Who Is Responsible for My Treatment? The Triangle of Psychiatrist, Patient, and Medicine

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I graduated cum laude in chemistry from Occidental College in 1976, although I had two psychotic episodes the year before graduation. At that time I was diagnosed as schizophrenic, a diagnosis that was changed ten years later to manic-depressive. I also complicated matters by binge drinking until 1981. Now, in 1999, I do not drink, and my primary mental health diagnosis is schizoaffective disorder, bipolar type.

Since 1978 or thereabouts, I have been blamed by family and therapists for discontinuing my medicine four times. This accusation is simply not true. Four different therapists—and I have received treatment in Texas, California, Connecticut, Pennsylvania, and Delaware—have each independently found their own reasons for discontinuing all my phenothiazines. Even though I pleaded with the psychiatrists to keep me on phenothiazines, each said he or she would not continue this medication. The medicine was abruptly stopped, and I was off and running, always with an "adventure" before being hospitalized. It seems to be a rule that if one changes psychiatrists, then diagnosis and medication also change.

At times my medical therapists found a need to prescribe antidepressants, notably tricyclics. Unfortunately, I react to tricyclics by becoming very excitable and hyper; I do not tolerate even some of the "lighter" antidepressants well. Whether or not I take phenothiazines, it is dangerous for me to ingest an antidepressant.

For these reasons, I have had to be very careful about the medicine I ingest. Depakote is the choice for a "stabilizer" over Tegretol because it minimizes grandiosity. Taking Depakote, an antipsychotic, and lithium carbonate, while avoiding other medicines such as antidepressants, makes it possible that I may never have to face psychosis again.

In the near future, I can see only one change in my medicine regimen, from a phenothiazine to an atypical antipsychotic. It will occur primarily because of the likelihood of decreasing both short- and long-term side effects, in particular extrapyramidal side effects and tardive dyskinesia. I must rely on a trusted psychiatrist to walk me through these difficulties. However, as a patient, I must be responsible for what I can learn from my psychiatrist and for obtaining and ingesting the correct medicine.

All in all, medicine affects thought, and thought affects behavior. Moving along the medical pathway that is tricky and arduous for the patient, I often wonder if doctors really appreciate what effects these medicines have on the brain. Do they know that when a person is abruptly taken off a phenothiazine, "mental speeding" can occur within days? Do they know that for me, taking antidepressants reduces inhibitions? Do they truly know the power inherent in these medicines?

I know a man named Hector who frequently attends a 12-step support group in Wilmington, Delaware. He quite frankly tells people not to take the medicine that psychiatrists prescribe simply because of the bad experiences he has had with psychiatrists and medicine. To some, he is "blowing hot air"; to others, he is a vestige of a time gone by when many people abhorred any pill at all, especially if it made one feel better. If I had been around years ago, I could be like him—or, worse, dead, or in a condition worse than death.

Some clergy regularly discourage the use of medicine because, they say, a patient can get "hooked," or perhaps "addicted." (In fact, if a drug serves no purpose or cannot be used for recreation, then most people will stay away from it.) Some clergy believe that less earthly and more spiritual approaches than medicine are meant to be used to ease the discomfort of the mentally unhealthy.

All of this makes me wonder if I am really different from others. Do I really need any medicine? Why don't I taper myself off these pills? I know I feel even healthier when I miss one dose—why not miss more? In truth, if I did not take most of my medicine, then after the first few days I would not be fit to be in society. It is not just a matter of me feeling comfortable. I am dependent on my psychiatrist. Also, in order to stop binge drinking, I had to attend some support meetings. It is necessary to have reminders of what could happen to me; besides, it keeps one truly honest. Even Dr. Einstein or Dr. Freud would have admitted to needing reminders.

I have thought a great deal about the nature of the relationship between psychiatrist, patient, and medicine. What functions do psychiatrists serve? My answer is that just as a parent

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shows a child, or a teacher shows a student, or a journeyman an apprentice, so does a psychiatrist give instruction or directions on how to use pills. Too many times psychiatrists are expected to enter into all aspects of patients' lives, and just as often they are accused of being controlling. If the patient does fall, the psychiatrist is accused of not doing enough. But—on the contrary—there needs to be an understanding or agreement between the doctor and the patient about the role of each.

Patients should take the responsibility for dealing with their own lives when they can, and should let the doctors help only where the deficiencies lie. The first quality needed between doctor and patient is trust. A sign of lack of trust comes when one of the two simply reacts, rather than responding appropriately. Trust is shown in a relationship in which both parties seek a higher value in the relationship, and neither uses the defenses that are found in simply reacting.

For me this means that once the door of my psychiatrist's office is shut, closing out the confusion of an office complex, and the psychiatrist is engaged with me in one-on-one conversation, I can talk freely and feel heard. It means that I do not bring up extraneous topics. A feeling of regard brings healthy responses.

Second, the patient needs two qualities: faith that the treatment will work, and patience to let it work. I must realize that it took me years to get where I am now, and that there is still further to go. Treatment agreed on with the doctor will sometimes bring results only years later.

It is possible for a physician to not generate trust, yet still "do no harm." At one time I spent six months receiving outpatient treatment from a psychiatrist who at the end of each session would inject Prolixin decanoate into my derriere. Talking therapy went nowhere, as I resented his syringe. From this experience I learned that I could be prescribed medication and find interactional support elsewhere, as a separate and distinct treatment. As a result, I received his point as graciously as possible. The medicine was needed.

Though medicine is a substance that generally I obtain and I ingest, there seems to be a transference to it as one would have with a person. If the medicine is right, then it does not matter if I like the psychiatrist or not—or his behavior. The ambience of where I first take the medicine can be just as important as who gives it to me. What is the initial setting in which I am given the medicine? How does it make me feel? Am I being ordered to, or asked to, take the medicine? Does the person giving it to me act as if it is "just another pill"? My current psychiatrist gives me time to read about atypical antipsychotics before he prescribes them for me. He also allows me to choose, within reason, when to take the first dose.

I like to think of patient, psychiatrist, and medicine as each corner of an equilateral triangle. For this model to be successful, each point on the triangle must respect and associate with the other points. It is also important to realize that the medicine remains stable despite the possible vicissitudes of the human beings.

For a long while in my early treatment, my theme was simply "All I need is the medicine—you keep your distance." Even now I do not want a troupe of social workers entering my home and telling me how to live. With all the difficulties that I have faced over the years, it was still possible for me to work as a nurse's aide for three years and as an alcoholism counselor for three more. (I have had a host of jobs.) Working in many different settings has given me the confidence to relate to different people. Relationships with psychiatrists improve as I become able to listen to what they are telling me. In general, people seem more understanding. However, I yearn for more consistent employment.

At 20 years of age, I became depressed because I had the chronic illness of schizophrenia. The danger of having too high expectations weighed on me. I did not have the mettle to face up to facts. Now, 25 years later, I can glean hints for bettering myself and have more self-respect. As I become more familiar with my treatment team, I can be less afraid of expressing myself, and can tolerate their actions better as well. No longer is it always "my way" or "their way." Sometimes we can work out better "ways" and not have to call them compromises. I hope for the best and look for clear, succinct, and accurate explanations from my physician and from myself. Honesty is the only value necessary for making headway in this nonstatic world of medicinal therapy. I feel that I have the quality of honesty necessary to continue working with my equally honest psychiatrist.

The positive results are due to the efforts of many people. Now more than ever, I need consistency in my relationship with my psychiatrist, and more constancy in my vocation. It's time for action. ♦