Four Therapists and a Client: A Personal Journey

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Several years ago, when I was working as a psychiatric nurse therapist in a major metropolitan area, my colleagues and I would play an informal "what if" game. Taking turns, each of us asked, "What if I had a psychiatric illness—what would my diagnosis be?" Of course, playing the game assumed that we were beyond the reach of such problems, and so we joked and smiled about the possibilities.

For me, however, the ability to joke in that manner came to a sudden end one day. With little warning, the simple act of taking a bath triggered a sense of panic and unloosed tortured fragments of memory, and my usual ways of calming myself were suddenly useless. The days and nights that followed brought exhaustion and deepening despair.

Dostoevsky wrote, "Every man has reminiscences which he would not tell to everyone, but only to his friends. He has other matters in his mind which he would not reveal even to his friends, but only to himself, and that in secret. But there are other things which a man is afraid to tell even to himself, and every decent man has a number of such things stored away in his mind" (1). These words ring ever true when I consider my torment at that time, for I had hidden layer upon layer of fear beneath a facade of invincibility. Still, I balked at seeking help, feeling the shame of my imagined weakness at the same visceral level as my terror.

Finally, though, grasping for some way to stay afloat, goaded by the alarm and confusion in my partner's face and the growing doubt that life was worth living, I battled the shame and made an urgent call to a psychiatrist. A short time later, in a tiny, sterile room, I was offered a few words of hope, two prescriptions, and the first of several diagnoses.

Between yawns and tic-like mannerisms, Dr. A concluded that I was dealing with posttraumatic stress disorder. I could get relief from medication, he assured me, then added that it was unclear how much of my trauma might be or even should be revealed. Realizing that I wasn't in the most objective position to judge my situation, I buried my own differing ideas about my diagnosis. Subsequent visits with three other therapists, however, confirmed my original view and added several more.

In retrospect, my experience is like the story of the blind men who, touching separate parts of an elephant, each reached a different conclusion about what was before them and how they should react. To Dr. A, my description of a recurrent and disturbing childhood image looked like posttraumatic stress disorder, leading him to propose low-dosage benzodiazepines indefinitely and eye movement desensitization and reprocessing (EMDR). Because of the need for multiple sessions, he suggested that I hold myself together as best I could for several months until my insurance renewal at the end of the year, at which time I'd have 12 more billable visits.

So I waited, and then, hopeful but still feeling on edge, I made an appointment to start the treatment. In what I later learned was only a halfhearted attempt, Dr. A proceeded with EMDR for about half an hour. The session ended with his expressing concern about the possibility of abreaction, suggesting that my traumatic memories were a powder keg ready to explode. He recommended that I pursue the treatment with a local expert—"the person who does the training," he explained.

Unfortunately, we never discussed the fact that individuals with intrusive, obsessive patterns of thought—such as those that troubled me—may also experience involuntary mental imagery that is easily mistaken for repressed memories of childhood trauma (2). Nor did I have the chance to weigh the serious possibility that searching for the meaning of my intrusive thoughts might actually intensify my difficulties—that is, if the thoughts were rooted in obsessive-compulsive disorder (3). Dr. A's eagerness to identify trauma blinded him to other possibilities and provided me with the shortsighted hope that I would soon get to the bottom of what was causing my troubles. However, my appointment with the EMDR expert, Dr. B, a psychologist, quickly disabused me of this notion.

Dr. B explained that he had become disenchanted with EMDR because it did not always produce the expected results. He said that thought field therapy—a type of "energy healing" that "addresses the acupuncture meridians and employs therapy localization to determine effective treatments" (4)—promised a quicker and more useful resolution of the phobic reactions that he regarded as my primary problem. However, if I insisted on having EMDR, Dr. B said, he would oblige me. "It's really a matter of what you are most interested in—insight or resolution," he remarked.

I was now embarked on a series of ethereal interventions aimed at re-

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lieving my fears. Following the general guidelines set out in Gallo's (4) text on energy psychology, Dr. B earnestly worked to identify my "psychic allergens"—idiosyncratic reactions to phenomena ranging from smells to detergents that would inhibit my progress. He also queried my subconscious with specific questions about my past, present, and future. This rather mysterious procedure led to the determination that a pivotal traumatic event had occurred when I was between one and two years of age, and that it involved my mother. In the wake of this finding, Dr. B remarked that EMDR was even less likely to be useful in my case, because it generally relies on some type of verbal memory, which was probably missing for my early traumatic event.

Thinking that I was fortunate not to have followed a dead-end path any further, I clutched even tighter to the hope that I had indeed stumbled across the cure. My sessions with Dr. B reinforced my faith in this new approach, and although he soon suggested that I was now liberated from my fears, it rapidly became apparent that the treatment was hollow, and I was left with renewed terror and despair. Feeling as though I had few choices left, I pressed Dr. B to suggest a psychiatrist who might help in reevaluating my medication regimen. On some level I also knew that I needed another diagnostic opinion as well. Reluctantly, he gave me the name of a psychiatrist, Dr. C, for whom he expressed less antipathy than he did for others.

Dr. C, though affable and soft-spoken, nonetheless had the air of detachment and authority that seems reserved for physicians. He quietly listened to my story, fastening on my description of intrusive thoughts, and barely 30 minutes later he pronounced my problem to be obsessive-compulsive disorder. But what about the traumatic memories and the phobic imagery, I asked? "Well," he observed, "if it quacks like a duck and walks like a duck, it probably is a duck," meaning that all signs in my case pointed to obsessive-compulsive disorder.

The bluntness of this statement added to the devastation I felt. Obsessive-compulsive disorder has been described as "one of the world's ten most burdensome illnesses" (5). Still, within two weeks the medication that Dr. C prescribed brought significant relief—an intervention for which I remain grateful. I soon learned, however, that pharmacotherapy defined the full range of his expertise. Nor was he able to refer me to someone with experience in cognitive-behavioral therapy, a proven treatment for obsessional problems.

Guided only by the list of allowable providers in my insurance policy, I selected another psychologist, Dr. D, an eccentric and somewhat erratic clinician who glimpsed something quite different from anyone else. Disdainful of labels, he bowed to the necessity of putting something on the insurance forms and listed panic disorder. Strangely, though, the decision to use this diagnosis made it nearly impossible for him to consider any alternatives later.

Where Dr. D excelled, however, was in dealing with the spiritual dimensions of my turmoil, something with which none of the other clinicians seemed comfortable. Yet spiritual guidance by itself does not address the entirety of my situation, any more than a narrow focus on other approaches could. Clearly, a mental illness is never just a chemical imbalance, a spiritual crisis, or an interpersonal challenge. It is all of these and more.

Ultimately, for me, finding real hope has required close attention to how psychiatric professionals are blinded by their own biases. This has meant trusting my intuition and ideas about the value of therapists' comments and recommendations, even amid the inner turmoil of my illness, and reminding myself to hold on to what is useful and to let go of what is not. Real hope has also meant looking for ways to help myself while continuing my search for a therapist who can see both the parts and the whole.

"In the middle of the road we call our life," Dante wrote in the *Inferno,* "I found myself in a dark wood with no clear path through." The dark wood in which I found myself was made all the more impenetrable by the avoidable mistakes and narrowed vision that I encountered in therapy. What I have learned is that light comes from recognizing such problems, moving on to more helpful strategies, and sharing my experience to highten awareness of the need for a more enlightened approach to diagnosis and treatment. And, in a deeper and more profound way than ever before, I have also learned that real hope truly is as much about the therapist as it is about the client. ♦

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