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Guest Editorial

Overcoming Barriers to Supervised Mood Medication Trials: The Power of Empathy and Analogy

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In my many decades-long work as a clinical psychotherapist with clients encompassing a wide bio-psycho-social variety, a consistent challenge continues to emerge, despite the research progress in the field: the reluctance of many clients to begin a mood medication trial. The reasons are manifold…

Eight logical and psycho-logical barriers to exploring a psychotropic meds trial:

1. The stigma around or confirmation of having "mental illness" or being "crazy," in one's own mind or, especially, in the mind of others; dislike being judged and feeling less than",
2. The fear of having a record in a professional or student file; not trusting organizational or institutional confidentiality,
3. Having had disruptive or "Zombie"-like side effects from previous mood meds experiences (too often prescribed, not by a psychiatrist or psychiatric nurse practitioner but a by a GP, who, alas, is not trained in psychotropics; (also, an unsupervised meds trial coupled with the lack of scheduled follow-up re: meds impact, in my mind, borders on malpractice),
4. Seeing family members or friends having had the above disruptive and disorienting side effects during an unsupervised meds experience,
5. Believing the mood meds are a crutch; the individual can deal with their depression, anxiety, bipolarity, etc. through will power, vigorous exercise, and/or the latest diet or reality-altering mushroom,
6. The client not appreciating the difference between, for example, situational and chemical depression, the former typically more responsive than the latter to therapeutic intervention, improved sleep patterns, exercise, and a sense of purpose; in contrast, while perhaps triggered or exacerbated by situational stress, having a decidedly bio-chemical/physiological origin or component, clinical depression is often refractive to the more common sadness/depression interventions; also, bio-chemical depression may be genetically latent, thus when it does manifest (induced, for example, by either acute or chronic pressure, aging, etc.), its intensity and resistance to psychological treatment may be surprising/disorienting,
7. The client (or therapist) not understanding the difference between grief, complicated grief, and grief morphing into clinical depression; or, as once happened, a therapist thinking an active client just has a "sadness condition" even though the two are unable to influence her dark mood state despite all kinds of counseling and mind-body exercise and efforts; p.s., for years, the client calling, thanking me for that referral to a psychiatrist who prescribed effective mood medication, and

8. The individual does not realize, perhaps in denial, that they are already medicating, i.e. numbing themselves through other means, albeit, in a self-defeating manner - drugs, drink, food, sex, work, gambling, video gaming, etc.

Finding the pass in the impasse

So how have I helped clients make less prejudicial, more thoughtful, head and heart decisions about moods medication trials? Naturally, I engage the client gradually - exploring fears and self-defeating thinking, initially gently, gradually more firmly - around the relevant issue(s) listed above. I let the client know they are in charge of the trial; if side effects become aversive, or if having second thoughts, they have the power to preempt or stop the trial. In addition, the client can always confer with me before, during, and after consulting the meds provider. For example, I have sat in on phone and Tele-Zoom meds meetings. My presence helps bolster the client's confidence in the evaluation process or in an ability to voice their thoughts and concerns with an unknown medical authority.

Now, let's focus on another tool to increase a client's understanding of their mood disorder and open a client's mindscape regarding a meds trial option. I have found analogies to be a powerful head- and heart-expanding resource. Analogies, making uncommon comparisons and finding meaningful similarities between two seemingly different situations or events, e.g. being chronically depressed and not taking needed mood medication, akin to running a hundred-yard dash with an invisible fifty-pound weight around your ankle. Such comparisons often provide vivid images if not mini-stories that help clients understand their darkness, angst, helplessness and inertia along with prejudicial perceptions of a meds trial. Meaningful parallels and patterning help clients grasp the consequences of trying to tackle overwhelming clinical situations and emotions without critical resources. And these analogous reframes help individuals be less judgmental about supervised experimentation with appropriate psychotropics while being more accepting of one's natural vulnerabilities.

Mood-meds analogies

So here are the two primary mood-meds analogies for opening a client's head- and heart-space. The first, employed for many decades, was briefly referenced above; the second has a more contemporary reference, utilizing both prosaic and neuro-cognitive references:

1. Clinical depression/anxiety as running a race burdened by an invisible ankle weight. This analogy was particularly apt for people who, while greatly burdened by their depression and anxiety, were still fighting to preserve an image of productivity and adequacy. Some of these folks were quite productive, perhaps, even driven… but they had to push themselves so hard to stave off the looming dark pit, the fear of failure, being less than perfect. Exhaustion seemed ever-present. Not only can folks identify with the unfair burden of competing with added baggage, i.e. the 50-lb. weight, but the ankle albatross was invisible. Others only saw a hard-working, if not driven, performer not someone on the edge of emotional, if not existential, dis-ease or despair. No wonder many of these extra-freighted racers saw themselves as impostors, ever on the verge of being exposed. The prospect of clients being able to attribute their mind-body-spirit difficulties to something other than weakness or "being mentally ill," to a biochemical variable that might be addressed by supervised medication… well perhaps there was some light at the end of that dark tunnel.
2. Clinical depression/anxiety as driving on a roadway littered with potholes. This analogy posits clinical depression/anxiety as a road of increasingly numerous and ever-widening and ever-deepening potholes, the longer the biochemical component is not addressed. And what happens if you persist on driving on this precarious road - blown out tires, broken axles, even car fires (as happened to a client recently.) Or you keep trying to drive around the potholes, increasing chances of crashing into a fellow driver; perhaps become so frightened you drive at a crawl, itself a sign of near paralysis and heightened agitation and/or depression.

However, if mood meds can be viewed as the biochemical filler needed to eliminate the precarious potholes and smooth the roadway, then everyday travel becomes less disruptive and dangerous. One is more confident behind the wheel and has an increased sense of control. And what's also cool about this analogy, it lends itself to a meta-analogy: biochemical filler can be viewed in a neurocognitive frame. An appropriate meds trial has the potential to fill those mindscape potholes. Brain neurons can now race quickly and smoothly along the

brain circuitry, allowing conscious and unconscious perceptions and sensations, thoughts and feelings to effectively and efficiently operate and connect… to dance and flow together as more harmonious, productive, and life-affirming partners.

Closing

Helping a client engage with some or all of the "Eight logical and psycho-logical barriers to exploring a psychotropic meds trial" is foundational for heightening client understanding of: a) the consequences of not addressing the biochemical component of a mood disorder, b) exploring and mitigating fear and shame about contemplating a trial, and c) in conjunction with the analogies, helping the individual envision the potential for more effective mood regulation, some inner peace, and more positive, if not more "normal," daily functioning. The common thread in both analogies is the oppressive and dangerous challenges to a sense of natural and productive movement posed by disruptive brain biochemistry levels. And the therapeutic key: clients realizing that their biochemical make-up, perhaps reflecting prolonged stress, and/or often having a family history/genetic component, was the 50 lb. weight or the potholes in the landscape and mindscape. Meds and therapy helped shrink the invisible weight, filled the dangerous, undetected holes in the road-pathway. Now they could view their bio-psycho-social challenge with less shame; psychotropic meds were not a crutch. Engaging a meds trial was allowing individuals to compete fairly, to drive safely… biochemically unencumbered. Folks were finally ready to risk the meds trial and to "Confront their Intimate FOE: Fear of Exposure".

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