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Travelers in the Land of Sickness

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THE PROBLEM OF knowing another person and the world in which that person lives, particularly someone with major mental illness, is addressed in this interesting and rich essay. The number of different metaphors and concepts Potter employs to describe the task of crossing into and then understanding the thoughts, emotions, symptoms, constraints, context, and perspectives of another testifies to the difficulties involved.

Yet, as I read the essay, it was not clear what the clinician world traveler, moral tourist, empathizer (and other categories) is *supposed to do* on the journey to another person. Why do we reach out to the sick person? What is it that we want to know or do that makes this trip necessary? Potter is primarily concerned with mental illness—the examples she cites are patients with schizophrenia—while my experience has in the main been with persons with physical illness, but for the moment, the differences are less important than the central lesson. The illness that the patient presents—the experience of the symptoms, the impairments, disability, and disruptions of the emotional and social existence that happen because of the disease result from an amalgam of the disease process with the specific nature of the sick person. There is no disease in pure form; there is no disease in abstract for clinicians. There is only this sick person. She correctly quotes me, because of all this, as pointing out the importance of integrating knowledge of *this particular* patient with the abstract knowledge of disease to understand the illness as it is expressed in this person. All to form a basis for the treatment of the patient and especially to help relieve suffering because suffering is always personal, particular, and individual. (It is important in thinking about this topic to remember that most serious diseases, psychiatric and otherwise, are chronic and take place over significant lived time. The acute schizophrenic symptoms or the acute infectious diseases, as dramatic as they are, distract attention from the importance of the place of the sick person.)

In physical disease, our long (and continuing) history of separating human beings from nature and the body, and the importance medicine places on objectivity and the objective, have made the inevitable personalization of the disease and symptoms virtually invisible. After ages of explaining psychiatric diseases as the alienation of the person, and a long psychoanalytic period of finding their origins *in* the person, in the last 30 years these diseases have become increasingly objectified. The place of the person has been diminished as psychiatry has entered the DSM, neurotransmitter, and effective psychotropic drug era. For both physical and

mental disease, however, and whatever the current ideology, the nature of person is crucial in determining the onset, diagnosis, course, treatment, and outcome of each illness. It is in order to have an impact on these crucial aspects of sickness that clinicians must come to know their patients to the degree possible. **[End Page 225]**

But there is something more. Nancy Potter quotes a woman with schizophrenia as saying, "All that was my former self has crumbled and fallen together and a creature has emerged of whom I know nothing. She is a stranger to me . . . She is not real—she is not I . . . She is I—and because I still have myself on my hands, even if I am a maniac, I must deal with me somehow." (Potter, 2003, p. 215)Must she deal with this crazy self alone? Is that not what her doctors and caregivers are for? But how can they take care of her, protect her, keep what is left intact, and sustain her until she is (hopefully) better without knowing who she is? She makes clear in those few phrases that inside her there is a person with a past, a family, a world, a culture, a role(s) in life, relationships, a body, dreams for the future, things she does, and all the other things that make up a person. It is in terms of those things that she is ill. The disordered thought of her disease may be the reason, but the disordered person is the illness. We can see the person with cancer in similar terms, although without the serious disorders of thought.

Think what the healthy generally need and have and you will know more what it means to be sick and why the physician or other clinicians must reach out specifically to the sick person. The healthy have security; they are not racked with fears and irresolvable worries. They have a sufficiency and are not hungry, unclothed, or exposed. They have meaningful human interactions of their choice. They are not lonely or kept among others not of their choosing. They have a community of choice with others to depend on and are not alienated. They have purposes, goals, and intentions; hopes, desires, and expectations. They are not purposeless, at sea, or hopeless. They are aware that they can do things and make things happen. They do not feel useless or helpless. They have a realistic desire to be like others and to be admired. These are not beyond possibility. They have a sense of self-worth and they do not feel persistently worthless. They have an identity and they know it and so do others; *anomie* is not their fate. They have privacy and are not continuously exposed to the eyes and probing of others. Their world is orderly and coherent and they know what things mean. They are not like those who often cannot comprehend what things mean in their chaotic world. The healthy expect to learn and change. A seemingly unending stasis is not their lot.

Reflect on these aspects of life and you will realize that people with serious disease can be like the well or like the sick. What happens to them can be helped by others. It is more difficult to help the mentally ill be like the healthy, but it is not impossible. It requires clinicians who can travel into their world and know what to do in terms specifically of them. Reflecting on these criteria of health and sickness it is obvious that telling Lenny that, "There are no women who are also paintbrushes in this group," even in company with effective antipsychotic medication, is not sufficient treatment for mental illness. It dehumanizes Lenny and the others in the group to see them as if they were just people whose behavior is psychotic rather than sick persons painfully injured in those areas I just described whatever the nature of their psychosis. Similarly chemotherapy, or radiation, or surgery, as effective as they may be, is insufficient treatment for patients with cancer because they too are sick. It dehumanizes them to act as if, whatever their disease, their autonomy is preserved. As if that was possible

without the aid of others. Someone has to reach across a void to help sick people; to find them and know them as authentic in the midst of the sickness. The agent of treatment is a world-traveling empathic clinician.

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Reference

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