

Performing (Non-) Compliance – Body, Subjectivity and Medication in Psychiatry

Shu-Chung Lii, School of Medicine, Chang Gung University, Taiwan
Chun-Lin Chu, Chang Gung Memorial Hospital, Taiwan
Ya-Huei Huang, Chang Gung Memorial Hospital, Taiwan

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Abstract

Medication and its compliance is regarded as the cornerstone for therapeutic relationship and efficacy by the contemporary psychiatry. From the perspectives of the patients, however, the question of being compliant or not with psychiatric medications is a serious and complicated issue beyond what psychiatry can figure out. As the recipient subject of psychiatric medication, patients always think, act on, re-act and even resist to psychiatric medications and its symbolic meanings through their bodies, which reflect not only biology but also personal sufferings, idiosyncracies and subjectivities embedded within their local moral worlds. More often than not, medication compliance or non-compliance does not work in a fashion of either-or manner for patients, but rather in a strategic and performative way, which indicates the struggle between subjectivity, illness and medical governmentality. Based on a long-term ethnographic investigation in a chronic psychiatric ward, this study presents two cases to show that compared to the simplistic view about patients and their (*non-*) compliance generally hold by medical staffs, what a more realistic and intricate picture of patients' compliance or not could be. By studying the (*non-*)compliance issues from both sides of psychiatric treatment, an insight into the nature and reason behind the dilemma of medical non-compliance in psychiatry can be gained, a deeper understanding and appreciation of patients' agency and subjectivity within medical contexts can be made, and even a better idea for overcoming this dilemma can be obtained as well.

Keywords: Compliance, medication, body, subjectivity, patient, psychiatry

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Introduction

This report is consisted of four section. The first section is an introduction to the issue around clinical compliance, including a brief sketch of its history and associated problematiques; the second section is mainly about examples of critiques of compliance from social sciences; the third is the main body of this field study and its results: a summary of nurse interviews and stories about compliance provided by my informants; and the last section a discussion and some tentative conclusions for this study.

According to the review by Ballard(2004), Compliance as a practical challenge and problem for clinical work dated back to at least to the time of Hippocrates or even earlier. However, it is not until the 70s of last century that compliance had reemerged as a major concern for medical practices on an overall and global scale. There are many reasons behind this phenomenon, and one among which that is more than apparent is that compliance as a common measure of treatment efficacy, it has been deemed by medicine itself as the major factor for treatment failures and also for causing the skyrocketing expenditure on medicare and wasting of prescribed medications in many modern countries. Since then, there have been many researches done with the goal for improving patients' compliance or removing their non-compliance. However, no tidy conclusion has ever been reached on this. Then before the end of last century, some new frames or concepts like Adherence or Concordance were proposed for moving beyond the limitations and ideology cast by Compliance to furthering our understanding of the difficulties brought up by the clinical compliance phenomenon. But, again, still no general agreement about the nature of compliance and it solution can be met. One possible reason behind this could be the complicated nature of compliance itself. In clinical world, compliance covers a broad and diverse ranges of issues concerning what to comply, who complies to whom, compliance-specific medical conditions, disease types and phases; (which) medical departments/specialties involved for requiring for patient's compliance; and variations of compliance with patients' demographic features such as age, gender, or ethnicity. It' is pretty sure to say that all these variables and diversities are contributing to the messy picture of compliance and its many controversies. However, among these variations and along the long line of debates, compliance to medication can be said as the primary focus and concern all the time in compliance studies.

Take the summary table by Pollock (2005) as an example. In her study, Pollock shows that varying outlook of the medication compliance or non-compliance, which can include so many different dimensions, such as taking-or-not-taking medicine, the quantity, frequency, timing, patterns of medication, modifications of medication for reasonable or unreasonable concerns such as work, stopping the medication or discontinuing the refill, or combining with other medicines beyond prescription. It becomes evident that reasons for making these variations of medication non-compliance or compliance are worthy of deeper explorations and interpretations than simple measuring based on rigid conceptual frames or tools commonly done in the mainstream compliance studies.

In 2003, WHO published a book on medical adherence, in which a more systemic approach to clearing the mess caused by previous studies of compliance was taken to create a much more systemic view of the overall phenomenon under the label of

compliance. It was asserted that there were five dimensions of medical compliance, including 1. health and medicine systems or structure factors, 2. medical conditions factors, 3. patient factors, 4. treatment practice factor, and 5. socio-economic and cultural factors. WHO's model of compliance demonstrates again the breadth and complexity of medical compliance, and if we exam how these five dimensions of compliance were defined and measured by WHO, and we may still worry the struggle and difficulty over defining and solving issues and problems of clinical or medication compliance can still continue.

The challenge of Compliance is mysterious, and some ruminations on this can bring some clue or insight into view. For example, if we put some certain essential or orthodox research paper on compliance in to analysis, the conceptual complex and cross-linkings around Compliance can be easily revealed. In a word cloud centering on Compliance I made informally, many concepts and jargons highly overlapped or correlated with Compliance were identified, most of them could be located along the social continuum with the bi-polars of Medicine-centric and Patient-centric ends. Typically, at the Medicine end, we can locate concepts like compliance or adherence, while at the patient's end, concepts or jargons like resistance, autonomy or subjectivity show up. Still, there exists some more 'neutral' concepts or issues dwelling between these two ends such as concordance, communication, or agreement. It is still unclear, however, whether the complexity around Compliance is a truthful reflection of phenomenological reality happening in the clinical encounter, or the complexity itself is confounding or distorting the reality Compliance means to indicate to.

If go through the development of compliance studies, we can find some undercurrents within it, which resonated with the shift of stress on and reconceptualization of compliance in the later and more recent time. Early researches on compliance concentrated on how many people are non-compliant with medicines and their related characteristics. However, it was indicated that a different measurement of non-compliance may lead to different estimate of non-compliance. Also, it was found that compliance rates varied with either type of drug, the length of time of medication, or the complexity of the drug regime. Besides, there was no consistent correlation found between patients' characteristics and non-compliance actions. Seemingly, in these early studies some questionable assumptions about Compliance were held, such as 1. that the 'problem' of non-compliance was deemed as being situated within the context of the doctor-patient relationship ONLY, and 2. that patients were just passive recipients of health care.

Stimson's ground-breaking study in 1974 showed a quite different picture of clinical compliance. In his eye-opening conclusions, Stimson asserted that patients were not passive recipients of medial instructions, and patients had their own ideas about illness and the use of medicines. Stimson suggested that the focus of compliance research should be on the social context in which illnesses are experienced and treatments used. Also it was found that neither compliance nor non-compliance was stable, and both would change according to the change of information and experience patients got. The shift on social context of medical interactions and patient's subjective role within it has thus prompted patients' beliefs and their impacts on medication as the new research focus. Other researches pointed to some obvious conditions or correlation about clinical compliance overlook by studies of earlier time,

such as compliance and non-compliance not being in an all-or-none, or either-or condition (Donovan and Blake 1992), a more-than-clear fact that clinical miscommunication could cause non-compliance (Britten et al., 2000), or the possibility that materiality of medications, including drug's physical attributes, may shape patients' perceptions of medical treatment and their inclinations of being compliant or not.

Helman's study (1981) on the 'metaphor' for taking psychotropic medications and its relation to patients' felt sense of control on medical encounter demonstrates lively the interesting relation between the materiality and symbolic functions of medications and their compliance by patients. This was an early indication of patient's subjectivity playing a role in the phenomenon of clinical compliance, through the function of medication's materiality. This study is echoed by the work by Stephan Ecks's, *Eating Drug* in 2004, in which the same observation of making patients compliant to antipsychotics through some metaphors such as "mind food" by some psychiatrists in Calcutta was made.

Later on, it has become more than clear that compliance as a concept or frame for certain clinical problems encountered between medical staffs and patients was problematic, basically on two grounds: 1. patients hold their own beliefs about medicines; and 2. patients are active in treatment decisions. Therefore, in 1997. The Royal Pharmaceutical Society proposed a new concept, Concordance, to replace Compliance, with the hope that the former and newer one can overcome the conceptual and practical dilemma caused the latter and older Compliance. In the Concordance framework, an open negotiation and subsequent agreement between patients and doctors about medications was emphasized, and it was believed that Concordance can best be achieved when patients and doctors can openly express beliefs about illness and medication towards each other. In the Concordance model, it was well recognized that the patient as active participant in decisions about health care, and that rather than disobeying, patients leave the consultation with an agreed decision about their treatment. The Concordance model was based on a hypothetical and idealized equality of status and power between patients and medical staffs, but how much this can be true in clinical reality is still quite uncertain and questionable.

From a more recent study on the doctor-patient relations (Duggan and Thompson 2011), which was a 'softer' approach than 'psychoeducation' or "management" ones to compliance, it is still evident that compliance interacts complicatedly with other clinical outcome measures, a fact which reconfirms the complexity of Compliance and its possible reason on the conceptual level: it was pointed out that the outcome elements with great correlation with clinical compliance include health outcomes, quality of life, medical adherence, treatment recommendation, and provider-patient Interaction (such as provider satisfaction, or communication).

It becomes curious that why even when the emphasis has been changed from the paternalistic Adherence or Compliance frameworks to the more egalitarian Concordance, there is still no general agreement reached. It seemed to be that within medicine the challenging conditions between medical requirements and patients' reactions have been improved by these reframing of emphases, but, the interpretation of this change is still in debates and many challenges from clinical compliance are still there (Leibing 2010). To see from a different angle, however, it seems that

whatever framework for clarifying the complicated relations between medical regime and patients was adopted, its the approach itself looks quite medicine-centric, flattened and self-fulfilling in nature and essence. For example, the measurements for verifying the degree of Compliance seemed to be confounding within themselves and with Compliance itself. Even for the other realms of measurements like patient-physician relations or communication studies, which could open the scope of and bring more insights and reflections on the exploration of Compliance itself, the analysis is still pretty limited in the dyad framework, leaving aside those important factors like power relations, structural factors or deeper cultural meaning behind this problematic phenomenon of Compliance.

Examples of studies from social sciences with t different frames for analyzing and interpreting could shed certain light on this. James Trostle_(1988), based on his analysis on medical systems, asserted that Compliance is, in fact, an ideology held by professional sector, such as biomedicine, against the common medication patterns and styles adopted by users in other medical systems, for example, the pretty usual mode of self-medication in folk sectors. This insight from comparative study of medical systems indicates that the compliance issues framed by medical systems could themselves the ‘problems within problems’, which means the conditions and challenges brought by compliance issues should not be named, defined, interpreted and even dealt by one party itself involving into this dilemma, that is, the medical staffs and medical system. Sometimes it becomes hard to tell the compliance problem from the intricate and unaware self-justification by medical staffs without necessarily negative intentions, which may be resulted from the messy and complicated clinical interactions and works. Study by Jose Dumit (2010), an anthropologist and STS scholar, goes beyond the realm of equating Compliance as indexing of treatment efficacy and makes the claim that issues of Compliance can be deconstructed as the modern or postmodern discursive formation, in which the instrumentalization of Compliance is operated by and through various medical or care systems, institutions and actors to make a modern biomedical subject or citizen, whose nature is then by definition in constant need of biomedical monitoring, controlling and curing for various risks commonly encountered in this high modern or postmodern milieu. By the ethos of globalization and neoliberalist governmentality actualized by medical concepts and practices, the individuals with mental issues will inevitably fall into the only reasonable and justifiable subject position as patient with biological problems. Borrowing from Althusser’s “Interpellation”, Dumit re-makes it as “Inter-pill-ation” to indicate this unique subject formation through discourse like Compliance in contemporary psychiatry.

Another pretty insightful example is from Taiwan and provided by the late professor Shirley Lin. In her study, Lin combines anthropological perspectives on cultural phenomenology, embodiment, subjectivity and materiality to study patients’ subjective meanings and experience of antipsychotic medications and their compliance issues. By focusing on patients’ subjective and embodied experience of illness and medication, and also on the symbolic power and mobility associated with antipsychotic medication as things with their own social lives, Lin transforms the compliance or non-compliance problems into a set of anthropological questions, which center on the complex among cultural body, self, illness experience and meaning, medication and subjectivity. Through her thorough analysis, Lin indicates four fundamental conflicts in and confusions from patient’s cognition of antipsychotic

medications and thereof the compliance issue:

- 1 Medication is helpful vs. (Western) Medication is damaging to the body.
- 2 Side-effects vs. Beneficiary efficacy (of antipsychotics).
- 3 Medication brings about “antibody” (metaphor) for improvement vs. Medication brings about side-effects that complicates illness
- 4 Taking medication means improvement or even cure vs. Taking medication means or indirectly proves of (you still and may continuingly) being sick.

Lin’s work is important, because it reframed those dimensions of Compliance proposed by WHO in 2003 by anthropological concepts and methods, and by doing so a deeper interpretation and understanding of complicated phenomenon and conditions under the name of Compliance can be regained, way beyond the rather mechanic and flat explanations from the originally helpful and comprehensive system of analysis suggested by WHO.

The Study:

Before entering into the interesting data about clinical and medication compliance provide by friends (so-called *informants*) in my fieldwork, a simple but essential interview with senior psychiatric nurses with whom I have been acquainted during my study in a chronic ward for mental patients is provided as follows.

All interviewees are senior workers with clinical experience more than five years in psychiatric ward, and most of them had previous experience in another medical specialty, such as internal medicine or surgery. The result of the interview with these experiences psychiatric nurses shows no surprise, compared to the general comments by clinical nurses on compliance from other studies. In this interview, the overall agreement is that the (antipsychotics) medication non-compliance is, according these experienced nurses, generally caused by or related to the following :

- a. Insight: All agreed that lack of insight is the main reason behind patients’ non-compliance behaviors.
- b. Stigma: Stigma associated with psychotic medications leads to many non-compliant behaviors by patients across many different occasions, such as work or interpersonal interactions.
- c. Side-effects: Obviously, the side-effects of antipsychotic medications can sometimes cause more troubles than disease or symptoms themselves; and side-effects could also be so disturbing as to be intentionally terminated altogether by patients.
- d. Personal variations: This included both the variation of different doctors’ styles of medication regime, and also the variation of different patients’ reactions to antipsychotics, or even the same patient’s different reactions to the same medication at different points of his disease course
- e. Family attitudes: Family’ attitude, experience or value orientations about antipsychotic medications are definitely making impacts on patient’s compliance behaviors. Besides, the family relation and family function also complicate the picture of patient’s compliance.
- f. “Medication” itself: It’s still pretty common in Taiwan, even nowadays, the belief that medicine in general, esp. the Western Medicine (i.e., biomedicine and its

medications), can have damaging effects on human body. Comparatively and relatedly speaking, it is generally hold that traditional medicines, including TCM or other folk systems like the herbalist, is relatively less damaging or mild, and sometimes in many disease cases nutrient food are deemed as beneficial and even therapeutic in positive manners than bio-medications with their damaging and negative impacts on human body. This sort of beliefs can result in the inclination of being non-compliant in patients or their significant others.

- g. Others: The use of alternative medical systems, including their medications and various nutriments and tonics, also complicates the picture of patient's compliance behaviors. It was suggested by these interviewees that alternative substances could interact with antipsychotics and confound their effects and results. This could change patient's inclinations or intentions of compliance or non-compliance. However, the relative limitation and uncertainty of psychiatric knowledge on psychopathological mechanism and pharmacology of antipsychotics, and the problems of treatment efficacy in psychiatric medications, all can contribute to the increasing likelihood of using alternative medications by mental patients.

Generally speaking, this interview demonstrates the similarity in evaluation of factors connecting to the clinical or medication non-compliance by many clinical practitioners, but it may also indicate the more complicated and dynamic picture of the clinical and medication compliance in psychiatry and its medication practices.

Ethnographic vignettes

Story One - Mr. H.

The following is a series of stories from some friends I have gawn acquaintance with during my fieldworks in psychiatric wards. Their stories shows the cultural and subjective aspects of persons engulfed by their metal conditions and ensuing psychiatric treatments, which bear great significance on patients' behaviors of medication compliance or non-complince, but are generally ignored by the mainstream study of clinical and medication compliance.

Mr. H., is a middle-aged, chronic patient diagnosed as bipolar with mild MR. He has been hospitalized for almost two years, and always shows his strong inclination of being compliant to medical order of medications or any sorts in the chronic ward. However, after getting know to each other with more acquaintance and trust, when we discussed about the etiology of his sickness, thing begins to change. As a deeply devoted and self-labelled Buddhist, Mr. H. believes that mental illness is ultimately caused by Karma, and that those with bad Karma or debts from previous lives will be more vulnerable of being afflicted with mental diseases. Therefore his etiology of mental disorder can be seen as a synthesis of Buddhist cosmology and biological psychiatry because the immediate 'cause' of mental disorders is deemed as something biological but the remote and ultimate reason or cause of making this sickness happen in this present world and life is something from the person's previous life. This etiology discourse on mental disorders is a synthesis of religious and scientific discourses, and in which the former 'primes' the latter without denying its existence or legitimacy in disease-formation explanations. In an occasion, when with great frankness and his mind opened to our dialogue, Mr. H. told me his real ideas about psychiatric hospitalization and medications by showing me the divine guide on a

paper he got from a visit to a “Living Buddha” in a temple which he worships greatly for certain time. On the front side of this paper of divine orders given by the “Living Buddha”, a personification of Bodhisattva through a wooden statue of that great deity and mediated through a ritual mediator, the divine order or guide revealed to Mr. H. the ultimate reasons of his sickness in this life and this world, and at the back side various suggestions of how to deal with his mental illness were given to Mr. H.. In this divine suggestion given by a “Living Buddha” requested by Mr. H. through a formal and serious ritual process, it was predicted that Mr. H. would be discharged fairly soon, but he still has to comply to order of psychotropic medications for a longer period of time, until his mental conditions subsides. Then I tried to push Mr. H. into a hypothetical situation of extreme by asking what if the “Living Buddha” gives him a direct and clear suggestion of quitting his medications altogether, which is totally against the medical order?! What he will do?! Mr. H. hesitated for a while, and replied that if he receives such a suggestion, he will comply to divine order rather than medical one after making repeated confirmations with the “Living Buddha” on this matter through several ritual requests, making sure it’s the exact opinion from the divine above, because, after all, it’s religion the ultimate truth behind the phenomenon of his worldly suffering caused by mental sickness. The decision-making process over this hypothetical question by Mr. H. shows exactly the nature of his synthesized model of the mental disorder and its etiology, that is, both religious and biological realms having roles in the formation of mental conditions suffered in this life and world, with the former as the primer cause and higher authority over the latter. However, according to his wisdom of eclecticism, which resonates well with his etiological understandings, it is better for him to reserve certain obedience and respects to the authority of this world and life, that is, the medical staffs, for his own good, and by doing this, he is sure, the greater authority governing the fate and cause of life and world from the upper and deeper order won’t be offended because there exists no contradiction between these two actions. Therefore, Mr. H. has been planning to gain the understanding and acceptance from his doctor and nurse of his possible decision of gradual decreasing of psychiatric medications in the near future, just as what that “Living Buddha” suggested. It is hard to tell what the medical staffs would react to Mr. H’s ideas formed from his personal and religious beliefs, but it seems obvious that Mr. H.’s compliance to medications will not be steady once his symptoms subsides and religious authority becomes more prominent to his life, both of which becoming more possible after his discharge.

In Mr. H.’s story, decision of complying or not, is complicated by the etiological discourse from the religion that Mr. H. has deeply believed in. Where he will keep constant compliance to medical orders is pretty unsure, but the reason behind and making this uncertainty seems not well concerned, or deemed just as superstitious, by the medical staffs.

Story Two - Mr. C.

Mr. C. is a repeatedly hospitalized psychotic patient with a long history of mental problems. Coming from a family with many psychotic relatives, since very early on had Mr. C. suffered from the mental disorder and its associated stigmata within and without his family. Therefore, since the inception of his disease, he had been in the cycle of violent abuse and abandonment by his family. During the abandonment, Mr. C. gradually grew up an unique worldview, with which he could make the minimal

sense of his life, suffering and fate in his hometown world.

In hospital, Mr. C. presents himself as a polite person and seems quite compliant to most medical orders and management. He has no problem, at least on the surface, with antipsychotic medications or whatsoever medical staffs have orders on him. There is only one disagreement happened repeatedly between he and medical staffs, that is, the little shrine he set up for himself around the bed side. This personalized space of sacredness and its accompanying worshiping practices initiated by Mr. C. himself were deemed by staffs not only as the manifestation of psychopathological symptoms, such as religion delusions, but also as obstacles for ward management. These interesting personal things set up by Mr. C. were repeatedly removed by medical staffs or by his folks under staff's request during his hospitalizations. I become interested in what these personal things mean to Mr. C.

In an expected occasion, I had an unusual talk with Mr. C. which touched the issue of compliance: One day, after the morning meeting, I went to Mr. C.'s ward and checked with him as I had already known from the morning meeting that he had been suffered from the serious side effects from his medications. While I was concerning how he recently felt about his medications, Mr. C., who had just taken his morning medication, suddenly came to whispering to me. He said he wanted to tell me a secret, just between us. He touched his throat, and then moved his hands downward and stopped in the middle of his chest, claiming that the medicines he just took were stopped right there, by the deity of certain temple that has been governing this specific organ area within his body. It depended on the deity's control and judgement as how the medicines will work, help or harm, and where or which organ area these medications with their effects-to-be-judged will go next. And the efficacy of medications will be evaluated by the total opinions of various deities governing different organs within his body, and then a final general decision of compliance or not will be made. When asked why he didn't just decline the order of taking medications by staffs, Mr. C. smiled and replied that this hospital was itself like a temple, within which the doctor is the governing deity and according to his previous experience with so many local temples, it's better comply a little bit with any sort of powerful authority, because only by doing so can help him avoid troubles and even gain some helps he needed. I was totally amazed by this explanation and started to wonder how this sort of body image was built up by Mr. C., and how it worked for him as the ground of his being to face the challenge by the fierce mental illness and the powerful psychiatric countermeasure. Then little by little and piece by piece through our conversations, the story behind this amazing body architecture of Mr. C's become comprehensible. Just like another amazing self-made "Lunar Calendar" by Mr. C. shows how the temporal dimension of his life has been structured by the time order of sacred events held orderly by various temples in his hometown, his body or spatial dimensions of his life is a reconstruction from the tragic experiences of his early life which combined poverty, family mental illness and abuses, ethnic issues, and social inequality of the local moral world into which Mr. C. had been born. The unique body perception is in fact an embodiment of his experience of being multi-marginality constituted of the mental disease, abuse and social inequality. Since very early on, whenever he was in an episode of mental condition, abused and then abandoned by his folks, probably due to the uncontrollable troubles or conflicts brought by his conditions within his family, which had some more mental patients within in, Mr. C. started wandering around in his hometown world and usually he was taken in by different local temples for religious charity or mere pity. Mr. C. then survived by offering his labor as appreciation and exchange for the local temple's

kindness and help. Gradually through repeating this survival mode, Mr. C. became deeply involved in those temples which had saved his life during his episodes and abandonments, both in terms of beliefs and practices, and then his life, once deemed as meager and valueless, grew to mix with these local religious institutions and then transformed into an unique map and architecture of time and space inscribed onto human flesh. Through this transformative process of his suffering and salvations, Mr. C. develops a sanctified body with unusual spatial and temporal design of his own being-in-the-world, and this body becomes the interface between his personhood and many other worldly authorities, including biomedicine. His saved and transformed life and body by religious institutions, and in which the body is defended by those local forces that once had saved him from extinction, and the tempo of his life is conditioned by rhythm composed of those local sacred events, including the celebrating rituals for the birthday of the main deity of certain temple, or purgatory ceremonies for living persons or wandering souls, and the collective praying for the public or personal blessing.

In Mr. C's story, medical compliance is not just about the process of rational-choice on the individual plane, but also much more about the unique performance of suffering subjectivity in a rural world.

Story Three – Ms. S.

Ms. S., a rather young female in her mid-20s, had already developed a full-blown and highly fixed system of delusions. One main feature of Ms. S's delusion is her insistence of the scare on her face, which no one else but herself could see, touch and feel. During my stay in the ward, Ms. S. had been repeatedly admitted for acute episode many times, and therefore it became apparent for all that Ms. S had not been compliant to antipsychotic medications at all once discharged from hospital. However, an ethnographic probing with focus on more details and in-depth information allows a better grasp of what runs behind or under the insistent non-compliance of Ms. S.. After a long and nuanced process of ethnographic interviews, it became evident that there existed something not falling into medical awareness yet seemingly relevant to Ms. S's complicated and bizarre mental symptoms, her persistent con-compliance to antipsychotic medication, and the pessimistic prognosis of her illness.

First of all, Ms. S's parents were both users of mental service, and this fact unfortunately did not come to medical staff's notice. This was found during my field observation of the interaction between Ms. S and her father and mother together or separately. Many times in the family visit, it was found that Ms. S's mother appeared pretty dramatic in her emotion expression, which made Ms. S fairly angry and emotional, while the father was just pacing around, murmuring and looking pretty embarrassed, nervous and helpless. Then through the repeated observation of the historic play of Ms. S's mom, I started to explore and finally realized that there existed a long-lasting and intensive conflicting relationship between Ms. S and her mother, and also the fact that both parents had visited psychiatrists before, for Ms. S's case and their own problems, too.

Second, there exists a long and complication history about the formation of the delusion or hallucination of a scare on her face. To make it brief and clear in a simplified manner, this symptom symbolized both the fundamental conflict between Ms. S and her mom, and the resulted dilemma in Ms. S's mind. This conflict was

based on the contradiction between two psychological facts: on the one hand, there was a fact that Ms. S had great resemblance in her appearance to her mom's, but on the other hand the other was that she felt being emotionally abused so profoundly by her mom since her childhood. The later fact made Ms. S. decide not to become a person having anything similar or close to her mom, but the former fact has become an inescapable irony to it. There was another set of conflict with significance in Ms. S's mind, which complicated the conflict above even more: on the one hand, Ms. S. had strong anger toward her abusive mother, but on the other hand, she expressed from time to time, esp. in the acute episode, with the manner of infantile regression, her need of the warmth, caring and love from her mom, which she had felt never being given to. Therefore the tension among her appearance resemblance to, resistance of identifying with, and unrealistic need of mother and maternal love had put Ms. S in a constant sense of confusion, conflict, self-doubt and contradiction. The symptom of having a scare on her face only visible to herself seems to serve as the symbolization of that essential dissonance within the life and world of Ms. S.'s, and through such a defensive mechanism a minimal function of self preservation was provided.

Then what about the compliance issue in Ms. S's story? It seems evident that the reason behind Ms. S's non-compliance to medication was that once in the remission stage after being discharged from the hospital, where she usually had the forced and scheduled medications by the medical staffs, Ms. S would go back home facing that same conflicts of identity with her mom, with a much clearer mind and more lucid consciousness. Therefore the irony is that the beneficiary effects of antipsychotic medications would inevitably make Ms. S clearly sense that essential and unresolvable conflict with her mother again. Therefore, in a strangely reasonable way, Ms. S. would stop her medication and recede into the ego-defensive cage of delusional symptoms, which secludes herself from the harsh reality deeply residing in her life by inventive and fanciful distortions of meanings. In reality, Ms. S. always stopped taking her medications sometime not too long after she went back home, and the psychosis resumed and then she started wandering again. Hence the vicious cycle of (re-)admission, medication, remission, discharge, going back home, and relapse repeats.

In this condition, non-compliance becomes reasonable or inevitable for Ms. S., when the psychopathogenic family dynamics is considered. However, unfortunately, this dimension of Ms. S's psychopathology has not always been given adequate concerns by the medical staffs, who usually target the complex symptoms of mental disorders as the primary object for immediate interventions, and decode them in terms of biology and individuality with psycho-pharmaceuticals in hand for counter-measurement. In the heyday of biomedical and neurological reductionism, non-biological meanings or social relations, including family dynamics, have been pretty much discarded or recast as confounding variables. However, in the story of Ms. S. and her dilemma, it seems that compliance to medications has reduced or overcome the pathological part of Ms. S' mind, but in some twisted way also melted down those meanings and relations complexes deeply incorporated into a frozen system of delusional symptoms, unexpectedly making them as pathogenic or pathodynamic all over again. Ironically, in Ms. S' case, she could not comply to medical orders, because once she complies, those pains and irreconcilable conflicts between she and her mother will come to Ms. S. and break her down again. On the other hand, for Ms. S,

non-compliance could reserve the chance of receding into the fragile and distorted symptoms of delusions, which seems to be a somewhat valid and alternative way to provide the function of self protection and preservation desperately needed for her subjectivity squeezed by the compression of a harsh and unchangeable reality and a distorted psychology.

In MS. S's story, it becomes clear that compliance is something much more than a decision-making based on decontextualized rationality, but rather is having a lot to do with the complexity of individual mental history, social development, subjectivity and complicated symptom-formations.

Discussions and Conclusions

Some tentative conclusions from this study can be made for further discussions:

First of all, Compliance covers a wide range of issues and related concept. It's a very complicated domain to study, but study of Compliance can have great value for both clinical practices and theoretical analysis.

Second, Compliance has strong interactions with other significant issues, such as clinical insight, disease category, symptoms and psychopathology, psychopharmacological treatment, side-effects, illness experience, individual difference and subjectivity. Compliance also overlaps significantly with other indexes of clinical outcomes such as treatment satisfaction, quality of life, and communication. All of these point to the complexity of Compliance again.

Third, Compliance has been a term widely used across different professional domains such as Law, Police, Medicine or Education. This fact implies the possibility of a shared modern origin for these institutions or professions; and therefore it becomes potential for investigating the contextual specificity behind this seemingly universalized use and conceptualization of Compliance.

Fourth, studies of Compliance by clinical social sciences have gone beyond bio-medicalization and recast and recontextualized 'mental patients', their subjectivity and sufferings back into their "local moral worlds." (Kleinman 1992) Hopefully, by doing so, we can take back more personhood from patienthood, and also shuck off the technical and managerial linings of Compliance to reveal more of subjectivity and its socio-political, cultural and existential meanings.

Fifth and the last. This study is by no means suggesting that non-compliance is a better principle than compliance for facing modern medical intervention and medication. Neither does this study deny the benefit and positive effect of modern medications. Rather, this study is making a suggestion that by adding up the dimensions of socio-economics, politics, culture, history, religion and human psychology into the clinical concerns, a better and more balanced framework for dealing with issues around medication compliance can be reached. In addition, social study of clinical compliance can be a window through which we can discern a specific mode of human conditions and their modern consequences.

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