psychotropic medications may require a trial and error cycle as some symptoms may prove to be resistant to some types of drugs, the more so as their effect might depend not only on the individual features of the patient's body but also on age, sex, diet, lifestyle, etc. (see, e.g., Petronis 2003). Efficacy of medications, however, is evaluated in terms of the frequency of relapses or hospitalizations and not in terms of the side effects (see, e.g., Dembinskas and Goštautaitė-Midttun 2003). In psychiatric texts, medications are regarded as having opened new ways for understanding and treating mental illness: their introduction has fostered the development of psychiatry, changed the status of mental patients (drug treatment helped to regain patient's social functions, working ability and improved the quality of life) as well as society's attitude towards psychiatry. By and large, it is not the undesirable effects that are viewed as a serious problem in drug treatment but mental patients' non-adherence to a treatment regimen. Patients are seen as non-adhering either because of the negative side effects of medications or because they are uncritical towards illness or fail to understand the importance of treatment (see, e.g., Dembinskas and Goštautaitė-Midttun 2003; Kampman et al. 2001). In psychiatry, this has itself led to the development of new forms of drug treatment – injections that secure long lasting effect of the medications (the so-called depot drugs) – that allow better controlling of the problem of adherence (Blažienė 2004).

From the sociological point of view, drug treatment is a controversial issue

¹² The advance of major tranquilizers in the mid 1950s revolutionized hospital care allowing for the “open-door” hospital policies.

and not only because of the negative side effects. According to Barham (1992), medications are certainly important in keeping previously hospitalized mental patients in the community but the over-reliance on drug therapies may obscure the need for other forms of service provision, particularly the need to solve the patients' social problems. The introduction of new drug treatments in the 1960s had a particular influence on psychiatric practice. According to Barham, psychiatrists could now style themselves as:

. . . experts in pharmacology rather than experts in human behavior. Abnormal behavior patterns could be controlled: they need not be understood. The psychiatrist could carry out his work as other doctors did – relieved of the burdens of attempting to follow the processes of disturbed minds, the trains and complexities of unfamiliar lifestyles, the pressures of unemployment, squalid housing conditions and poor nutrition. There was no need to enter the jungle of human emotions – love, hatred, pain, grief. It was a great deal less wearing and a great deal more respectable in strictly medical terms (Barham 1992, 14).

Even if psychotropic drugs are effective in reducing symptoms, this does not mean that they develop patients' ability to deal with his or her problems. Ingleby raises this issue:

What do we call "effective"? Almost all treatments have undesirable side-effects; and if ECT reduces the pain of events only by helping the patient to forget them, or if tranquilizers make people able to handle their emotions only by leaving them with no emotions to handle, then talk of a "cure" becomes rather ironical. In that sense, after all, death "cures" everything (Ingleby 1981, 37).

The psychiatric conception of an effective treatment raises an important observation: the treatment is considered to be successful not only when symptoms are eliminated but also, and perhaps this is even more important, when the patient complies with it by strictly following a doctor's advice, taking prescribed medications and attending medical consultations.

The patient's non-adherence, particularly in case of a drug treatment, can be traced in almost every branch of medicine; in case of mental illness, however, it is considered to be particularly problematic. Psychiatric literature regards treatment non-adherence as one of the major obstacles to the effectiveness of psychiatric care. Colom and Vieta (2002) note that the patient's failure to adhere leads to chronification, poor psychosocial outcomes and increased suicide rates in case of psychotic and mood disorders. According to them, patient's non-adherence is often a result of a poor insight (i.e., lack of illness awareness) that is considered to be a common feature in some mental illness (see also Kampman et al. 2001). Insight itself is seen as consisting of three overlapping dimensions: recognition that one is mentally ill, the ability to relabel unusual mental events as pathological and adherence to the treatment

or recognition of the need for treatment (Trauer and Sacks 2000, 211). The mental patient's failure to demonstrate any of these dimensions is explained as a lack of insight and consequently as a sign of persisting pathology.

Psychiatric conception of non-adherence provides an idea about the roles that psychiatric discourse attributes to the doctor and the patient. According to Playle and Keeley (1998, 306), implicit in the dominant professional world-view is a belief that the role of the professional is to diagnose, prescribe and treat. In its turn, the patient is expected to comply with the diagnosis and treatment. The non-adhering behavior is seen as challenging professionally held beliefs, expectations and norms. According to the authors, this has led to a tendency to view non-adhering patients as both deviant and culpable.¹³ Playle and Keeley maintain that psychiatric discourse fails to take into account what the non-adherence or adherence itself means to the patient.¹⁴ They note that the patient is left with no choice but to comply with the treatment in order to demonstrate insight and competence. It is when patients do comply with treatment the professional may presume that insight has been achieved and that a collaborative and trusting relationship has been developed.¹⁵ If the patient fails to comply, the presumed lack of insight provides both the justification and opportunity for the professional to act paternalistically, diminishing the autonomy of the individual (Playle and Keeley 1998, 309). In other words, non-adherence is often seen as a fault on the part of the patient rather than failure of the psychiatrist to accommodate patient's needs and expectations to the treatment (Lowry 1998; Playle and Keeley 1998).

It is not only non-adherence that is problematic in the psychiatric treatment. According to psychiatric conceptions of some mental illnesses like, e.g., somatization disorder, hypochondria or some personality disorders, the patient might be not only non-compliant with the doctor but also inclined to various manipulations over the latter. Thus, communication with such a patient requires specific "tactics." The paranoid personality, for example, is described as suspicious and hostile. Thus, the psychiatrist should retain distance from the patient but also to be "honest and not afraid to acknowledge his or her mistakes" in order to decrease or prevent the patient's mistrust (Milašiūnas 2003, 446).¹⁶ The histrionic type of personality is viewed as constantly trying to dominate. According to

¹³ Also, as Lowry (1998) notes, the medical model of adherence tends to look for certain features of the patient that might determine non-adherent behavior: age, gender, social class, educational status or ethnic origin. This, according to Lowry, is problematic as it reinforces the notion of every patient as potential defaulter.

¹⁴ The medical model in general tends to eliminate the reasons a patient might have for non-adherent behavior or these are defined as misconceptions and "unrealistic expectations" (Trauer and Sacks 2000).

¹⁵ Breeze (1998) notes that doctors are more likely to consider patients who agree with treatment to be mentally competent than those who are uncooperative.

¹⁶ Trust in general is seen as an important aspect in psychiatric encounter. It is the patient that should trust the psychiatrist; the latter, however, should maintain some distance. According to Dembinskas (2003a), familiar relationships harm both the doctor and the patient.

Milašiūnas (2003), the psychiatrist should clearly define and determine the roles of both participants of the therapeutic encounter in order to deal with this problem and to control the situation. In other words, psychiatry tends to construct the picture of a mental patient as a potential defaulter, the one who should be treated with caution.¹⁷

Since the mentally ill individual might be unable to apprehend the reality and to retain critical insight towards his or her health problem, there is also a question of how a psychiatrist should discuss illness related issues with the patient. Psychiatry maintains the view that the disclosure of illness related information to the patient should be well considered and weighted. It is rarely suggested to discuss illness related issues openly, at least not with every patient:

When talking to a patient, the psychiatrist should say that he or she has diagnosed, let's say, symptoms of central nervous system exhaustion. If patients are more educated it can be explained to them that they have some passing mental disorder necessary to treat (Dembinskas 2003, 102).

As Shergill et al. (1998) point out, the reasons for not disclosing mental illness related information may include a reluctance to distress the patient, particularly if a diagnosis is stigmatizing or has a poor prognosis. As Gefenas (2003) notes, the Hippocratic Oath obliges the doctor to do all the best for a patient and to protect him or her from a harm and offence. This protection is understood not only as inducing no harm to a patient but also as protecting him or her from suffering and anxiety that might be caused by disclosing information about illness. This ethical principle inherent to traditional medicine is called paternalism (Gefenas 2003).¹⁸

In psychiatric and other medical discourses, withdrawing of the information from the patient is often justified as being exercised for the patient's own sake. Gefenas points out, however, that limiting the information that might be decisive in making important life decisions restricts the individual's free self-determination and hence it creates an ethical dilemma (Gefenas 2003).¹⁹

To summarize, mental illness in psychiatric discourse is conceptualized

¹⁷ See, e.g., Dembinskas (2003) on the "misbehaving" mental patient.

¹⁸ Paternalism can be defined as "an action which restricts a person's liberty justified exclusively by consideration for that person's own good or welfare and carried out either against his present will or his prior commitment" (Breeze 1998, 260). In this way a paternalistic relationship is similar to a relationship between the parents and the child. It can involve using coercion to achieve the good that is not recognised as such by the recipient (Breeze 1998, 260).

¹⁹ Contemporary legal frameworks and professional codes of ethics like, e.g., *Declaration of Hawaii* adopted in 1977 or the *Madrid Declaration on Ethical Standards for Psychiatric Care* (approved in 1996 and later amended in 2002), put greater value on patients' autonomy and informed decision making. *Lithuanian Mental Health Care Law* (1995) also promotes the patients' right for illness and treatment related information. It is the psychiatrist, however, that decides whether there are any indications for withdrawal of such information from the patient (see Article 15, Chapter 4). Hence, even if the Law grants certain rights to the mental patient, this does not mean that the patient will be able to exercise them.

as pathology that may affect the ability of a sick individual to apprehend the reality and to retain critical insight towards his or her health problem.²⁰ Hence, certain mistrust towards the mental patient becomes characteristic of psychiatric care. Since the patient is seen as potentially lacking insight, it is the professional that has to retain control over the medical encounter and to decide what is best for the patient. This suggests that paternalism in psychiatric care might be legitimated and further sustained by the very conceptualization of mental illness that in turn requires specific behavior towards the patient.

Also, the psychiatric notion of a mental illness could be seen as lacking a more optimistic scenario. The concept of “remission” used instead of “recovery” has no clear boundaries that would allow separating between health and illness. This locates an individual who has once suffered from a mental illness in a more or less permanent sick role and dependency on the health professionals.

Sociologists have long been critical towards the psychiatric conceptualization of mental illness and its consequent approach towards mentally ill individuals. Since the psychiatric diagnosis has been criticized as being based on rather vague criteria that do not allow making clear demarcation between “badness” and “sickness” it was seen as lacking objectiveness. Thus, psychiatry has been largely seen as an institution of social control rather than care (Busfield 2000).

According to Navarro (1976) medicine plays an important ideological role in strengthening the capitalist social order since in its emphasis on the physical causes of illness and ignorance of the social ones, it individualizes and de-politicizes the illness. It shifts the focus from the social structure to the physical realm and mutes the potential for action by the patients to change the conditions that trouble them. Ingleby (1981, 44) maintains a similar position in claiming that “psychiatry protects the efficient functioning of social institutions by converting the conflict and suffering that arises within them into ‘symptoms’ of essentially individual (or at best familial) ‘malfunctioning’; it thus attempts to provide short-term technological solutions to what are at root political problems.” The tendency of psychiatry (as well as medicine in general) to medicalize social problems is one of the major themes within sociology of mental illness. The ability of medicine to extend its professional dominance rests in the power of the medical profession to define and control what constitutes health and illness. Through redefining deviance “from badness to sickness” medicine has acquired a political role. It imposes its treatments more or less forcibly on those who would otherwise protest against intolerable living conditions or political repression (Gerhardt 1989).

Psychiatric claims to value neutrality in diagnostic and treatment practices have been also extensively criticized. Warner (1994), for example, has

²⁰ This also suggests that at least in some branches of psychiatry (e.g., biological psychiatry) the professional does not regard patient’s subjective meanings of illness or treatment as important.

studied the life-stories of people with schizophrenia in Western societies during the 20th century in order to demonstrate how political and economic factors shaped the course of schizophrenia. According to him, recovery rates for schizophrenia in industrialized societies are closely linked to fluctuations in economy and the requirements of the labor market. Warner concludes that changes in the outcome of schizophrenia reflect changes in the perceived usefulness of the mentally ill individuals for the labor market and are not merely effects of psychiatric treatment.²¹

Since modern scientific medicine and psychiatry have a monopoly in deciding what illness is and what it is not, it effectively excludes patients' perceptions of it from the medical encounter and conceptualization of illness itself. Foucault (1987) noted that by imposing artificially unifying analytical categories on different forms of mental illness, modern psychiatric practice effaced the specificity of each individual case of mentally disturbed condition. According to Foucault "to be properly understood, mental pathology requires methods of analysis that are fundamentally different from those of organic pathology" (Foucault 1987, 15).

Foucault criticizes the alienating effects of psychiatric practice in its negative understanding of mental illness. Mental illness involves not only negative but also positive sides and these should be analyzed in order to better understand individuals and the meanings they have of their own condition.²² This should be contextualized with respect to a broader cultural conception of madness focusing particularly on the historical transformations of the concept. Such a focus would highlight the cultural and historical relativity of the concept and would lead to the understanding that there is nothing natural or inevitable about the modern strategies of mental illness management (Foucault 1987, 15).

Discussion

Contemporary mental health care policy and reforms, including the one taking place in Lithuania, are directed towards the integration of the mentally ill into society and empowering them to a more active participation in health and treatment related decision-making. To be empowered, *inter alia*, also implies gaining control over one's life (Onken and Slaten 2000). Empowerment of the mental patients thus is crucial for deinstitutionalized psychiatric care that aims at reinforcing capabilities of the mentally ill individuals to lead a self-dependent life in the community.

²¹ Warner also notes that economic climate may affect level of (in)tolerance towards mentally disordered people in the family or in the community: such persons may be more discriminated against and stigmatised during the times of economic hardship.

²² Note the similarity of these ideas to Pečiulis's (2002) account of the personal experience of mental illness.

Empowerment, however, might be difficult to achieve for mentally ill individuals not only because of the nature of the mental illness itself but also because of the nature of psychiatric care and ideas about mental illness inherent to professional discourses.

McCubbin and Cohen (1996) maintain that empowerment of the mentally ill patients and representation of their interests might be problematic as long as the medical model dominates the psychiatric care. The medical model implies that by drawing on some notion of mental illness, which questions patient's abilities to apprehend reality, psychiatrists tend to take on a paternalistic stance "the doctor knows best." In this way, the medical model legitimates and sustains institutionalization of paternalism in the psychiatric care.²³

Paternalistic relationship by its very nature is a relationship of domination and subordination maintained by the differential access to power and resources and justified by some ideology that emphasizes the caring role of the paternalist (Abercrombie et al. 1994). Paternalism is a collective form of social organization in that it exceeds the confines of a single relationship between two individuals and has a tendency to be institutionalized. It is typically a diffuse relationship that covers all aspects of subordinates' lives (Abercrombie et al. 1994, 307). Hence, paternalism in the medical encounter both reinforces and is reinforced by the powerless situation of the mental patient in the wider society.

Paternalism, if it is ingrained in the health care system, might impede the patient's ability to take on a more active and critical stance and is in general incompatible with the contemporary notion of a health care service user who is seen as having legitimate needs and expectations towards the health care system (Williams 1994). Different studies point out that asymmetry in power and dependency on the health care providers are intrinsic to the experience of care in chronic illness and that this experience in various ways inhibits patients' ability or willingness to participate in health related decision-making or to evaluate their experiences of the medical encounters critically (see, e.g., Anderson 1996).²⁴ This is particularly characteristic of people suffering from mental illness as well as other vulnerable populations (e.g., the elderly, the disabled, women, etc.). It may make the mentally ill individuals feel not entitled, not competent and also not willing to openly question their powerlessness both in the psychiatric encounters and in the wider society. This may also explain

²³ On the other hand, in some illness situations paternalism might be indispensable and even contribute to the treatment outcomes (see, e.g., Baltrušaitytė 2006; Lupton 1997).

²⁴ Those who are dependent, vulnerable, dis-empowered and feeling incapable to control their illness and their lives will be more likely to accept the way they are treated and approached by the medical professionals. According to Williams (1994), the more powerless people consider themselves to be, the more likely that they will adjust their expectations and needs to the services that are offered to them.

why mental health care reform in Lithuania proceeds without a more active involvement of the mental health care service users.

Similarly, due to the prevailing professional discourses on mental illness some professionals, policy makers and society in general might look upon the mental patients as not capable to define their needs and interests; hence, reform objectives are being pursued without taking into account patient's perspective. As Pūras (2000) has noted, the Lithuanian mental health system still continues to satisfy its own demands instead of meeting the patients' needs.²⁵

In sum, the dominant professional conceptions of mental illness, institutionalization of paternalism and patient's dependency on the health professional might shape the way in which the individual will respond to illness situation and own capabilities to manage it. Furthermore, the disempowering medical practices and discourses together with stigmatization, discrimination, exclusion as well as illness-related disability might make it quite difficult for mental patients to challenge their powerless situation in society. Also, since empowerment in fact involves acquiring power to challenge the dominant psychiatric discourses and the roles that are ascribed by various professional paradigms and society to the individual suffering from mental illness, it requires collective action, which in turn implies assuming a collective identity, i.e., identifying and defining oneself as a group – in this case a group of individuals suffering from mental illness. This might be problematic for the mentally ill individuals due to the stigma related to mental illness (which itself is reinforced by the disabling professional conceptualizations of mental disorder), which in turn may result in attempts to conceal illness from the public rather than construct a group identity on the basis of it (Baltrušaitytė 2006).²⁶

Further research in this field, however, should focus on how the lack of alternative mental health services in Lithuania that would secure comprehensive treatment and rehabilitation programs for people with severe mental illness living in the community affects the psychiatric approach towards mental patients. Pūras (2000) has argued that financing of psychosocial interventions is inadequate in Lithuania and limits the possibility to provide services that would create a comprehensive alternative to the traditional system of

²⁵ Turner (1987) has noted that system needs oriented approach was characteristic to the Soviet health care: the Soviet medical system was developed primarily to satisfy professional interests and the requirements of industrialization rather than patient's needs. Such approach is generally characteristic of institutionalised psychiatric care settings.

²⁶ The fear of being "disclosed" and the lack of a collective identity might explain why various organizations in Lithuania that draw together mental patients and their relatives are often led by psychiatrists or patients' relatives instead of the mental patients themselves. Usually it is not the individuals suffering from mental illness themselves but the "healthy others" that become public spokesmen for these people. On the other hand, it is very likely that such organizations would not succeed in making themselves "visible" if they were represented mainly by patients often regarded by the public as incapable of defining their own interests.

psychiatric hospitals and boarding houses. Hence, it well may be the case that maintenance of a medical model and paternalistic approach towards mental patients are indispensable strategies applied by professionals that help them to manage mental illness outside the hospital walls in the situation where alternative mental health services are poorly developed.

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Psichiatrija ir psichikos liga sergantis pacientas: paternalistinio santykio prielaidos

Santrauka

XXa. viduryje prasidėjęs deinstitutionalizacijos bei bendruomeninio pobūdžio psichikos sveikatos priežiūros paslaugų plėtros procesas pareikalavo naujo – įgalinančio – požiūrio į psichikos liga sergantį žmogų ir jo galimybes savarankiškai gyventi bendruomenėje. Šis požiūris reiškia, kad psichikos liga sergančio asmens nuomonė ir poreikiai yra laikomi legitimais priimant su psichikos sveikatos priežiūra, savo liga bei gyvenimu susijusius sprendimus. Tačiau nepaisant pastarąjį dešimtmetį Lietuvos psichikos sveikatos priežiūros sistemoje vykstančių pokyčių deinstitutionalizacijos link, psichikos liga

sergantis pacientas išlieka pasyviu sveikatos priežiūros paslaugų gavėju, kurio poreikius apibrėžia sveikatos specialistai, institucijos ar artimieji, bet ne pats pacientas.

Straipsnyje keliama prielaida, kad psichikos liga sergantis žmogus ir toliau yra traktuojamas kaip nesugebantis suvokti ir apibrėžti savo poreikių bei interesų. Toks požiūris į psichikos sutrikimus turintį žmogų iš dalies yra sąlygojamas ir palaikomas profesinio psichikos ligos diskurso bei praktikų. Psichiatrinėje literatūroje vyrauja (bio) medicininė psichikos ligos ir jos gydymo samprata, prioretizuojamas medikamentinis gydymas. Šioje sampratoje liga yra lokalizuojama individe ir tokiu būdu tampa jo elgsenos ir asmenybės vertinimo kriterijumi. Psichikos liga yra apibrėžiama kaip sąlygojanti sergančiojo realybės suvokimo jausmo praradimą, nesugebėjimą kritiškai įvertinti savo situacijos. Tai tampa pagrindu patologizuoti sergančiojo elgseną: pacientas laikomas nepatikimu, linkusiu manipuliuoti gydytoju, todėl paciento elgsena turi būti nuolat stebima ir kontroliuojama. Tokiu būdu yra pateisinamas paternalistinis požiūris į pacientą. Paternalistinio santykio išsisknijimas psichiatrinėje priežiūroje sąlygoja psichikos liga sergančio žmogaus priklausomybę nuo sveikatos priežiūros sistemos ir tokiu būdu gali neigiamai įtakoti jo galimybes aktyviau ir savarankiškiau spręsti gydymo ir gyvenimo problemas.