**Title:** Mental Illness and Addiction: Lessons from the County Hospital Inpatient Psychiatric Ward

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**Discussion Points:**

1. Can you see yourself in your patients?
2. There but for the grace of god, go I: understanding that we could be on the other side of the physician-patient relationship one day.
3. 21% of Americans experienced mental illness in 2020, while 6.7% of Americans experienced both mental illness and a substance use disorder simultaneously.
4. How can we better understand our psychiatric and addiction medicine patients?
5. Stop placing blame on the addicted and mentally ill; you never know where you might end up.

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**ABSTRACT**

There is often a stark difference in how people interpret their first exposures to physical illness versus mental illness and addiction medicine. Many times, there is a tendency to sympathize with physical illness but separate ourselves from mental illness and addiction. I've slowly learned to see myself in each of my patients, regardless of diagnosis. In this experience article, I describe what it is like to interact with and care for psychiatric patients and how my thoughts on their care changed during my inpatient psychiatric rotation.

**KEYWORDS**

Psychiatry, addiction medicine, schizophrenia, psychosis, delusions

**THE EXPERIENCE.**

Sometime during the sixteenth century a group of prisoners were being led to execution past the onlooking John Bradford, a proponent of the English Reformation. When Bradford saw the group pass, he spoke the now famous words, “there, but for the grace of god, goes John Bradford.”[1] Since then, English and literature scholars have found those words to mean to both the religious and non-religious that “I too, like someone seen to suffer misfortune, might have suffered a similar fate, but for God’s mercy.”[2] Similarly, my interpretation of the phrase is that anything can happen to anybody, good or bad, and that includes myself; I am not precluded from any potential misfortune.

During my third year of medical school my required psychiatry rotation took place at the inpatient psychiatry ward of the county hospital in the town I attend school. There were several other prominent hospitals in the area, but being one of the few public hospitals, many low income and court-ordered individuals ended up there. This brought patients from across the psychiatric and addiction spectrum to the hospital; from moderate depression to severe schizophrenia, from intravenous methamphetamine users to patients with delirium tremens from alcohol withdrawal. Many of these patients were considered “potential for violence,” “elopement precaution,” and “routine suicide watch.”

Admittedly, for my first week or so on the unit I found myself wondering how a human being could become so mentally troubled. How could a 62-year-old man have delusions of his backyard being under attack by foreign countries? How could a 34-year-old man be so paranoid as to believe that government agents were following him around with a video camera? How could a 41-year-old woman be so addicted to Adderall that she was found by the police vandalizing a golf course naked while in a psychotic state? These were all questions I asked myself regularly, without any semblance of an answer.

It wasn’t until I started asking these patients about their lives before their diagnoses or addictions that I started to get some answers to my existential questions. I’d commonly find myself talking with some of the younger patients about sports, video games, and other hobbies we had in common. During those conversations I would often forget how different our current situations appeared to be. These were people who had normal and even successful lives, lives not too dissimilar from mine. They had siblings, husbands, wives, parents, and children just like I did. They went to school and had jobs just like I did. Yet somehow, they were the patient and I was the student.

About midway through my psychiatry clinical rotation I realized, just as John Bradford had realized centuries before me, there but for the grace of god go I. I could’ve been that one schizophrenic patient. I could’ve been that bipolar patient. I could’ve been that patient with drug addiction. These are conditions that can strike anyone. I am not “safe” from these misfortunes. The future makes no promises as to who, whether it is someone close to me or even myself, may one day become one of these patients. This lack of certainty of who we may become may not change how I live my life, but it does change how I view many of those suffering from mental illness.

Our society is often quick to judge those with mental illness and addiction. We assume the mentally ill all have some overarching risk factor that the rest of us don't, thus we don't need to worry about ourselves falling down similar paths. We tend to blame the misfortunes of addicts on their "mental weakness" and even worse, tend to believe they deserve any misfortunes that come their way. But what about cancer patients? What about tobacco users with COPD and respiratory illnesses? What about COVID patients? We don't blame any of them for their diseases and conditions. This occurs even though we know that both mental illnesses such as schizophrenia and major depression[5] as well as many cancers[6] each have genetic and hereditary components to them. They both have predictive elements. However, for some reason we sympathize with the latter patients but overlook and blame the mentally ill and addicted. I believe that we, as an international society, can and should adopt a more holistic view to all our patients, not just the physically ill.

There have been multiple studies over the past several decades that show that medical students, on average, tend to become less empathetic during their school years and that this trend continues through residency[7-8]. I can personally attest as a third-year medical student that I have had to continually battle back against the temptation of treating medicine purely as an objective science rather than treating the person behind that science as a human being with emotion. It seems plausible that this ever-increasing challenge of empathy is one of the reasons so many of us might find it challenging to relate with the mentally ill and addicted.

In the United States alone, nearly one million Americans have died from drug overdose since the year 2000, and the rate continues to rise. The country's declining average life span has even been attributed in large part to increasing overdose numbers. On an annual basis, nearly 12% of Americans misuse illegal drugs every year.[3] When it comes to mental illness, 21% of U.S. adults experienced mental illness in 2020, and 5.6% of U.S. adults experienced serious mental illness in that same time frame. Additionally, 6.7% of U.S. adults experienced both mental illness and a coexisting substance use disorder in 2020.[4]

Although my psychiatry rotation has come to an end, my time with patients who may be battling some form of mental illness is just beginning. Seeing ourselves in our patients rather than judging them based on pathology is a practice that can take an entire career to hone but will hopefully be well worth it. As future physicians, we all have a responsibility to our patients to put aside our preconceived notions, provide excellent care, and above all else, do no harm.

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