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The vicious cycle of distrust: Access, quality, and efficiency within a post-communist mental health system

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ABSTRACT

Trust –a critical mechanism to manage vulnerability amidst uncertainty– may greatly influence healthcare practices, and consequently, its objectives. Building upon the work of Jürgen Habermas and the framework of trust chains, the aim of this article is to unpack how trust dynamics between the state, the provider, and the service user shape the functioning of mental healthcare in one of the former Soviet states –Lithuania. The case is of interest to medical sociology due to the region's historical and contemporary context. By drawing on in-depth interviews with healthcare providers and users, I demonstrate how the chains of reciprocal distrust underpin the workings of the mental health system and how the actors in turn employ a range of responses to such distrust. The instances of trusting relations nevertheless demonstrate how trust might facilitate the strive for mental healthcare that is more accessible, efficient, and of higher quality.

1. Introduction

The health systems in Europe, as elsewhere, are constantly juggling between a range of objectives, the core of which encompasses access, quality, and efficiency. They strive to provide "high-quality services for all citizens on an equal basis […] with little waste and duplication" (Blank and Burau, 2010: 97). In practice, they nevertheless face challenges in achieving said ideals. The reliance on the objective measures in assessing such successes or failures of health systems –for instance, the volume of human and physical resources, healthcare expenditure, or the breadth, scope and depth of coverage– tend to mask the importance of subjective or micro-level mechanisms that likewise influence healthcare practices (Brown and Calnan 2011, 2016). (Dis)trust can be viewed as a critical facet of the latter, and in turn, consolidate or compromise the fulfilment of said objectives (Brown and Calnan 2011, 2016; Brown et al., 2009; Gilson et al., 2005; Stevenson and Scambler, 2005).

While fundamental to healthcare in its entirety, the role of trust has been particularly accentuated in the context of mental health (Brown et al., 2009; Maidment et al., 2011; Stasiulis et al., 2020). For mental healthcare seeking and utilisation involve a great extent of vulnerability and uncertainty associated with the treatments, negative attitudes that continue to surround mental illness, or the nature of symptoms themselves, which lack clear biological markers. The latter also uncovers the salience of effective and sensitive communication that facilitates disclosure in a clinical encounter, that is, "mak[ing] oneself vulnerable in order to overcome vulnerability" (Brown, 2021: 102).

Yet, the concept of trust reaches beyond the limits of the user-provider dyad by embracing trust between providers or in the institution and the state (Brown and Calnan, 2016; Gilson, 2003; Wilk and Platt, 2016). The literature addressing such multi-layered trust dynamics in mental healthcare is, nevertheless, limited (Brown and Calnan, 2016; Brown et al., 2009; Stasiulis et al., 2020). Building upon the work of Habermas (1984, 1987) and the framework of trust chains by Brown and Calnan (2016), the aim of this article is to unpack how trust and distrust between the state, the provider, and the service user may influence the functioning of mental healthcare in one of the former Soviet states –Lithuania. Although still understudied (Raikhel and Bemme, 2016; Winkler et al., 2016), the region presents a case of interest to medical sociology due to its unique historical and contemporary context.

Besides the misuse of psychiatry for political repression, which complemented the practice of deportation to Gulags (Raikhel and Bemme, 2016; Tomov et al., 2007; Van Voren, 2013), mental healthcare under communist rule may be characterised by its extremely low priority, and in turn, deficient investment into the sector, as well as by reliance on biological approaches to mental illness and a *de jure* rejection of psychoanalysis (Marks and Savelli, 2015; Raikhel and Bemme, 2016). Excessively paternalistic, it nearly entirely relied on hospitalisation,

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restrictions, and institutional care, which was rooted in "the widely-held belief that the primary task of the mental healthcare system is the safety of 'regular' citizens" (Tomov et al., 2007: 406). All of this contributed not only to a falling behind the Western mental health practice at the time (Tomov et al., 2007) but also to the profound stigma and delegitimisation of psychiatry that remain rampant to the present day (Doblytė, 2020; Raikhel and Bemme, 2016; Winkler et al., 2016).

Restructured over the course of the last decades, current mental healthcare provision in Lithuania appears to be rather comprehensive (Šumskienė et al., 2018). Psychiatrists and clinical psychologists provide outpatient medication-based and psychological services in mental health centres that are widely distributed across the country, and that can be accessed without the necessity of referral from a gatekeeper. For mild and moderate disorders, such services may also be provided by general practitioners. The density of general practitioners and psychiatrists, among others, has increased substantially: from 39 per 100,0000 inhabitants in 1992 to 103 in 2019 for the former and from 13 in 1992 to 23 in 2019 for the latter (source: Eurostat). Both of the figures are amongst the ten highest rates in Europe. If said outpatient treatments result ineffective, the users may be hospitalised or referred to day-treatment clinics. Although remaining relatively high, the number of psychiatric care beds in hospitals has decreased over time: from 149 per 100,000 inhabitants in 1992 to 97 in 2019 (source: Eurostat).

Despite this, Lithuania, as many of other countries in the region, continues to suffer from inequities, inefficiencies, and quality issues in its mental health system (Šumskienė et al., 2018; Tomov et al., 2007), as well as from very high levels of suicide mortality, alcohol consumption, or violence towards others (source: Eurostat; WHO GISAH Data), which signal poor mental health of the population. More broadly, scholars (Carlson, 2004; Djankov et al., 2016; Growiec and Growiec, 2014) discuss the persistent and profound gap in health and mental well-being between Eastern and Western Europe. The equally profound east-west gap in interpersonal and institutional trust has been suggested as one of the possible explanations (Carlson, 2004; Growiec and Growiec, 2014). In turn, the analysis of trust within the mental health system may contribute to a better understanding of these challenges.

In the following sections, I first consider the concept of trust and describe the data collection and analysis methods. I then present the findings, which is followed by their discussion. I finally conclude the article, where I consider its contribution, limitations, and implications.

2. The concept of trust

Trust can be defined as a disposition to believe that "the person being trusted has the truster's best interests at heart and no agenda to the contrary" (Brown et al., 2009: 451). Being inherently relational, trusting is in turn a dynamic, conditional, and fragile process (Brown and Calnan, 2011; Mechanic, 1996), shaped by past experiences, yet being future-oriented (Brown, 2021). By its definition, it "presupposes a situation of risk" (Luhmann, 1988: 97), where the truster is "vulnerable to the actions of the other" (Gilson et al., 2005) but assumes "compatible agendas or interests […] which enable positive expectations" (Brown and Calnan, 2016: 288). An individual can avoid taking the risk and being disappointed, but at the same time they lose a positive future outcome associated with a risky situation or behaviour.

Thus, by seeking mental healthcare, one demonstrates an extent of trust in a clinic or healthcare provider, notwithstanding the uncertainty and risks of this behaviour (e.g., experiencing stigma of mental illness or the adverse events of the prescribed treatments). Luhmann (1988) stresses that such risks should be greater than the advantages individuals seek by engaging in a determinate action. That is, the risks of healthcare seeking can make one's life more difficult than suffering alone. Alternatively, it is a question of rational calculation rather than trust "because the risks remain within acceptable limits" (Luhmann, 1988: 98).

The literature addresses trust as interpersonal, which involves face-work (e.g., the user-provider relationship), or as social or institutional, which is more abstract, impersonal, and faceless (e.g., providers' or users' trust in the state) (Mechanic, 1996; Stevenson and Scambler, 2005). Whilst defined as separate concepts, the two types of trust frequently interplay by reinforcing one another. Trust in the health system, for instance, may provide the basis for trust in healthcare providers, and the reverse (Gilson, 2003). For a better comprehension of trust dynamics in the health system, we should therefore analyse the chains or cycles of (dis)trust (Brown and Calnan, 2016; Gilson et al., 2005), which consists of both interpersonal and social trust between the state, the provider, and the user. In this article, I consider all of the actors as both trusters and trustees, that is, as forming reciprocal loops of trust or distrust, which are rooted in personal experiences and sociocultural milieu (Luhmann, 1988).

Being a relational process, such trust involves speech acts or communication (face-to-face or faceless). The Habermasian concepts of communicative and instrumental/strategic action, which (re)produce the lifeworld and the system (Habermas, 1984, 1987), can therefore provide a helpful tool to analyse and explain trust (Brown and Calnan, 2016; Scambler and Britten, 2001). Healthcare forms part of bureaucratised system, and in turn, is generally shaped by instrumental or strategic rationality oriented to success more than by communicative action oriented to dialogue, cooperation, and reaching understanding. The latter is situated in the lifeworld, and as such, ingrained in our culture, social relations, and personal identities. While there is an element of success or "carrying out one's plan of action" (Habermas, 1987: 126), such success in communicative rationality is achieved by the consensus/agreement rather than force or influence as in the case of instrumental or strategic rationality.

Since health belongs to the lifeworld, the challenge of health systems lies in this constant conflict between the orientation to an end result in the system and the orientation to means in the lifeworld, that is, between the provider "exerting an influence *upon* others" and the provider "coming to an understanding *with* them" (Habermas, 1984: 286). The former may be imposed instrumentally by following medical protocols and rules, or strategically by "influencing the decisions of a rational opponent" (Habermas, 1984: 285). In the meantime, the latter "is considered to be a process of reaching agreement" (Habermas, 1984: 286), which is achieved subjectively rather than objectively by force. Put differently, the ideals of health systems such as access, quality, or efficiency intrinsically imply goal-oriented rationality. Yet, mental health itself is relational, contextual, and grounded in the lifeworld.

Brown and Calnan (2016: 288) argue that trust may be compromised whenever the truster interprets the trustee "as being insufficiently embedded within the instrumental or communicative logics, or rather, too deeply embedded in the one and not in the other". Which of the actions or rationalities becomes more salient to trust is a matter of empirical inquiry. Barry et al. (2001), for instance, evidence how instrumental rationality (*the voice of medicine*) enacted by the provider through the use of purely technical communication on causation or mechanisms of drug action and accepted by the user may create trust in some relational contexts, but fail in others, when the contextually-grounded *voice of lifeworld* is favoured by the user, yet ignored by the provider. The framework of trust chains adds that increasing or diminishing trust in one relational context transforms actors' practices in another by orientating them to more communicative or instrumental/strategic action, which in turn influences trust in said new context. Put differently, trust in one of the links can facilitate trust building in another by modifying social practices (Brown and Calnan, 2016), which may consequently generate a virtuous cycle of trust (Stasiulis et al., 2020).

3. Methods and materials

The article forms part of a larger research project that explores how the institutional and cultural contexts shape the process of mental healthcare seeking and utilisation in Lithuania. It aims to identify some

of the possible generative mechanisms that underpin said health behaviours (Danermark et al., 2002). As a result, qualitative research methods –in particular, in-depth interviews with mental healthcare providers and users– were employed. The interviews addressed the experiences, barriers, and facilitators –witnessed or enacted– in the process of healthcare seeking and utilisation. The users were asked to recount their journey towards and within the mental health system. The participants were also probed with more direct questions about the relationships between healthcare providers, users, and/or policymakers. In all of the interviews, the issues of trust, nevertheless, emerged prior to these questions, which signals its salience.

The study protocol –the study information sheet used as a recruitment aid, informed consent document, interview guides, and sociodemographic forms– was reviewed and approved by the author's regional research ethics committee in 2017. The participants were recruited from three mental health centres, two health centres/polyclinics and a psychiatric hospital that provides both inpatient and outpatient services. Several additional participants were identified through professional or personal acquaintance and using a snowballing technique. Due to the sensitivity of the topic in the region, and consequently, anonymity concerns, as well as for logistic reasons, the interviews were conducted face-to-face (at participants' home, providers' offices, or in the public place) or over the telephone/skype.

The sample consists of 25 in-depth interviews, twelve of which are with mental healthcare providers and thirteen with users (eight women and five men). The latter group represents a range of mental disorders (depressive episode/disorder, phobic or other anxiety disorders, personality disorders, or schizophrenia), ages (five participants younger than 36, four between 36 and 50, and four older than 50), and educational levels (three participants with secondary education or below, three with vocational training, and seven with university degree). At the time of the interview, all users were receiving or had recently received outpatient mental health services; six of them had also been hospitalised; and another four had attended day-treatment clinics. Two users had their first contact with psychiatric services under the Soviet regime (receiving their first diagnoses in 1976 and 1989).

The healthcare providers are also diverse in terms of medical speciality (three general practitioners, six psychiatrists, and three clinical psychologists), setting (centre or periphery), and length of their clinical practice (from 4 to 37 years; mean = 20 years). While heterogeneous in many respects, all participants share life history (Robinson, 2014): they sought public mental healthcare or regularly treat and interact with such healthcare seekers/users. Their discourses, therefore, may enable a better understanding of trust dynamics and their meaning in mental healthcare.

The transcripts of interviews were managed with software for qualitative data –MaxQDA. They were coded and analysed in Lithuanian, employing reflexive thematic analysis (Braun and Clarke, 2006; Nowell et al., 2017). The method encompasses multiple phases of analysis: familiarising with the data, developing the initial codes and coding the data, searching for patterns of meaning by clustering different codes, and finally, reviewing, refining, and defining the identified themes. The analysis was both inductive or data-driven, and theoretical or analyst-driven. While described linearly, the process nevertheless was flexible and involved moving back and forth between the theoretical literature and the interview data, on the one hand, and between the phases of analysis, on the other.

The interviews were conducted and analysed by the principal researcher and author of this article. This may have an effect upon results due to the researcher's influence on the participants (particularly if power differences are considerably in favour of the researcher) or due to the selective choice of data in analysis and reporting. In other words, since the development of sociological knowledge takes place within figurations of interdependent individuals, including the researcher her/himself, complete detachment may not be attainable (Kilminster, 2004). My academic and personal interest in the topic meant my involvement. However, commitment to academic research standards, having no affiliation to any mental health institution, and being 'distanced' from the Lithuanian context as a scholar located abroad enabled me to achieve a degree of detachment and self-reflexivity.

Put differently, involvement and detachment are not based on a 'zero-sum' principle and should be seen "as a dynamic tension balance embodied in social activities" (Kilminster, 2004: 31). In turn, the users might have felt listened to because of my "heightened sensitivity" towards their perceptions (Perry et al., 2004, p. 138), yet simultaneously safe and anonymous. My relatively low power position due to age and socioeconomic background might have further enhanced the latter. Likewise, this helped the healthcare providers to feel like experts in a power position. Several of them also expressed their interest in interpretations from a 'distance' or 'outside'. All of this encouraged providers' active participation in the study. During the stages of analysis and reporting, said balance and self-monitoring have been strengthened through rigorous and transparent sampling and analysis procedures, as well as through discussions on emerging themes in conferences, workshops, or other academic meetings.

4. Findings

The functioning of mental healthcare in a post-communist context appears to be underpinned by chains of distrust, the dimensions of which are explored in the first sub-section. Healthcare providers and users in turn employ a range of responses to such distrust that are examined in the second part of the findings. Yet, instances of trusting relations demonstrate how trust might facilitate mental healthcare that is more accessible, efficient, and of a higher standard.

4.1. The vicious cycle of distrust

How the state and the provider (dis)trust. The monitoring or 'checking' of providers –via the organisational targets, protocols, and highly bureaucratised reporting– may be viewed both as "the *modus operandi* of quality and performance management" (Brown and Calnan, 2011: 21) and as a tool for surveillance of providers that demonstrates state's distrust in them. Whilst widespread in this study, such state pressures tend to transcend geographical borders (Brown and Calnan 2011, 2016). In Lithuania, however, they are accompanied by the risk of sanctions (fines, salary cuts, or additional workload), which consequently results in providers' disempowerment and increased vulnerability:

> If they check, they will definitely find something. […] everybody makes mistakes and let's say a code is not assigned to a reimbursable medicine because of hurrying or something. Then they will write it as damages to the Sickness Funds and you will have to pay. […] This traumatises people who are more sensitive or just starting to work. (psychiatrist)

The providers stressed uncertainty related to continuously changing rules, protocols, and paperwork imposed from above and undiscussed. The narratives were marked by feelings of disappointment and weariness. Perceived corruption at the political level further contributes to such providers' distrust in the state:

> Oh, how many times mental healthcare was reorganised. Ideas were beautiful, but again everything resulted in pharmaceutical treatments. […] We once had a psychotherapist as health minister and what? Well, it's public, the only thing he did was to found his private clinic. (general practitioner)

While Brown and Calnan (2016) discuss distrusting relations between the provider and the institution as a matter of erosion, it represents continuity rather than a change in Lithuania. For the state's dominance in the organisation of medical work and centralisation of decision-making were characteristic features of Soviet healthcare

(Freidson, 1988). Trusting relations and cooperation between the healthcare provider and the policy-maker appear to have not been developed throughout the transition:

> Doctors have never been respected in these 30 years. We have been left behind everybody else. (psychiatrist)

In light of this, several of the providers also spoke of broader social distrust in them, which is initiated and reinforced by the state and which explained their own distrust in patients (the concept '*miscure*', used in the narrative below and also employed by the users, is a common Lithuanian verb that connotates an aggravation of one's health due to negligent treatments in the public health system):

> Some of the physicians have an attitude to despise or even to humiliate a patient. […] Perhaps it is due to that 'campaign' of shaming doctors in mass media and everywhere […] that we are all killers, that we don't cure people, just *miscure*. (psychiatrist)

The state's 'checking' and sanctions may simultaneously increase workplace distrust. On the one hand, the narratives signal how paperwork results in the lack of time for effective communication between providers, which may directly impede trust building (Gilson et al., 2005; Wilk and Platt, 2016). On the other hand, the sanctions imposed on some providers may create additional workload or new mechanisms of monitoring for all, which also affect trust between them:

> The Sickness Funds checked general practitioners and fined them because they prescribe medicines without any justification in medical records, […] and now they do not prescribe – we are not allowed, they say. They ARE allowed, but they defend themselves with this […] 'Go to a psychiatrist', they say; and now they come to us for sleep disorders. […] Our workload is now inhumane. (psychiatrist)

Monitoring by the state also extends to the user of mental healthcare. Being the legacy of the Soviet regime, certain civil rights may be restrained upon diagnosis of mental illness (Doblytė, 2021; Raikhel and Bemme, 2016; Šumskienė et al., 2018), including depression, and in some cases, anxiety disorders. Under the regime, a psychiatric register was an effective mechanism of social control, with the aid of which individuals were restrained from finding a job or housing, among other things (Van Voren, 2013). Such state's distrust –via documentation and reporting by the healthcare provider– continues to prevent individuals from working in certain institutions and fields (for example, law or law enforcement), getting/renewing a driving licence, or owing a gun:

> There is a pile of Soviet orders that are still in force. […] maybe 200 pages. So, based on every clause, you can restrict a person and do not allow them to work. (psychiatrist)

The user as truster. "[I]f trust is primarily a belief of the truster that the trustee is *willing* and *able* to put their interest first, and has no agenda to the contrary" (Brown et al., 2009: 453), it is clearly undermined in the case of the latter, that is, when the state restricts individuals' work and life chances upon the diagnosis of mental illness. Put differently, the state's distrust in the user generates user's distrust in the state or the health system. Several of the users spoke about their fear of diagnosis and its consequences. As one summarised:

> If you go to a psychiatrist, and if they register a diagnosis with a letter F […] your opportunities are immediately restrained. They write you off as invalid straight away. If invalid, you are not able to support your family. Everything is connected. (male user, aged 39)

While such restrictions undoubtedly undermine individuals' trust in the health system and providers, competence and concern/personal commitment are equally critical for trust building in the user-provider relationship (Brown and Calnan, 2016; Mechanic, 1996; Stevenson and Scambler, 2005). The perceptions of providers as competent or as caring tend to reinforce one another (Gilson et al., 2005). On the one hand, narratives of distrust due to perceived incompetence indeed interplayed with the provider's poor communication and listening skills:

> I didn't trust that doctor. I simply didn't trust her […] I didn't want her to give me a prescription for the same medication. She didn't ask me anything. She just prescribed and that's it. (male user, aged 65)

On the other hand, the lack of providers' concern –that is, the dominance of strategic or instrumental action oriented to an end result through, for example, their commitment to medical protocols and rules rather than to dialogue and reaching understanding (Habermas 1984)– was highlighted more than technical competence. This may be shaped not only by users' limited capacity to assess the latter, but also due to the specificities embedded in mental illness and healthcare such as "heightened uncertainty of the disorders, risk of rejection and stigma" (Stasiulis et al., 2020: 2). The perceptions and experiences of providers who are disrespectful, arrogant, distant, rushing, and even humiliating towards the user were repeated in large part of the interviews. One user recounted several of such experiences during her stay in a psychiatric hospital:

> Once the head psychiatrist called me 'intellectually underdeveloped', because a normal person would not drink and take medicines simultaneously. (female user, aged 28)

Such lack of concern or empathy can decrease acceptability of services and generate angst, which becomes "detrimental to patient experience, quality of life and clinical outcomes" (Brown et al., 2009: 452):

> In the end, after all of that, particularly because of psychiatrists, who only prescribed medications but didn't talk, I got even worse. (male user, aged 34)

The sense or intents of humour, which forms part of communicative utterances in the lifeworld, may be employed by the users to make their experiences more secure and less impersonal. The interview fragment reveals how such expressions of the lifeworld can be blocked or ignored, which may result in poorer health outcomes and healthcare quality (Barry et al., 2001):

> He was cold and formal. I tried to joke about sockets […] there was a hideous socket in that old surgery and I tried to joke that something is running through it. He didn't like it. He thought that it was a symptom of my illness. (male user, aged 27)

Distrust in individual health providers and in the system as a whole is further reinforced by the perceptions and experiences of corruption through informal cash or in-kind payments. Although not unique to the region, such illegal practices flourished in the context of scarcity under communist rule and have remained prevalent after the regime collapse (Baji et al., 2017; Morris and Polese, 2016; Stepurko et al., 2015). In Lithuania, Stepurko et al. (2015) find that the lifetime prevalence of informal healthcare payments in cash is 48 per cent. In the meantime, the 12-month incidence amongst users reaches 20 per cent for outpatient services and 51 per cent for inpatient ones. In many of the countries in the region (including Lithuania), the health system is in turn perceived as the most corrupt institution (Eurobarometer, 2017).

In this study, several of the users expressed their concerns about such unfairness and inequities due to their inability to pay. The importance of connections or *blat* –a phenomenon that emerged under the Soviet regime as "an exchange of 'favours of access' […] to public resources through personal channels" (Ledeneva 1996: 48)– was also discussed. *Blat* may be employed to access public services, the waiting time for which would otherwise be lengthy. Besides political and economic factors, its resistance to disappear can also be related to the distrust between the provider and the state, which fails "to develop a sense of *ownership* amongst many of the professionals whose cooperation is essential" (Brown and Calnan, 2011: 21).

One user narrated her own experience, where she was denied

sanitary pads during her hospitalisation following a suicide attempt, which is an example not only of disrespect, but also of in-kind contributions that individuals may need to "provide for their own hospitalisations" (Baji et al., 2017: 86). Such experiences led to her deep distrust in healthcare providers and the system in general:

> I had a hygiene issue –my period– and nothing, it didn't matter … I asked 'can you please give me at least some paper towels or napkins, because I don't have anything?', and they replied 'why don't your relatives bring it?'. (female user, aged 28)

By and large, chains of distrust between different actors appear reciprocal and generate a vicious cycle of distrust. The providers felt that distrust by the state, particularly via monitoring and sanctions, as well as state's distrust in its citizens through restraining their rights, which is dependent on medical collaboration with authorities (Doblytė, 2021), required substantial time and caused stress, which consequently influenced their relations with colleagues and patients. Feeling vulnerable due to such state and society inflicted pressures, they may resort to more instrumental or strategic action, which is more amenable to the logic of 'checking' but can result in bureaucratised and defensive patient care (Brown and Calnan, 2016). This was illustrated by providers' practices of prescribing medications and documenting symptoms but, as the users recounted, 'not talking to them'. Wittingly or unwittingly, they also rushed, disregarded or kept their distance from the users, that is, by reinforcing power imbalance they oriented their action to success understood as quick diagnosis, intervention, and the ending of clinical encounter.

In other words, the imposition of organisational targets and protocols is framed as a means to build patients' trust through the guarantee of higher quality care and society's trust through the promise of safety amidst the danger and unpredictability of mental illness. Yet, it may lead to a contrary result: distrust in the provider-user relationship due to the dominance of instrumental rather than communicative rationality, as well as user's distrust in the system. Such a vicious cycle of distrust results in healthcare that appears to be less acceptable, appropriate, and therefore, effective.

4.2. Responses to distrust

The analysis uncovers that both providers and users respond to their distrust and being distrusted, which may further compromise the objectives of healthcare (see Fig. 1). In other words, distrust "changes the way people decide about important issues" (Luhmann, 1988: 103). One of the immediate responses to this is to avoid a particular situation or behaviour, where trust is lacking. When the avoidance is not an acceptable solution either because the matter implies one's source of income or because the suffering is intense, the interviews suggest that distrust may be managed by actively modifying a behaviour.

Provider-enacted responses. The two main responses that emerged in the interviews with the providers can be defined as 'gaming' or quitting the system. The system's subversion (Brown and Calnan, 2011) may be considered as a providers' tool of resistance to state's distrust. The providers discussed their disregarding of certain protocols (e.g., not reporting to authorities for the purposes of restraining individual's rights upon diagnosis) or the constant and stressful necessity to alter information in order to help a patient, and at the same time, to satisfy the protocols of pharmaceutical rationing imposed by the state. One psychiatrist commented how their head physician even encouraged ignoring a new protocol that generates more paperwork, notwithstanding the possibility of auditing and sanctions:

> All about that Lorazepam … Our head doctor told us that we should continue to prescribe it as we used to do and let's wait for the auditing by the Sickness Funds. (psychiatrist)

A head psychiatrist in one mental health centre also spoke of their difficulties to recruit new providers who instead opted for the private sector or emigration. Similarly, several users recalled their (caring) physicians, who quit the system to practice abroad. As one psychiatrist summarised:

> I simply left the system, which hampered my work. (psychiatrist)

Thus, frustration and defeat provoked by the *status quo* of relations between the state and the provider may encourage them to 'game' the system, on the one hand, or to quit it altogether, on the other. Such responses to their distrust, which generates work stress, non-transparent use of resources, and the loss of qualified workforce, undermine the efficiency and quality of healthcare.

User-enacted responses. Mental health forms part of "communicatively structured areas of life" (Habermas, 1987: 304). When it is managed through purely strategic or instrumental action without reaching understanding, "this produces disturbances in the symbolic reproduction of the lifeworld" (Habermas, 1987: 305), that is, distrust in particular providers or in the system, and consequently, mechanisms of managing such situations. First, individuals intuitively intend to abandon the situations of distrust by means such as discontinuation of treatments, which is usually implemented without clinician's support, and in turn, with a higher risk of relapses and rehospitalisations (Maidment et al., 2011; Salomon and Hamilton, 2013). The dominance of strategic rather than communicative action in a clinical encounter –as evidenced in the previous section– may be more decisive in non-compliance than the impact of side effects themselves (Salomon and Hamilton, 2013). Several of the users employed such narratives of 'disliking a provider' or 'not feeling understood' to explain their decisions to discontinue psychopharmaceutical or psychological treatments.

A more widespread response to distrust, nevertheless, proved to be the avoidance of future healthcare seeking. After clinical encounters,

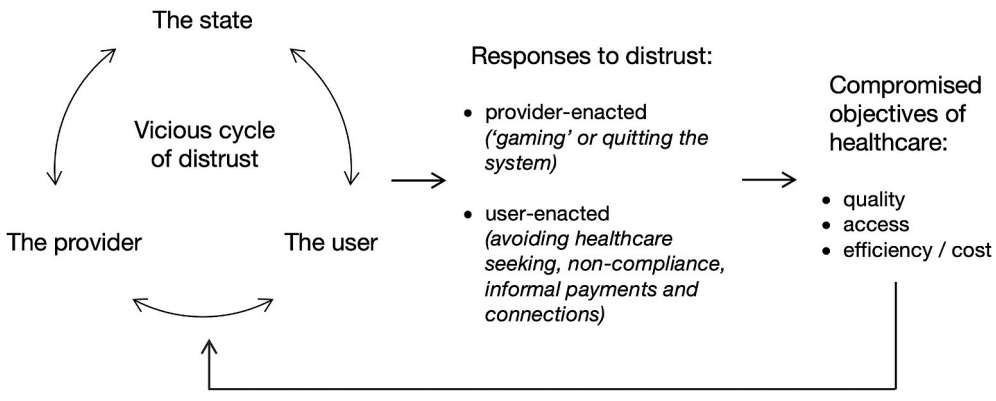

Fig. 1. Distrust and its effects in the post-communist mental health system.

where they felt vulnerable, the users tended to avoid or to substantially delay healthcare seeking for future episodes. The delay, coupled with the alternative strategies of dealing with symptoms that some of them employed (e.g., self-medication or alcohol), may lead to worsened health and social outcomes. As one user, who was diagnosed with schizophrenia and who perceived a lack of dialogue, concern, and understanding in his experience of hospitalisation, recounted:

> After a year, new symptoms started […], hallucinations were stronger, much stronger than the time when I sought help. But after all those experiences [*with doctors*], I didn't seek their help for a long time, just lived and observed how I managed with the new symptoms. (male user, aged 27)

Finally, whilst the perceived corruption of healthcare diminishes individuals' trust in it, the use of informal payments and *blat* can also be viewed as "a 'do-it-yourself' approach where citizens on their own adopt extra-legal and often illegal strategies to improve services provided by the government" (Cohen, 2012: 286). By such means, they may achieve better quality or more attentive care at the individual level (Baji et al., 2017; Cohen, 2012). In other words, they enable trust building in the user-provider relationship by manifesting "a differentiation for both giver and receiver in terms of affective meaning and recognition of personhood" (Morris and Polese, 2016: 485). Yet, informal payments undermine equity of access and efficiency of healthcare by easing access and providing procedures to patients who can afford to pay but are not necessarily in most need. It leads to a *de facto* privatisation of healthcare (Stepurko et al., 2015).

While the interviewed users did not acknowledge their own informal payments, which could be shaped by the perceived immorality of such behaviours, several of them did speak about the use of connections (relatives, friends or friends of their friends) to access certain providers, who were perceived as more trustworthy. Yet, they described this without recognising *blat*. That is, while they distrusted the system due to the prevalence of corruption, they "knowingly or unknowingly withdrew the term from describing their own contacts and personal relations" (Ledeneva, 1996: 48). This ambivalence –condemning corruption and perceiving *blat* or informal payments as an ordinary practice– has also been demonstrated in other post-communist societies (Ledeneva, 1996; Morris and Polese, 2016) and could be discussed in the light of the phenomenon called 'amoral familism' (Tyszka, 2009). Employed to describe social *habitus* in the region, it implies the disappearance of the common good or morality as long as the interests of one's close-knit group are satisfied.

To sum up, such provider- or user-enacted responses to distrust can be considered points of resistance or 'do-it-yourself' strategies to secure work autonomy or handle workload, on the one hand, and to control the course of one's illness experience, on the other. Such responses by the providers, however, may impede the implementation of new measures and information sharing within the health system, as well as result in the loss of qualified workforce. In the meantime, avoiding healthcare seeking or non-adhering to treatments may generate poor health outcomes at the individual level (late access to healthcare when symptoms are more severe, among others), whilst the use of informal payments or *blat* results in poor use of resources at the system level. Taken together, they compromise the objectives of access, quality, or efficiency, and consequently, may reproduce and reinforce the chains of distrust between the state, the provider, and the user.

4.3. The benefit of trust

The users narrated not only their experiences of distrust but also of trust, where security replaces uncertainty. The dominance of communicative means rather than strategic success in these accounts signals the centrality of the lifeworld in mental healthcare, which is frequently missing. Whilst trust building requires effective communication and information provision, which may characterise both communicative and strategic actions, it demands provider skills and attitudes beyond said ability (Brown et al., 2009; Gilson et al., 2005). The providers towards whom users demonstrated trust were attentive ("she remembers what you said or drew"), caring ("if something happened, I could call her"), listening ("I could tell them everything", "she listened"), not rushing ("she talks with a person almost an hour"), or with a sense of humour ("with a sort of jokes, she somehow reassured me and calmed me down"), among others.

Several users also emphasised the importance of dialogue, negotiation, and reaching agreement about treatments, that is, the idea of concordance that "may be interpreted as a call for communicative action" (Stevenson and Scambler, 2005: 13). Barry et al. (2001) evidence the effectiveness of such communication in mental healthcare, where both the provider and the user use the voice of the lifeworld to reach mutual understanding. As one user detailed:

> It was that she considers my opinion and that I have a right to choose, whether I want medications or I want to deal with it by using other methods. And if I opted for other methods, she would support my decision. I really liked it. I think now that if I went again, I would choose her. (female user, aged 34)

This interview fragment illustrates how trust in the user-provider relationship secures not only more acceptable care, and as such, of higher perceived quality, but also facilitates future healthcare seeking. Thus, while destigmatisation of mental illness may indeed encourage timely help seeking in the post-communist context, where stigma remains pervasive (Doblytė, 2020; Tomov et al., 2007; Winkler et al., 2016), experiences of trusting relations between the user and the provider can likewise improve access to mental healthcare.

Inter-professional or workplace trust, built through the facilitating of communication, dialogue, and cooperation (Wilk and Platt, 2016), enables learning and knowledge-sharing (Brown and Calnan, 2011). This may consequently improve quality of care by making it more appropriate/effective or acceptable, and efficiency of the system, when more effective care diminishes the probability of relapses. As one clinical psychologist commented:

> It's very good that I know a school psychologist of our district […] because when you have severe cases, it's great that you can easily call her, talk about the case management and what we should do next. (clinical psychologist)

Hence, trust between the actors increases the likelihood of achieving the objectives of healthcare. It may enhance efficiency of healthcare by facilitating the search for an appropriate course of treatments and reducing duplication of services through better inter-professional communication, as well as by improving adherence to treatments that are communicatively negotiated in a clinical encounter, and consequently, require less monitoring (Gilson, 2003). Communicative speech acts also serve "to manifest experiences, that is, to represent oneself" (Habermas, 1984: 308), and as such, enable the disclosure of symptoms. Dialogue and mutual understanding, which are facilitated by and facilitate such readiness to disclose symptoms, generate higher acceptability of care, patient satisfaction, and consequently, perceived quality of services.

Trust may likewise contribute to equity of access due to the increased willingness to seek mental healthcare in the future by those who are in most need, and simultaneously, tend to be highly vulnerable (Brown et al., 2009; Maidment et al., 2011). The instances of trusting relations between providers or between providers and users, however, were not accompanied by such relations between the state and the provider. The few encountered experiences of trusting, therefore, are likely to be the matter of individual cases rather than the beginning of building a virtuous cycle of trust.

5. Discussion

The vicious cycle of distrust between the state, the provider, and the user, which is explored in this article, shapes "the communicative and learning functioning of local healthcare services" (Brown and Calnan, 2016: 287). Not only are face-to-face interactions underpinned by distrust, but there is also a broader cultural tendency towards reciprocal distrust in this post-communist context. East European societies were and still are low-trust societies, which may be viewed both as the communist legacy (Dimitrova-Grajzl and Simon, 2010) and as the result of transition and poor government performance (Mishler and Rose, 2001). All are (dis)trusters and (dis)trustees. Such chains of distrust influence expectations and consequent actions of actors at different levels. For instance, the analysis demonstrates how providers, distrusting and being distrusted by the state, resist and enact their agency by means of 'gaming' or quitting the system.

Distrust likewise shapes the user's experience such as perceived access to and quality of care, as well as generating a range of 'do-it-yourself' strategies to handle their distrust, including avoiding mental healthcare seeking, discontinuation of treatments, or employing informal payments and *blat*. The latter –witnessed or enacted– is both a driver to distrust and a response to it. While the chronic structural shortages and severe underfunding of healthcare systems may explain the prevalence of petty bribery in Lithuania under the Soviet regime, such interpretations are less compelling thirty years after its collapse, particularly in the light of the increasing remuneration of healthcare providers (Stepurko et al., 2015). Public healthcare expenditure has also nearly tripled over the last two decades: from 586 constant PPP per capita in 2000 to 1551 in 2018 (source: WHO Global Health Expenditure Database).

Whilst not rejecting the importance of institutional explanations such as poor enforcement of laws (Tyszka, 2009), the persistence of these corruptive practices points to cultural influences such as deeply embedded institutional and interpersonal distrust (Cohen, 2012; Stepurko et al., 2015). Patients undertake said means to overcome their lack of trust in the health system and healthcare providers. At the same time, however, such experiences and perceptions of corruption in public services result in their increasing distrust. When examining the east-west gap in happiness, Djankov et al. (2016) indeed find that Eastern Europeans are strongly affected by perceived government corruption and performance, but not by petty bribery. Such practices appear deeply inculcated through socialisation processes (Dimitrova-Grajzl and Simon, 2010) and remain an acceptable mechanism of coping with distrust at the individual level.

The chains of distrust are, therefore, "costly in terms of personnel, monitoring time, and emotional energy" (Mechanic, 1996: 175). Put differently, distrust may compromise the ideals of healthcare such as equity of access, quality, or efficiency. While healthcare interventions oriented to success and following technical rules, that is, implemented as an instrumental action (Habermas, 1984), may indeed achieve efficiency and quality goals (Barry et al., 2001), they may also result in distrust. Mental health issues are inherently embedded in the lifeworld by involving different aspects of social relations and personal identities. The article discusses how blocking or ignoring the voice of the lifeworld in a clinical encounter (Barry et al., 2001) may cause side effects, and in particular, distrust. In the meantime, the instances of trusting relations in the workplace or between the user and the provider evidence that communicative action based on dialogue, negotiation, and reaching "common situation definitions" (Habermas, 1984: 286) may be more effective and acceptable.

Such cooperation towards mutual understanding of the situation requires full disclosure of symptoms and full information about treatments and illness course, which enables and is enabled by trusting relations. Put differently, while instrumental action is underpinned by the objective world relations, "communicative utterances are always embedded in various world relations at the same time" (Habermas, 1987: 120). In mental healthcare, all of them are fundamental in order to establish interpersonal relations in a clinical encounter (the social world) so that the users self-represent or disclose their experiences (the subjective world) and the providers in turn represent the states of affairs (the objective world), which cover the diagnosis, plan of treatments, and illness course. The agreement is reached if all of them are believed to be true, right, and sincere, that is, a consensus "rests on the intersubjective recognition of criticisable validity claims" (Habermas, 1984: 17).

6. Conclusion

To summarise, the article contributes to the literature by exploring the connections between different levels of trust in a context beyond Western Europe, which remains understudied (Brown and Calnan, 2016). It also adds to research addressing mental health and healthcare in the region of Central and Eastern Europe, as well as the legacy of authoritarian rule by providing evidence to the hypothesis of 'low trust trap' (Growiec and Growiec, 2014), which creates a vicious cycle of distrust and continues to be persistent in the region. That is, distrust represents institutional continuity rather than an erosion of trust. By demonstrating how the functioning of mental healthcare is trapped in such chains of distrust, I argue that health policies in the post-communist context should focus not only on the modernisation of their healthcare by investing in technologies, training, and facilities, but also on trust building on the basis of communicative rationality.

Communicative rather than strategic actions are "processes of social integration and of socialisation" (Habermas, 1987: 139), which develop and renew the responsibility of and solidarity among members, that is, trust between them. While "a *trusting* and *trusted* health system can contribute to building wider social value and social order" (Gilson, 2003: 1461, my emphasis), and as such, to wider social and interpersonal trust in society, the reverse might also be possible. Thus, the development of stronger formal social capital and civil society, which is weak in Central and Eastern Europe and may partially explain the east-west health and mental health divide (Carlson, 2004; Growiec and Growiec, 2014), can contribute to more trusting relations within the health system.

The findings, nevertheless, should be treated with caution. The most obvious reason for this is a rather small sample. But recall and self-selection biases are also important. While the former signals that some of the results may have been influenced by how the users recalled and legitimated their trajectories towards and within the mental health system, the latter –voluntary participation– is inevitable in interview-based research and fundamental to ethical practice and reliable results.

Finally, in this article I considered how trust or distrust shape the truster's practices, and in turn, fortify or undermine the goals of healthcare. Nevertheless, trusting relations also impact the trustee "through the moral obligation it places on them in the light of the truster's positive expectations" (Brown and Calnan, 2011: 27) or the reverse. On the one hand, it re-affirms how critical it is to build up trusting relations in the mental health system. On the other hand, a better understanding of such influences might reveal further particularities or implications of trust, and therefore, signal a direction for future research. Trust or distrust in technology (e.g., psychopharmaceuticals) may likewise form part of a virtuous or vicious cycle of trust and could be approached in future research.

Credit author statement

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