

This article also came from a presentation I made in Japan. I was given the task of giving a lecture cryptically titled "Thoughtful Psychopharmacology" and I had to prepare a written text for the translator before I got there. Once there, I tried to find out what "Thoughtful Psychopharmacology" meant. When alternate translations turned out to be "Compassionate Psychopharmacology" and "Person Centered Psychopharmacology" I realized I'd prepared the wrong lecture, and, to the dismay of the translator, gave an entirely different speech about moving from illness centered treatment to person centered treatment.

Nonetheless, I chose to include it closing this chapter because I think it returns to my psychiatric roots. From time to time recovery is described as an anti-psychiatry or anti-medication movement, which I think it's not. From time to time I'm described as anti-psychiatry or anti-medication as well, which I think I'm not. Although it never mentions recovery, I think that this article succinctly describes medication being used by me in a mature, "thoughtful," recovery promoting manner.

Thoughtful Psychopharmacology

(2005)

When I first learned psychopharmacology, I thought a great deal about diagnosis and symptom relief. I learned to carefully make an accurate diagnosis to direct my treatment and to assess my patients' progress by assessing their ongoing symptoms and side effects. I became increasingly sophisticated in my choice of medications, titrating dosages, and considering medication interactions. As I got to know my patients better, I thought about the long term implications of medications, not just the short term symptom relief. For example, I thought about addiction, increasing manic cycling with antidepressants, and long term side effects like tardive dyskinesia and Lithium induced renal and thyroid damage.

After a while, I realized that people weren't always taking medications in the careful way I was prescribing them. I began to think about practical things in people's lives that got in the way of taking pills. Were they too disorganized to remember to take pills multiple times a day? Maybe they got lost going to the pharmacy or were too restless to wait there for their pills. Maybe they couldn't pay for these pills. I began handing out maps to the pharmacy, pill boxes to keep track of the pills, working with their insurance to make sure pills were paid for, and getting help from families.

Sometimes the problem was more than that. Sometimes my medications were helping them be less ill, but not helping them have a better life. It's good to hear less voices, but if the pills made them too sleepy to work, or unable to get up at night when their baby cries, or shake so much their friends made fun of them, they probably wouldn't keep taking them. I had to think about their whole life, not just their illness.

There were also problems from how the person felt about medications. Some people are frightened of them. Did I really think about how to explain the pills to them in a way they could understand me? I can use emotional words or even spiritual words if they will connect better than medical words. Maybe they felt ashamed of being mentally ill and having to take pills. Some people feel if only they could get rid of

the pills, they could get rid of their illness. To help with these feelings I had to think about not just the objective signs and symptoms of their illness, but also their subjective experience of their illness. I learned some surprising and highly individual things about people. I learned that when they first invented long acting antipsychotic injectable medications a number of people killed themselves because they weren't able to face reality after years of psychosis without help. I learned that one man had been hiding his pills and his illness from his wife for 15 years and he sometimes skipped pills or missed appointments when he was afraid she'd find out. Now I think a great deal about the meanings people attach to their illnesses and their medications.

I noticed that people who had a good relationship with me tended to stay in treatment, take their medications more regularly, and had better effects from their medications. I had to think about my relationships with my patients. How can I be more likable? Often I am friendly and share information about myself. I show them pictures of my family. Most patients appreciate a doctor who is not just knowledgeable, but listens well to them and who they feel understands them and cares about them.

There are both placebo effects and placebo side effects. Many people who are dragged into treatment and resentful of their family who brought them complain about lots of bad effects from medications. I had to think about their role in their own treatment. I want them to be hopeful. I learned that hopeless people don't take medications very well because they don't think anything will help them. Sometimes with very serious illnesses I have to work harder to be hopeful. I also want them to take responsibility for their own treatment and not leave everything to me. I can include them as a partner in the process, teach them about treatment, give them choices, and help them find things to help themselves. I want them to use medications, not just take medications.

When I first learned psychopharmacology, I thought it would be fairly simple to master. Now that I have so many things to think about I realize I will always be learning from my patients. Fortunately, they are very good teachers.