

On Flourishing: Redefining the Connection Between Psychiatric and Physical Health

We called her Blanche Dubois*. Blonde, pretty, and a complete mess. From West Virginia she had come bearing the ills of a life led between entanglements. Alcohol had poisoned a first marriage; she had since lived with a variety of men, each leaving her, inevitably, to the bottle. Between drinking and pills, she had given up her job as a counselor and become an agoraphobe. Trapped in her house, she watched TV and drank and forgot to eat. Her elderly parents were desperately worried and convinced her to travel to Maryland for treatment. Their affection was the sole anchor keeping her here. She wanted out, badly.

This story must necessarily begin *in medias res*, as Blanche had been there several weeks when I started on the ward. Some of my impressions of her were shaped by the comments of physicians and nurses. This is not uncommon in medicine. Our system necessitates handoffs, where the departing team shares information about patients and passes down important facts (some absolutely vital, like Mrs. S is deathly allergic to ibuprofen, others a bias, like Mrs. S is difficult). These adjectives are encoded: pleasant (harmless), lovely (smiling and friendly), difficult (insert negative trait of choice). This system, I think, succeeds largely in avoiding major errors. It is actually quite efficient in treating disease. I'm not sure that it succeeds in promoting fundamental wellbeing.

In that morning handoff I learned that Blanche was a difficult patient. She exasperated everyone, was famously stubborn and attuned to each milligram change made in her medication. She had even been known to refuse or demand certain doses. She was keeping the psychiatric formulary solvent. Her pills sounded like an arsenal of biological warfare. I had never seen so many z's or s's clumped together. Reading the list felt like hissing.

Leaving the team room on that first day, I was very curious about Blanche. I expected a voluptuous middle-aged siren, more Dallas than Dubois. To my surprise, she was quite a lady, in the old-fashioned sense of the term. Soft-spoken, legs demurely crossed, she greeted us all with a dignified nod. A far remove from the histrionic I was prepared for, she spoke calmly and enquired reasonably about her symptoms. Her expression, however, was curiously flat. It was hard to awaken joy or anger in her. It was clear that there was some rot at the root. Something deep and gnawing had taken hold and made her incapable of flourishing. Flourish, from the Latin *florere*, to flower, to blossom, to grow. That state beyond just health, or I should qualify, health as we view it now – the absence of infirmity, rather than the vitality of thriving. In her I saw her past selves: Southern belle, debutante, popular girl, varsity athlete girlfriend, socially conscious counselor, and finally, hollowed out by disappointment and booze, a woman in her mid-40s who no longer cared. For herself or anyone.

* Names and identifying information have been changed and certain details fictionalized to protect privacy

Attired in old sweats, she took promenades around the ward. She struck up a flirtation with another patient, a deeply disturbed cell phone salesman with sociopathic tendencies and bipolar disorder. She favored a pair of rose-tinted glasses. These she wore most of the day, as if their blush might shield her from something frank and fluorescent in the light. She affected vulnerability like her namesake—“soft people have got to shimmer and glow- they've got to put on soft colors, the colors of butterfly wings, and put a paper lantern over the light”[†]—yet negotiated with us every morning, wheedling and cajoling with considerable charm. Her objectives shifted. One day it was a pass to leave the ward and visit the cafeteria with a friend. Another it was for sleeping medicine. The funny thing was she didn't seem happy when she was successful. It was almost as if she were passing the time.

She also had various somatic complaints: dizziness, headaches, abdominal pain. These ranged from mundane to quite alarming. She complained that her eyesight was coming and going. We had her evaluated by neurology and sent for an MRI. She said she had black dots in her vision. Again, neurology, and again, nothing. Powerful migraines afflicted her. There were days when she would not eat much more than pudding. Her stomach felt tense and painful. We got an abdominal X-ray, concerned about peritoneal signs. This returned negative. And though we examined her and changed her medications almost daily, it struck me that we were missing something. That, though we had made every effort to help her achieve optimal mental health, this standard might not be enough.

Blanche had a particularly vexed relationship with our attending, Dr. O'Neill. Dr. O'Neill was a hospital institution. Now in his late 70s, he had been instrumental in establishing aspects of modern psychiatry. He arrived punctually at 7:30 to make rounds, a genial figure in a brown suit, his broad Boston accent heard down the corridor. He had a twinkling blue eye and a way of giving each patient's story a dramatic bent. Fond of the classics, he quoted liberally from Homer and Dante. He had a strong traditionalist streak, and when he discovered our ideological differences (summed up for him by the fact that I read the New York Times), he shook his head.

Then he said, “But do you know the Divine Comedy?”

“I do,” I said. He chuckled and we were friends.

On the first day of rounds Dr. O'Neill invited us all to retire with him into the biofeedback room, a dark, cozy closet he called his “office.”

“Let's bring in Ms. Dubois.”

Blanche came in slowly, and then followed what I imagine was a ritual developed over weeks. Dr. O'Neill asked her how she felt. Bad, she said. Still bad. Could she have more insomnia medicine? He told her we would like to try how she did without it, that it

[†] Blanche Dubois, *A Streetcar Named Desire*, by Tennessee Williams

knocked her out and made her day pale. She then changed tack. Could she go home soon? He asked her if she thought she was well enough. She said, well enough to go home. But are you well, are you really well? She didn't answer.

The conversation struck me as paternalistic. How could we know what was good for Blanche? A medical degree and advanced training does not give us insight into the soul. Perhaps she would be better off in West Virginia with her family than stagnating in our ward for months. Most importantly, how could we know when she was truly well? My discomfort with the situation was the same I have felt throughout my training: a discomfort with providing advice despite imperfect knowledge. This is true when dealing with medical or mental illness. Hypertension guidelines change almost annually –today's high blood pressure could be tomorrow's normal. We still don't know the cholesterol level at which statins become beneficial. Drug resistant bacteria continue to evade us by mechanisms too numerous to understand. We build our argument on the best current evidence, and we use this to assess health. What were we striving toward with Blanche? What was her version of health?

A possible answer to that question was that her version was a minefield. It may have been to return home, spend time with her parents, overcome her illness, and be functional. But she might equally crave the unsupervised privacy of her house with its flasks and bottles. The competing priorities of her autonomy and safety were concerning and prolonged her stay. Yet our approach was a reprieve from symptoms and not much else. Even if she improved over the next few months, she would eventually return to the same life. Healthy, but fading. If she relapsed she might be readmitted or worse. This reset to baseline was our model of treatment. But who wants to live at baseline? I wondered if Blanche – like any of us would—craved something more.

The feeling of being alive. The crispness of it. The ability to impart to meaning to our days. The autonomy of deciding what to do, whom to see, what to eat, read, when to sleep. The hope, however possible or impossible, of changing one's lot in life. It was this feeling that I sensed absent in Blanche. After she left, Dr. O'Neill and I talked a while. I asked him why the interaction was so difficult.

He thought. Then said, "Ms. Dubois is floundering. Has floundered for a long time." He then told me something else: she had been deeply religious. During one of their conversations she said to him something that stayed with him and has, in turn, stayed with me.

"They have taken my God from me," she said.

Those words resounded with him like the words of Lady Gregory's "Donal Óg": "You have taken the east from me; you have taken the west from me; you have taken what is before me and what is behind me; you have taken the moon, you have taken the sun from me; and my fear is great that you have taken God from me."

“What kind of loss must that be?” Dr. O’Neill asked me. He looked stricken. I saw then that he pushed Blanche because he wanted more than recovery of her health. He wanted to help her recover something vital to her life, perhaps her soul. He would talk about it later in a lecture. The sickness that eludes the most seasoned physician. The sickness that is not a marauding illness but the absence of true health.

I thought about Blanche’s loss of faith and about Lady Gregory’s poem, a lover’s lament of such heartbreaking pain that it feels like a bodily collapse. Then I considered the “they” whom Blanche said had taken everything from her – the “they” of alcohol, drugs, lovers, friends, family, caregivers, addiction and illness, the demons of her own thwarting. Finally I thought about her dizzy spells, headaches, pains and aches and insomnia, the collapse of a physically healthy person consumed by psychological and emotional losses. In her the mind and body were so intimately woven that her mental suffering had sapped her physical vitality as well. And it was this rift that we were unable to overleap. As we did with any other disease, we could piece her apart and treat each symptom. We had sophisticated drugs for depression, pain, and insomnia; doses could be titrated and levels measured. Each troublesome episode could be stamped out one by one and she would be functional. But this would not renew an intangible quality: her ability to flourish.

The pressures of time, money, patient volume, and limited personnel in an increasingly overstretched system have shaped our model of health to mean absence of disease. It is a “rule out” culture where patients are discharged or visits are ended when all possible organic illness has been eliminated or treated, screening tests performed, and medical disaster averted until the next visit or admission. On the mental health side, the model is not that different. Psychiatric admissions tide patients over into outpatient follow-up. Primary care doctors (internists, pediatricians, psychiatrists) are trying to alter this by becoming not only medical gatekeepers but watchmen of mental and physical health. They know their patients deeply and can better assess their vital status as a result, but with fifteen-minute visits and heavy patient loads their task becomes almost impossible, forcing them to focus on the rapid medical screening that rules out major somatic or psychiatric disease. We are terribly good at getting patients to baseline. How about getting them to thrive? Perhaps we should be striving for more than optimal.

The evidence is beginning to point in this direction. Corey Keyes has made himself an expert in the field of flourishing, establishing dimensions and scales of subjective wellbeing. His studies show that people who are not just healthy but thriving have better work and personal lives, lower risk of cardiovascular and chronic disease, and fewer health limitations[‡]. The intermarriage of physical and mental health could not be more evident. In her lovely book *God’s Hotel*, Victoria Sweet talks about her years at Laguna Honda hospital in San Francisco, where she practiced the kind of slow medicine that allowed her to focus on her patients’ flourishing. She got to know their backgrounds and aspirations. She was a traditional biomedical doctor, enjoying diagnostic puzzles and

[‡] Keyes et al, “Promoting and protecting mental health as flourishing: a complementary strategy for improving national mental health,” *Am Psychol*. 2007 Feb-Mar; 62(2):95-108.

competently treating liver disease and occult dementia, but she also restored to them the vitality of health through conversation, fresh air, vocation, and community.

It was ultimately through vocation that Blanche began to transfigure. Dr. O'Neill appealed to what she used to be: a guidance counselor with a passion for helping children. This was aspirational. She was far from ready, but instead of arguing with her about doses and symptoms or incentivizing her by promising an absence of depression or dizziness or anxiety, he tried to reach what she had been and what she could be again. It was old-fashioned, really, but I liked it. Blanche liked it too. She emailed her old school and began planning what she wanted to do when she left. When Dr. O'Neill left the service she said that they had had an understanding.

I was on the cardiology ward when I met someone who seemed to me Blanche Dubois' doppelgänger. Jessica Smythe was only forty. As a baby, she had a major cardiac surgery and had been chronically ill her entire life. Now, her heart was failing and she was a transplant candidate. Medically there was almost everything wrong with her. But she was flourishing. Her zest and vitality were palpable. She took immense pleasure in a Subway sandwich that her nephew brought her. She had read and watched everything, and was a font of information on books, television, film, and music. I asked her once how she maintained her energy.

"Well," she said, "I think about it this way. I should have died when I was born. So every day since then is a gift."

Leaving her room after she learned she was off the transplant list, I felt anger. She was joyful, alive, despite her crippling medical condition. Her mental life was so rich that she could feel healthy in spite of it. She deserved a transplant. But then I recognized that she would still enjoy each day with the same vitality. And I thought how deep run the channels between mind and body. Her illness had taken from her the east, west, sun, and moon, but not her nature. These factors are immeasurable by aliquot or vial; the astonishing psychology of a woman whose heart had broken and another woman with a broken heart.

We should strive toward physical and mental flourishing for our patients, though this may mean different things for each. Jessica showed me that sometimes it is a gift beyond anyone's control. For others, it could be acknowledging that they are something more than their illness or asking them what they perceive as vital and important. It may be that people see doctors to solve problems, but I think that at the core of the encounter there is still a mutual wish: to see and be seen and achieve something more profound than a checklist of items. Most of all, I think, it is an expectation of more. More than optimal or baseline or cleared or discharged. It aspires toward a renaissance of the body and mind. It asks more of us than before. It is difficult and time-consuming and frustrating. It makes demands upon us and our patients, just as Dr. O'Neill made demands upon Blanche and she made demands upon him. Her flourishing began when she saw herself as dynamic rather than faded and still. When I left the ward, she was not yet there, though she

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understood that her journey was not to health but to something beyond. And for Blanche,
I think that could be everything.