

## Viewpoint

*Readers: This article ran three years ago in Newslines. I've had several requests to reprint it, so here it is.*

### **Psychopharmacology and the Crisis of Self An Open Letter to My Doctor**

By Linda Logan

*I have been treated for bipolar disorder for more than 15 years. Over one two-year period, I was hospitalized intermittently for 17 months. I've been treated with more than 60 different medications (and over 100 different doses and/or combinations of medications). I will remain on meds the rest of my life.*

*The following letter reflects some of the philosophical issues raised by severe mental illness and its pharmacologic treatment.*

Dear Doctor,

A friend of mine just marked the fifth anniversary of her diagnosis with breast cancer. Cancer-free for five years, she has been returned to her life, restored and recovered. She is radiant, even buoyant, in her recovery and, while I am happy for her, I am jealous. My return to life after a severe mental illness has not been marked by such joyousness. While I have been relieved of the desire for self-annihilation, I have, more accurately, been *rescued*, not restored. I am nowhere near the person I used to be. My old self has disappeared, a pale reminder of who she was in her place. My illness precipitated not only a crisis in my life with my husband and children, it precipitated a crisis of self, as well.

I have raised the issue of authenticity and the crisis of self with you a number of times over the years. I suppose, from your viewpoint, such philosophical questions on my part must seem an indulgence, no different than adolescent omphaloskepsis. I sense you think that I should be grateful I'm not dead and move on. Yet every hour of the day, I feel and watch myself go through such dramatic changes in mood, cognition, energy that I am unsure as to whether there is any sustaining self underlying these beings. I'm troubled by my inconstancy, by fact that there seems to be no transcendent "me."

I don't think you understand how pervasive--and disturbing-- a problem this is for me. And I don't think it is unique to my experience of mental illness. I believe that it is something that you, as a doctor, need to understand.

I've been monitoring my moods, energy, cognition and behavior for decades. (A closetful of journals can attest to that.) Many of my entries concern the juxtaposition between my robust former self (my premorbid personality, as you would call it) and its pale survivor. I suspect that the crisis of self results from a

combination of three factors: the biochemical consequences of the illness itself, residual symptoms, and psychopharmacological effects.

### ***The effect of mental illness on the brain***

If mental disorders are caused (at least in part) by some type of dysfunctioning and/or dysregulation of the brain's neurochemical systems, couldn't the *illness itself* further alter the brain's chemistry and structure? Depression, for instance, may have a neurochemical "signature," as it were, that may wreck the same degree of havoc on the brain as the blows a boxer sustains to his head.

If mental disorders not only reflect a disturbance in the brain, but in turn, go on to cause brain disturbances, could this damage be reversed? (Remember, until very recently, scientists scoffed at the notion that brain cells are capable of regeneration.)

It's as though the depression and despair I felt when I was sick was a conflagration, a firestorm that raged through the affective landscape until there was nothing left but seared soil and charred stumps. As a result, my affective repertory is limited to fear and anger. Empathy, sadness, despair, etc. are affective states I *have*, but do not feel. I have learned to navigate the affective world by compensating with my intellect. Like the blind person who "sees" with his fingertips, I feel by *telling* myself, "I am sad," rather than *feeling* sad. On a bad day, being emotionally de-cathected makes me feel like a robot. But most of the time, like W.C. Fields, I comfort myself by "considering the alternative."

### ***Residual symptoms***

Over the years, our conversations have veered away from recovery to those other "R" words: response, remission, and residual symptoms. As you and your colleagues treat us as we move through the harrowing course of the illness' acute phase toward stabilization, your presumptive goal is to match, as closely as possible, the selves of the persons we were before.

Zoloft commercials notwithstanding, I'm not sure severe mental disorders are curable illnesses. Treatable, yes, but not necessarily curable. No amount of pills or therapy can return me to the person I was before I got sick. Like Elvis, that competent, confident person has "left the building."

The literature on psychosocial impairments following a mental illness does not address the *experience* of mental illness, the *phenomenology* of the disorder. Instead, researchers measure degrees of therapeutic responses by monitoring eye contact, facial expressiveness, social and vocational statuses, etc.). *They've analyzed everything but the state of our selves and the nature, and consequences, of their alteration.*

Paradoxically, on the eve of my first hospitalization, I was at the height of my career, experiencing some of the best moments of

my life. I had completed my Ph.D. a few years before and had begun teaching as a lecturer at MIT. My short stories were getting positive feedback from one of the country's top editors, I had three achingly beautiful children whom I loved ferociously, a great husband, and a small group of close friends. Life truly could not have been better. Except, of course, that I was suicidally depressed.

18 years later, I am not affiliated with a university, cannot write short stories or poetry, and, since moving from Boston to Chicago, have been unable to replicate the social world I had before I was sick. Moreover, I can easily go three days without leaving the house or talking to anyone other than my immediate family. Fortunately, my children have grown into wonderful young adults and, unlike many of the women I met in the hospital, my husband and I are still married (37 years last June). But many of my days are still colored by dread, fear and worry---residual symptoms that persist like stubborn laundry stains.

#### ***The paradox of psychopharmacology***

The psychopharmacologic armamentarium marshaled to combat my mental disorder has, in fact, wrecked their own kind of mental havoc. While I have no doubt that these medications played a large part in my ability to go home---and stay home--they come with some profound psychological consequences. For instance, before Elavil (the first medication I was put on for depression), my daily mood ranged from bad to worse, each accompanied by extreme depth of feeling. Elavil successfully curbed the depth and range of my despair, but it blunted everything else, as well. Now I couldn't feel *anything*. My therapist explained that Elavil helped steady the wide amplitude of emotions I was experiencing, but in so doing, also affected the experience and intensity of normal feelings. The logic of this escaped me. It seemed like hacking off a leg to treat a stubbed toe. So there I was: in a Mephistophelean exchange of psychic pain for nothingness, I became the affective equivalent of someone with a C-3 spinal cord injury. It was like going from satellite TV to one lousy channel.

Drugs similarly affected my cognition. Lithium, while successfully reigning in my mood swings, turned my formerly agile mind into mush, leaving me so cognitively stupefied that if my brain could drool, it would have. My creative writing was stopped dead in its tracks. Where I used to write short stories and poetry as easily as if someone were whispering them in my ear, now nothing I did could summon the muse. Even talking became difficult; word retrieval was painful and slow. Finding the right word was like being a child at a carnival trying to manipulate a claw-and arm machine to pick up a toy. How could I write when I couldn't even think?

#### ***Me, my self and my dopamine***

As you know, paralyzing fatigue was the presenting symptom of my depression. Central nervous system stimulants have been an integral part of my regimen just to keep me awake. On a bad day,

I could sleep right through them. The inconstant self is only exacerbated by my medication regimen.

Watch what happens:

At breakfast, I take my handful of pills (Wellbutrin, Cymbalta, Abilify, lithium, Provigil, Zoloft, synthroid and Ritalin) and flip through the newspaper. Genocide, tornadoes, celebrity shoplifting---none of the articles interests me. The newspaper columns appear endless, the font, impenetrable. Then, out of what William James called the "bloomin' confusion," comes the first signs of alertness.

Dawn is breaking in the prefrontal cortex.

Now articles do not just seem interesting, they are *fascinating*. I want to know everything about the subject I'm reading about: its historical context, antecedent events, implications and ramifications, underlying socio-political ideologies. Physically, my body, which was being propped up by the counter, suddenly snaps to attention, as though a spinal column has been retrofitted in my back. Once energized, I am eager to start my day and go to my study where various writing projects await me.

John Dewey called desires "the moving springs of action." I would argue that desire *needs* energy, it does not *produce* energy. For example, even if I really want to write about something, I can't do it without energy. Desire alone cannot propel me toward action. Desire without energy is like an airplane sitting on a runway without Jet A. Once my Ritalin kicks in, I have the energy to fuel desire. Yet energy alone is not sufficient to propel desire into action. Desire needs an engine, and that engine is motivation. Desire without motivation is like a psychic dust devil: my ideas would just swirl around unproductively in my head, banging against the inside of my skull. Properly equipped with energy, desire, and motivation (and concomitantly mental alertness and concentration), I attack my writing project with an optimism veering on the familiar (not to say, wonderful) "can do" feeling of mania.

Energy affords me the opportunity to get things done that most people take for granted. Errands, for instance. With energy and motivation, I am able to go grocery shopping, buy stamps, return library books, etc. After having wallowed in a state of inertia for years, incompetent to fulfill even the most mundane tasks of the housewife, being able to do errands is a blessing.

But Ritalin's incursions into my brain are not limited to the physical realm (energy), the cognitive realm (desire, motivation, concentration), they affect my social behavior, too. As you know, I've always been an introvert, reticent about interacting with the outside world. Fueled by Ritalin, however, I become socially gregarious--voluble and perky as a talk-show guest, effortlessly chatting up the woman at the dry cleaners for a good

ten minutes. To my horror, I've been accused (during one of these moments) of having "a delightful personality."

### ***The afternoon antipodes***

While my morning is characterized by the stimulant going through my bloodstream, the afternoon is colored by its withdrawal. By 1:00 p.m., I am back in the grip of frontal lobe syndrome. In a matter of a few hours, I've gone from energy to fatigue, from interest to apathy, from confidence to despair, from sociability to avoidance. When the Ritalin runs out, the show is over: Cinderella's carriage reverts to a mouse-driven pumpkin. I am struck by a fatigue so overwhelming, it feels like paralysis. It is motoric retardation writ large. I see in the literature your colleagues struggle to differentiate between "physical fatigue" and "mental fatigue." That is beside the point; phenomenologically, they are identical. When I've complained to you of my neurovegetation, you've assured me I could get off the sofa if the house were on fire. I'm not so sure.

Without energy, interest flags, motivation stalls. Subjects that seemed so interesting in the morning are met in the afternoon with indifference. How insightful John Dewey was when he wrote: "All of us have desires, all at least who have not become so pathological that they are completely apathetic." Nothing interests me. I don't want to go anywhere or do anything. The indecisiveness that is characteristic of depression results, I think, from an absolute lack of desire. Apathy and anhedonia are a consequence of depletion of energy. I'm too *tired* to do anything. Even breathing seems like work.

The work I was doing in the morning, by afternoon seems like crap: pointless, worthless, meaningless. The phone calls I answered in the morning go unanswered in the afternoon. By 3:00, my day is effectively over. And then, the next morning, it begins anew.

So I ask you: Do I possess a "core" self? And, if so, which elements (if any) can be removed from this self, leaving the the core self intact? Am I now by "real" self, only minus the depressive symptomatology? Or am I a new self comprised of the effects of the illness and the medications used to treat it? Why do some people make complete recoveries from mental disorders, while others make only partial ones? Does each person have a maximum level—a ceiling—of therapeutic response? Are some people stuck with residual symptoms no matter what the psychotherapeutic and pharmacologic treatments?

We can discuss this next time we meet. In the meantime, be mindful that each patient that comes through your door is more than an illness with some vague premordbid personality hovering in the background, they come in with a premordbid *life*. They may never approximate whom they once were, may never recapture a range of affective response, may never come close to fulfilling their potential. Their issues go beyond the psychological: they are ontological, striking at the very core of our beings. •

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