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Experience

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

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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 have slowly learned to see myself in each of my patients, regardless of diagnosis. In this experience, 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.

Key Words: Psychiatry; Addiction medicine; Schizophrenia; Psychosis; Delusions (Source: MeSH-NLM).

The Experience

Sometime during the sixteenth century, a group of prisoners was 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 my local county hospital. 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 was not 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 would 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 often forgot how different our current situations appeared. These were people who had normal and even successful lives, not too dissimilar from mine. They had siblings, husbands, wives, parents, and children just like me. 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 clinical psychiatry rotation, I realized, just as John Bradford had realized centuries before me, that I could have been that one schizophrenic patient or that bipolar patient, or 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 do not; thus, we do not need to worry about falling down similar paths. We tend to blame the misfortunes of addicts on their "mental weakness" and, even

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worse, tend to believe they deserve any misfortunes that come their way. But what about cancer patients? What about tobacco users with chronic obstructive pulmonary disease and respiratory illnesses? What about COVID-19 patients? We do not 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] and many cancers,[6] each have genetic and hereditary components. 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 of all our patients, not just the physically ill.

Multiple studies over the past several decades 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 mainly been attributed 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 severe 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.

References

1. Bickersteth E. A Treatise on Prayer. L.B. Seeley; 1819.
2. There but for the Grace of God, go I. In: The Phrase Finder. Gary Martin; 1995.
3. Drug Abuse Statistics. Available from: https://drugabusestatistics.org/. Last Updated 2021; cited Dec 6, 2021.
4. Mental Health By the Numbers. Arlington. Available from: https://www.nami.org/mhstats. Last Updated 2021; cited Dec 6, 2021.
5. Geschwind DH, Flint J. Genetics and Genomics of Psychiatric Disease. Science. 2015;349(6255):1489-94.
6. LaDuca H, Polley EC, Yussuf A, Hoang L, Gutierrez S, Hart SN, et al. A clinical guide to hereditary cancer panel testing: evaluation of gene-specific cancer associations and sensitivity of genetic testing criteria in a cohort of 165,000 high-risk patients. Genetics in Medicine. 2019;22(2):407-15.
7. Costa-Drolon E, Verneuil L, Manolios E, Revah-Levy A, Sibeoni J. Medical Students' Perspectives on Empathy: A Systematic Review and Metasynthesis. Academic Medicine. 2021;96(1):142-54.
8. Neumann M, Edelhauser F, Tauschel D, Fischer MR, Wirtz M, Woopen C, et al. Empathy Decline and Its Reasons: A Systematic Review of Studies With Medical Students and Residents. Academic Medicine. 2011;86(8):996-1009.

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