

# Empathy Factory: How Louisiana Can Treat Mental Illness

BY ALEXANDRA LENCZYCKI AND LEEANN DERDEYN, PH.D.  
SOUTHERN METHODIST UNIVERSITY, TEXAS

Throughout human history, illnesses and the way they alter individuals have been treated in two parts, with the healing of both the body and the mind. While these treatments may be more tailored for physically presenting illnesses, the remedy of mental ailments with few concrete symptoms and even fewer concrete treatments can pose a more complex quandary for physicians and the public as recipients of medical advice. This begs the question: If using the same duality and two-step prescription to heal the ailing body part and the mind, is it possible to treat the mind twice?

In Rebecca Solnit's "The Separating Sickness" the history of leprosy and its effects on patients is examined, with an emphasis on the disease as having two separate impacts—the physical symptoms, and the social ramifications that linger even after the antibiotic course is completed.<sup>1</sup> Solnit analyzes the treatment process of leprosy patients carried out by doctors of the National Hansen's Disease Programs in Louisiana, and develops a treatment model consisting of a physical cure based in biology and medicine and an overwhelming dose of emotional support. When comparing this practice to other physically altering diseases in modern medicine, any illness with the potential to be life-altering is almost always treated with medicine as well as clinical compassion that follows a similar model. Despite the growing volume and momentum of conversations on mental illness in the modern world, this two-part treatment of biological and social understanding is prescribed tentatively at best—if at all to those suffering from it due to setbacks on both fronts. This lack of social healing is rooted in the pervasive stigma on mental illness that persists in societies today, which both inhibits the seeking of initial help and reforming social relationships even after treatment is sought. Furthermore, the biological treatment of mental illness is restricted through not only the restriction of research on these illnesses and ways to cure them, but also by the lack of access to treatment that some may experience due to social or economic disparity. These factors culminate in a treatment system for mental illness that lacks in biological remedy, as well as social compassion. It is a system

that would become far more effective if it became more contingent with the powerful treatment of drugs and empathy that is described in Solnit's leprosy clinic.

Despite the simplicity of treating physical illnesses with physical cures, often times there is more to treat than solely the body. Solnit surmises this best in her discussion of leprosy when she states that it is "really two diseases: the physical effects and the social response to them."<sup>1</sup> Her entire essay details both the physical debilitation of the disease and the steps taken to treat patients, and the emotional support given to them by their caretakers as a more holistic course of treatment even after the patients had been medically cured of their leprosy. Often times, there were lingering symptoms that necessitated treatment of a different kind, often laden with emotional support and education. Solnit underlines this claim with the declaration that "[t]oday, most leprosy research focuses not on the bacterium but on patient care."<sup>1</sup> While the treatment of leprosy consists of an "effective multiple-drug solution" followed by routine patient care, in other instances of chronic illness or lingering side-effects of acute illness, the physical effects of the illness are treated alongside the psychological ones.<sup>1</sup> Trisha Greenhalgh describes this method of treatment in her article "Chronic Illness: Beyond the Expert Patient," which functions as a sociological record for patients' adaptation to chronic illness during their course of physical treatment. In her examination of a patient with diabetes, she reported that "both patient and clinician had to work hard to achieve the goal of getting on with life . . . health care should be seen not as a series of decisions made by the patient or clinician at particular times (as in shared decision making) but as never ending, full of surprises, and having continuously to adapt."<sup>2</sup> Despite this seemingly effective model of patient and clinical expertise, Greenhalgh warns that in order for this model to work, there must also be effective change within society that accommodates these changes on a larger scale. Moreover, there needs to be challenges to the current model of patient care, where the focus is placed solely upon medical improvement. While helpful to the patient, Greenhalgh

asserts that "it is time to move beyond [these methods] and embrace richer, more holistic models which consider a person's family, social, and political context. . . . We need more whole systems programmes [sic] of change, especially where social determinants of health inequalities loom large."<sup>2</sup> While in recent years there has been an increase in advocacy regarding the social empowerment of those struggling with disability or chronic illness, there has been less discussion of this model in relation to mental health. The care and treatment of those suffering from mental illness has improved dramatically in the last fifty years with the increased exposure it has gained from activism of all sorts, and many effective treatments for mental illness today consist of proper medication and consistent psychological services that parallel the management systems discussed by Solnit and Greenhalgh. However, as Greenhalgh and Solnit also implied, there is a necessity for change that would allow complete acceptance of individuals that are currently marginalized by the broader common public. This is especially true of those affected by mental health problems, as the rampant stigma against these individuals is still prominent in many societies today, despite more intensive efforts to mitigate these harmful social issues.

The stigma associated with mental illness poses a troubling paradox—in spite of its more widespread acknowledgment and validation on the global health stage, it still persists as an elusive and underreported issue due to the threat of alienation from the common public culture. Peggy Thotis addresses these subjects in her article, "Resisting the Stigma of Mental Illness," citing the idea that "[t]he mentally ill" are believed to be unpredictable, irrational, dangerous, bizarre, incompetent, and unkempt," and when these stereotypes were tested "[i]n laboratory studies, desire for social distance is evident in awkward interactions and negative ratings of persons believed to have had mental health problems."<sup>3</sup> The negative association of those with atypical neurological behaviors has been a pervasive cultural theme that only seems to solidify as societies continue to marginalize those requiring mental care. As societies continue to pressure individuals toward growth and

advancement, those deemed outside the “normal” curve are believed to be a hindrance, and are ejected from classes of productivity for being unable to keep up in the midst of their own mental and emotional quagmires. Solnit considers this in her own thoughts on suffering, where she muses that “[u]p close, aggressive measures are required to be impervious to suffering; you have to convince yourself that . . . their suffering has nothing to do with you.”<sup>21</sup> This offers some insight into the stigmatization of others perceived to be outside the normal functioning whole, expressing an idea possibly shared by larger societies that one’s struggles are uniquely their own, and should not be brought to the social or vocational table. Angela Thachuk validates these claims with her own research, offering that “[mental illness] undermines [patients’] consideration as eligible candidates for employment, threatens job security, and limits possibilities for professional advancement,” with her own references to Otto Wahl’s book, *Telling is Risky Business*.<sup>4</sup> These facts of disparity are rooted in the earlier research of Thotis, creating a debilitating set of stereotypes that prevent many from speaking up about their illness and advocating for the help they require due to the fear of being labeled “mentally ill.”

However, even after asking for help despite these social pressures, patients may also be discriminated against in the medical sphere. Thachuk surmises this by stating: “the legitimate concerns of those patients already labeled mentally ill are often viewed through the lens of their diagnosis. When histories of psychiatric treatment are disclosed, individual complaints are often not taken seriously, and care is compromised.”<sup>4</sup> This sort of treatment from any medical professional can have debilitating impacts on patients who may already be compromised due to mental problems. When a history of mental illness is uncovered, Thachuk argues, a patient ceases being a patient and instead becomes a statistic or laundry list of intimidating symptoms, stripping the individual of their identity and instead offering alienation instead of treatment. Solnit describes something similar with her studies in the leprosy clinic in Baton Rouge, where she notes that when one of the patients enduring a rare, modern case of the disease sought treatment in a general hospital, “the medical staff at the hospital regarded [him] with puzzlement and dread, asking his parents to put on gloves, masks, and gowns when visiting him.”<sup>21</sup> His experiences in the hospital had followed his visit to another doctor about skin rashes, to which the doctor prescribed topical treatments that were of no use. Only after he was in a situation of extreme stress involving

loss of consciousness was he ushered to the hospital, and even still was regarded warily by medical professionals. In both cases, patients experienced alienation from the public and hesitancy from physicians, making it incredibly difficult to guarantee proper treatment or even acknowledgment from the wider, more “normal” societal whole. In addition to these social hardships, in both situations the lingering effects of a diagnosis of mental illness or leprosy left a larger impact on their lives, and continues to leave the same type of impacts on patients with mental illness today.

Studies have displayed a correlation between the prominence of mental illness and socioeconomic disparity. In a study conducted by Ann Bartel and Paul Taubman, individuals diagnosed with mental illness were separated and categorized by severity according to the type of illness, and comparisons were made with earnings made by the individual over a period of years. Following their findings, they conclude “no elaborate economic theory is needed to believe that mental illness affects success at work. Thus it is not surprising that Bartel and Taubman found that those suffering from any mental illness had lower earnings and worked fewer hours.”<sup>25</sup> In spite of this rather broad conclusion, Bartel and Taubman did discover that there was “a reduction of 15% in earnings on diseases first diagnosed 15 or more years earlier.”<sup>25</sup> This is further emphasized by Thachuk’s argument addressed earlier, where those labeled as mentally ill find themselves at a significant disadvantage while job-hunting beneath stigmatizing employers. As a result of these factors, the reduction in wages serves as a detriment to an individual’s standard of living overall, limiting the ability to access healthcare, housing, and higher-paying jobs.<sup>4</sup>

Access to mental health treatment also experiences disparity based upon race, as outlined in an article published by Julian Chun-Chung Chow, Kim Jaffee, and Lonnie Snowden titled, “Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas.” In their report, Chow, Jaffee, and Snowden state that “poor areas with a high proportion of minority residents generally lack the resources needed to maintain community services at a minimum level. This dearth of services decreases access to mental health treatment and exacerbates mental health problems for minority and other residents in those communities.”<sup>26</sup> The lack of economic promise based on race and status may create a barrier to healthcare for some, as those with lower economic status are less likely to have the access to the insurance or finances needed for mental health treatment. This lack of access contrasts directly with

the level of access granted to those in need of treatment for leprosy, with the National Hansen’s Disease Clinical Center (NDHCC) offering free physician consultations for doctors treating patients across the country, pathological reviews of biopsies, and treatment antibiotics available at no cost to patients.<sup>7</sup> While these services are available exclusively to physicians treating patients, the abundance of resources made available for individuals at little to no cost across the country—despite the NDHCC’s sole location in Baton Rouge—allows patients to benefit directly from these services. In contrast, the difficulty of accessing mental health care is far greater with the consideration of social alienation as well as racial and economic status as well. These added stigmas and restrictions of care place a vast amount of pressure upon individuals already struggling with mental illness. With these factors combined, they may also act as a buffer against re-assimilating with the rest of “normalized” society. For some that remain trapped in a system of privilege and animosity toward those beyond the center of the productive neurotypical bell-curve, the pressures wrought by the toxic blend of socioeconomic disparity and personal health needs can create a debilitating issue that requires more than medicine to fix.

In addition to the difficulty of access to healthcare for some, throughout history it has also not been uncommon for research and treatment options in mental healthcare to lose funding as budgets constrain healthcare providers and drug companies. In her article, “No New Meds,” Laura Sanders discusses the current idea plaguing the playing field for many mental health care professionals. She posits that many doctors and researchers are bemoaning the fact that “drug development for complex psychiatric illnesses is misguided . . . faulty assumptions, animal models that don’t look anything like human diseases, hazy diagnoses and a lack of knowledge about how the brain works have all thwarted the search for better drugs.”<sup>28</sup> The press for funding cuts against a wider, marginalized public in desperate need of treatment mirrors other situations of historical significance, as seen in the need for leprosy treatments discussed in Solnit’s article. Her discussion of the history of the Carville treatment center is precluded by the notion that they could only offer palliative care to patients in the early years, instead of offering viable treatment options, due to the restricted availability of drugs that actually worked. This mirrors the discussion proposed in Sanders’ article, with her assertion that the drugs that are currently on the market do little to actually treat the mental illnesses of trial patients; rather they offer some semblance of treatment for the

symptoms at the cost of results and an assured future for the psychiatric drug market. Some drugs are even purported to cause the chemical imbalances they are attempting to fix, as discussed in Robert Whitaker's "Bitter Pills." Whitaker discusses the rise of the "chemical imbalance" theory of mental illness in the 1960s, when scientists were first testing antipsychotic medications and they appeared to be working in mentally ill patients. As a result, "this led them to hypothesise [sic] that schizophrenia was caused by too much dopamine activity," and they continued to prescribe medications that blocked dopamine receptors as a viable source of treatment.<sup>9</sup> After a while, however, scientists began to theorize that these medications were actually the ones causing the imbalances due to the brain's adaptation to the chemical levels. Whitaker supports this theory by explaining that "the brain is trying to nullify the effects of the drug . . . [and] is functioning in a manner that is 'qualitatively, as well as quantitatively, different from the normal state.'" The release and continued prescription of these drugs for over fifty years now, despite the side effects and research on them, is alarming. However, with Sanders' analysis of the drying psychiatric pharmaceutical pipeline, there may be few other viable options to treat patients which only adds to the necessity of different, more comprehensive treatment models for those needing mental health care.

The reasons behind the difficulties to find viable treatment options for these diseases may be rooted in problems with pathology research itself. Solnit cites that research and development for more effective treatment of leprosy is slowed by the difficulty to pin down the cause of the disease itself, a trait that is also shared in the realm of research on psychological ailments. She writes that "the bacterium is delicate and slow. . . . Unlike almost all other bacteria, *M. leprae* cannot be grown in the laboratory, putting ordinary research methods out of reach. . . . Today, most leprosy research focuses not on the bacterium but on patient care."<sup>1</sup> This idea, while not necessarily the exact same as the manifestation of mental illness in patients, proves true with both parties. Testing for mental illnesses and how they respond to tests and treatment is an immensely delicate process, one that must be tailored to an individual and results in a rather large amount of resources for effective research and development. In addition, research and treatment courses for specific illnesses may not always be applicable to every case of illness, with variance being a large factor from patient to patient. It is through these reasons that both leprosy and mental illness treatments are slow to be realized, and there

exists a threatening possibility that effective treatments for these ailments may not be realized in the short-term, if at all. Solnit's case illustrates why it is vital in spite of these barriers to do the best that clinicians are able to mitigate the symptoms of their patients and treat them with compassion. With this model in mind, in spite of its slow research and limited treatment viability, the validation and empathy that is offered to patients suffering from mental illness can behave as a vital step on the road to improvement.

The prevalence of mental illness on a global stage is growing at a rapid pace, while the global record of leprosy cases continues to dwindle. In spite of these differences, the establishment of parallels and differences in care access, treatment, and the potentials of both sets of patients are paramount in assessing how to better treat patients in both categories. Overall, however, one of the most vital pieces of treatment that cannot be overlooked is the way each patient in both categories must be treated with respect, validation and compassion. The existence of empathy on the prescription or treatment schedule for any patient is vital, regardless of physical or mental illness. This continued remedy has been bustling around Carville and Baton Rouge for years, as Solnit notes, and the practices of the so-named "empathy factory" ought to be exported to all other patients as a side treatment for whatever they struggle with.

## References

- <sup>1</sup>Solnit, R. (2014) "The Separating Sickness." *In The Best American Science and Nature Writing*. Blum, D, ed. Houghton Mifflin Harcourt. Pg 345-357.
- <sup>2</sup>Greenhalgh, T. (2009) "Chronic Illness: Beyond the Expert Patient." *BMJ: British Medical Journal*. 338.7695. Pg 629-31.
- <sup>3</sup>Thotis, P. (2011) "Resisting the Stigma of Mental Illness." *Social Psychology Quarterly*. 74.1. Pg 6-28.
- <sup>4</sup>Thachuk, A. (2011) "Stigma and the Politics of Biomedical Models of Mental Illness." *International Journal of Feminist Approaches to Bioethics*. 4.1. Pg 140-63.
- <sup>5</sup>Bartel, A. and Taubman, P. (1986) "Some Economic and Demographic Consequences of Mental Illness." *Journal of Labor Economics*. 4.2. Pg 243-56.
- <sup>6</sup>Chow, J., Jaffee, K. and Snowden, L. (2003) "Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas." *Am J Public Health American Journal of Public Health*. 93.5. Pg 792-97.
- <sup>7</sup>N.A. "National Hansen's Disease (Leprosy) Clinical Center, Baton Rouge, Louisiana." *Health Resources and Services Administration*. U.S. Department of Health and Human Services. <<http://www.hrsa.gov/hansensdisease/research/>>. (Accessed 04/20/2016)
- <sup>8</sup>Sanders, L. (2013) "NO NEW MEDS: With drug firms in retreat, the pipeline for new psychiatric medications dries up." *Science News*. 183.4. Pg 26-29.
- <sup>9</sup>Whitaker, R. (2011) "BITTER PILLS." *RSA Journal*. 157.5547. Pg 16-19.