Throwing Away the PITS

by: Richard Metzner, M.D.

These are based on true stories. The author has changed information in order to preserve confidentiality.

It would be much easier to practice psychiatry these days if life were as simple as some of our reigning experts would have us believe. Like the extreme right-wing in American politics, these influential voices have teamed up with hard-core business interests to dispense their oversimplified, rigid and compassionless prescriptions for solving the complex problems of real people. Two recent referrals inspired this reflection on the subject.

In the first case a woman in her forties became psychotically depressed after suddenly being "down-sized" out of a mental health counseling job she had held for over twenty years. She was placed on an involuntary hold and treated for over a month at the same institution where she had been employed. In reviewing the voluminous chart after she left the hospital, I noticed that the psychiatrists who treated her for her agitated depression with mood-congruent delusions had relied only on medication. She was discharged on a combination of two antipsychotics, an antidepressant, and an anti-Parkinson agent. As a result of receiving this potent cocktail, she left the hospital less depressed, anything but agitated, and only mildly delusional, but functioning at a very constricted level with memory impairment and other cognitive dysfunctions. The doctors felt that her cognitive symptoms had to do with "conversion pseudodementia" and recommended an Amytal interview post-discharge. In fact, it was only because I have taught and published on the subject of narcotherapy and narcodiagnostic interviewing that I was consulted.

From the chart review and through hours of interviews with the patient, her husband and several very concerned sisters, I gathered that very little attention was paid during her expensive and prolonged hospitalization to anything but her biological and behavioral status. In other words, she was given the same kind of treatment one might expect a disturbed dog or cat to receive at a high quality veterinary hospital. Blood was drawn, tests were performed, drugs were administered, and when she quieted down, she was sent away with lots of prescriptions. What was missing — the element that differentiates human from veterinary care and used to differentiate psychiatry from anesthesia — was attention to the *person in the situation* (PITS). Such attention doesn't require intensive inpatient psychoanalysis or group therapy. It just means having regular encounters with patients that make them feel that there current problems are being considered and understood. Throwing away the PITS, it would seem, has become the essence of modern in-patient psychiatry.

The problem is that pits are, in fact, seeds. No biological system is unaffected by the environment. The person in the situation is the substrate out of which future psychobiological transformations emerge. In the language of genetics, genotypes only give rise to phenotypes under the influence of specific intra- and extra-cellular triggers. Firing a dedicated employee from a long held job without warning isn't just a trigger — it's a firing pin. The private explosions set off by such traumas can disorganize minds even as they disturb biochemical balances.

The benefits of psychopharmacology — and there can be no argument that they are myriad — can be lost in the individual case when the PITS are thrown away. Just as millions of health care dollars are lost when people with undiagnosed psychiatric disorders are subjected to expensive medical tests and treatments, so are they wasted when biological biases, managed care mandates and poor professional training conspire to keep all eyes on the prescription pad and the exit. Why? Because, as every well-trained psychiatrist knows, talking to people about their situations and helping them to come to terms with the impact of experiences like being fired, divorced, cheated on, lied to, passed over, and discriminated against can profoundly impact the course of their disorders.

In the case of this employee, the failure of the staff to address what their institution did to her was a collusion with the process. Their failure to include talking to her about it as either a component of her inpatient care or a recommended part of her outpatient treatment devalued her as a person, reinforced her feelings of worthlessness, allied her psychiatrists with those who fired her (counseling was no longer valued in her department either), and caused her to be overmedicated.

This last point is a particularly important one. As a psychopharmacologist, I'm as aware as anyone of the pitfalls of over-prescribing. I've seen enough side-effects and drug interactions over the last thirty years to know that more isn't necessarily better. Overmedication is the typical reflexive

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reaction on the part of biological psychiatrists when their neglecting to consider the person in the situation has led to a sub-optimal result. This lady's symptoms have steadily improved as her dosages have been decreased, and she has finally had a chance to tell her story. The idea that she needed an outpatient Amytal interview to "uncover" the cause of her "memory" problems leaves me scratching my head. Must we now administer drugs just to legitimize listening to people? I refused to do the procedure much to the relief of the patient and her family.

The second case, which I'll only mention briefly, underscores a potentially more lethal effect of pharmacoblindness. This executive in her thirties took a near-fatal overdose following rejection by her lover. In the zeal of her doctors to treat her suicide attempt quickly and clear the bed for the next customer, she was sent home as soon as she was ambulatory on the same tricyclic antidepressant she'd used to overdose. In lieu of getting her onto a safer antidepressant before discharging her, they limited the quantity in her outpatient prescription to a sublethal amount. Unfortunately, she received a call from some well-meaning nurse a few hours after she got home telling her that a prescription bottle with her name on it had been found on the unit. She was told to come back and pick it up right away. The contents? A deadly quantity of tricyclics -- the ones she hadn't ingested from the bottle she'd overdosed on. She is still alive now because her rage the the hospital's mindless invitation to disaster outweighed her suicidal impulses. As for the meaning of the incident, I consider it just another example of the problem I'm talking about. Handing out drugs indiscriminately is considered far less a crime these days than spending too much time listening to the people receiving them.

Speaking of listening to patients, when they say "Life is the PITS," we should pay attention.