2. Perspectives of Mental Illness

2.1. Concepts of Mental Illness from a Historical Perspective

“There is still much to be learned about the specific causes of mental and behavioural disorders” (WHO 2001, 10).

To develop an understanding of mental health care I shall, first of all, consider how conditions of mental illness have been understood historically. Overall, aetiology as well as treatment and therapies of mental illness have always been subject to discussions. Essentially, assumed causes for mental illness have changed considerably over the last two centuries (Prior 1993). The notion that ‘madness’ is a form of illness has not always existed as such which is mostly mirrored in the absence of any form of specific treatment up to the 19th century. As Ingleby (1985, 146) interprets Foucault, “up to the mid-17th century, the mad had been allowed to remain in the open, either cared for by their families or set loose to roam the countryside.” From that time onwards until the end of the 18th century, the ‘insane’, the criminals and the poor were ascribed a kind of similar status and were usually kept in custodial care as a heterogeneous group in some sort of asylum (Foucault 1973; Goodwin 1997).

With the beginning of the industrial age, separate places such as prisons for punishment, ‘working-houses’ and mental asylums were established. From then on, the mentally ill where kept separately from other groups on the social margins. For example, in 1784, the Viennese ‘Narrenturm’ was built for that purpose under Joseph II (Döcker 1994). According to Busfield (1999, 59) “the new asylums [were] standing in an institutional space somewhere between hospitals for the sick, prisons or penitentiaries for criminals, and workhouses for paupers, just as insanity, a lay more than a medical concept, stood in the conceptual and practical space between deviance, sickness, poverty and normality”. During that period, regulations of admission and discharge were judicial rather than medical ones and reasons for confinement can be summarised as having been mainly moral ones. “Thus it was the particular conception of sanity embraced by the ‘age of reason’ that constitutes, by opposition, the category of madness” (Foucault 1965 in Ingleby 1985, 147).

At the beginning of the 19th century, mainly triggered by the proceeding secularisation, madness was increasingly believed to be curable (Döcker 1994). Hence, the status of asylums began to change. Supported by a wave of therapeutic optimism, inmates were freed from chains, straitjackets and other physical instruments of restraints (Busfield 1999). A regime based on ‘morale treatment’ (in German ‘psychische Kurmethode’) was introduced which was viewed as a ‘more humanitarian’ approach to lunatics. Asylums were no longer solely regarded as places for custody and care but also as places of treatment and retreat
away from encumbering places of dirt and chaos in town centres (Lesky 1978). Notably, a separation between the ‘curable’ and the ‘uncurable’ mad took place. Due to the changing requirements a number of asylums were newly built or adapted.

In the geographic area of what is now Austria, reforms only took place selectively. Thus, in Vienna, the first asylum for ‘traitement morale’ was established in 1819, when Bruno Goergen was authorised to open a private ‘Heil- und Irrenanstalt’ in Gumpendorf which was transferred to Döbling in 1831 (Jetter 1982). Only in 1853, the first public ‘Heil- und Pflegeanstalt’ which operated according to ‘no-restraint principles’ was established ‘auf dem Bründelfelde’ (Lesky 1978). Although the fact that a form of therapy was carried out mirrors a notion of illness, the concept has not been a medical one in an orthodox sense. Rather, it can be described as a form of pedagogical behavioural therapy which was influenced by a mixture of patriarchal, romantic and enlightenment ideas (Dörner 1974). Marxist writers have argued that what is described as humanitarian approach, was in fact the ‘reprogramming’ of the insane in order to function as productive members of society (e.g. Scull 1985). Overall, attempts of improving conditions had limited effects and the situation was still more custodial than therapeutic in character (Goodwin 1997). Not least, analysts have emphasised that during that period new forms of repression replaced the old ones (e.g. Döcker 1994).

The 19th century was also the time when the epistemological positivist revolution led to the development of medicine as a natural science, which brought about the rise of the medical profession. During the second half of the 19th century, psychiatrists (who had so far specialised in the caring of mentally ill patients) became increasingly eager to adopt the medical model, hence, turning psychiatry into a medical science. With the entering of psychiatry into medical science, mental illness became an illness of the brain. The origin of this concept in the German-speaking area can be traced back to the psychiatrist Wilhelm Griesinger who’s biological concept was published in 1845 in ‘Pathologie und Therapie der psychischen Krankheit’ (Lesky 1978; Gröger 1999). In the positivist climate his ideas became increasingly accepted whilst other, more holistic approaches by so-called ‘philosophical doctors’, won little recognition. This development was accompanied with the psychiatrists’ claims to base psychiatry at university teaching hospitals which led to a separation between university psychiatry and ‘non-clinical asylum-psychiatry’. The separation persisted for numerous decades, with university psychiatrists gaining increasing reputation (Lesky 1978).

Within the developing medical psychiatric approach, several discrepancies emerged. While some psychiatrists followed an anatomical-physiological approach of explaining mental illnesses with (sometimes keen) brain-physiological hypotheses, others held the view that psychiatry had to be restricted to a merely descriptive science. In Austria, a well-known dispute in that context
emerged between Theodor Meynert, who was a representative of the former opinion and Richard Krafft-Ebing, who adopted the latter view. When Julius Wagner-Jauregg researched the interrelations between physiological processes in the body and mental illness, another important development within the medical model of mental illness appeared, which can be described as scientific shift from research of physiology and pathology of the brain to physiology and pathology of the body (Gröger 1999; Lesky 1978). What all of these approaches had in common was that they based the causes for and/or treatment of mental illness on a biological concept of illness.

In the early 20th century, some further and rather rivalling concepts of mental illness emerged which have significantly influenced today’s psychiatry. One of these concepts was developed by Emil Kraepelin, who followed the biological strand and the related concept of mental illness as a disease of the brain. His observations resulted in a new type of classification which differentiates between manic-depressive and schizophrenic forms of mental illness (Andreasen and Black 2001; Katschnig 1998). This classification is still valid in modern psychiatry, albeit in a more elaborate form.

The second person, who has significantly contributed to our current concept of mental illness was Sigmund Freud. According to his theory, mental illness is a disease of the mind. In his well-known publication about hysteria which he had written together with Joseph Breuer, he argued that some types of trauma that occur early in life can lead to manifest pathologies of the mind which later on cause irritations (Bolognese-Leuchtmüller 1994; Lesky 1978; Prior 1993). After a period of biological-dominated theories, this model added a completely new dimension to mental illness. Undeniably, it has shaped psychiatry and its concepts and theories.

Finally, a third model was the ‘social model’. Thus, influences of the social environment on mental health and illness became an important issue with respect to aetiology and therapy. Although interests in the association between social issues and mental illness cannot be traced back to one point of origin, one significant contribution for that approach has been made by Émile Durkheim. He developed his concept out of the results of an empirical analysis where he discovered a strong correlation between high suicide rates and bad social conditions (Katschnig 1998). Unlike previous theories, in this view, mental illnesses are ‘social illnesses’.

Although the outlined arguments have become a lot more differentiated over the last decades, these three styles of thoughts, namely the biological, psychological and sociological principle, have considerably influenced today’s theories of mental illness3. Thus, according to the WHO (2001), modern science is

---

3 Although it will not be addressed in the thesis, it has to be noted that during the period of Nationalsozialismus, psychiatry entered a disastrous period; the concept of mental illness in that period resulted in killing of thousands of people due to eugenic practices.
still showing that mental disorders have an organic, a social and a psychological base. The relationship of these factors is, however, complex and multidimensional. For example, while genetic risk factors for mental illness have been identified which has enforced biological arguments, more recent research has shown that it is predominately the interaction of multiple risk genes with environmental factors which leads to the onset of some disorders (WHO 2001). Influences of postmodernity have, furthermore changed the perception of mental illness from being a single fact at a point in time to the understanding of mental illness as a process. This requires addressing different factors such as predisposition, onset and proceeding of the illness. Additionally, the scale of what is regarded as mental health problem has grown. An increased range of behaviour patterns, such as substance abuse, is nowadays seen as product of a mental disorder.

On the whole, the complexity of causes of mental illness is still unclear. None the less, knowledge about treatment methods has increased considerably including biological, psychotherapeutic and socio-therapeutic approaches. In summary, ‘modern Western’ psychiatry is a rather eclectic field notwithstanding the overall domination of the biological medical model in treatment and therapy (Pilgrim and Rogers 1994). Apart from professionals’ concepts of mental illness, one should bear in mind that patients and lay people usually define their own individual concepts of mental illness. These are likely to differ from expert ones due to different perspective and different personal concerns. These fragmented sets of perspectives show that diverse concepts are not merely a matter of terminology but also reflect different types of reality.

While the positions summed up so far emphasise the factual reality of mental illness, some researchers have raised a rather contrasting perspective. Thus, some sociologists and also psychiatrists themselves have argued that the whole concept of mental illness is nothing else than a social fabrication which is scientifically worthless and socially harmful (e.g. Szasz 1974). An additional critical approach is provided by the so-called ‘labelling-theory’. It is mainly concerned with how individuals react to and categorise deviance, the associated negotiation and maintenance of the patient’s role and the way symptoms become diagnosed as mental illness (e.g. Goffman 1973). These theories are either entirely or at least partly based on a social constructivist position. Some of the critics mentioned have also specifically addressed the role of professionals in context with concepts of mental illness. While conventional historiography by psychiatrists describes medicalisation of psychiatry as revolutionary breakthrough, other writers have contrasted this view with the argument that mental illness has been constructed and used by professionals to legitimise their position. Thus, the rising profession of psychiatrists gradually discovered the ‘insane’ as their clientele, only to finally replace old places of social control with new ones, which were the mental hospitals (e.g. Dörner 1974). In the critics’ view, the beginning of the medical treatment of mental illness was neither due to an altruistic motive nor was it the
result of available effective treatment methods but it was rather due to the self-interests of medical professionals.

What these critical positions have in common is that they draw attention to the issue that what has been defined as mental illness has also to be seen in the light of various forms of social control and norms. Although the theories have somehow fallen out of fashion nowadays, similar topics have also been raised in more recent work. For example, Astbury (2002, 149) remarks that “all diagnostic criteria and assessments of mental health depend on the theoretical constructs of human behaviour, on what is believed to constitute the normal, and how this can be clearly distinguished from the pathological.”

To conclude, this thesis is based on the notion of a factual reality of mental illness. Nevertheless, the critical arguments are particularly valuable to maintain a reflective approach concerning value-judgements and tacit cultural knowledge which may constantly shape this reality.

2.2. Terminology and Definitions

The previous chapter has shed some light on the historical developments in psychiatry. In the following paragraphs this information will be applied in order to define terms which will be used in the remainder of the text. Hence, I am going to outline what I mean by ‘mental illness’ and ‘mental health care’ and which terms will be used for people who are affected by a mental illness.

As I have shown in the previous part, rather than being based on a single concept, markedly different perspectives and frameworks of the nature of mental illness exist. When referring to ‘mental illnesses’\(^4\), the definition according to the ‘International Statistical Classification of Diseases and Related Health Problems (ICD-10) will be used (Dilling 2000). This classification includes a wide range of categories of mental disorders and, thus, reflects a very broad concept of mental illness. The definition I am using does not include mental disability. I am aware that nosologies to classify mental ailments are arbitrary in essence and that they have also been subject to criticism. It has, for example, been debated whether the instruments which are used for data collection and classification reflect the actual entities of mental disorders or whether they reflect biased constructions of mental diseases (e.g. Cermele, Daniels and Anderson 2001; Copeland 1981). Prior (1993, 110) has put it this way: “They [instruments] could only produce the phenomena which they were supposedly designed to discover and measure.” These critical voices need to be remembered.

If it is not completely understood what ‘mental illness’ is, the definition of what does or does not constitute ‘mental health care’ is similarly difficult to

---

\(^4\) Although a differentiation can be made between mental ‘disorder’, ‘illness’ or ‘disease’, for the purpose of this thesis these terms will be used synonymously.
determine. Indeed, concepts of mental illness have changed considerably over the centuries and, not surprisingly, so has the organisation and provision of mental health care. According to Prior (1993, 12), "in any event, it is clear that what people think and believe about mental disorder is invariably reflected in some manner in the conceptual, material and bureaucratic tools which they use to organize such conditions." In other words, with changing concepts and theories for mental illness the organisation of mental health care changes. However, Prior (1993) argues that the changing practice of care is not exclusively a direct reaction to an objectively given nature of specific disorders (which is to be discovered by the development of medical knowledge) but practice of treatment and care also implies a constructivist element of 'creating and inventing', that is a socially conditioned knowledge which is influenced by structural factors of society. The quote also makes clear that current perceptions of mental health care have been influenced by preceding historical styles of thought about mental disorders.

These processes need to be remembered when outlining the 'modern’ definition of mental health care which will be followed in this thesis. The analysis in the following chapters will illuminate the current concept of mental health care in more detail. For the purpose of definition at this stage 'mental health care’ is understood in a very broad manner, including various institutions and being related to manifold policy sectors. Thus it includes acute as well as long-term care and health care as well as social (care) issues. Apart from services which specifically address the mentally ill, mental health care is also regarded as being part of more general social and economic policy. It is clear that this understanding mirrors a specific concept of aetiology and treatment of mental illness which, in correspondence to the concept of illness discussed earlier, can be summarised as multidimensional.

Finally, it needs to be considered which term to use for people who receive services. History has shown that different interest groups have claimed their right to define these terms. In the recent past such claims have increasingly been made by user groups. This has not necessarily resulted in a consensus on which vocabulary to use. On the contrary, terminology remains a controversial issue in that context. For example, the term ‘mentally ill’ has been rejected by some persons of the anti-psychiatric movement whereas others regard it as appropriate way of understanding their distress (Barnes and Bowl 2001; Mueser et al. 1996). Meanwhile, a great variety of terms exists ranging from ‘users’, ‘ex-patients’, or ‘survivors’ to ‘patients’, ‘consumers’, ‘clients’ or ‘customers’. As Sayce (2000, 14) points out: “No term is without pitfalls.” In chapter 0, particular attention will be drawn to these issues. For the overall thesis, where possible, I refer to people by the terms they choose themselves. Since the thesis argues for a factual reality of mental illness, in the remaining cases people who are affected by such an illness will be termed ‘mentally ill persons’, ‘patients’ or ‘users’.
2.3. Dimensions of Mental Illness

The following parts will provide a rough picture of mental disorders from an epidemiological and socio-economic point of view.

2.3.1. Epidemiology

Mental illness belongs to the most prevalent and disabling diseases world-wide. The World Health Organisation has recognised the importance of mental health and illness for a long time and has dedicated the World Health Report 2001 to this issue (WHO 2001). According to results of their literature surveys, on average more than 25% of individuals worldwide develop one or more mental or behavioural disorders during their entire lifetime. Intercountry variations are, however, wide and range from a lifetime prevalence rate of 12.2% in Turkey to 48.6% in the US (WHO 2000). According to Katschnig et al. (2001), large epidemiological studies in the EU and USA have detected a one-year prevalence of mental disorders of 30%. Hence, within a period of one year, around one third of the population is affected by a mental disorder. The overall lifetime prevalence rates are similar for men and women, notwithstanding marked gender differences for specific disorders and the process of illness. Most commonly diagnosed distresses among women are depression and anxiety disorders, while men most frequently suffer from substance abuse and dependencies. For severe conditions such as schizophrenia and bipolar disorder, lifetime prevalence rates are much lower (0.1% to 3% for schizophrenia and 0.2% to 1.6% for bipolar disorder) and gender differences have not been detected (Astbury 2002). However, gender differences exist in other dimensions of severe mental illness. For example, women have later onsets of schizophrenia than men (Piccinelli and Homen 1997) and are more likely to develop rapid cycling forms of bipolar disorders than men (Leibenkuft 2000).

In Austria, large-scale epidemiological studies of mental illness have not been undertaken so far. In 1993, a survey asking for mental well-being was carried out using a representative sample of 1,408 persons aged over 14. Calculated 4-week prevalence rates for depression, anxiety disorders and psychosomatic disorders were 17.5 % for women and 15.1 % for men (Katschnig et al. 1993).

One form of mental disorder which - due to demographic changes - has received increasing attention over the last years is dementia. For the year 2000, Wancata, Kaup and Krautgartner (2001) calculated a prevalence rate of 5.41% among the Austrian population aged 60 and over. The prevalence for the population which was older than 65 years was 6.93%, whereas for the over 80 years old it was 18.5%. In absolute figures, in 2000 90,500 people suffered from dementia. This figure has been estimated to rise 2.58 times by the year 2050 to
233,800 persons with Dementia in the Austrian population (Krautgartner, Berner and Wancata 2001).

On the whole, incidence and prevalence rates of mental illness have risen considerably over the last decades. It is, however, unclear whether this can be explained by factual rises of illnesses or by higher detection rates of formerly hidden cases.

2.3.2. Socio-economic Status and Mental Illness

The relationship between socio-economic factors and mental illness is a multidimensional one. While several studies have shown a correlation between poverty (associated with low socio-economic categories) and mental disorders, the direction of these relationships is unclear. Thus, according to the social causation explanation, poverty is a risk factor for the development of mental illness. On the other hand, the so-called social selection or social drift argument goes on the assumption that higher rates of mental illness in lower social classes are a consequence of the drift of the mentally ill into lower social classes.

In a US comorbidity survey, six-month prevalence of any DSM-III disorder was calculated to be 2.86 times higher in the lowest socio-economic status category than in the highest, controlling for age and gender (Kessler et al. 1994). Furthermore, Saraceno and Barbui (1997) have summarised several studies on poverty and mental illness and outline that people with the lowest socio-economic status have 8 times more relative risk for suffering from schizophrenia than those with the highest socio-economic status. Compared to people without a mental disorder, people who suffer from schizophrenia are 4 times more likely to be unemployed or partly employed and 3 times more likely not to have graduated from high school. Mörchen et al. (2002) showed for two German areas that 38%, respectively 31.9% of mentally ill patients lived under conditions of material poverty. Only up to one third were regularly employed. With regard to gender, studies have shown a correlation between female gender, low education and poverty and mental disorders (Patel et al. 1999). However, gender differences related to the socio-economic status are usually difficult to analyse, since gender disaggregated income-data are hardly available.

Apart from social causation and social drift hypotheses, the socio-economic status is also a predictor for the outcome of treatment. Thus, Warner (1994) has shown that recovery from psychosis with regard to time spent in hospitals and

---

5 Low socio-economic categories are defined according to the WHO (2001, 40) as conditions of unemployment, low education, deprivation and homelessness.
6 DSM denotes the ‘Diagnostic and Statistical Manual’.
7 Usually family or household income is used as a proxy-variable to substitute the sum of the income of each family member.
number of admissions is worse in the lower socio-economic groups. However, from a cross-country perspective, people suffering from psychosis in developing countries have a better outcome than their counterparts in developed countries (Jablensky et al. 1992).

2.3.3. The Burden of Mental Illness

In Europe mental disorders account for 20% of disability adjusted life years (DALY) and 43% of all years lived with a disability (WHO 2001). Among the group aged 15 to 44 years, mental illness accounts for seven out of ten leading causes for DALYS. The greatest disability related to mental illness is imposed by depression. Depression is, moreover, the most frequent cause for DALYs among women, whereas the most frequent cause for DALYs among men is alcohol dependency (Murray and Lopez 1996). Overall, mental and behavioural disorders are estimated to account for 12% of the global burden of disease (WHO 2001).

From an economic point of view, mental illness is associated with high economic costs. These include direct costs for treatment and care but also indirect costs such as loss of productivity or costs for relatives involved in caring. Rice, Kelman and Miller (1992) have estimated that in 1985 in the US the total economic costs of mental illness were $103.7 billion. A more recent study from the UK estimated total costs of mental illness up to £32.1 billion (1996/97 prices) of which one third was due to lost employment and lost productivity from suicide (Patel and Knapp 1998). Schizophrenia is considered to be the most costly mental illness. Thus, in the US total economic costs of schizophrenia were estimated to be 65 billion $ in 1991 (Salize, Rössler and Reinhard 2001). In Germany, expenditure for schizophrenia in 1994 was estimated to account for 2% of the total health care budget which is higher than the percentage spent on dementia or depression (Salize 2001). Tarricone et al. (2000) showed that the annual mean costs of schizophrenia in Italy were nearly 50 million ITL, of which 70% were for indirect costs. On the whole, indirect costs for schizophrenia are higher than direct costs, although calculations vary considerably. For example, Launois, Tourni and Reboul-Marty (1998) showed that indirect costs account for 81% of the total costs, whereas Guest and Cookson (1999) calculated a percentage of 49% for indirect costs in relation to 51% for direct costs.

---

8 DALY (disability adjusted life years) is an indicator which has been developed for large scale cross country epidemiological studies to measure disability which results from illness. Overall, the indicator reflects the burden of non-lethal diseases and combines life years lived with a disability with lost life years due to premature death. The latter are measured according to standardised life expectancies. Years lived with disability are transformed into standardised time losses via a mathematical formula.
Apart from schizophrenia, cost-studies for single forms of illness are mainly related to depressive disorders. In Portugal, costs associated with depressive disorders were estimated to be 50 million € (at 1992 prices) of which 80% were due to losses in productivity due to a temporary incapacity to work (Ramos et al. 1996). In Germany it has been investigated that in 2002, 18 million workdays were lost due to depression with total cost to employers of around 1.59 billion € (Gesundheitsreport der Techniker Krankenkasse 2002).

In Austria, costs of illness have solely been estimated for dementia in a study by Krautgartner, Berner and Wancata (2001). Depending on the method of calculation, for the year 2000 the costs for dementia were estimated to have accounted for 569 million € or 1.24 billion € respectively.

Overall, Salize (2001) has emphasised that cost studies hardly ever address entire costs of illness. Very often, the figures are restricted to direct costs and do not include indirect costs such as costs for informal care and secondary illnesses which may result from it, nor do they usually include intangible costs such as loss of quality of life. That costs falling on caregivers can be significant is for example shown in a Belgium study which compared average earnings after tax for the Flemish population with that of families with psychiatric patients. While the former were earning 30,474 € on average, the average earning for the latter were 23,302 € (De Rick et al. 2000).

A rough picture about the economic dimensions of mental illness in Austria may be provided by absenteeism and early retirement statistics. While overall days of absenteeism decreased by 13 % between 1993 and 2002, days of absenteeism due to mental illness increased by 56%. The length of absenteeism for male employees with a mental illness increased by 37%, for female employees it rose by 72% (figure 1). It needs to be questioned whether the changes are the result of factual increase of mental illness, increasing awareness of mental illness or whether they are simply the result of technical changes in registration. Since the yearly variation is quite irregular (figure 2), both, registration differences and epidemiological changes seem to be most likely.

Similarly, total number of early retirement entrants decreased by around 1 % between 1993 and 2002. By comparison, in the same period new early retirement cases due to mental illness increased by 84%. The rate for male persons increased by 64%, whereas the rate for females increased by 115%. In 1993, new entrants due to mental illness accounted for roughly 12 % of all entrants. In 2002, their percentage rose to 22%. Compared to other forms of illness, new entrants due to mental illness are on the second highest rank. Additionally, total cases of early retirement increased by 13 % between 1993 and 2002, while total early retirement cases due to mental illness rose by roughly 50% (figure 3).
Figure 1: Changes in days of absenteeism in percentages 1993-2002; Source: Social Insurance Statistics

Figure 2: Annual changes in days of absenteeism in percentages 1993-2002; Source: Social Insurance Statistics
2.4. Conclusion

The previous paragraphs have opened the scene with some features and facts about mental illness and a brief historical overview about the stages in development of the concept of illness and treatment up to the 21st century. To arrive at a conclusion, the most significant issues seem to be the obvious controversies which have accompanied those developments. On the one hand, these controversies make it difficult to follow a straight line of argument. On the other hand, however, they make clear that the terms and definitions used are the result of negotiation processes between different interest groups. Not least, they add to an understanding of the complex processes which have shaped our perception of mental health and illness. This information is thus valuable for exploring subsequent questions of mental health care financing from a multi-level perspective. In the following chapters the focus moves to more recent processes of change with the main emphasis on mental health care service structure, mental health care financing, recent reform processes and reform objectives.