Patient experience and the psychiatric discourse: Attempting to bridge incommensurable worlds

K. S. Jacob
Department of Psychiatry, Christian Medical College, Vellore, Tamil Nadu, India

ABSTRACT

Divergent worldviews, incommensurable frameworks, contrasting models, distinct foci, dissimilar logic, different realities, disparate cultures, and complex patient-physician interaction impact the clinical process and problematize decision-making. Attempting to understand the disease-illness divide, engage patient perspectives, go beyond the traditional biomedical understanding of mental illness and negotiate a shared plan for treatment are serious challenges for psychiatry. The challenge for psychiatrists is to appreciate patient reality and negotiate a shared plan of treatment.

Key words: Biomedical model, patient perspective, psychosocial context, symptom checklists

INTRODUCTION

Patient and physician accounts of consultations often differ markedly in details and perspective and are a fertile ground for misinterpretation and misunderstanding. Different foci, distinct logic, dissimilar models, disparate cultures, and divergent worldviews result in incommensurable frameworks and contradictory realities, which impact the clinical process and problematize decision-making.

DIFFERENT FOCI

The different worldviews held by patients and psychiatrists often result in divergent interpretations of the clinical encounter. Psychiatrists focus on symptom counts, which improve diagnostic reliability. However, diagnostic criteria do not account for the role of context, stress, personality, coping, and supports, as these would require observer interpretation and are a major obstacle to reliable diagnosis. The individual's experience, colored by the immediate milieu (such as gender, social class, economic status, caste, minority grouping, sexuality, and religion), is ignored. The skewed dominance of the instrumental subtext (e.g., interview schedules, symptom checklists, and diagnostic criteria) diminishes the significance of the patient's story (experiential text) and the meanings it hold for patients.[1,2] Such bias besides making integration of these subtexts into a larger meaningful whole difficult if not impossible also highlights a key epistemological problem in medicine and psychiatry, namely, how subject-object relationships are worked out in clinical practice.

The absence of gold standards and laboratory tests, lack of pathognomonic symptoms, use of individuals' perception of unpleasant feelings and phenomena within the normal range of emotions, discounting of stress and context makes it difficult to separate normal human distress from mental disorders. Psychiatric labels medicalize mental distress.[3] Stress and trauma can be acute (e.g., bereavement), recurrent (e.g., domestic violence) or chronic (e.g., poverty); interpersonal difficulties, marital discord,
financial stress, gender injustice, cultural tensions, social discrimination, political oppression, structural violence, ethnic cleansing, armed conflicts, and forcible displacement of populations are associated with symptoms of depression and anxiety. Poverty works through the experience of insecurity, hopelessness, rapid social change, the risk of violence, and physical illness to produce poor mental health. Clinically and statistically significant relationship between psychosocial adversity and mental ill-health (i.e., distress, illness, and disease) complicates the simplistic “atheoretical” approach to psychiatric diagnosis. The current classifications provide labels by arbitrarily dividing the many complex dimensions of mental health, distress, illness, and disease into dichotomous normal/abnormal (disorder) categories. The discipline with its biomedical framework transfers the disease halo reserved for severe mental illness, to all psychiatric diagnoses. It locates primary pathology in the individual when causal mechanism can lie in the environment.

**UNIVERSAL TRUMPS LOCAL**

The Diagnostic and Statistical Manual-5, unlike its predecessors, concedes that culture influences identity, norms, concepts of distress, stressors, coping, supports, tolerance to specific symptoms, vulnerability, suffering, help seeking behavior, treatment adherence, and stigma. Nevertheless, despite its aim of culture-sensitive care, much of the discussion on cultural issues is restricted to the introduction and appendices of the manual. The complete absence of cultural standards in diagnosis argues for universal models for mental illness. It basically supports traditional psychiatric categories and subdivisions, which are ideological and based on Euro-American thought. Biomedical models trump cultural and contextual understanding of mental health, distress, illness, and disease every time.

**DISTINCTIVE LOGIC AND MODELS**

Biomedical models of illness consider naturalistic explanations of disease, degeneration, and deficiency as causal. On the other hand, people with mental illness also invoke personalistic and supernatural explanations such as sin, punishment from God, karma, black magic, and evil spirits. While biomedicine argues for logical insights and beliefs that people hold single, consistent, and rational explanation for their illness, people with mental illness, their families, and the local community seem to simultaneously hold multiple and often contradictory beliefs for their misfortune. Consequently, they concurrently and sequentially seek diverse forms of cure, therapy, and healing from a variety of traditional and faith healers and from practitioners of modern medicine and psychiatry.

**PATERNALISTIC CULTURE**

Medicine, in keeping with its status in society, always had a paternalistic culture. Medicine and psychiatry tend to dismiss individual’s rights of self-determination as inconsequential to the science of cure. The discipline implies that refusal to accept treatment is often part of the lack of decision-making capacity and argues that compulsory treatment (e.g., hospitalization, physical restraints, electroconvulsive therapy, etc.) are in the best interest of patients. Custodial care was the norm, and the focus was on the protection and welfare of society in the 19th century. However, legislation over the last century changed the emphasis to the protection and welfare of patients and added the paternalistic duty of therapy and care.

The gradual shift from the paternalistic model to a contractual relationship between patients and physicians, in the late 20th century, was an important milestone. Nevertheless, while psychiatry acknowledges that individual autonomy and choice are fundamental, they also support the takeover of decision-making in certain situations. Most countries have mental health laws which allow compulsory hospitalization and treatment of people with mental illness in specific circumstances. These laws permit psychiatric interventions without patient consent in contexts where they are said to lack decision-making capacity and when there are risks of harm to self or to others.

While the use of force was delegitimized across many sectors (e.g., rules against self-incrimination, the prohibition of torture to extract a confession and the need for consent for treatment for physical illness), coercion is occasionally permitted in people with mental illness under specific conditions. While the provision of treatment for physical illness without consent is seen as assault, the use of force is only considered problematic when employed for people without mental illness. Mental health legislation and legal frameworks allow for coercion and compulsory hospitalization, enforced psychiatric interventions and community treatment orders.

**CONTRASTING PARADIGMS**

The movement of people with psychosocial disability has challenged the biomedical and psychiatric discourse. They argued against use of compulsory treatment for psychosocial conditions including mental illness, suggested that such approaches are informed by prejudice, and breach of human rights to equality and nondiscrimination. The movement resulted in the United Nations Convention on the Rights of People with Disability (UNCRPD) a watershed in the human rights discourse. The convention changed perspectives when it shifted the standard from medical model (disease) to social paradigm (disability). It argued
that people with disability have the rights equal to others and have rights to legal capacity, liberty, physical, and mental integrity and the right to informed consent. While the UNCRPD does not explicitly ban force in treatment, its logic suggests a prohibition of compulsion to treatment without consent.

Those who support nondiscrimination argue that while decision-making capacity is similar in physically ill and mentally ill populations, psychiatry presumes capacity in people with the physically disease while questioning it in those with mental illness. They argue that assessing capacity only among people with mental illness is discrimination. They also argue that legislation specifically targeted at people with mental illness adds to the disadvantage of an already marginalized group. They suggest that such laws are an easy way out for mental health professionals and that they reduce communication, negotiation, and persuasion skill.

INCOMMENSURABLE WORLDS

Divergent foci, different models, distinctive paradigms, dissimilar logic, discrete cultures, and differing legal points of view result in incommensurable worldviews. Consequently, patients and their psychiatrists are often on the opposite ends of many divides: Illness-disease, healing-cure, mind-body, and subjective experience-objective clinical phenomena dichotomies. These distinctions are also hierarchical with disease, cure, body and laboratory results privileged over illness, healing, mind, and subjective symptoms. Such value-laden structural dichotomies complicate the task of comprehending complex issues. Patient experience and narratives are trivialized and clinical phenomena, syndromes, and diagnostic categories considered universal and transcendental. The singularity and incommensurability of patient perspectives with medical assessments are dismissed when universal theoretical formations are applied to clinical practice.

The physician-patient divide prevents good communication and impacts on most aspects of clinical interaction. A retelling of the patient’s story, despite the use of the same anchor points, results in the construction of divergent narratives. However, the biomedical retelling, favored by the current political economy of health, seems to argue that is the only authentic version.

The multiple dimensions within patient and physician worldviews also mean variable degrees of overlap. On one hand, people with mental illness can hold personalistic models of their suffering, subscribe to local cultural belief systems, seek healing from traditional healers, deny mental illness, refuse consent for treatment, oppose coercive strategies, argue for their human rights, and fail to subscribe to the biomedical model even while acknowledging disability. Or they might buy into psychiatric models of disease, with variable degrees of agreement about the diverse aspects of their problem.

Psychiatry argues that all those who do not subscribe to the biomedical model can be educated about its scientific basis and advantages; they also tend to dismiss local beliefs, cultural and alternative points of view. Psychiatrists also take over management in the best interest of the patients when they consider a diminished capacity for decision-making. The complexity of the issues provides a fertile ground for differences, disagreement, debate, and dispute.

Nevertheless, both psychiatric concepts of disease and patient perspectives about illness have many similarities: (i) They are conceptualizations, which attempt to explain the episode of sickness, (ii) they are complex, dynamic and total phenomena, (iii) they derive from and help construct reality, (iv) they are culture and value-laden, and (v) they are also part perceptions. The incommensurability of these frameworks suggests that psychiatrists and their patients inhabit different worlds.

The diversity and heterogeneity of people with mental distress and illness also means that a single approach or a simple strategy by mental health professionals to address their concerns will prove unsuccessful. Similarly, no single point of view (e.g., user-survivor) can speak for all those with mental health concerns.

BRIDGING THE DIVIDE

The heterogeneity within psychiatric diagnostic categories mandate individualized assessments and treatment to optimize care. Consequently, the biopsychosocial model became the standard perspective in medicine and psychiatry. Nevertheless, the difficulties of integrating the diverse and contradictory strands, which predispose, precipitate, and maintain mental disorders, often mean a very superficial and idiosyncratic approach to its implementation. Although the elicitation of psychological and social issues in causation is possible, their management in practice is much more difficult. Psychotherapeutic strategies require time and expertise while social interventions are beyond most psychiatrists. Consequently, the biopsychosocial model is often praised and yet it is the biomedical model that is routinely practiced.

Nevertheless, the biopsychosocial model operates within the paternalistic medical culture, where psychiatrists decide the diagnostic formulation and choose management solutions. Despite its attempts at "patient-centered" medicine, psychiatry continues to be undergirded by the "doctor-centered" biomedical model. Social and cultural issues are often on the back burner. In fact, many issues...
related to patient beliefs about causation, impact, treatment and outcome expectations are never systematically elicited, as they are not essential to diagnosis and classification. This results in a neglect of large swathes of information about the patient’s background, concepts, culture, and local reality.

On the other hand, psychiatric assessment, which suggests diminished decision-making capacity in people with mental illness with the risk of harm to self and to others, often results in major disputes over management between patients and their physicians. Compulsory hospitalization and treatment orders, though legally implementable, often strain patient-physician relationships.

Clinical practice demands a negotiation of shared model of care and treatment plan between patient and physician perspectives. The diversity of patients, problems, beliefs, and cultures mandates the need to educate, match, negotiate and integrate psychiatric and psychological frameworks and interventions. Nevertheless, the divergent frameworks and perspectives also mean different worldviews. These worldviews may be incommensurable just as in figure-ground illusions (e.g., Rubin vase/profile illusion). They demand that psychiatrists view the world through patient’s perspectives to understand their reality. Rapid alternations, switching between worldviews, will allow psychiatrists to fully appreciate the complexity of mental illness, its implications and impact on people.

However, beliefs are difficult to change, particularly, if disciplinary training and background socialize psychiatrists into the biomedical role and model, which then define their world. Science, history, tradition, power, privilege, and prejudice combine to produce a medical understanding of mental distress and illness and reconfirm firmly held beliefs. Privileging the biomedical discourse means that patients who value health over personal autonomy find it easier to buy into psychiatric models while it results in discordance with those who favor individual autonomy.

The challenge is to be able to accept the 21st century context, the new sociolegal environment, the innovative disability paradigm, and the nonpaternalistic patient-physician relationship to understand and respect patient perspectives, share power, and negotiate a treatment plan acceptable to people with mental illness and their families.

**CONCLUSION**

The clinical process encompasses the translation of the patient’s world. However, history, politics, identity, power, culture, and context situate the patient and the psychiatrist in markedly different worlds. Their different horizons make a translation of the other difficult. Translating the patient’s narrative, culture, experience, thoughts, and emotions into biomedical language, with its symptom counts sans contexts also means much loss in translation. Despite similar anchor points to the patient’s story, the translation is often problematic. The nuances of the context and situation demand fine calibration. Good translations of the patient experience require expertise, compassion, and trust. Psychiatry needs to acknowledge the serious divide between patient and specialist worldviews and attempt to develop concepts and language to bridge the chasm. There is a need for new synthesis, albeit eclectic, embracing the essence of contemporary biology and humanism.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

**REFERENCES**

1. Duggirala V, Seemantnini N. Patient questions. In: Zachariah A, Srivatsan R, Tharu S (on behalf of the CMC-Anveshi Collective), editors. Towards a Critical Medical Practice: Reflections on the Dilemmas of Medical Culture Today. New Delhi: Orient Blackswan; 2010. p. 246-65.
2. Jacob KS. Patient experience and psychiatric discourse. Psychiatrist 2012;36:414-7.
3. Heath I. Commentary: There must be limits to the medicalisation of human distress. BMJ 1999;318:439-40.
4. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. Bull World Health Organ 2003;81:609-15.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: APA; 2013.
6. Jacob KS. DSM-5 and culture: The need to move towards a shared model of care within a more equal patient-physician partnership. Asian J Psychiatr 2014;7:89-91.
7. McCabe R, Priebe S. Explanatory models of illness in schizophrenia: Comparison of four ethnic groups. Br J Psychiatry 2004;185:25-30.
8. Saravanan B, Jacob KS, Johnson S, Prince M, Bhugra D, David AS. Outcome of first-episode schizophrenia in India: Longitudinal study of effect of insight and psychopathology. Br J Psychiatry 2010;196:454-9.
9. Jacob KS. Insight in psychosis: An independent predictor of outcome or an explanatory model of illness? Asian J Psychiatr 2014;11:65-71.
10. O’Neill O. Some limits of informed consent. J Med Ethics 2003;29:4-7.
11. World Health Organization. Mental Health Atlas 2011. Geneva: WHO; 2011. Available from: http://www.who.int/mental_health/publications/mental_health_atlas_2011/en/. [Last accessed on 2015 Nov 09].
12. Monahan J, Hoge SK, Lidz C, Roth LH, Bennett N, Gardner W, et al. Coercion and commitment: Understanding involuntary mental hospital admission. Int J Law Psychiatry 1995;18:249-63.
13. United Nations. Convention on the Rights of People with Disability People (UNCRPD); 2006. Available from: http://www.un.org/disabilities/convention/conventionenfull.shtml. [Last accessed on 2015 Nov 09].
14. Grissos T, Appelbaum PS. Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals. Oxford: Oxford University Press; 1998.
15. Jacob KS, Kallivayalil RA, Malik AK, Gupta N, Trivedi JK, Gangadhar BN, et al. Diagnostic and statistical manual-5: Position paper of the Indian Psychiatric Society. Indian J Psychiatry 2013;55:12-30.
16. Boyd KM. Disease, illness, sickness, health, healing and wholeness: Exploring some elusive concepts. Med Humanit 2000;26:9-17.
17. Das S, Saravanan B, Karunakaran KP, Manoranijtham S, Ethirarasu P, Jacob KS. Effect of a structured educational intervention on explanatory models of relatives of patients with schizophrenia: Randomised controlled trial. Br J Psychiatry 2006;188:286-7.
18. Eisenberg L. Disease and illness. Distinctions between professional and popular ideas of sickness. Cult Med Psychiatry 1977;1:9-23.
19. Engel GL. The clinical application of the biopsychosocial model. Am J Psychiatry 1980;137:535-44.
20. Ghaemi SN. The rise and fall of the biopsychosocial model. Br J Psychiatry 2009;195:3-4.
21. Jacob KS, Kuruvilla A. Psychotherapy across cultures: The form-content dichotomy. Clin Psychol Psychother 2012;19:91-5.