

**Keeping the Balance and Monitoring the Self-System:
Towards a More Comprehensive Model of Medication Management in Psychiatry**

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If his (Dr. Cabot's) patients wanted to talk diagnosis, he talked drugs. If they wanted to talk symptoms, he talked drugs. Stress? Drugs. Suffering? Drugs. Family problems? Drugs. Job? Drugs.

---Dr. Roy Basch, *Mount Misery*, (Shem, 1997, p. 299)

Your little 'talk therapy' is now a minor sub-specialty. A hundred twenty an hour tops. Chump change...Managed care and insurance won't pay for talk. They pay for drugs.

---Dr. Erol Cabot, *Mount Misery*, (Shem, 1997, p. 301)

I was prepared to expose myself, but they didn't want to listen, only medicate. Take this and shut up, they said.

---(Johansson & Eklund, 2003, p. 343)

I don't think very highly of psychiatrists...I tolerate them because I have to take this medicine...They've got a drug for everything...they like to tinker with the body through these drugs rather than have people express what they're feeling.

---(Karp, 1996b, p. 85)

There remains plenty of room for human misery after the drugs have been most skillfully applied.

---(Ostow, 1966) quoted in Goldhamer (Goldhamer, 1983, p. 176)

When medications take the place of relationships, not only do patients suffer the side effects of aggressive medication, but they lose the healing power of the relationship.

---(Luhmann, 2000) quoted in (Gabbard & Kay, 2001, p. 1961-1962)

Introduction

Beginning with the discovery of rauwolfia (i.e., reserpine) in 1931 and chlorpromazine in 1952, and accelerating during the 1960s, drug therapy has become an increasingly central part of psychiatric care (Cruz & Pincus, 2002; H. I. Kaplan & Sadock, 1998; Tasman *et al.*, 2000). In the last ten years, however, several forces have converged to create a situation in which drug therapy is the dominant and, at times, the only type of treatment some chronically mentally ill patients receive (Kandel, 1998). The recent rise to prominence of drug therapy and brief medication management are part of a larger set of changes currently affecting the U.S. health care delivery system. The effects of these changes on cost and quality are poorly understood (Durham, 1998). However, there is reason to suspect that key patient, professional and societal goals may not be achieved by drug therapy and brief medication management alone. For many

patients, the quality of psychiatric care depends on the quality of drug therapy and medication management. Therefore, it is important to carefully consider some of the factors that may improve the quality of this type of care.

Overview

The purpose of this essay is to contribute to the development of a model of psychiatric medication management that better reflects the needs, beliefs and preferences of both psychiatrists and people living with mental illness. We begin by reviewing the recent increase in psychiatric medication use during the last decade. Next, we review negative indicators that highlight challenges in the current practice of drug therapy and medication management within psychiatry, and we attempt to identify problems with existing models of medication management. Section four sketches the outlines of a new perspective that is emerging around a more comprehensive model of medication management. This section reviews theories from several different intellectual traditions which converge on the idea that medication management must focus on the meanings of medication and medication effects, especially the manner in which these meanings affect a patient's ability to sustain a preferred identity and maintain a cohesive sense of self. The fifth and final section represents our initial effort to turn the conceptual model into a set of concrete suggestions for improving the practice of medication management. This section consists primarily of recommendations about how to communicate in medication management interviews.

Intended Audience

This chapter is directed at several audiences. Our arguments are developed primarily in the context of psychiatry, but we believe they have much broader relevance. Practicing psychiatrists at all levels of training (i.e., residents and attendings) will be interested in the

analysis of negative quality indicators in psychiatry, as well as in the specific ideas for improving the quality of medication management interviews with psychiatric patients. Non-physician therapists who provide treatment in conjunction with psychiatrists will be interested in the sections on the meanings of medication as they relate to identity and biography. Health communication researchers will be interested in symbolic interactionist accounts of health and illness and their implications for provider-patient interaction, especially in the context of medication management. Finally, health professionals involved in medication counseling, including pharmacists, nurses, and physicians from outside psychiatry, will be interested in the meaning and identity-centered analysis of medication adherence.

1. The Growth of Drug Therapy and Medication Management

This section reviews the evidence of recent growth in the use of drug therapy and brief medication management for psychiatric outpatients. With respect to the receipt of drug therapy generally, the National Ambulatory Medical Care Survey (NAMCS) indicates that the percentage of psychiatric outpatients receiving one or more medications has increased from 46% in 1985 to 71% in 1996 to 73% in 1997 (M. Olfson, 1992; Woodwell, 1997). In 1997, only cardiologists and family physicians prescribed drug therapy to a higher percentage of their patients (Woodwell, 1999). Drugs commonly used for mental illness accounted for roughly 11% of all drugs mentioned in outpatient visits during 1997 (Woodwell, 1999). Four of the twenty most frequently prescribed drugs in outpatient practice were for the treatment of depression and/or anxiety (Prozac[®], Xanax[®], Zoloft[®], and Paxil[®]). These drugs alone accounted for 3% of all office-based prescriptions (Woodwell, 1999). By 2002, antidepressants were the second most frequently mentioned class of drugs in U.S. outpatient medical visits, trailing only non-steroidal anti-inflammatory drugs (e.g., ibuprofen) (Woodwell & Cherry, 2004).

Medication management visits (defined as any visit of 20 minutes or less during which a medication was prescribed) increased from 6.7% of all visits in 1985 to 40.4% of visits in 1997 (M. Olfson, 1992; Woodwell, 1999). Olfson's recent analysis of trends in office-based psychiatric practice showed that, from 1985 to 1995, office visits "became shorter, less often included psychotherapy, and more often included a medication prescription" (M. Olfson *et al.*, 1999, p. 451). For the most common type of psychiatric visit, those related to depression, the use of drug therapy has increased dramatically in the last 10-15 years, and this increase has been more pronounced among psychiatrists than among other office-based physicians (Mechanic *et al.*, 2001; M. Olfson *et al.*, 1998; Pincus *et al.*, 1998). The proportion of psychiatric outpatients receiving an antidepressant more than doubled in the period between 1985 and 1994, from 23% to nearly 49% (M. Olfson *et al.*, 1998). More recent data confirm this trend. Between 1987 and 1997, the number of patients receiving outpatient treatment for depression increased; the proportion of treated patients receiving antidepressant medications doubled to 74.5%, and the proportion of patients receiving psychotherapy declined from 71% to 60% (M Olfson *et al.*, 2002a). During the same period, medication use by psychotherapy patients increased significantly, from 14.4% to 48.6% for antidepressants, from 5.3% to 14.5% for mood stabilizers, and from 1.9% to 6.4% for stimulants.(M. Olfson *et al.*, 2002b) These same patients were also increasingly likely to be receiving psychotherapy from physicians as opposed to psychologists or other non-physician mental health professionals.

2. Outcomes of Drug Therapy and Brief Medication Management: Negative Indicators

In spite of the successes of psychopharmacology, documented elsewhere (Schatzberg & Nemeroff, 1998), there is ample room to improve the quality and effectiveness of medication management in psychiatry (Gabbard & Kay, 2001; Lamberg, 2000; Medawar & Hardon, 2004;

Tasman et al., 2000). Evidence takes the form of negative quality indicators, most notably in regard to poor adherence to medication regimens, poor rates of appointment-keeping, and significant rates of patient and professional dissatisfaction. Clearly, not all problems in psychiatry are due to poor medication management, but the following section illustrates that there is room for quality improvement in this core area of psychiatric practice.

Medication Adherence

Poor adherence (i.e., noncompliance) with medical regimens is commonplace across all medical specialties (DiMatteo *et al.*, 2002; Kravitz *et al.*, 1993). It is not unique to drug therapy nor to psychiatry. What's more, low rates of adherence to drug therapy regimens are not solely the responsibility of health professionals, nor do they always reflect poor outcomes (e.g., some patients discontinue therapy because they feel better, though they may relapse later) (Demyttenaere, 1998; Demyttenaere *et al.*, 2001). Nevertheless, in an optimal system of care, patients and providers should be able to agree on a therapy that patients can stick to (Chewning & Sleath, 1996; DiMatteo *et al.*, 1994). Even if they are not a perfect indicator of the quality of medication management, low adherence rates often represent evidence of the failure of treatment to achieve its desired effects. According to a recent review, "acceptance or rejection of prescribed pharmacological regimens is often the single most important determinant of these treatments' effectiveness" (Fenton *et al.*, 1997, p. 637).

In psychiatry, adherence to drug therapy regimens is notoriously poor, regardless of the underlying illness. In a recent study of depressed patients, roughly half stopped taking the medication after 12 weeks (Maddox *et al.*, 1994). Another study showed more than two-thirds of patients had stopped drug therapy after 90 days (Demyttenaere, 1998). It should be noted that one common reason for stopping was that the patient felt better. Overall, Demyttenaere estimated

2-3 month adherence to antidepressant drug therapy at 25-50% (Demyttenaere, 1998; Demyttenaere *et al.*, 1998). Other reviews of noncompliance in depression report similar rates (Demyttenaere *et al.*, 2001; E. M. Kaplan, 1997; Lin *et al.*, 1995; Lingam & Scott, 2002; Pampallona *et al.*, 2002; Souery & Mendlewicz, 1998). The situation is no better among patients with schizophrenia, where median rates of noncompliance across a large number of studies range from 25% to 55% (Bebbington, 1995; Fenton *et al.*, 1997; M. Olfson *et al.*, 1997; J. L. Young *et al.*, 1986; Zygmunt *et al.*, 2002). In a recent landmark study of the newest drugs for schizophrenia, 74% of patients had discontinued drug therapy within 18 months of initiating (Lieberman *et al.*, 2005). Short and long-term noncompliance rates of 50% have also been observed among people with bipolar disorder (i.e., manic depression) (Hilty *et al.*, 1999; Johnson & McFarland, 1996; Keck *et al.*, 1996; Lingam & Scott, 2002).

Thus, it is clear that poor adherence to prescribed drug therapy is a significant problem in the three most serious psychiatric illnesses. As a consequence of poor adherence, patients often suffer unnecessarily, relapse faster, and are rehospitalized sooner and more often than would be the case if adherence were improved (Fenton *et al.*, 1997; Hilty *et al.*, 1999; Kelly *et al.*, 1990; Lingam & Scott, 2002; M. Olfson *et al.*, 1997; Valenstein *et al.*, 2002).

Appointment-Keeping

Another (imperfect) indicator of quality and satisfaction is the extent to which patients keep scheduled appointments. Our assumption is that if patients feel safe, respected, cared for, and listened to, they will be more likely to keep scheduled appointments than if they are dissatisfied, alienated or estranged from their doctor. Missed appointments are a problem across all medical specialties, but the problem seems especially acute in psychiatry, where the rate of missed appointments may be twice as high as in other specialties (Killaspy *et al.*, 2000). Of

course, dissatisfaction is not the only reason for missing an appointment. Demographics, diagnosis, chaotic lives, rapid recovery, homelessness, drug addiction, and lack of transportation also play a role. Nevertheless, missed appointments can be viewed as a negative quality indicator because an association has been found between appointment-keeping and subsequent outcomes. For example, patients who miss appointments tend to be sicker and more likely to be readmitted to the hospital than people who do not miss appointments (Grunebaum *et al.*, 1996; Killaspy *et al.*, 2000; Matas *et al.*, 1992; Nelson *et al.*, 2000; Sparr *et al.*, 1993). Overall rates of missed appointments range from 10-55% (Dotter & Labbate, 1998; Grunebaum *et al.*, 1996; Matas *et al.*, 1992; Pang *et al.*, 1996). Half of the patients referred by primary care providers failed to keep their psychiatric clinic appointment in another study (Grunebaum *et al.*, 1996). The problem is not unique to the U.S. In a two-month study of outpatients in Hong Kong, 15.4% of all follow-up appointments were missed (Pang *et al.*, 1996). In a two and a half year Canadian study, 17.8% of appointments were missed (Matas *et al.*, 1992). Rates of missed appointments tend to be higher for medication checks than for psychotherapy, intake, or other types of appointments (Sparr *et al.*, 1993).

Dissatisfaction

Patient. Although levels of patient satisfaction are generally quite high in psychiatry (as they are in most specialties) dissatisfaction tends to focus on treatment planning and medication management issues (Howard *et al.*, 2003). For example, substantial minorities of mental health patients at Kentucky hospitals reported not receiving medication education (13.8%) or not being told what side effects to watch out for (17.4%). Fourteen percent said they were not asked what they thought would help to make them feel better, and 17% did not feel free to complain (Howard *et al.*, 2003). Qualitative studies of satisfaction also reveal strong feelings about the

quality of medication management: “I hardly know what treatment I get; which medication I get or why I get it” (Johansson & Eklund, 2003, p. 344). Quantitative results reinforce these perceptions. For example, 27% of respondents to a British survey of mental health patients reported never having a discussion about their medications with their doctor; 46% received no written drug information, and 62% were not offered any choice of medications (Demyttenaere, 2003).

Practitioner. There is widespread concern and discussion about job dissatisfaction among physicians (Zuger, 2004). During the 1990s this concern was especially acute in psychiatry as the number of residents choosing psychiatry as a specialty steadily declined. This trend has reversed since 2000. Recent surveys suggest that most psychiatrists are satisfied with their jobs. However, older, typically less biomedically-oriented psychiatrists are significantly more dissatisfied than their younger colleagues, presumably as a result of the increased emphasis on drug therapy (Sturm, 2001). Across medical specialties, satisfaction has declined only slightly in recent years (Landon *et al.*, 2003). When dissatisfaction is expressed, it is often attributed to time pressures, perceived lack of autonomy, the decreased significance of the narrative history, and the dominance of drug therapy over psychotherapy (Andreasen, 2001).

Understanding the Negative Quality Indicators

No single fact can explain why, in such large numbers, patients miss appointments, report dissatisfaction, and do not follow their drug therapy regimens. There are undoubtedly many system-, provider-, and patient-level factors at work. In this chapter, we focus on the quality of medication management since it has become such an integral part of modern psychiatric treatment and because it poses such an interesting challenge for health communication research. So why, one might ask, is psychiatric medication management achieving less than optimal

results? Many explanations have been offered: not enough time to spend on medication issues; not enough collaboration between patients and providers; not enough collaboration between different types of providers; too much emphasis on biological reductionism; not enough training in psychotherapy or the art of medication management; and not enough focus on the meaning of medications and illness experience (Charmaz, 2000; Chewning & Sleath, 1996; Conrad, 1994; Demyttenaere, 1998; Gabbard & Kay, 2001; Holzinger *et al.*, 2002; Karp, 1996c; Lambert *et al.*, 1997; Medawar & Hardon, 2004; Tasman *et al.*, 2000). In addition to these system and provider factors, some of the negative quality indicators are also due to patient factors such as poverty, substance abuse, homelessness, and to the severity of the underlying illnesses. Among all these explanations, we find the arguments about self, identity, and the meaning of medication to be the most compelling: They cut across the other explanations; they seem central to the lived experience of illness; they are rooted in deep traditions in both psychiatry and sociology; and they appear to offer new and constructive suggestions about how to move out of the present situation. Specifically, we believe that to improve medication management, providers will first have to deepen their understanding of the relationship between the meaning of medication, the patient's identity, and the dynamics of the underlying chronic illness. Of course, a deepened understanding alone will not be sufficient unless it is accompanied by new and different ways of communicating with patients about their medications, identities and biographical narratives.

3. The Trajectory Model of Chronic Illness:

Conceptual Foundation for Better Medication Management

Although recovery is not unheard of, all of the major psychiatric illnesses (e.g., depression, schizophrenia, bipolar disorder) are regarded as chronic and incurable. A great deal has been written in the last 20 years about chronic illness from a social scientific viewpoint, most

of which has focused on non-psychiatric illness and injury (Charmaz, 2000; Corbin & Strauss, 1988b; Roth & Conrad, 1987). The models of chronic illness which have been developed are consistent with the traditional commitments of psychiatry: patient-centeredness, biopsychosocial framework, focus on the meaning of medications and of illness, the importance of the doctor-patient relationship and on the centrality of the narrative history (Andreasen, 2001). We believe psychiatrists would benefit by integrating these contemporary models of chronic illness into their practices. By internalizing a detailed conceptual model of the lived experience of chronic illness practitioners might better be able to anticipate problems and conflicts, to read between the lines of patients' questions and complaints, to understand patients' goals and motivations, and to understand where suffering comes from and how it might more effectively be alleviated.

The Trajectory Model of Chronic Illness and the BBC Chain

Inspired in many respects by Goffman's analysis of identity, stigma and chronic illness (Goffman, 1961, 1963), the trajectory model was developed by Juliet Corbin (a nurse) and Anselm Strauss (a sociologist) and further refined by sociologist Kathy Charmaz and others (Charmaz, 1987a, 1987b, 1991, 1999, 2000; Corbin & Strauss, 1987, 1988b; Strauss & Corbin, 1988b). The full complexity of the model cannot be summarized here. Instead, we focus on one main idea: the BBC chain. According to the trajectory model, one enjoys a subjective sense of health and well being only when the three elements of the BBC chain—body, biographical time, and conceptions of self—are in balance, interactively stabilizing and reinforcing one another (Corbin & Strauss, 1987, 1988a; Lambert et al., 1997).

The body. The body is the physical, material self, skin and bones, organs, cells, molecules and DNA. Most importantly for the model, the body is the means through which performances in the world can be enacted (Goffman, 1959). Body failure—in the form of

paralysis, tremors, limps, memory loss, incontinence, fatigue, constipation, shortness of breath, impotence, weakness, pain, blindness, deafness, slurred speech, scars, sores, deformities, etc.—is the prototypical concern of biomedically-oriented physicians. But in the trajectory model, body failure takes on significance only when it impacts identity-relevant performances (Corbin & Strauss, 1987, 1988a). An identity-relevant performance is one which is essential to the maintenance of a given identity. A gardener needs to be able to dig in the dirt; a musician needs to be able to play her instrument; a grandfather needs to be able to play with his grandchildren; a baseball player needs to be able to run, jump, throw, catch, and hit. Body failures take on biographical significance only when they interfere with identity-relevant performances (Corbin & Strauss, 1987, 1988a; Lambert et al., 1997).

Biography. Biography (or biographical time as Corbin and Strauss refer to it) refers to the more-or-less explicit narrative that gives meaning, coherence, purpose, and direction to a person's life (McAdams, 1993). In the trajectory model, chronic illness is understood primarily as biographical disruption (Bury, 1982; Corbin & Strauss, 1987; Frank, 2000; Williams, 2000). At its worst, body failure can prevent chronically ill people from engaging in performances which are crucial to the maintenance of their identities and thereby keep them from realizing the plans, hopes, dreams and aspirations that are expressed in their biographies. According to the trajectory model, one of the three types of work that chronically ill patients must do (in addition to illness work and household work), is biographical work (Boeije *et al.*, 2002; Corbin & Strauss, 1987; Ville, 2005). Biographical work refers to all of the effort spent preserving, restoring or recasting one's self image and identity as well as the work done to rewrite the story of one's life and to mourn for hopes, dreams, and identities rendered unachievable by body failures.

Conceptions of self. Conceptions of self refer to all of the constructs that are typically described as self-image and identity (Ashmore & Jussim, 1997; James, 1961; McCall & Simmons, 1978). These may include role identities (father, teacher, brother, friend), social identities (American, Republican/Democrat, baseball fan), or spiritual identities (Christian, Muslim, Jew, child of God). Conceptions of self also include information about both actual or real selves as well as ideal selves. In the wake of a chronic illness, the discrepancy between real and ideal selves is often exacerbated by body failure and failed performances, and this discrepancy may bring about feelings of sadness, depression, guilt, shame, and anxiety (Corbin & Strauss, 1987, 1988a; Higgins, 1987; James, 1961). The primary form of suffering in chronic illness, according to Charmaz, is the progressive loss of self that results from mounting body failures, repeated failed performances and subsequent social isolation (Charmaz, 1987a).

When these three component structures—body, biography, and conceptions of self—form a coherent alignment, reinforcing and interactively stabilizing one another, one enjoys a subjective sense of well being (Albrecht & Devlieger, 1999; Lambert et al., 1997). When the BBC chain is destabilized by changes in body, self, or biography, then one has the subjective feeling of being unwell or ill.

The BBC chain has many desirable qualities as a model of health, not the least of which is that it is a biopsychosocial model (Engel, 1977; Gabbard & Kay, 2001). It does not succumb to the temptation of either biological reductionism or “mere” social constructionism (Pickering, 1990). By placing the body in the BBC chain, the model is thoroughly materialist, admitting a central role for biology. At the same time, by including biography and conceptions of self, the model captures most of what seems important about anthropological and sociological theories of health and illness (Charmaz, 2000; Kleinman & Seeman, 2000). By defining health in terms of

stable alignment and balance between these component structures, it gives equal weight to each and draws attention to the processes by which a stable alignment among the components is disrupted, restored, and maintained.

The BBC Chain and Patient Motivation

Seeing health and illness in terms of stability or instability in the BBC chain leads to new insight into patient motivation. Patients are motivated, above all, to maintain or restore stability among the elements of the BBC chain. What were once puzzling patient behaviors begin to make sense in this context. Why do some types of body failure, even very serious body failures, sometimes appear not to bother patients at all? When they are offered medications to deal with these body failures, they do not seem motivated to take the medication. On the other hand, why do seemingly insignificant body failures or medication side effects sometimes cause patients to stop taking medications, even when the medication has other obvious benefits which, from a biomedical perspective, far outweigh the side effects? To put it more concretely, why do many patients forget to take their blood pressure medication but not their erectile dysfunction or acne or weight loss medication?

The answer is obvious when seen from the point of view of the BBC chain. A person only feels healthy when the three elements of the BBC chain are in a stable, mutually reinforcing alignment, when the body enables a person to do the performances that are consistent with one's self concept and that allow one to realize the life narrative that is spelled out in one's biography. Body failures only matter if they destabilize this alignment by impacting on identity-relevant performances. When body failures impede identity-relevant performances, patients are strongly motivated to repair the body failure. When body failures fail to impact on identity-relevant performances, then patients are less motivated to do anything about them, especially if the

recommended treatment for the body failure causes new body failures that may have identity-relevant consequences. These observations lead to a very simple (perhaps overly simplistic) theory of adherence to regimens: If a recommended regimen helps a patient maintain or regain stability in the BBC chain, then the patient will stick with the regimen; if the regimen destabilizes or fails to impact the BBC chain, then it will likely be abandoned.

The biomedical model and the trajectory model attribute significance to body failure in starkly different ways (Lambert *et al.*, 2000). In the biomedical model, a body failure is significant if it is objectively measurable, if it impacts on a fundamental physiologic process, and if it can be linked, however remotely, to increased risk of future morbidity or mortality. The goal for biomedically-oriented physicians is to restore all measurable physiological parameters to their normal ranges. In psychiatry, where physiological measures are rare, rating scales and symptom checklists take their place. In the trajectory model, where the focus is on maintaining the integrity of the BBC chain, body failure is significant if and only if it disrupts the alignment of the BBC chain—if it has identity consequences. The goal for patients is to preserve or restore the integrity of the BBC chain, regardless of the biomedical consequences. We want to argue that the trajectory model, through its emphasis on the stability of the BBC chain, does a better job than the biomedical model of capturing the lived experience of illness.

The Meaning of Medications

Along with the trajectory model's focus on body–self–biography, another major insight from social scientific work on chronic illness concerns the meaning of medications (Adams *et al.*, 1997; Conrad, 1994; Gabbard & Kay, 2001; Karp, 1996b; D. Mintz, 2000, 2002; Montagne, 1996; Pound *et al.*, 2005; Rogers *et al.*, 1998; Trostle *et al.*, 1983). Again the contrast between biomedical and social scientific (i.e., symbolic interactionist) conceptions of medications is

instructive. From a biomedical perspective, medications are certainly meaningful. They have brand (Prozac[®]) and generic names (fluoxetine), strengths (e.g., 20 mg), dosage forms (e.g., tablet, capsule), routes of administration (e.g., oral, intramuscular), indications (e.g., antidepressant, antipsychotic), pharmacologic categories (e.g., benzodiazepines, selective serotonin reuptake inhibitors), chemical structures, mechanisms of action, side effects, contraindications and so on. The biomedical model explains medication effects in terms of mechanical actions at the molecular, cellular, or organ-system level. The efficacy of a medication may be assessed with respect to its ability to affect objectively measurable physiological parameters (e.g., blood pressure, blood glucose, respiration rate, temperature) in predictable ways. In psychiatry, where such measures are not available, efficacy may be measured by changes in rating scales or symptom checklists.

Along side the biomedical meanings, medications may have many additional meanings to patients living with chronic illnesses. Drugs may symbolize, among other things, dependence or independence, malevolence or benevolence, toxin or tonic, normality or stigma, sickness or health, fuel, food, status, affection, or escape (Adams et al., 1997; Conrad, 1994; Gabbard & Kay, 2001; Helman, 1981; Karp, 1996c; Montagne, 1988, 1996; Nichter & Vuckovic, 1994; Rogers et al., 1998; Trostle et al., 1983; Vuckovic, 1999; Vuckovic & Nichter, 1997). A medication itself may have potent symbolic meanings, as in the case of *Prozac*[®] or *Viagra*[®] (D. Mintz, 2000) or *AZT* or opiates or birth control pills. The meanings may be idiosyncratic or widely shared in popular culture. Apart from the meaning of any specific medication, the very fact of “being on” any medication, especially lifetime regimens, can have powerful significance for patients, often in relation to themes of autonomy, dependence, illness causation and control. What is important about all of this is that medications can destabilize the BBC chain not only by

their physiologic effects (e.g., when they cause fatigue, nausea, hair loss, weight gain, or sexual dysfunction), but also by virtue of their symbolic effects.

Medication and the self-system. In order to understand people's medication-use behavior, psychiatrists and other prescribers must understand not just the physiologic mechanism of action and its effects on biological systems, but also the *symbolic* mechanism of action of the drug and its effects on the *self* system. Failure to understand medication effects on the self-system is analogous to failure to understand the effects of medications on the liver. A medication might 'cure' depression while causing liver failure. Doctors rarely fail to consider the potential effects of a drug on a non-targeted organ system, but they often fail to consider the effects of medication on the self-system. This is because doctors are well trained in physiology and in *pharmacodynamics* (the way drugs have their physiological effects), but they are relatively poorly trained in *psychodynamics* (i.e., the way the meaning of medications effects the self-system via its effects on cognitions, interactions and performances) (Gabbard & Kay, 2001; D. L. Mintz, 2005).

Medications are the linchpin that connects the space of molecules (i.e., biomedicine) to the space of meanings (i.e., the trajectory model, the sociology and anthropology of health and illness). Medications have biochemical potency and they have symbolic potency. They have a biochemical mechanism of action and a symbolic mechanism of action, a biochemical route of administration and a symbolic route of administration. They have effects in the space of molecules and in the space of meanings. Medication management is the most common form of treatment in modern psychiatry (and in the rest of medicine as well). Therefore, clinicians must be trained to manage the biochemical and the symbolic (i.e., meaningful) effects of medication.

The meaning of asthma medication. To begin, a non-psychiatric example helps to make the point about the connection between medication-taking and illness self-definition. Adams and colleagues interviewed people with asthma in Great Britain (Adams et al., 1997). Asthma is a common chronic condition worldwide. It can be effectively controlled with a combination medications for prophylaxis (the “preventer” medications) and symptom control (the “reliever” medication). Unfortunately, asthma mortality rates are still quite high. Much of this mortality is what experts call unnecessary or excess mortality, so called because the deaths could be avoided if only patients received appropriate primary care and followed the prescribed drug regimens. One underlying purpose of Adams’ study was to understand how and why people made decisions about whether or not to take their asthma medications.

Based on their interview responses, patients were placed into three groups: denier/distancers, accepters, and pragmatists (Adams et al., 1997). The deniers denied that the label “asthmatic” applied to them. In spite of this denial, they acknowledged frequent coughing and difficulty breathing, and they reported heavy use of the “reliever” medications. Deniers did not take the preventer medication, because it was only for people with “proper asthma,” which they did not acknowledge having. Deniers viewed “true asthmatics” as being crippled, infirm, and unable to engage in most ordinary work and leisure activities. Deniers perceived the asthmatic’s identity in plainly negative terms, and they were not willing to accept a diagnostic label or an illness identity that would lead to such a negative re-definition of self. Rejecting preventer medications was the primary way these patients could dramatize their rejection of the asthma identity. The decision to take a medication is a transformative event for self and identity (Karp, 1996c). When the identity transformation is seen to be negative—to involve a loss of self—then the decision is made not to take the medication.

Accepters, on the other hand, saw asthma as more of an annoyance, something to be managed and lived with, not something to be dreaded or avoided (Adams et al., 1997). As a consequence, the accepters readily took both their preventer and their reliever medications. In fact, for the accepters, the medication was seen as enabling them to avoid stigma, illness, and infirmity, by helping them prevent hospitalizations as well as public episodes of breathing trouble and outright asthma attacks. Accepters were able to integrate asthma into their existing identities without significant loss of self. Pragmatists fell somewhere in between the deniers and accepters, for the most part taking their medication as directed but not embracing or integrating their asthma identities as fully as the accepters. Of course what this analysis does not tell us is how we transform deniers into accepters so that they can enjoy the benefits of drug therapy without the attendant loss of self. Nor does it tell us which of the deniers might be engaging in reasoned and sensible non-adherence, based on their own cost-benefit analyses. What it does show is that the decision to take medication is often grounded in the acceptance or rejection of an illness identity implied by the drug regimen.

Medications Destabilize the BBC Chain via Physical Effects and via Meaning

There are several pathways by which medications can destabilize the BBC chain. The first and most obvious is when the medication, by virtue of its biological mechanism of action, brings about changes in bodily functioning. The classic example concerns side effects or unintended effects of drugs. With psychiatric drugs, common side effects include weight gain, dizziness, drowsiness, sexual dysfunction, urinary problems, increased cholesterol, increased blood sugar, tremors, and mental clouding. If any of these side effects intersects with an identity-relevant performance, then the BBC chain will be destabilized. The extent of the destabilization will depend on the severity and persistence of the side effect and on the salience of the affected

performance. This type of medication problem is the one psychiatrists are probably most comfortable addressing. A great deal of present-day medication management consists of searching for the drug (or combination of drugs) that maximizes intended effects while minimizing unintended effects (Sin & Gamble, 2003). One opportunity for improvement here is in discerning which side effects are most likely to be disruptive of a given patient's BBC chain. To do this requires good understanding of the patient's identity and biography so that one can identify the crucial identity-relevant performances that need to be shielded from side effects. In the absence of side effects, the mere need to be on (even an effective and easily tolerated) medication can still be disruptive to identity and biography. Thus, providers should consider offering non-drug therapies to the patients who are most troubled by the need to start a long term drug regimen. Once a regimen is started, providers must be attentive to and respectful of patients' identity concerns, and must not minimize patient concerns about side effects or be judgmental about the cost-benefit formulas patients use to weigh their own decisions.

The BBC Chain in Psychiatric Illness

The trajectory model was developed primarily in the context of chronic physical illness (e.g. migraine headaches, back pain, paraplegia, congestive heart failure, stroke, rheumatoid arthritis, diabetes, asthma, Parkinson's disease, cancer, multiple sclerosis, heart attack, myasthenia gravis, ulcer, hypertension, lupus, emphysema, renal failure, incontinence, chronic fatigue syndrome) (Charmaz, 1991; Corbin & Strauss, 1988b). One might ask, then, whether there are differences between chronic mental and chronic physical illnesses that would prevent application of the trajectory model to chronic mental illnesses without significant revisions or elaborations. The main difference would appear to be that mental illnesses, especially those with psychotic symptoms, impair cognition in ways that most (but not all) physical illnesses do not.

The crucial question is whether or not these cognitive impairments stop people with chronic mental illnesses from doing the biographical work which is central to the maintenance of the BBC chain.

Part of the process of maintaining a stable alignment between body, biography, and self-image is being able to interpret one's own performances in relation to one's biography and identity and to revise and reconstruct biographical narratives in light of ongoing body failures (Charmaz, 2000; Corbin & Strauss, 1987; Lambert et al., 1997). Observation and evaluation are processes fundamental to the development and maintenance of the self system (McCall & Simmons, 1978). We observe our own performances, and we evaluate our own performances both with respect to our ideals of performance and with respect to their consistency with our biography and identity (Corbin & Strauss, 1987, 1988a; Higgins, 1987). In addition, in order to develop, sustain, and revise one's own biography or self-narrative, one also requires the capacity for temporal integration of information, for minimal self-reference, for storing and recalling autobiographical memories, for personal agency, and for reflective metacognition (Gallagher, 2003; Lysaker *et al.*, 2005a). One potentially important difference between chronic physical conditions and chronic psychiatric problems is that in many psychiatric conditions, the *self system itself is impaired* (Lysaker & Lysaker, 2002; Sass & Parnas, 2003). That is to say, when a chronic condition brings about primarily physical limitations, the cognitive ability to do interpretation, evaluation and narrative construction is left mostly intact. There are obvious exceptions to this generalization (e.g., Alzheimer's disease, stroke, head injury, brain tumor, etc.).

In contrast, in some chronic psychiatric conditions (schizophrenia in particular), the cognitive skills needed to do the interpretations, evaluations and narratives may themselves be

impaired (Franck *et al.*, 2001; Kapur, 2003; Lysaker *et al.*, 2005c; Lysaker *et al.*, 2003c; Sass & Parnas, 2003). The most obvious examples involve delusions and hallucinations, where a person's observations may not jibe with reality. But even patients without active delusions or hallucinations may have impaired or distorted evaluations of their own performances as well as limitations in memory, perception, attention, judgment, decision making, and the ability to construct coherent self-narratives (Hofer *et al.*, 2005; Kurtz, 2005; Lysaker & Lysaker, 2002; Lysaker *et al.*, 2005c; Lysaker *et al.*, 2003c).

Because it was developed primarily to explain chronic physical illness, the trajectory model has not had much to say about how to deal with cognitive impairments that may distort or disable the narrative and interpretive mechanisms that allow for the maintenance of a cohesive sense of self. If the trajectory model is going to be applied successfully to psychiatric medication management, this is an important area for future research. Several questions need to be answered (Lysaker *et al.*, 2005c; Lysaker *et al.*, 2003b): What cognitive functions (e.g., attention, memory, perception) are essential for the accomplishment of biographical work? In which chronic mental illnesses and under what circumstances are these cognitive functions impaired? To what extent do impairments in cognitive functioning impede biographical work? What interventions are available to improve cognitive functioning and thereby improve one's ability to engage in biographical work? At what level of severity do the cognitive impairments begin to impede biographical work? What are the consequences of pursuing biographical work with patients who are cognitively impaired?

While not minimizing the cognitive impairments that may accompany chronic psychiatric illness (notably schizophrenia), there is reason to believe that these impairments may not always be severe enough to preclude biographical work. For example, the majority of seriously mentally

ill people in America are not institutionalized, and large numbers of seriously mentally ill people live independently. Furthermore, when given standard tests of neurocognitive function, non-institutionalized (i.e., community-dwelling) patients with schizophrenia performed only slightly worse than population norms, and their overall mean scores were not in the range normally defined as 'impaired' (Ganguli *et al.*, 1998). The level of cognitive functioning appears to be stable over time (Kurtz, 2005). Supportive employment intervention and vocational rehabilitation can be successful even among seriously mentally ill people (Cook *et al.*, 2005a; Cook *et al.*, 2005b). Lysaker and colleagues have demonstrated improvements in narrative structure among schizophrenic patients after psychotherapy and vocational rehabilitation (Lysaker *et al.*, 2005b; Lysaker *et al.*, 2003a; Lysaker *et al.*, 2003b). From the point of view of professionals and people suffering from mental illnesses, there is an increasing recognition that fostering the ability to reconstruct a coherent narrative of one's own life is a key step in recovery and a central goal of treatment (Corin, 1998; Davidson & Strauss, 1992; Holma & Aaltonen, 1998; Holma & Aaltonen, 1997; S. L. Young & Ensing, 1999).

It should also be noted that chronic mental illness, like chronic physical illness, is episodic, not constant. It may be true that, in the midst of an acute depressive episode, a manic phase of bipolar disorder, or psychotic break in schizophrenia, that a person may be too sick to do biographical work. But this is really no different than in physical illness, where biographical work can only be done during relatively stable phases of the illness, and where exacerbations, acute episodes, and physical setbacks temporarily derail biographical work. What's more, the cognitive impairments that limit the capacity for biographical work are most common in psychotic illnesses such as schizophrenia, but patients with schizophrenia comprise only 6-7% of patients with mental illness in America (U. S. Department of Health and Human Services,

1999). The remaining 93-94% have other mood or anxiety disorders which are unlikely impair cognition severely or persistently enough to prevent people from engaging in biographical work.

In summary, the cognitive impairments that accompany serious mental illness present a theoretical and practical challenge for the trajectory model. Such impairments are not unheard of in chronic physical illnesses, where the trajectory model has most often been applied, but they are likely to be both more common and more severe among people with chronic mental illnesses. Still, even among these patients, whose insight, memory, perception, attention, language skills and capacity for self narrative may at times be impaired, we believe there remains significant capacity to do biographical work, especially as it relates to the meaning of medication in relation to illness identity. In the end we conclude that, with a few exceptions, patients with chronic mental illnesses can do biographical work, and there is no reason to believe that the trajectory model cannot be used to understand their experience. In spite of the linguistic distinction between mental and physical illnesses (with all of its Cartesian dualistic implications), what both have in common, and what the trajectory model excels at explaining, are the challenges and consequences of *chronicity* itself, i.e., how does one cope with and adapt to a serious, identity-threatening, life-limiting, unending illness? The following two sections illustrate what this process looks like in the context of patients taking medication for depression and psychosis.

The meaning of antidepressant medication. Perhaps the best illustration of the relationship between medication, identity and illness in psychiatry comes from David Karp's interview study of 50 people with depression (Karp, 1996c). Many of Karp's interview subjects described a distinctive sequence of identity transformations—what he termed their depression career (Karp, 1996a). Depression careers began with inchoate feelings of sadness, emptiness, or despair. In the early stages, these feelings were not labeled as depression, nor were they seen as

pathological, just normal sadness. Inchoate feelings were followed by a phase during which people sensed that something was really wrong, that the bad feelings they were having went beyond ordinary sadness. Next came a crisis, often a “breakdown” and subsequent hospitalization, and finally a period during which people attempted to come to grips with their new identity as a depressed person.

One important characteristic of the depression career concerns attributions of causality. As the participants in Karp’s study moved through their careers, there was a general progression from external to internal attributions of cause. In the early stages, feelings of sadness were often attributed to the external environment (e.g., work, family, or intimate relationships). As time passed, crises mounted, illness became undeniable, and as medical definitions were gradually accepted, the feelings were blamed instead on a pathological self (Karp, 1996a). What is interesting for our purposes is the role medication experiences play in these identity transformations. According to Karp, “a patient’s willingness to begin a drug regimen and stick with it involves an extensive interpretive process that includes consideration of such issues as the connection between drug use and illness self-definitions, the meanings of drug side effects, attitudes toward physicians, evaluations of professional expertise, and ambiguity about the causes of one’s problems” (Karp, 1996c, p. 81).

Most of Karp’s informants were initially reluctant to take medication. Some of this reluctance had to do with fear of side effects or a general unwillingness to use medication, but for the most part the reluctance stemmed from the realization that agreeing to take antidepressant medication would lead to negative changes in identity and illness self-definition (Karp, 1996b). For many people, the decision to take antidepressant medication signals an acceptance of the biomedical definition of depression. Accepting a biomedical definition may cause substantial

dissonance for people who had defined their troubles as rooted in external social, economic, or family circumstances. Biomedicine defines depression as a chronic, incurable disease. Accepting this definition requires coming to terms with lifelong consequences which may be difficult to integrate into one's pre-illness identity and biography. The biomedical definition of depression also raises difficult challenges vis-à-vis autonomy. On the one hand, the biomedical conception of depression as a "chemical imbalance" or serotonin deficiency frees a person from responsibility for their condition. On the other hand, it puts them in the grip of a biomedical determinism which leaves little opportunity for patients to minimize or escape the consequences of depression by their own persistence, creativity, or hard work. Ironically, the more effective the medicine is the more difficult it is to deny the biomedical definition—because if the condition was not biological, then the medication would not work so well.

The lesson to draw from Karp's interviews is that medication decisions are never separate from identity struggles. If health professionals insist on thinking about medications only in terms of their biomedical meanings, they will continue to be puzzled by patients' apparently irrational "noncompliance." If they think instead about the meaning of medications in relation to the BBC chain, then patients' decisions about medications may begin to appear rational, sensible, and predictable.

The meaning of antipsychotic medication. Rogers' interviews with patients on antipsychotic medication produced similar insights (Rogers et al., 1998). Patients with schizophrenia often saw neuroleptic medication as a means of controlling symptoms that were either personally or socially undesirable. In this example, the lay and professional meanings of the medication overlap. Patients weighed the benefits of symptom control against the cost of side effects. Reinforcing what we said earlier about identity-relevant side effects being most

significant, patients were not bothered by the side effects themselves but by “the way in which physical and psychological side effects acted to inhibit everyday social interaction” (p. 1317) (Rogers et al., 1998). What is important is that side effects were most likely to take on negative meanings when they interfered with identity-relevant performances.

Summary. Karp’s study of the meaning of antidepressant medication (Karp, 1996c), Rogers’ study of the meaning of neuroleptic (i.e., antipsychotic) medication (Rogers et al., 1998), and Adams’ study of asthma sufferers illustrate the many meanings medications may have and the various ways in which these meanings enter into patients’ decision-making process. The key is for health professionals to appreciate that decisions about whether to take medication, as well as the experience of being on medication, are deeply embedded in the ongoing process of identity transformation—the biographical work—that occupies so much of the time and energy of people with chronic illnesses. To the extent that medications bring about positive transformations in identity, e.g., by helping to maintain or restore identity-relevant performances, they will be embraced. But when medications bring about negative identity transformations, either directly, by causing identity-damaging side effects, or indirectly, by virtue of what it means to “be on” a given medication, then they will be resented, avoided, and eventually abandoned. If there is one take-home message from this essay, that is it.

4. Comprehensive Medication Management: From Theory to Practice

Thus far we have offered a review of negative quality indicators related to medication management in psychiatry and the theoretical outlines of an approach that might improve the situation. In this final section, we offer some suggestions about how to put our theoretical ideas about chronic illness and the meaning of medication into practice. This is not primarily a “how to” chapter, but we would be remiss in not offering at least some ideas about how to address

these issues during typically brief (i.e., 15-30 minute) medication management visits. For more thorough and detailed practical guidance about how to do medication management in psychiatry, the interested reader should follow up on the excellent work that has been done in this area recently (Chewning & Sleath, 1996; Cruz & Pincus, 2002; Gabbard & Kay, 2001; D. Mintz, 2002; D. L. Mintz, 2005; Tasman et al., 2000; Weiden & Rao, 2005). The paragraphs below focus on several key issues: Which patients are most likely to benefit from discussion of medication, identity, and illness? How can clinicians resolve conflicts over treatment goals and methods while still respecting patients' autonomy over medication decision making? What are some of the key issues to be handled in initial and follow-up medication management appointments?

Which Patients Might Benefit?

Not all patients will benefit equally from a consideration of the meaning of medications in clinical practice. For example, some patients have 'purely biological' problems that the medicine alleviates. For them the medication has either benign or beneficent meanings which don't need to be discussed. Indeed, by engaging in this type of discussion clinicians may be perceived by patients as playing devil's advocate or second guessing the decision to take medications. In contrast, there are some patients who have a problem that is treated well by the medication, but for whom the side effects create problems in the space of meanings and identity (e.g., impotence, a humiliating tremor, hair loss, etc.). Here the task is to deal with the identity-damaging, personal meanings so that the patient can enjoy the biomedical benefits.

The decision to try and deal at length with the meaning of medications may also depend on the severity of a patient's illness. At one extreme on this continuum, severely psychotic patients may be too sick to tolerate long appointments, or their speech or thoughts may be too

disorganized for discussion to be worthwhile. Active drug addicts (i.e., those not in recovery) may be uninterested in this sort of self-examination and may simply want to get medications. In the middle of the continuum are large numbers of patients who are sick enough to want and need longer appointments and well enough to tolerate and benefit from them. This middle group is likely to benefit most from detailed discussion of the meaning of medications. Finally, at the other end of the severity spectrum, there are very high functioning patients who have good social support and just want to refill their medications. Although these patients are capable of discussing the meanings of medication, their high functioning suggests that they have already successfully integrated the drug regimens into their identities and biographies and therefore may benefit less than others. These are generalizations, of course, but they illustrate the types of patient- and disease-specific factors that may impact the usefulness of the approach we have been advocating.

Anticipate Resistance and Disagreement

It is often a mistake to assume that the patient likes, trusts, or values the relationship with the clinician. Patients are often brought to a psychiatrist's office under duress – a family member is insisting that he/she get care, an employer is requiring an evaluation or documentation to support disability, or treatment may be court-ordered. It is reasonable to expect some level of conflict, whether it be internal on the patient's part, interpersonal between patient and other parties including the clinician, or intrapsychic around the issue of medications and identity. In addition, in some cases, combativeness, resistance, and a tendency toward interpersonal conflict may be symptoms of a patient's underlying illness (D. Mintz, 2002).

As a result, medication management needs to be approached as a negotiation. Attempts to exert undue influence over patients, by using fear appeals, appeals to expert knowledge, or

threats of abandonment (“either follow my advice or find another doctor”), will ultimately backfire since patients can exercise absolute autonomy over medication use once they leave the hospital or clinic. A more productive approach may be to acknowledge and accept patients’ autonomy from the outset, and to view one’s role as that of an advisor, not as one who dictates proper medication use behavior (Butler *et al.*, 1996; Chewing & Sleath, 1996; Cruz & Pincus, 2002). In spite of the likelihood that patients and clinicians will define problems and goals differently, it is often possible to find common ground between clinicians’ biomedical goals and patients’ quality of life goals (Lambert *et al.*, 2000). The purpose of medication management should be to seek this common ground and expand it whenever possible.

The Initial Visit

During a medication management evaluation, which can range between 30 and 60 minutes, there is a significant amount of information to be obtained. This includes current information regarding symptoms, precipitating events, substance abuse, current medications and any medical conditions, relationships and work, mental and cognitive status (e.g., suicidal or homicidal ideation, as well as psychotic symptoms). It may also include past psychiatric history, past medications and other treatment modalities, family history of mental or medical illness, past trauma, childhood history, and so on. This is a daunting amount of information to be obtained and doesn’t even include problem solving with a patient and establishing a mutually acceptable plan of care. The trend toward briefer (i.e., 30 minute) evaluations is disturbing not only because important information may be missed due to lack of time, but the pace of such initial contact may convey to the patient that being rushed will be the rule rather than the exception, an expectation which can affect future interactions, i.e., not wanting to initiate discussion about more personal or intimate details because of limited time. Given this limited time frame, it is important to set up

a situation wherein the meanings of medication can become knowable. This means listening without judgment and without interruption as much as possible.

By the end of an initial interaction, a clinician will want answers to several questions. Some of these questions can be asked directly: What brings you into treatment? Why now? Why here? Later in the interview, one can ask: How do you feel about being here? What do you want to achieve? How do you feel about me being the person talking to you? Patients will differ in their willingness to respond to these questions. A patient who comes of her own accord and identifies her symptoms as being alien and unwanted may be open to answering these questions directly. A patient who is ambivalent about treatment or who has come to treatment under duress may not be as forthcoming. In this case, a clinician has to listen with the “third ear” (Reik, 1948). This is a process of active listening in which one observes the verbal and non-verbal behavior of the patient and anyone accompanying her. It means being aware of what is being said, what is not being said, and any inconsistencies in the process or content of the interaction.

Clinicians must then generate and test inferences based on these observations. For example, a patient sits silently with her arms crossed while her spouse reports on her symptoms. When asked about the accuracy of these reports, the patient replies, “I don’t see it the same way.” One might infer that the patient is in denial about her symptoms. When this is offered to the patient in the form of, “it sounds like you don’t believe that you have a problem,” she might respond with, “I don’t.” Yet in the context, it may be that the real issue is that her symptoms have become an interpersonal issue between her and her spouse. Admitting that she is symptomatic means admitting that her spouse is right and she is wrong which, in the context of their relationship, may be difficult to do. Inferences need to be tested out with patients. If an inference is incorrect, the clinician can correct a misinterpretation which could have adversely

affected the patient-doctor relationship. If the inference is correct, the patient will feel heard and understood by the clinician, and this can impact the patient-doctor relationship positively. One inference that often needs to be tested is that the patient will have a positive response to symptom relief. This may not always be true. Illnesses serve multiple social functions for patients. Often, a cure based on medication is threatening and unwelcome because it threatens the secondary gains of the sick role, i.e., the extra sympathy and attention, as well as the temporary exemption from normal obligations (D. Mintz, 2002; Wolinsky, 1980).

Building the Therapeutic Alliance During Subsequent Visits

Psychiatric residents must learn and master the skills that are needed to create a positive relationship wherein a patient will be forthcoming about the raw material that underlies the meaning of medication. These skills include active listening, minimizing interruptions, testing inferences and recalibrating any assumptions based on the patient's behavior, and involving the patient in decision-making (Chewning & Sleath, 1996; Cruz & Pincus, 2002; Tasman et al., 2000). It's vital to establish an 'authentic', non-judgmental, person-to-person contact in the midst of the authoritarian relationship between doctor and patient (Berger, 1993). After a therapeutic alliance is established, the patient may open up.

In the absence of a therapeutic alliance, patients are unlikely to disclose the meanings of medication, because those meanings can be highly personal, private, intimate, and threatening to self. One way to welcome these disclosures is to normalize 'noncompliance' by reminding patients that self-regulation of drug therapy is the rule not the exception (Conrad, 1994). Part of this involves providers learning how to be passive and receptive. Providers must realize that despite their privileged professional position, the patient needs to be in control of the treatment process. Patients must have autonomy with respect to their medications. As outpatient

practitioners, residents may have difficulty transitioning from managing patients on an inpatient unit during which they are writing orders and managing 24 hour control of the patient. The reality is that patients are capable of making numerous types of decisions for themselves, and except in the cases of threat of harm to self or others, they are also capable of making decisions about their treatment. In this context, clinicians—both in and out of training—are merely consultants (Chewning & Sleath, 1996). The key to promoting a therapeutic alliance is to convey that you, the health professional, understand that the patient is doing the best she can to get better and that you can provide additional strategies to augment whatever steps she has already taken to get better.

In this context, patients' behavior can be best understood as improvisation directed at maximizing quality of life as they define it. This means that patients will often not take medication recommendations literally. They will gather information from multiple sources about how to alleviate their own suffering, and then they will go home and implement the parts of those recommendations that make the most sense to them, modifying them as needed. This pattern of behavior is too often construed as noncompliance but is actually self-regulation of medication therapy (Conrad, 1994). It's critical to be nonjudgmental about this process. The clinician needs to see this as a normal expression of autonomy on the part of the patient—it may not be a personal rejection of the doctor or the diagnosis but rather a means to maintain some control over what can be a frightening, destabilizing, and unpredictable life experience.

Most young clinicians will readily accept that the meaning of medication is important, but they know no techniques to get at those meanings. The following questions may be a useful starting point: What does your medication mean to you? How does your medication fit into your life? How does it make you feel about yourself to be on medication? What does the medication

symbolize? What does it represent? Does the medication help you be the person you want to be or does it keep you from being the person you want to be? Do you think you have been given the right medication? What side effects have you had? Often the patient will not be able to answer these questions, nor is it always appropriate to ask them directly. Nevertheless, these questions should remain in the clinician's consideration as s/he tries to understand the patient's unique situation.

From a client-centered perspective, medication management is about facilitating achievement of patient's goals (Chewning & Sleath, 1996). It's not about symptom control (i.e., doctor's goals) unless symptoms are getting in the way of patient's goals. Not dealing with the meaning of medications may lead to loss of the patient, but dealing with the meaning is not always therapeutic. Dealing with the meaning of medication may be a necessary but not a sufficient step. There may be meanings of the medication that are not relevant to the patient's underlying discrepancy between real and ideal selves (Higgins, 1987). Since our perspective sees this discrepancy is the main source of suffering, the meaning of medications should only be dealt with when it affects identity/discrepancy issues.

Implications for Structural Change and Patient Empowerment

We have focused primarily on the implications of the trajectory model for practicing clinicians and how they conduct medication management interviews, but the trajectory model has larger implications as well for both structural change in the health care system and for patient empowerment. Many of the structural changes implied by the trajectory model are summarized by Strauss and Corbin in their book *Shaping a New Healthcare System* (Strauss & Corbin, 1988a). There they identify five main themes for reform efforts: (1) health care should focus on quality of life in addition to biomedical outcomes; (2) home should be recognized as the central

site of care; (3) resources should be more evenly distributed between home care and hospital care; (4) access to non-medical supportive services (e.g., financial, marital, legal, sexual, etc.) should be greatly expanded; and (5) services should be tailored to fit the stage and phase of the illness (Strauss & Corbin, 1988a, p.49). One additional structural reform suggested by our analysis is the need to reimburse physicians and pharmacists for the time it takes to talk about the meaning of medication and its relationship to illness and identity. In discussing the policy implications of their client-centered model of medication decision-making, Chewning and Sleath (Chewning & Sleath, 1996, p. 395-396) make several more recommendations: (1) to evaluate reimbursement policies with respect to their ability to encourage patient involvement in medication decision-making; (2) to use regulation, especially in large federally funded programs like Medicare and Medicaid, to require a certain minimum amount of “medication counseling”; (3) to pass and enforce laws like HIPAA (the Health Insurance Portability and Accountability Act of 1996) to protect the privacy of patients’ medical information, including their preferences (U. S. Department of Health and Human Services, 2005); and (4) to reform health professions education so that newly trained doctors, nurses and pharmacists both understand the importance of patient involvement in decision making and accept their roles as consultants in (as opposed to dictators of) drug therapy.

In regard to patient empowerment, we endorse Chewning and Sleath’s notion of client centered medication decision-making (Chewning & Sleath, 1996). In this model, patients and health professionals collaborate to identify treatment goals, choose regimen options, monitor symptoms and evaluate regimens, and refine or change regimens when needed (Chewning & Sleath, 1996, p. 390). The role of the health professional is more like that of a consultant, making sure that the patient understands the alternatives, and the consequences associated with each

alternative. Patients empowered in this manner would have many responsibilities, including the duty to communicate their preferences, to be honest about their self-care practices, to monitor and communicate the outcomes of care, and to share insights and concerns about regimens (Chewning & Sleath, 1996, p. 394). Of course, not all patients will be willing or able to take on these responsibilities, so one goal for research is to determine how to identify these patients and how to care for them once they are identified.

5. Limitations

The analysis presented here has several limitations. One is that we have focused quite narrowly on medication management. There is more to mental health care than medication management. One important additional component is the rehabilitative mission, which we have only addressed in passing. Rehabilitation involves, among other things, collaborating with patients to develop treatment plans that are meaningful to them, helping patients become more self-sufficient, and facilitating the development of a wider range of pleasurable and productive activities.

With regard to the meaning of medications, we have focused almost exclusively on what the medications mean to patients. But medications also have meaning for the physicians, nurses, pharmacists, family members, friends, co-workers, and the public at large. At any moment these other meanings may impinge on the patient's experience of illness, affecting the decision to start or stop or change the therapy in ways which we have not discussed (D. L. Mintz, 2005; Montagne, 1988, 1996; Tasman et al., 2000).

Much of our presentation has been theoretical. As such, practicing health professionals and communication professionals looking for more concrete examples and suggestions are likely to be frustrated by the paucity of clinical cases presented here. For those readers we can

recommend several more didactic presentations that come from a similar point of view (Beitman *et al.*, 2003; D. Mintz, 2002; D. L. Mintz, 2005; Tasman *et al.*, 2000).

We have focused on psychiatric medication management because of the relatively recent trend toward increasing medication use and decreasing use of talk therapy in psychiatry, but we believe essentially all of the arguments we have offered apply beyond mental health to all other medical specialties (Pound *et al.*, 2005). Nearly all of the work on the trajectory model and the meaning of medications has been done outside the domain of mental health. Still it bears repeating that understanding the meaning of medication in relation to a sick person's identity and biography will be essential to successful drug therapy in any setting.

6. Summary and Conclusion

Brief medication management is increasingly the most common form of treatment that patients with psychiatric illnesses receive. This is a historically significant trend, one which illustrates psychiatry's transition from a marginalized medical specialty that offered talk as its primary form of treatment to one that is thoroughly committed to the biological basis of mental illnesses. Evidence of noncompliance, missed appointments, and poor patient and provider satisfaction suggests that there is room for improvement in the way medications are managed. Social scientists, working outside psychiatry and focusing primarily on physical impairments, have developed detailed theoretical models of the lived experience of chronic illness. These models define health as a balance between body, self, and biography, and they portray chronically ill patients as primarily motivated to reverse or minimize the loss of self that results from body failures.

The main point of this chapter is that the quality of psychiatric medication management might be improved if it were based more closely on this social scientific analysis of chronic

illness experience. From this perspective, medication management is not merely about symptom control. It is about assisting patients in restoring the balance between body, self, and biography. Medication therapy is one among many strategies that patients will try in their attempts to restore this balance. If clinicians want to understand what appears on the surface to be harmful, ignorant, or uncooperative medication use behavior, they will need to understand each patient's identity struggles, the impact of the illness on each patient's biography, and the meaning of the medication and its side effects in relation to all of these issues. Then, with the modesty that comes from acknowledging patient's ultimate autonomy over decision making, they will need to negotiate treatment goals and drug therapy regimens that patients can live with. None of this can be done quickly or easily. It may not work with all types of patients, and it cannot be done at all without first establishing a therapeutic alliance based on mutual trust and respect. But if medication management is reframed in the ways suggested above, it may be possible to improve the overall quality of medication management in psychiatry and thereby reverse many of the negative quality indicators reviewed above.

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