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History, policy and everyday life

Edited by Michael Rasell and Elena Iarskaia-Smirnova

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5 Between disabling disorders and mundane nervousness

Representations of psychiatric patients and their distress in Soviet and post-Soviet Latvia

Agita Lūse and Daiga Kamerāde

Based on the premise that mental illnesses are socially constructed phenomena, this chapter examines their conceptualisation by professionals, the general public and mass media in Latvia during the late Soviet years and the subsequent post-Soviet decades.[1] We discuss the growing discrepancy between professional and societal understandings of mental health issues, arguing that this divergence is a corollary of two interrelated factors: firstly, the professional ambition of Latvian psychiatrists from the 1990s onwards to assert their familiarity with international disease classifications and treatment methods; and, secondly, the endeavours of major stakeholders to bring Latvia's mental health policy in line with care models developed in the West. These developments have involved redefining the psychiatric concept of mental disorder to include a significantly broader and more diverse range of phenomena. Psychiatrists now claim expertise not only over explicit, severely disabling and long-lasting varieties of mental distress, but increasingly also over more mundane, transitory and relatively widespread forms of 'nervousness'. The Latvian public, on the other hand, still tends to associate psychiatry with the stigmatising conceptions and practices of the Soviet period.

To make these arguments, this chapter employs data from three studies conducted in Latvia between 2004 and 2008. The aim of these studies was to examine how mental health-care professionals, the general public and mass media conceptualise mental illness in Latvia in the post-Soviet period. The chapter also occasionally draws on ethnographic research that Agita Luse has conducted since 2003 with several Latvian NGOs active in the mental health care field. In presenting these diverse data we intend to identify patterns between these various understandings and the actual circumscription of psychiatry's borders in Latvia. The structure of this chapter has been organised around this task. We first introduce our theoretical position that mental distress is a social construction and then illustrate this process by sketching how people with psychiatrically defined illnesses were treated in Soviet times. Thereafter we chart the major transformations that

affected psychiatry and its patients after Latvia regained independence in 1991, focussing primarily on developments during the first decade of the post-Soviet period. Subsequently, the findings of a review of professional literature and two empirical studies are presented in order to map the most significant changes in the ways in which mental illness in post-Soviet Latvia has been constructed and represented by professionals, the general public and the media respectively. We observe that mental capacities, including in relation to emotional well-being, have often been a basis for limiting a person's rights and opportunities in the post-Soviet world because the label of psychiatric disability carries intense state and societal stigma.

Mental illnesses as socially constructed entities

As with other fields of disability provision, the distinction between 'medical' and 'social' approaches to mental health problems provides an important conceptual tool for understanding the development of Latvian psychiatry and mental health services. Internationally the most influential medical classificatory system for mental disorders is undoubtedly the *Diagnostic and Statistical Manual* (DSM) that the American Psychiatric Association has elaborated over many decades. During the 1990s this document considerably shaped the *International Classification of Diseases* (henceforth ICD) published by the World Health Organisation (Manning 2001: 85). By translating the ICD into dozens of languages, the WHO promoted the unification and standardisation of diagnostic criteria, including those for mental disorders, throughout the world.[2]

The *Diagnostic and Statistical Manual* is based on a medical or disease model that conceptualises disorders as discrete entities (Mechanic 1999: 16). The same holds true for the ICD, which is based on the same classificatory principles as the DSM in that attention is primarily paid to symptoms (Yevelson *et al.* 1997: 1552). A more detailed account of the ascendancy of the disease model in North American psychiatry can be found in Luhrmann's book *Of Two Minds: An Anthropologist Looks at American Psychiatry* (2001). The author notes that a new group of psychiatrists began to emerge in the 1970s who were 'committed to what they called strict standards of evidence … determined to create a psychiatry that looked more like the rest of the medicine, in which patients were understood to have diseases' (Luhrmann 2001: 225). One of the main aims of the DSM when it was updated in 1980 was to defend such a medical model. A patient's personal history became irrelevant; what mattered was that symptoms could be matched to criteria for a certain disorder. As a result, biomedical or biopsychiatric treatment styles in the United States superseded psychodynamic approaches and drug therapies were increasingly prioritised (see also Gold and Olin 2009: 46).[3]

Although advances in neuroscience and psychopharmacology tend to discuss diagnostic categories as objective realities 'discovered' in nature, transcultural psychiatrists and medical anthropologists have argued that these categories are social constructions and have demonstrated how they have been put to social uses (for instance, Kleinman 1988; Ware and Weiss 1994; Young 1995; Skultans

1995, 1998). Some forms of mental distress have been extremely sensitive to influences from the wider social system. Hacking has argued that the way in which psychopathologies have been classified has always influenced sufferers, both individually in terms of how patients reflect on their condition and treatment and as a group in that classifications inform treatment practices. Being (re)classified thus changes the ways in which individuals experience themselves (Hacking 1999: 104–15).

An illustration pertaining to the Latvian context can be found in Skultans' work. During her fieldwork in Latvia in 1991 Skultans observed that among the most common diagnoses assigned by the Riga emergency ambulance service were: dystonia – a dysfunction of the autonomous nervous system (*veģetatīvā distonija* in Latvian) – and profound fatigue or neurasthenia[4] (*neirastēnija* in Latvian) (Skultans 1995: 16). Both could display themselves in a number of quite diffuse physical and neurological symptoms. Skultans points to an important aspect of these diagnostic categories: they carried no stigma of mental illness since, according to Soviet diagnostic practice, both were classified as physical disorders of the nervous system and not conditions based on mental ill-health. Dystonia,[5] in particular, was seen as a condition that anyone could experience as a reaction to an excessive workload or heightened sense of responsibility. Patients, however, resisted the diagnosis of neurasthenia because it had the potential to portray socially engendered unhappiness as weakness of individual physiology (ibid.: 17). Now, what made it possible for doctors to align their diagnoses with patients' wants and choose a particular way of construing a range of symptoms? The answer can be found by examining the distinctive classificatory principles of Soviet psychiatry.

From the late 1950s onwards consecutive editions of the ICD (7, 8 and 9) were available throughout the USSR in Russian translation. Nonetheless, Soviet psychiatrists used a terminology quite different from that of their colleagues in the West and their practice was actually guided by a different classification system of mental disorders (Skultans 1995; Yevelson *et al.* 1997; Skultans 1998; Skultans 2003: 2425). This system was based on an approach that sought to establish a clear relationship between a symptom and its cause or 'aetiology' (Yevelson *et al.* 1997: 1552). Although some sections of the WHO official classifications were slightly altered in the respective Soviet editions, this attempt to link them to Soviet diagnostic practices appears to have been little more than an exercise in interpretation, mostly driven by the need to facilitate research cooperation with mental health professionals from the West (ibid.: 1551).

A significant feature distinguishing the perspectives of Soviet doctors on mental distress was the division between so-called major and minor psychiatry.[6] At the basis of this division were two respective subfields of mental health care. Major psychiatry was by and large concerned with psychotic illnesses[7] and practised in psychiatric hospitals. In contrast, minor psychiatry focused on neurotic complaints[8] that were called 'nerves' (*nervi* in Latvian) or 'nervousness' (*nervozitāte*) in popular usage and most often treated in polyclinics, especially in neurological units, as well as by the emergency ambulance service (Skultans

1998: 182). Minor psychiatry could hardly be regarded as a less medicalised approach than major psychiatry since both were equally interested in the manipulation of neurophysiological processes. It is noteworthy that neurology and psychiatry were largely overlapping fields in the USSR, hence the frequent use of the terms *psycho-neurology* and *psycho-neurological* to denote categories of symptoms, administrative entities and medical specialisations: an American researcher in the 1950s observed that, 'A neurologist is also a psychiatrist and the psychiatrist is, for the most part, also a neuropathologist' (Field 1960: 281). At the same time, neuropathologists were more likely to treat what were called 'nervous diseases' while psychiatrists worked with 'psychic disturbances' or psychoses (ibid.: 282). In this respect, 'minor psychiatry' appeared as a field in which psychiatrists may have dealt with cases that they did not regard as belonging to their proper field of expertise.

The WHO's Classification of Diseases appeared for the first time in an official Latvian translation in 1996, when the ICD-10 was published in Riga. As with earlier Soviet translations, the introduction of a new terminology and classificatory principles did not change practices overnight. After four decades of being integrated into the Soviet mental health care system, certain institutional arrangements and diagnostic practices for dealing with mental distress had become entrenched in Latvia. Western diagnostic practices were only gradually adopted as mental health specialists in Latvia retrained and new pharmacological treatments became available. These transformations have inevitably involved changes in the representation of mental illness, not only among psychiatrists, but also among the general public and mass media, as will be discussed in the following sections of this chapter.

'Partially or completely incapable of work': mental illness and disability in Soviet times

In 1980 a Soviet official exclaimed that 'there are no disabled people in the USSR!' when a Western journalist enquired whether the Soviet Union would participate in the first Paralympic Games (Fefelov 1986). This incident summed up the situation of mentally and physically disabled people in the Soviet Union, including in the Soviet Republic of Latvia: their apparent invisibility was created by practices, if not official policies, of social exclusion and stigmatisation (Dunn and Dunn 1989).

Compared to practices in pre-Soviet times or in other European countries, Soviet medicine and psychiatry introduced few innovative approaches to widespread forms of human distress. Throughout most of Soviet history, the state apparatus thus subscribed to physiological and functional models of physical illness, mental disorders and disability. These models focused on the corporeal manifestations of illness and individuals' ability to work (cf. the contributions by Beate Fieseler and Darja Zaviršek in this volume). Both illness and disability were seen in a narrow and medical way as physiologically based deficiencies or the loss of bodily functions (McCagg 1989). Except for the first decade after the

Second World War (Merridale 2000) the dominant trend in Soviet psychiatry was the elaboration of biological understandings of mental illness inherited from German psychiatry of the late nineteenth and early twentieth centuries.

Disability, called *invalidnost'* in Russian (from Latin *invalidus*, weak), was defined in the USSR as 'a condition of an organism (*organizm* in Russian) transformed by disease or aging and characterised by enduring or irreversible functional disturbances that results in the permanent or prolonged, complete or partial, loss of one's ability to work' (Vved'enskiy 1959a). It is noteworthy that in the Soviet definition it was not even a person, but just a body or organism, which suffered damage. Such an understanding of disability was based on the ideological premise that physical health and productivity were crucial preconditions for social participation. An individual was seen first of all as a body capable of performing certain functions that not only ensured its reproduction, but could also be organised as productive activity for the good of society. Consequently, one's inability to work not only meant classification as an *invalid*, a weak and inefficient being, but also as lacking a basic attribute that a member of Soviet society was expected to possess, namely productivity.

The vast majority of Soviet psychiatrists adhered to these physiological and functional models of illness and disability.[9] Moreover, until the 1980s, they were primarily concerned with psychotic diagnoses that fell into the domain of 'major psychiatry', such as schizophrenia, manic-depressive psychosis and alcohol-related psychoses. The entry on 'mental illnesses' in an encyclopaedia for the general public published in the late 1950s in fact treats mental illnesses and psychoses (*psikhicheskie bolezni* and *psikhozi* in Russian) as synonymous (Vved'enskiy 1959b). The leading Soviet school of psychiatry, the Moscow school, focused on the concept of psychosis while neuroses attracted much less attention (Eglītis 1997: 89, 92). Indeed, the whole range of neuroses largely existed within the sphere of neurologists' expertise due to the impact on Soviet medical science and clinical practice of an ideologised form of Russian physiologist Ivan Pavlov's teaching on higher nervous activity as well as most doctors' unfamiliarity with psychoanalytical concepts. As physiologically understood conditions, neuroses had little chance to be associated with mental illness, then the proper subject matter of psychiatry. Nor were neuroses among the categories that the general public in Soviet Latvia and other Soviet republics considered as health problems of a psychiatric kind. Even chronic sufferers from 'neurological' forms of mental disorders managed to adapt to a variety of social and vocational roles and their neuroses usually did not serve as the basis for a diagnosis of disability.

Psychoses, on the other hand, were understood as more severe and persistent mental disturbances, marked by certain symptoms that were to be treated primarily and fundamentally by medical means – not only with psychotropic drugs, but also by such procedures as prolonged sleep (induced by barbiturates or weak electrical current), electro-convulsive therapy and only occasionally by hypno-suggestive therapy (Cohen 1989: 58–59, Lūse 2006: 99–102). Some non-biomedical means, however, were also recognised, work therapy being the most widespread

among them (Cohen 1989: 60; Lūse 2011; Yankovsky 2011) and individual psychotherapy being another occasional exception.

The association of mental health concerns with individual shame and inadequacy developed in part because seeking a psychoneurologist's help in the USSR usually involved 'being listed' (*nonākt uzskaitē* in Latvian, *postavlen na uchet* in Russian) on a Psychiatric Case Register. Registered patients were not permitted to travel abroad, take up certain types of employment and in some cases even to drive a car (Pilgrim and Rogers 1999: 178). Moreover, *being listed* could also become known to colleagues, bosses, neighbours or other citizens, the majority of whom regarded mental illness as not only irreversible and untreatable, but also dangerous. At the level of Soviet ideology, people with disabilities of any kind were perceived as a threat to the state-cultivated image of happy and productive Soviet citizens. Therefore they were likely to be kept out of public sight and treated in psycho-neurological hospitals (Kikkas 2001).[10] Thus one can speak of two forms of stigma affecting psychiatric patients in the Soviet Union, one ensuing from co-citizens' stereotypes and another rooted in official ideology. Given such attitudes many people preferred to seek informal or private help if they felt mentally distressed, especially if they had symptoms of a non-psychotic kind (Cohen 1989: 53–54).[11] Patients or their relatives found ways to circumvent the routine medical referral system by obtaining an unofficial appointment with a respected doctor through informal networks, very much like practices in other sectors of the Soviet 'economy of favours' (see Ledeneva 1998).

The institutional organisation and legal procedures underlying psychiatric care in the Soviet Union were predominantly oriented towards patients whose symptoms suggested a disturbance of a psychotic kind. If an individual with mental health problems came or was accompanied to a district health centre (called *poliklinika* in Russian), he or she would be referred to an outpatient psycho-neurological dispensary (*dispanser* in Russian, a word that has been adapted from French *dispensaire*).[12] Dispensaries differed from polyclinics in that apart from offering treatment they also prevented registered patients from avoiding treatment and supervised the circumstances of patients' life and work (Jērāns 1984: 126). The rationale behind this system of treatment and control was to ensure that patients could participate in the productive processes of Soviet society in between periods of illness. At a dispensary an individual with a mental health problem could see a psychiatrist who would prescribe drugs or refer him or her to a specialised psycho-neurological hospital. Those who were employed at the time, but whom the dispensary doctor deemed to be not well enough to work, could take sick leave.

After four months of sick leave and before a person with mental health concerns had been absent from work for more than five months within a year, he or she had to be referred to a *Commission of Medical-Vocational Expertise*, commonly known by its Russian abbreviation *VTEK* (Minyajev 1987: 298–301). The Commission's function was to assess if the particular illness had decreased the individual's 'ability to work' to the extent that he or she had to be categorised as either only 'partially capable' or 'completely incapable' of work and thereby

certified as a disabled person (*invalid* in Russian). Depending on how severe the symptoms appeared to the Commission, a person was assigned one of three categories – officially called 'groups' – of disability *(gruppa invalidnosti* in Russian). The resulting disability certificate had to be regularly renewed once a year for the second and third groups and once every two years for the most serious diagnoses belonging to the first group (Vved'enskiy 1959a). Some psycho-neurological disorders did qualify an individual for permanent disability status, but few mental illnesses in the proper sense of the word were included in this list. Thus, according to a regulation issued by the USSR Ministry of Health in 1956,[13] most of the 12 psycho-neurological conditions that would qualify an individual for such a status were the outcome of physical damage to either the brain or central nervous system. Only two diagnoses would have fallen into the narrower field of psychiatry: 'post-schizophrenic feeblemindedness' (*slaboumiye*, literally 'a weak mind' in Russian) and 'epilepsy when accompanied by frequent seizures and explicit feeblemindedness'.

Discovering patient rights: post-Soviet perspectives on psychiatric disability

During the early 1990s, Latvia and other ex-Soviet countries experienced enormous socio-political and economic changes, regaining independence as the collapse of the state-controlled economy led to high levels of poverty, unemployment and increasing inequalities. The situation of disabled individuals and people diagnosed with mental disorders changed very slowly due to an absence of political goodwill and a resulting lack of resources in the public health sector (Tomov *et al.* 2007).

During the first post-Soviet decade a number of disability rights advocates, mostly sponsored by foreign non-governmental organisations, began to promote a social model of disability in formerly socialist countries including Latvia. According to the social model of disability, most barriers that mentally and physically disabled people experience in their everyday life stem not from their physical impairments or functional limitations, but from discrimination and prejudice towards them in society (Gignac and Cott 1998; Barnes *et al.* 1999: 30). Mental disability rights advocates in Latvia consequently focused on reducing discrimination and prejudice among the general public. Among the first steps in this process were the promotion of community-based mental health care and the critique of institutional care that was still taken for granted by many health administrators and, consequently, relatively better financed (see, for instance, Leimane 2001; Celms 2005; Leimane-Veldmeijere and Veits 2006; Leimane-Veldmeijere and Šulce 2008). From the late 1990s onwards, a number of representatives from the Latvian Psychiatric Nurses' Association as well as a dozen reform-minded psychiatrists have collaborated with the Latvian Centre for Human Rights and Ethnic Studies and the Resource Centre for People with Mental Disability, 'Zelda', the two leading advocacy organisations for mental health patients in Latvia.

Although the social model of disability has been popular among activists promoting the rights of people with disabilities, including those based on a mental health problem, achievements have been very slow. Although some day care centres currently operate in the capital city Riga and larger towns of Latvia,[14] thousands of people with psychiatric diagnoses still spend their lives in institutions,[15] mostly in care homes or secluded at home.[16] Latvia has signed and ratified the UN Convention on the Rights of Persons with Disabilities as well as its special protocol (see Lūse 2009), but the necessary amendments in law have not been implemented and few politicians have a clear vision of or interest in the ways in which the Convention should be implemented in real life.[17] Indeed, a draft law *On Psychiatric Assistance* has been in preparation since the 1990s, but its adoption has been repeatedly postponed.

After joining the European Union in 2004 Latvia, like other new member states, was expected to design its mental health policy 'to support action based on evidence, to promote prevention and appropriate treatment of mental disorders, to aid access to treatment and the integration of people with mental disorders into society' (Marusic 2004: 450; see also Knapp *et al.* 2007). However, the persistence of treatment in institutions, hesitation over effective preventive measures and the slow progress of social inclusion for people with mental illnesses suggest that physiological and functional models of mental health and disability are still strongly dominant in Latvia. To explore conceptualisations of mental health in Latvia, we now will present the results of our review of professional literature and two empirical studies.

'Minor psychiatry' comes to the aid: easing the neurologists' workload

Our analysis of literature aimed at mental health professionals in the Soviet and post-Soviet periods suggests that the definition of mental illness used by Latvian psychiatrists has been expanding since the late 1970s through the inclusion of mental disorders that used to be seen as within the competence of neurologists, namely psychosomatic and neurotic disorders. By the mid-1980s the number of people living with psychotic disorders had reportedly stabilised whereas the number of registered non-psychotic or 'borderline' disorders was growing in Latvia (Shirin and Malakhov 1985; Sochneva and Liepinsh 1985) as well as Estonia and Russia (Mehilane 1985; Severniy 1985). For example, a study conducted in Estonia between 1970 and 1984 demonstrated that neuroses constituted 16.8 per cent of all psychiatric illnesses (Mehilane 1985), which suggests that such conditions were recognised by psychiatrists. In particular, it was acknowledged that 'long-standing neuroses are responsible for the psychogenic development of the personality that could subsequently result in the need for prolonged hospitalisation' (Mehilane 1985: 353–55). Of all neuroses, their hypochondriac and depressive sub-types were most frequently reported. From 1978 onwards, the concept of psychosomatic illness was promoted among Latvian psychiatrists and doctors of other specialities (Eglītis and Sochneva 1979). At about the same time,

a group of psychiatrists in Latvia came forward with a preventative initiative, namely 'psycho-hygiene clubs', which invited members of the general public to popular lectures on psychological distress, alcoholism and even the occasional demonstration of hypnosis and auto-suggestion techniques. Neuroses were thus gradually reclaimed as an area of expertise belonging to psychiatrists rather than neurologists (Eglītis 1979).

Following the restoration of the country's independence in 1991, intensive contacts with colleagues in the West as well as the increasing accessibility of contemporary psychiatric literature were additional stimuli for the revision of psychiatric reasoning in Latvia. Once Western training programmes in psychotherapy had been introduced, psychodynamic and psychosomatic concepts could further evolve in Latvian psychiatry. Mental health practitioners increasingly focused on disturbances that could be interpreted as psychogenic or sociogenic in origin (that is reactive conditions as distinguished from endogenous ones which reportedly stem from brain disorders; see more on this distinction in Busfield 2002: 152–56). In 2004 a group of privately practising psychiatrists offered, with the help of psychotherapists and psychologists, to 'dismantle the fence' that in their view still segregated people with mental disorders in Latvian psychiatric hospitals. Such an appeal can be seen as challenging the habit, inherited from the Soviet period, of dividing psychiatry into 'minor' and 'major' components. That fence, the group claimed, instilled a fear of psychiatry in the general population and hindered people from utilising psychiatric help as 'an adaptive means towards the achievement of mental comfort'.[18] Such emphasis on 'mental comfort' proposed by psychiatrists in Latvia echoes a neo-liberal ideology (Rose 1998; Furedi 2004) that favours individual self-mastery. Mental health specialists have thus come to view difficulties in controlling one's mental and emotional states as deviations from the 'normal'.

The borders between minor and major psychiatry may have been eroded in clinical ideology, but a hierarchical relationship between the two still remains in Latvian health-care policy and practice. For example, the state funds medication and subsidises treatment expenses only for those diagnoses that have traditionally fallen within major psychiatry's expertise and whose sufferers are usually regarded as potentially dangerous to themselves and society. Responsibility for 'self-mastery', 'mental comfort' and employability rests with individuals: they are expected to invest their own means in sustaining or improving their mental health, for example with the help of private-sector psychiatrists. Ultimately mental health issues are not fully accepted as legitimate concerns within the health and welfare systems, pointing to a discrepancy between the definitions used by psychiatrists and those circulating in policy circles.

'Sheer otherness': representations of mental illness in Latvian society[19]

In order to analyse the fit between professional and societal attitudes about mental health in Latvia, understandings of mental illness in the general public were studied using focus group interviews in 2004. The sample for this study was

formed of 41 individuals in the age range 16–62 who read newspapers or magazines at least once a week and who had no direct experience of interacting with persons with mental disability or illness. The vast majority of focus group participants named the media as their primary source of information on mental health issues, emphasising that they wanted to know more about these issues, but that information is not readily available. A purposeful sampling method was used to obtain a sample that covered a wide range of demographic characteristics and levels of media usage to ensure broad representativeness and a diversity of views. All participants were divided into five mixed groups and a focused interview was conducted with each group. The agenda for interviews contained three main topics: firstly, general representations of people who are diagnosed as mentally ill (*psihiski slims* in Latvian) and attitudes towards them; secondly, sources of information on mental illnesses (*psihiskās slimības* in Latvian) and the media's role; finally, attitudes towards the social inclusion of people with mental illnesses (*cilvēki, kas slimo ar psihiskajām slimībām*, in Latvian). Each focus group lasted around one-and-half to two hours. The data from the focus groups were analysed using grounded theory techniques (Glaser and Strauss, 1967; Strauss and Corbin 2008).

The study found that mental illness is still viewed in Latvia as sheer 'otherness' that manifests itself as socially unacceptable behaviour and excessively emotional utterances or even thoughts, but not as emotional disturbance and suffering. The general inadequacy attributed to people with mental illness was described as 'something that is not as it's supposed to be' (female, age 35)[20] and 'strange and different' (male, 24). Unusual verbal expressions like 'talking to oneself' (female, 32) and 'singing without a reason' (female, 57) were also considered symptoms of mental illness (*psihiska slimība* in Latvian). Similarly, behaviour that was perceived as implausible or laughable was classified as a sign of mental illness, widely described as 'madness' (*vājprātība* in Latvian), for example 'when an old lady claims that she will become the next president of Latvia and organises an election campaign in a shop' (female, 19). Moreover, even people whose opinions either differ from the majority or who are critical of majority beliefs were perceived as having mental problems. For example, 'when somebody always has strange ideas, not like a normal person, you often start to think that he is mentally ill' (male, 27) or 'people whose opinions always differ from what most people would think' (female, 35).

Beyond unusual behaviour, mental health problems were associated with externally observable emotional instability such as 'mood swings' (female, age 35) or 'nervousness' (female, 57), which were repeatedly mentioned by research participants. Another inadequacy often used by members of the general public to define mental illness was an inability to control oneself as well as a perceived dangerousness to others that allegedly arises from the absence of self-control. Individuals who are diagnosed as mentally ill were described as 'aggressive, able to harm themselves and others' (female 44), 'dangerous because they are aggressive' (male, 27), and it was suggested that it is 'better to keep away from them because they are dangerous' (male, 16). Moreover, interviewees often remarked

that people who are diagnosed as mentally ill 'cannot be left without supervision' (female, 61) because they can cause danger to themselves or others, for example, 'can leave gas switched on' (female, 44) or 'if not supervised, they can set the home on fire' (male, 21). Overall the focus groups thus tended to distance themselves from people with health concerns, who were associated with an inability to follow social norms and related hazards.

In relation to support for mental health, the focus group participants expressed strong reluctance to approach professionals for help when encountering mental problems. For the general public, this hesitance is based on the related fears of being classified as abnormal (*nenormāls* in Latvian), mentally ill (*psihiski slims* in Latvian) or mad (*traks* in Latvian) and thus being stigmatised. Mental illness and visits to mental health care professionals were associated with shame and fears of being excluded from society. Thus 'a visit to a doctor is shameful, [it's] better to try to solve this problem on my own' (male, 25) and 'like going to a sex-shop, it is shameful to go to see a psychiatrist' (female, 43). Due to its association with abnormality, mental illness was identified with shame: 'it is shameful because others do not have such an illness' (female 59). In addition to shame, people were afraid of being stigmatised ('once you have been in a psychiatric hospital, you are lost' (male, 24) and 'you are going to be labelled for all your life' (female, 44). As a result of stigma, people are afraid of being excluded from society and losing friends and employment: 'they [friends] will not ask you out anymore and won't be friends anymore' (male, 21), 'people will avoid me' (male, 24), 'you are going to be fired from work … they will find an excuse to do so' (female, 37) and 'you won't be able to find a job' (male, 47).

Moreover, it seems that knowledge of non-biomedical treatments for mental health problems has not yet fully reached the general public in Latvia, as the focus group participants expressed strong concerns about the methods used in mental health care, focusing mainly on treatment with medicines: 'I am afraid of psychiatrists because I don't know what they will do to me' (male, 54). Treatment with medicines was perceived as being more harmful than helpful: 'The medicines are going to make it worse and worse' (male, 55). Moreover, the general public expressed strong fears about approaching mental health professionals due to concerns about being isolated in hospitals – 'I am afraid that I will be locked in a home for crazy people' (male, 21) – and being included in official registers of mental health care patients: 'people are afraid of being included in the register' (female, 35).

In summary, the focus group study suggests that the general public in Latvia defines mental illness entirely in external (behavioural and observable) terms, emphasising the inadequacy of people with mental health concerns and their deviance from widely agreed social norms. The results also indicate that mental ill-health and visits to mental health professionals are associated with stigma and fears around treatment. The fact that most participants identified the media as their main source of information about mental health issues suggests that media portrayals of people diagnosed with mental illness and mental health issues might play a crucial role in informing and shaping attitudes towards mental health issues in Latvia.

Stories about people with mental illness: changes in media representations

Numerous studies have demonstrated that the media is the main source of information on mental health issues in many countries, not only forming individual understandings of mental health and illness, but also shaping societal attitudes towards people with mental health issues (for example, see reviews by Edney 2004; Klin and Lemish 2008; Wahl 1995). Thornton and Wahl (1996) found that people who had read a newspaper article about a person with mental health concerns who had committed a murder demonstrated a significantly more negative attitude towards people with mental illnesses than individuals who had not read the article. A similar effect was observed by Wahl and Lefkowits (1989). Moreover, as studies conducted by Philo *et al.* (1996) indicate, the mass media has a more powerful effect on individuals' attitudes than their own positive personal experiences.

To examine how media representations of mental health and illness are changing in Latvia, content analyses of all publications in a representative sample of 15 magazines and newspapers published in Latvia between 6 May and 6 June (a randomly chosen month) were conducted in 2004 and 2008. It should be noted that Latvia joined the European Union in May 2004 and was thus increasingly exposed to inclusive approaches and attitudes to mental health.[21] Printed mass media were chosen because according to the Baltic Media Facts (BMF) (2004), they are the second most commonly used media in Latvia.[22]

The sampling frame for the content analysis was formed from a list of all 262 regularly published printed press titles in Latvian and Russian. Highly specialised titles with a low probability of discussing mental health topics were excluded, for example free advertising newspapers and magazines about cars or handicrafts. A stratified probability sampling method based on readership and national/regional publication was used to select publications for analysis. Around 25 per cent of regional and national titles were selected. The selection resulted in a total sample of 15 titles. All issues of the selected magazines and newspapers published between 6 May and 6 June in 2004 and 2008 were examined for pieces related to mental health or illness (news, reports, advertisements, anecdotes, interviews etc.). In the first step, all relevant articles were coded quantitatively using a codebook developed for this purpose. The articles on mental health were then analysed qualitatively using a grounded theory approach to identify the messages that appeared in texts without prior assumptions about the themes that could arise.

Comparison of the content analyses for 2004 and 2008 indicates that although mental health issues were rarely covered in magazines and newspapers, there were encouraging signs of a positive change – albeit slow and subtle – in the way mental health issues and people with mental disorders were portrayed by Latvia's print media. As in Soviet times, when neither individuals diagnosed as mentally ill nor mental health issues were present in the public sphere and public discourse, they also rarely received any attention from the Latvian press in 2004

and 2008. In 2004 and 2008 only six newspapers or magazines published at least one piece on mental health issues during the month of May/June. Overall 24 items were devoted to mental health issues during this period in 2004 while 26 mental health-related items were identified in the May/June period in 2008. Although there was no significant quantitative difference between the periods, there were important changes in the content and origin of mental health journalism.

In 2004 information on mental health issues in general and mental disorders in particular was very scarce in newspapers and magazines while in 2008 reporting on mental disorders, their possible causes and treatment was more precise and coherent. In 2004, the only item that discussed the causes of mental disorders attributed them to life events like relationship difficulties: 'after a relationship has finished, women can switch more easily [than men] to other things, thus avoiding depression and mental disorders' (an excerpt from a weekly newspaper in Latvian, 2004). Another explanation of mental illness was to be found in an advertisement for nutritional supplements in a monthly newspaper (2004). It was phrased in biomedical terms and claimed (in Latvian): 'Does depression start in the brain? Sometimes the problem comes from the glands.' The printed press gave little information about the treatments available to people with mental illnesses. One monthly women's magazine in Latvian published a report by the relatives of a well-known poet living with depression, describing how in the 1970s 'psychiatrists doped her with strong medicine'. They told the magazine that 'this medicine made her unable to write poems and even incapable of understanding the simplest plots on television'. An advertisement in a weekly newspaper in Latvian promoted a psychic healer 'who can cure depression' among other illnesses and ailments.

Information on the causes of mental illness was more extensive and coherent in the Latvian press of 2008, mainly because newspapers and magazines increasingly published articles written or consulted upon by mental health care specialists. These quantitative and qualitative changes in media representations of mental health and illness seem partly to be the result of public relations strategies elaborated by various organisations to which psychiatrists are affiliated, such as hospitals, university departments, professional associations, pharmaceutical companies and sections of the Public Health Agency.[23] The editors of printed media in Latvia were increasingly seeking sources of information that would be seen as more trustworthy and reliable by their readers. Mental health professionals may also have been increasingly likely to approach the media as a way of informing the general public on mental health issues. In 2004 journalists authored around half the articles published while doctors, generally not specialists in mental health care, contributed to three articles. Only in one case was a 2004 publication written by a mental health care professional. In the remaining articles, the occupation of the writer could not be determined, but were most likely to have been written by journalists. By 2008, the proportion of editorial items about mental health issues written by journalists had slightly decreased and the proportion by mental health care specialists had increased significantly, from a

very small initial sample. As a result, three articles discussed the possible medical (biological) and social causes of mental illness at length, all written by psychiatrists. It should be emphasised, though, that more than half of the space in all articles was devoted to the biological causes of mental illness and much less to social factors. Mental health care specialists thus continued to promote a predominantly physiological and functional model of mental disorders. At the same time, neither in 2004 nor in 2008 did newspapers and magazines contain any useful information related to state support for or the legal status of people with mental health issues, for example details on which mental illnesses qualify for disability status or benefits.

Another finding is that the attitudes towards people with mental health issues expressed in magazines and newspapers grew increasingly polarised between 2004 and 2008. During this time the proportion of media articles displaying a positive or favourable attitude towards people with mental health issues increased, but so did the proportion of publications conveying an explicitly negative stance. Not surprisingly, tabloids were more likely to express negative attitudes towards people with mental health issues. While three-quarters (in both years) of publications in weekly broadsheet newspapers and slightly less in daily newspapers had a positive attitude, a similar proportion of publications in tabloid newspapers expressed negative attitudes towards people with mental health concerns.

When writing about an individual with mental health issues, newspapers and magazines were most likely to refer to him or her as 'a patient from a psychiatric hospital' (*psihiatriskās slimnīcas pacients* in Latvian, daily newspaper, 2004 and 2008), 'a psychiatric patient' (*psihiatrijas pacients* in Latvian, daily newspaper 2004 and 2008, weekly magazine in 2008) or as 'mentally ill' (*psihiski slimais* in Latvian, daily newspaper in 2004 and 2008). Other labels were used less frequently and included such neutral terms as 'having serious problems with the psyche' (monthly magazine in Latvia, 2004) or 'being deeply depressed' (monthly magazine in Latvian, 2004) as well as negative terms like 'mentally ill deceiver' (*psihiski slims krāpnieks* in Latvian, weekly magazine in Latvian in 2004), 'mentally defective' (*garīgi nepilnīgais* in Latvian, weekly magazine in Latvian in 2008), 'psycho' and 'lunatic elderly man' (both in a daily newspaper in Russian in 2004).

In the vast majority of cases in both 2004 and 2008, mental illness was highlighted as a major or dominant characteristic of the person described. Although newspapers and magazines often printed the personal backgrounds of people with mental health issues, portrayals focused on their mental illness and related strange or dangerous behaviour as if these were the only characteristics of these individuals. In 2004, the only additional information, apart from personal details, that was commonly given about these individuals was a detailed description of their supposedly unusual behaviour (e.g. 'he sang in the cemetery for many years', daily newspaper in Russian) or the crimes they had committed (e.g. 'while arguing with another man about politics, he grabbed a knife and stabbed him in the neck', daily newspaper in Latvian). An exception was the aforementioned article portraying a

poet living with depression, which gave a detailed description of her life and achievements. Very often, articles emphasised that the offender (usually a man) had been sent to a psychiatric hospital, despite committing a murder, because of their mental illness, rather than being sentenced to serve time in prison.

Given the nature of coverage in 2004, it was a major change that stories about people with mental health problems had become more frequent in magazines and newspapers by 2008. Compared to 2004, when the only article related the story of the well-known poet struggling with depression, in 2008 there were three articles about individuals with mental health issues. In addition, there was an important editorial shift between 2004 and 2008, with one article in 2008 including a direct interview with a person with mental health issues. Although this article, which was published in a weekly magazine, focused mainly on the young man's mental illness, other details of his life, for example educational and professional achievements, were also discussed. Mental ill-health was therefore not presented as dominating identity and life experiences, but rather as part of the wider context of daily life.

Two articles in 2004 and three in 2008 discussed the experience of living with mental disorders in Latvian society, emphasising the barriers encountered in daily life. Thus in 2004, an article in a national daily newspaper described how 'it is still impossible in our country to contest the confinement of an individual in a psychiatric hospital which has happened against the will of this individual. Thus Latvia is violating the European Convention of Human Rights'. The same article emphasised that 'while there are nine psychiatric hospitals in Latvia and approximately 68,000 registered people with mental health problems; there is only one day care centre for people with schizophrenia based in Jelgava'. The source of this information was a mental disability rights advocate. The three articles in 2008, written by psychiatrists, focused more on the functional limitations that individuals with mental disorders encounter in their lives, such as their purported unsuitability for a range of jobs and inability to hold a regular job or maintain a permanent relationship. Their stance was nonetheless sympathetic to people with mental health issues, who were portrayed as victims of legal and social discrimination.

Over time people diagnosed as mentally ill were increasingly less likely to be the subject of ridicule in the Latvian media. After 2004 there was a significant decline in the number of anecdotes about people with mental health issues and an increase in factual editorial coverage. In 2004, mental health was still considered a topic of mirth as almost one-quarter of related items were jokes about individuals with psychiatric illnesses. For example, one daily newspaper in Russian published a supposedly humorous short story about a man called Kerk who reportedly had a mental illness. According to this newspaper, Kerk thought he was a bean and therefore wore only orange clothes and took a bath in baked beans every day. Similarly, a weekly magazine in Latvian published a joke about a man who had been admitted to a mental health hospital: 'The psychiatrist asks the man: "You like paying taxes. When did it start?"' In 2008 the proportion of such anecdotes had declined, mainly due to the lower number of jokes about 'psychiatric patients'

published in newspapers in Russian. Also in this period the style and focus of coverage of mental health issues increasingly shifted towards features and away from news, perhaps bringing with it a more in-depth examination of mental health issues and less implicit linkage with crime and wrongdoing. It is significant that magazines and newspapers in Latvia have recently begun to publish the life stories of people who use mental health services because it suggests that individuals with a diagnosis of mental disorder are becoming more visible in society and that their voices and stories are being heard.

Concluding discussion

This chapter draws attention to the significant discrepancy that has developed in Latvia in recent years between, on the one hand, psychiatrists' understanding of their professional sphere and, on the other hand, media and societal perspectives on the nature of psychiatric treatment. Since the late 1970s Latvian psychiatrists have increasingly dealt with mundane 'nervousness' or relatively less severe disorders such as neuroses, masked depression and other psychosomatic disorders. By expanding their field of expertise, they have been following in the footsteps of their Western colleagues for whom every new version of the DSM has signalled both an enlargement of their clientele and an increase in their professional status. Furthermore, since the 1990s new treatment methods have become available to mental health patients in Latvia, for example psychodynamic psychotherapy, family therapy and advanced pharmacological therapies. Clients have gradually become aware of the new vocabulary with which deep personal distress may now be spoken about and are more frequently turning to professionals whose treatment styles construct mental health concerns in a less stigmatising way.

Despite these developments at a professional level, mental health issues and individuals diagnosed with mental disorders are still rarely represented in the Latvian media, although information and reporting has become more detailed and balanced. In contrast, members of the public, as the focus group study presented in this chapter suggests, predominantly see mental illness as a dangerous deviation from social norms. Moreover, it appears that knowledge and understanding about non-biomedical and non-pharmacological treatments for mental disorders are still quite limited among the population of Latvia.

The resulting 'scissors' effect', namely the mismatch between mental health professionals' representations of mental health issues (including those circulating in the mass media) and attitudes towards people with mental disorders on the part of the general public, is very important. It is essential to understand the way in which mental health professionals define what is or what is not a mental disorder or mental illness since such a definition determines how mental health issues are dealt with and whether they are considered a legitimate reason for recognising a person as disabled. As discussed at the beginning of this chapter, psychiatry's function in Soviet times was basically to treat psychotic disorders. In recent decades, however, psychiatrists in Latvia have faced three types of novel demands.

Firstly, by increasingly including non-psychotic disorders in their sphere of expertise and paying more attention to prevention they have attempted to improve the public image of their profession that the general public perceived as threatening, not least because psychiatry in the USSR had had considerable power to encroach on patients' rights and determine their destiny. Secondly, as a profession, over the last 20 years psychiatrists have been expected to adopt their Western colleagues' categories, vocabularies and practice guidelines (see Lūse 2006, chapter 5, for a more detailed account) as well as integrate into international professional bodies. Finally, new psycho-pharmaceutical treatments have made it possible to reduce the number of in-patient hospital stays endured by 'clients' of the mental health system so that psychiatrists, along with a number of mental health professions new to Latvia, have to see more outpatients than before. These developments have gradually blurred the difference between what Soviet terminology called 'major' and 'minor' psychiatry.

In some respects the process of broadening the boundaries of psychiatry in Latvia is similar to the transformations that the two world wars initiated in British psychiatry (Rose 1986). As Rose notes, psychiatry increasingly broadened the range of mental illnesses within its remit. However, unlike the British case, the broadening of boundaries of mental health problems and psychiatry in Latvia has not yet led to an explicit policy move away from institutionalised mental health care towards community care. One reason for this seems to be the fact that the general public still prefers to have psychiatric patients locked away because, more often than not, it sees mental illness as a purely biological, irreversible disorder manifesting in aberrant behaviour. Another reason is that deinstitutionalisation would involve the decentralisation of psychiatric care, but establishing community care facilities outside a few large cities has neither been envisioned nor considered affordable within the tight strictures of the country's social care budget.

Whether mental health professionals support or resist the activities and agendas of disability rights advocates largely depends on their understanding of mental disorders. During the last two decades a number of psychiatrists – in particular those espousing a psychodynamic orientation – and most psychologists in Latvia have challenged previous assumptions that mental disorders are genetically based and irreversible conditions. The alliance that has been gradually forming between psychiatric patients' advocacy organisations, such as Zelda, and an increasing number of mental health professionals suggests that there is an ongoing shift in the ways in which the latter evaluate mental health patients as members of society. The general public's understandings of mental illness, in turn, facilitate or undermine the initiatives of disability rights advocates and the position that people with mental disorders may have in a community. The findings from this study therefore contribute to a broader understanding of how professional definitions, public attitudes and media representations of mental illness can interact and jointly better or worsen the prospects for dealing with mental health concerns which are, after all, a social and not a medical issue.

Notes

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2 See the WHO webpage on the International Classification of Diseases: http://www.who.int/whosis/icd10/language.htm (accessed 20 October 2010).

3 Psychiatrists in other countries embraced similar approaches as Western models of medical education and research spread to them. In Latvia, the earlier treatment style that was substituted by the DSM model in the 1980s and 1990s was shaped by a psycho-physiological focus on workings of the central nervous system rather than by a psychodynamic approach to human functioning.

4 The term 'neurasthenia' was coined by the late-nineteenth century neurologist George Beard for a disease of the nervous system. In 1881 Beard wrote of it as 'a physical, not a mental state'. Around the turn of the twentieth century it was very widely used to refer to profound fatigue and a range of physical complaints. Research in cross-cultural psychiatry has demonstrated that the diagnosis of neurasthenia enabled patients to legitimise 'neurotic' symptoms as 'real disease' and thus circumvent the shame and stigma associated with mental distress (Ware and Weiss 1994: 101–03; Kleinman 1988: 100–20).

5 Although dystonia is not included in diagnostic manuals commonly used in the West, one can come across such terms as neuro-vegetative dystonia, vegetovascular dystonia or vascular dystonia in English-language specialist literature. They correspond to clusters of symptoms that earlier versions of ICD classified as Unspecified Disorders of the Autonomous Nervous System and that are partly covered by the group Somatoform Autonomic Dysfunctions in ICD-10 (Yevelson *et al.* 1997: 1552).

6 The term 'major psychiatry' (*bolshaya psikhiatriya*) came into use in the early Soviet period after the Russian psychiatrist P. B. Gannushkin introduced the concept of 'minor psychiatry'(*malaya psikhiatriya*). Gannushkin (1964[1933]) coined the term *malaya pskhiatriya* to refer to his theory of 'constitutional psychopathies'. His special interest was inherited personality features that situate individuals on the borderline between mental health and illness.

7 An influential and internationally known psychiatry textbook defines psychosis as the 'inability to distinguish reality from fantasy; impaired reality testing, with creation of a new reality' (Kaplan and Sadock 1988: 170).

8 Kaplan and Sadock (1988: 170) characterise neurosis as a mental disorder in which reality testing is intact and behaviour does not violate gross social norms while symptoms are experienced as distressing and unacceptable.

9 There were few exceptions in this respect. Compared with the politically influential Moscow school of psychiatry (discussed later in this section), the Leningrad school placed greater emphasis on individual psychotherapy, mostly consisting of providing the patient with guidance, advice and support (Visotsky 1968: 651). More widespread forms of psychotherapy included hypno-suggestive therapy, autogenic training (most often practised in groups) and autosuggestion (see Segal 1975).

10 The number of psychiatric beds in Soviet Latvia in 1989 exceeded that in Sweden and Finland (Andrēziņa *et al.* 1994: 572). There still were 5,085 psychiatric beds in hospitals, equaling 192.4 beds per 100,000 population in Latvia, just after the country had re-established its independence in 1992 (Medicīnas statistikas birojs 1992). Only 2,398 of them were left in 2010. Nevertheless even with that reduced number Latvia still has the fourth highest ratio of psychiatric beds per 100,000 population among all European Union countries (Pulmanis *et al.* 2011).

11 A number of interviewees mentioned such patterns of help-seeking during interviews that Agita Lūse conducted with people living with depression in Latvia.

12 The dispensaire system was introduced by the Soviet state apparatus in 1921 in order to control the population's health and ability to work.

13 *Perechen' zabolevanii, pri kotorikh gruppa invalidnosti ustanavlivaestsya VTEK bez ukazaniya sroka pereosvidetel'stvovaniya* (*The list of illnesses for which the Commission of Medically-Vocational Examination assigns a disability group without further reconsideration*, in Russian). Available online at http://www.med-pravo.ru/OthDocum/MLab/ListInvalid1956.htm (accessed 19 October 2010).

14 In contrast to hospital and ambulatory psychiatric care, community care facilities are often seen in Latvia as the responsibility of local governments and/or the Ministry of Welfare rather than the Ministry of Health.

15 For instance, 1,882 adults with a diagnosis of schizophrenia (F20-F29), 325 children with learning difficulties (excluding 656 diagnosed with oligophrenia) and 43 children with a diagnosis of mental illness were institutionalised for long-term care in state and municipal social care homes throughout Latvia on 1 January 2010 (Labklājības Ministrija 2010). In the capital city alone, there were approximately 400 beds in 2011 for adults (excluding those of retirement age) with a psychiatrc diagnosis and classification in the first or second disability group. See *Valsts Sociālās aprūpes centrs 'Rīga'* (The State Social Care Centre 'Riga'), online at http://www.vsacriga.gov.lv/ (accessed on 26 October 2011).

16 One indicator of the low social inclusion of chronic sufferers from mental health problems is the very low number and highly unstable membership of psychiatric patient associations or self-help groups in Latvia as observed by Agita Lūse during her fieldwork in 2003 and 2006.

17 In 2008–10 the global economic crisis diverted the attention of Latvian politicians even further away from the implementation of the UN Convention.

18 Association of Private Psychiatrists, online at http://www.privatpsihiatrija.lv/public/ (accessed 1 August 2008).

19 Research on understandings of mental illness in the general public and on changes in mass media representation of mental health issues was conducted by Daiga Kamerāde.

20 All quotes from the participants are translated into English from Latvian or Russian. The gender and age of the participant is indicated in brackets.

21 About Latvia's ambivalent stance vis-a-vis the EU mental health policy objectives see the earlier section of this chapter 'Discovering patient rights: post-Soviet perspectives on psychiatric disability'.

22 Although the most widely consumed media was television, it was not chosen for analysis because the BMF suggests that people watching television mainly choose films whose selection and content cannot be significantly influenced by mental health advocates.

23 Positions of public relations specialists (alternatively called communication specialists) have recently been introduced in all major hospitals of Latvia, including psychiatric institutions. Latvia's Public Health Agency (which was reorganised in 2009 but still existed during the period under consideration here) employed PR specialists who may have significantly influenced the way in which the Agency's experts on mental health communicated with the general public.

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6 Living with a disability in Hungary

Reconstructing the narratives of disabled students

Eszter Gábor

Life stories represent a complex combination of individual and social factors and can reveal both the past perspectives of interviewees as well as their present-day interpretations (cf. Rosenthal 2005). The 'reconstruction' of life stories thus provides insight into the processes of identity formation, maintenance and change. This research technique can illuminate the biographical experience of living with a physical or sensory disability and also help to understand how disability is treated a particular society. In this chapter, I discuss the life stories and lived realities of 16 students with one or more physical impairments in three areas (*megye*) of Hungary. I examine how the students integrate disability and its effects in their lives and biographies, including changes over the life course. I focus on disability-related discrimination and stigmatisation in the context of self-esteem and ascription by others, looking at how these processes are affected by individual biographical experiences as well as collective events such as historical and political developments in Hungary.

Although there is no precise medical diagnosis of disability (Kastl 2010: 46ff), many discussions of the phenomenon operate on a medical basis or attempt to explain and even categorize various forms of disability through medical knowledge. Whilst disability is clearly an embodied reality, it cannot be reduced to an individual's physiology. It is instead important to emphasize that both the functional ability of the body and disability itself are socially constructed concepts and therefore dependent on context (cf. Kastl 2010: 44, Kálmán and Könczei 2002: 82ff). I use the term *impairment* to refer to the functional limitations of the body whereas *disability* concerns limitations in societal participation that arise due to impairment. Disability therefore includes society's reaction to impairment, although it is the impact on individual biographies that most interests me in this chapter. I use my biographical investigation to explore the social processes that disable people with impairments in Hungary.

Historical background

During Hungary's socialist past[1] issues such as poverty, unemployment and disability were largely ignored by the country's politicians since social problems were incompatible with the dominant political ideology of a happy society.