Clinical paths to empowering patients

By Peter Stastny, M.D.

A HOSPITAL PSYCHIATRIST operates with a distinct sense of power over the patients. He or she is the embodiment of a law that restricts and secludes, that regulates the freedom of those relegated to his or her care. He or she wields the tools of the trade, keys, pen and voice, mostly by rote, unconscionably so.

Psychiatrists learn to distrust the voices of hospitalized patients early on. They question face values, search for hidden meanings, and try to reveal the workings of the unconscious, to display the sequestered facets of madness. Medical folk are trained to diagnose and treat, to cure and rehabilitate, but they are not trained to trust the reports and judgments of those that come to them for help.

Seeking medical advice and intervention can put a person into a helpless role, reinforced by the physician's demeanor. A patient becomes a passive recipient of the doctor's services. Bodily ills are labeled and severed from the suffering mind, subject to curative agents, injected or applied. Psychiatry goes further; it attempts to submerge the person in question under a mountain of neurons, neuroleptics, diagnoses and symptoms, and forgets to ask the crucial questions: Who is in charge of this body? Who owns this mind?

Now seasoned recipients are answering: "We own our bodies and our minds! We would like to be in charge of our treatment!"

But what about serious and persistent mental illnesses? What about psychiatric disabilities? Do they not compromise a person's ability to maintain ownership over his or her body and mind? Do they not interfere with the capacity to pass judgment over what sort of therapy might be appropriate? The answer is complicated and varies from person to person, but without doing our utmost to put patients in charge of their minds, no matter how ill or disabled they may be, we will never know the answer to this key question. Indeed, the overarching goal of psychotherapeutic interventions is to increase a person's ability to master what incapacitates.

In treatment of persons with severe psychiatric disabilities, however, the goal of mastery is often replaced by adaptation. Hospital and community psychiatry still delivers care in a climate of excessive infantilization and professional control, leaving patients as humble petitioners for privileges or non-compliant deniers of illness.

As psychiatrists enter the path towards empowering their patients, they often set out with a laissez-faire attitude. They grant the patients unprecedented levels of freedom and lay back and observe their responses. This attitude can easily be interpreted as a lack of care or nonchalance, because patients have so often been taught that care is synonymous with overprotection and worry. On occasion these attempts to decrease our level of involvement or authority over the patient may become transformed into a stance oblivious to the pain and concerns of patients. Overall, however, the laissez-faire attitude may be a necessary preparation on the part of the psychiatrist for true empowerment, setting the stage for self-determination for patients and a redefinition of the psychiatrist's role.

It usually takes a few years along this road before we dare to ask ourselves the litmus questions of empowerment: Can we trust our patients to carry hospital keys, drive cars, run businesses and, maybe the most loaded question, can we allow the patients to make their own decisions about whether to remain on medication we prescribe?

The clinician must now realize that the laissez-faire stance does not go far enough, and may indeed be a dead-end street. Turning our backs to the patients in the hope of liberating them may very well leave them seriously lacking in skills to master their lives.

Rather than simply removing ourselves as active agents in the patient's treatment, we must begin to engage in a true collaborative effort with the patients toward addressing their particular needs and wishes. Only then can patients begin to move from the status of inmates to recipients to consumers and ultimately to ex-mental patients. Only then can we begin to listen to the voice of the person in our office as an authentic representation of needs and desires. Our trust in them is as important as their trust in themselves; neither alone will lead to rehabilitation. Both in consort can lead to recovery.

Peter Stastny, M.D., is Deputy Director for Program at the Rehabilitation Research and Training Center for Psychiatrically Disabled Individuals at Albert Einstein College of Medicine in the Bronx.

OMHNews