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First-person account on psychiatric disability: a case of bipolar disorder

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Summary

This "first-person account" on recovery from psychiatric disability has been written by the mental health-care practitioner diagnosed with a bipolar disorder. In sharing this personal account with professional colleagues, the author has three goals in mind: 1) explore the factors, which delayed his entering treatment for in spite of obvious clinical symptoms; 2) emphasize the importance of the long-term relationship with a compassionate and competent psychiatrist in supporting recovery, and 3) describe how the author's personal experience change his view of patients' struggles with accepting their own psychiatric impairments. Finally. The paper shows self-care strategies that have proven to be helpful for the author and that might be helpful for other professional colleagues with similar problems.

first-person account / psychiatrically impaired mental health practitioners / recovery from psychiatric disability / bipolar disorders

INTRODUCTION

I was often reminded in my clinical training that mental health practitioners have responsibility to carefully manage their own mood, motivation and attitudes in the service of others. Yet it took me over thirty-five years to realize that since late adolescence, I suffered from an undiagnosed and untreated severe mood disorder, including long periods of depression and relatively brief episodes of mania. Ironically, during all this time I was directing various psychiatric rehabilitative services for patients with severe psychosis who were equally unaware of their psychiatric impairments and not less reluctant to accept help than I was.

Responsible craftsmen are expected to protect their own tools. One can make a simple argument that for mental health practitioners, failing to take proper care of self is no less problematic than it would be for any other craftsmen to neglect their work tools. Of course various business and professional organizational create standards and codes to protect customers from irresponsible conduct of their psychiatrically impaired employees. However, these institutional safeguards are never completely foolproof. In one publicly reported case, the largest Australian Airline missed their pilot's worsening depression and anxiety and declared him fit to fly despite his repeated urges to crash an aircraft (1). Short of such possible catastrophic consequences, how much trouble my own psychiatric impairment might have caused others over the years - including my supervisors, professional colleagues and patients - will remain an open question that is not for me to answer. This personal account is intended instead to explore some factors that helped me come to terms with the need to begin and continue treatment. I will also describe how profoundly my present engagement in treatment has changed the way I view and treat patients

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who struggle with accepting heir own psychiatric disabilities. Hopefully this self-disclosure will be helpful to my professional peers who suffer from conditions similar to that which they are expected to treat. This brief paper has much more modest aims than the remarkable, emotionally charged testimony of Kay Redfield Jamison who learned to manage her disease and used her personal struggles to became a world expert on manic-depression (2). My teacher and mentor, Robert P. Liberman, Distinguished Professor of Psychiatry at UCLA School of Medicine, inspired this self-report. Throughout his highly productive and accomplished carrier, Dr. Liberman has been largely responsible for developing a field of psychiatric rehabilitation in the United State while suffering from a severe bipolar disorder. Dr. Liberman's openness and wisdom in describing his own experience with psychiatric treatment has given me the courage do overcome fear of the stigma still attached to mental illness (3).

PERSONAL REASONS FOR DELAYING TREATMENT

Living with depression for a very long time is probably not much different from experiencing a chronic physical pain. One gets used to it. Experiencing physical fatigue, sleeping too much or too little, having difficulty getting out of bed in the morning, making an extra effort to go through daily routines, losing enjoyment in recreational activities, feeling sad, having frequent doubts about self-worth, living with a generally pessimistic outlook on life: all this become life long experiences. One tends to consider these experiences as part of normal existence and unlike a physical condition which requires a medical attention. Having experienced persistent arthritis for many years following a hip injury, I was aware that my physical pain could at least be controlled to some degree by medication. When the pain became very severe, I consulted the orthopedic surgeon who strongly recommended a total hip replacement, which eliminated my suffering. In brief, going to the doctor was a logical solution. Unlike in a physical condition caused by the accident, I used to regard my depression as an existential condition and not a "brain disease." Going to a doctor to change who I was as a person seemed silly. In fact, I even ascribed a positive value in my depression. In spite of all the difficulties described before, my depression seemed to allow me to judge reality more accurately than most of people do. Because of this I would avoid disappointments resulting from the discovery that something is not as good as one believes. To me, those believing in the power of positive thinking seemed naive if not blind to the truth.

Posters of famous people with psychiatric disorders frequently displayed in mental health clinics to combat stigma of "brain disease" turned out to be paradoxically counterproductive for me. For example, a photo of my favorite political figure, Winston Churchill who might have suffered from bipolar disorder, inadvertently reassured me that habitually drinking several shots of whisky during a day and a bottle of champagne before going to bed each did not diminish his greatness as a world class politician. In all honesty (without blaming Churchill for being a poor role model) I have learned since my late adolescence, that that drinking moderate amount of alcohol made me happier, at least in the short run.

Of the all factors preventing me from running out of gas and seeking professional help, my work was the most important. It required from me discipline and provided structure and sense of purpose. Developing rehabilitative services in a small locked facility for the severely mentally was an innovation in Oregon in mid 90s and it received favorable attention from my supervisors and state officials. However, the greatest satisfaction came from my own employees who awarded me a plague for my heart-felt commitment to patient care.

It is worth mentioning that a slow pace of change typical in long-term residential treatment facilities was probably well suited to my usually low energy level. This balance was occasionally interrupted by bouts of increased energy, which resulted in sudden urges to make drastic organizational improvements accompanied by impatience and a burning desire to do work that was usually assigned to other employees. I was unable to notice during these manic states that my employees were becoming increasingly irritated with me. I also ignored those who at-

tempted to bring to their supervisor's attention that that I was not acting as my normal self. Just like it is impossible to quickly stop a locomotive running at full speed, it was equally impossible for someone like me, temporarily relived from painful depression, to realize that he was acting strange.

Riding the wave of these unrealistic feelings of self-confidence or excessive optimism inappropriate to the circumstances, I received promotion to a high level position in Oregon State Hospital, which at that time was under the investigation of the US Department of Justice for allegedly providing substandard care and violating patients' safety. In this large organization with a complex bureaucratic structure, fairly demoralized personnel and the climate of a surrounded fortress, as a clinical director with no executive management experience, I attempted almost single-handedly and forcefully to implement several improvements which quickly alienated me from almost everyone, It is important to say addition to the naiveté and poor judgment, public display of an eccentric humor under grim circumstances (e.g. making references to satirical pillorying of the Austro-Hungarian bureaucracy of Kafka's Trial), finally convinced the hospital superintendent that I became a liability for the organization and for him. As a psychiatrist he expressed regret that manic behavior might have contributed to my demise.

In spite of this clear warning, I soon moved to another clinical executive position in a smaller private non-profit addiction treatment agency. Being almost completely unfamiliar with the culture of addiction treatment, I found my new responsibilities extremely challenging, particularly after almost completely loosing direct contact with patients and getting buried deep in the paperwork instead. After several months of working long hours seven days a week without ever been able to complete regular duties, I stopped sleeping completely. Fear of loosing my job and not being able to support my family was constantly on my mind. All my professional confidence was gone. I became convinced that I was at a dead-end road with no way out. It felt like complete paralysis. One day, of out of desperation, I called my long-time friend, a psychiatrist who diagnosed me over the phone as being severely depressed. It was my good fortune that he immediately referred me to his colleague who specializes in treating psychiatrically impaired healthcare professionals. This was probably a lifesaver for me. It was not my clinical training but my life that finally convinced me that I needed help.

BEING IN TREATMENT

Having only one past encounter with a Gestalt-oriented therapist who directed me to express my feelings about my late mother to an empty chair, I anticipated my first psychiatric appointment with lots of apprehension. This time, being almost completely unable to function, I saw no other option but to be at the mercy of an unknown professional. My first outpatient appointment with a psychiatrist, a slender soft-spoken man began from the standard examination of my symptoms. The doctor listened to me attentively and after collecting family history, concluded that I might have experiencing severe exaggeration of depression in the course of a bipolar disorder. He reviewed medications that could offer me a symptomatic relief from depression and anxiety and, at the same time, protect me from becoming manic. After explaining pros and cons of each medication, he recommended Depakote (Sodium Divalproate) and small doses of Klonopin (Clonazepam) with the understanding that alcohol would no longer be an option for me. Once this agreement was reached, the conversation switched to the external stressors related my present employment, family and financial situation. Without even the hint of judgment and in a matter-of-fact manner, the doctor acknowledged the gravity of the situation. Normalizing my distress as being reality-based not only provided me with an instant relief but also offered a glimpse of hope that I might be able to a find a way out of my difficulties. Needles to say, couple of months later, I was on my feet again and able to find a job, which was very similar to the one in which I was fairly successful in past. Six years later, I still work for the same company and recently received an award for loyal and distinguished service. After recovering from an acute episode of depression, I continue treatment with the same psychiatrist. Initially, I felt entirely dependent on his expertise but over the years our

relationship evolved into a more collaborative one; although I always rely on his expert opinion in making decisions affecting my health. After a long period of psychiatric stability, my medication was switched to Lamictal (Lamotragine) with almost no side effects and I no longer need to take Klonopin (Clonazepam) every day. This is not just a story of a fairly good recovery but also the testimony to the strength of a long-term relationship with a psychiatrist who besides medication management finds time and patience to talk with his patient.

LESSONS LEARNED

In my case, facing the consequences of my own actions was the most powerful motivator for change. Treatment may either accelerate or hamper this change depending on therapist's ability to instinctively respect patient's boundaries during the process. Asking a patient to do too much too soon is almost always counterproductive. Attributing treatment refusal to the illness itself is also a simplification. It may be true for persons refusing treatment due to certain symptoms like euphoria or persecutory delusions. But we all, including mental health practitioners have capacity to grossly distort our subjective experience of reality. I personally used for a very long time the same mechanism of rationalization, minimization or denial that are described in the literature as typical behaviors of people engaged in unhealthy habits who are not ready to even contemplate a possibility of change (4). In summary, it is probably more constructive to look for what we have in common as human beings with those who express extreme emotions and unusual beliefs than label them as lacking insight due to their "brain disease."

Relinquishing control of one's life does not come easy. In my case, it was an extreme emotional distress combined with severe functional impairment, which finally forced me to finally pass control over to a professional helper. It worked great for me. It does not always work like that for everyone. Some people enter treatment on their own, other only under some sort of coercion, legal or informal. Either way, receiving treatment at the time of crisis implies that one is on longer capable of taking care of their own affairs. The risk of self-stigmatization, not to mention public prejudice directed against people in need of psychiatric treatment can be a huge deterrent to seeking treatment.

On my path toward psychiatric stability I found out that learning about my personal and professional limitations not only took several years, and also was painful, arduous, anxiety provoking and depressing. Continuing on this path requires a trusting long-term relationship with a compassionate professional who must be assertive enough to set necessary limits (e.g. in my case abstinence) and offer directions at the time of crisis, and flexible enough to encourage his patient to start making choices on his own once the crisis is over.

I have also realized that as someone professionally responsible for making positive contributions to the well being of others, I need to develop my own self-care plan. At the very minimum, I must be able to identify my personal triggers, my response to stress, and coping skills to overcome adversities (Attachment 1). This self-care strategy is not much different from assisting patients in managing their personal warning signs of relapse through the development of individualized emergency plans. In my workplace, all team members are expected to develop professional self-awareness as part of their clinical supervision. They are encouraged to share their plans with colleagues and to tactfully bring to each other's attention if they notice their work partners engaging in a clinically counterproductive behavior under stress. In my case, having such plan not only helps me manage better work challenges but also allows me to find some peace in my personal life.

CONCLUSION

I can admit with some degree of certainty that receiving a psychiatric diagnosis has not fundamentally changed the way I think about myself. It caused me to reflect that untreated mental illness may contribute to many serious mistakes; yet, being in treatment taught me to better tolerate my own imperfection. It might encourage my colleagues in the field who are facing similar problems to take the risk of a self-reflection,

irrespective how they are advanced in their professional carriers

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Attachment 1. My self-awareness plan

My Triggers	1. Loud repeated demands 2. Being completely misunderstood 3. My wife or children get seriously i ll 4. "Polish jokes"
Warnings signs which I and/ or others can observe	1. My voice is getting much louder 2. My tone of voice is harsh 3. I am overly critical or demanding 4. I am trying to do several things at once 5. I am becoming increasingly forgetful 6. I sleep less than five hours for two nights 7. I feel physically exhausted 8. I am losing concentration
My copings skill to regin balance	1. Keep quiet for moment and take a deep breath 2. Say to myself: "It is not that important" 3. Ask for a moment of privacy 4. Go to bed before midnight 5. See my psychiatrist