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Waiting for the Revolution

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As a third year medical student, I spent one month on an inpatient psychiatry unit. It was a locked ward in an old wing of the recently expanded hospital. From certain angles one might glimpse the brightly colored, glass-laden, spacious upper stories of the new towers, but mercifully there were few windows from which to see what we were missing, and even then the view was often obscured by the faded brick walls of administrative and research buildings that had sprung up throughout the last century.

I was the only medical student on the team, with a resident and a senior physician. We saw patients one by one for about ten minutes at a time every morning in the resident's office. The conversation would start with a discussion of how the patient had slept and how they were feeling that day. Sometimes we asked them to rate their mood on a scale from one to ten, and there was even an application designed to track this particular piece of information, which, one afternoon, I spent half an hour trying, unsuccessfully, to install on an elderly patient's smartphone. Each morning conversation ended with a review of the treatment plan, which generally included a list of medications and anticipated dosage adjustments.

Free from most of the paperwork and documentation, I got to spend my time talking to patients during the day and doing extended interviews and write-ups for those being admitted to the unit. Almost every new admission came with a thick file of past hospitalization documents and outpatient records. As I sifted through these files, it often seemed that the personal and psychological history was all but consumed by the medication history.

"Did this one work?" I would ask, trying to figure out why one antidepressant had suddenly disappeared or become another.

"For a little while, then it stopped" was a common response.

Often it appeared that certain medications had been discontinued before they could have gone into effect, and other times a particular drug existed unchanged in the record for years, though when we asked we learned that the patient never actually took it.

Initially, I was startled to see how frequently patients diagnosed with depression had prescriptions for antipsychotic medication.

"Usually it's a style thing," said my resident when I asked her about it on my first day, "but sometimes it's definitely necessary. Have you ever encountered someone with psychotic depression?"

“No,” I said, “I don’t think so.”

She shook her head. “You’ll know when you see it.”

The next day I admitted a depressed patient with a history of psychosis. Ms. Ross was a middle-aged woman with a soft, bemused smile, born and raised in Maryland, who was currently living on her own and holding down a job at a restaurant despite frequent incapacitating depressive episodes. We first spoke in an unoccupied office while her room was being prepared, and she told me slowly, but clearly and thoughtfully about her last hospitalization and her life since, including the recent end of a romantic relationship.

“He was a shithead,” she concluded.

“Good riddance then, I guess,” I replied.

“Guess so.” She laughed softly and her subtle smile never vanished. But, even then (perhaps especially then) she seemed strangely detached, as if she were talking about someone else’s life; someone she didn’t know particularly well, or care too much about.

When I went to visit Ms. Ross later in the day, I heard her speaking to someone in her room and I wondered which of the few friends and family members she had mentioned had come to see her. I stopped outside the closed door on which a small whiteboard hung, still bearing the handwritten name of a previous occupant, a Mr. McCrae.

While I waited, I wiped “McCrae” off the board with a paper towel and wrote in Ms. Ross’ full name. Then I reconsidered and erased her first name, still not sure how familiar everyone was supposed to be with each other.

I knocked at a pause in the conversation and, getting no response, slowly opened the door. Inside, Ms. Ross was alone, sitting rigidly upright on her bed, sort of bobbing her head and laughing quietly to herself.

“Hello?” I asked hesitantly, “are you ok?”

She turned her head away from me, but otherwise didn’t acknowledge my presence. I repeated the question a bit louder.

“I know. I know. I know. Hahaha. I know why I’m here,” she blurted out, still looking away, and laughing nervously with tears in her eyes. “It doesn’t matter, they’re coming and you can’t do anything.”

Haldol helped her calm down that evening, but she did not recover quickly. When I came in the next morning, I saw her standing motionless outside her room. It was cool in the hallway, but she wore only a thin hospital gown.

“How are you doing today?” I asked for lack of anything else to say.

No response. Ms. Ross just kept staring down the hall. I stood there for a moment, shifting my weight from one foot to another, not knowing what to do. At one point I began to repeat myself as I had the day before, but thought better of it and turned to walk away.

“I’m doing ok,” I heard as I took my first step.

Startled, I stopped and looked back. She had turned her head towards me slightly, but her expression remained featureless.

“That’s good,” I said, “did you get some sleep last night?” Again, no response, but now I waited more patiently.

“A little,” she finally replied after a similar delay.

We proceeded with small talk in this manner for five minutes or so, until it was time for morning check-in. Psychomotor retardation, as we learned in our first year of medical school, is a classic feature of major depressive episodes. I’m not sure how I imagined it would seem in person (perhaps akin to the mental and physical sluggishness everyone feels from time to time) but this was different. It was as though time were almost standing still for her while for me it sped by as usual.

When I returned to her room in the afternoon, Ms. Ross was lying in bed on her side, the sheets pulled up to her chin in balled fists. Her expression had changed yet again. Now I saw pain, fear, and confusion; like someone waking up from a bad dream, I thought, except the dream was still going on.

Her responses were faster, though still delayed, and we went through the same simple conversation we had had that morning.

“Hang in there,” I said eventually, “I need to check on some other people, but I’ll be around.”

“I’m not like other people,” she said forlornly as I stood up from my chair, pulling her sheets even tighter and closing her eyes for the first time since I had met her.

“Psychiatry today is like the field of genetics before Mendel,” announced a professor during a lecture in the spring of our first year. What he meant is that psychiatry is still waiting for its big revolution. The allure of the field, he went on to suggest, is the anticipation of that magical discovery which, finally, will be like turning on a lamp in the middle of a darkened room.

Psychoanalysis was first presented as such a discovery. While Freud counseled patience for the often slow and stumbling progress of science, he also placed his theories beside Copernicus’ heliocentrism and Darwin’s theory of natural selection. A century later, however, the prominence of psychoanalysis has waned. Like so many others, perhaps Freud’s revolution became a victim of its own grandiosity when it was ultimately unable to live up to the lofty claims of its most dogmatic adherents.

With dramatic advancements in modern technology and neuroscience, many have now turned their efforts and attention to biological research, and my very first experience with psychiatry in medical school was neither in the hospital nor the lecture hall, but at a cryostat in a cluttered lab, slicing frozen rat brains into micrometer-thick sections and sticking them onto glass slides for research in the burgeoning field of epigenetics.

Recently, certain biochemical mechanisms have been discovered, which act directly upon DNA and influence which of our genes get expressed and which stay silent, thereby altering genetic profiles which were once thought to be essentially fixed. These are known as epigenetic mechanisms, and they have powerful implications for medicine, especially psychiatry, because not only might they eventually lead to new treatments, they also illustrate something our intuition has always told us: that nature and nurture are fundamentally intertwined, that our innate predispositions and our environment do not simply battle for control of our

mental and physiological processes, but rather they are constantly interacting and modifying each other in staggeringly complicated ways.

The degree to which epigenetics will revolutionize psychiatry remains to be seen, of course. It is certainly already informing the way we think about interactions between genes and environment in mental illness, and it may even lead to effective new therapies. But, like every other step in the gradual progress of scientific knowledge, it will probably raise as many questions as it answers.

"I'm not like other people." I hear Ms. Ross' words now as I did then, both strange and hauntingly familiar. Strange because of their reference to a disease whose terror I cannot begin to imagine, a biological malfunctioning of the brain that twisted her mind in ways she was at times tragically aware of. And yet they are familiar because occasional feelings of despair and loneliness are part of human experience. That is why, perhaps, psychiatry will always be like genetics before Mendel; because life, even at its healthiest, can feel like groping in a darkened room, and the great reward for finally finding better treatments for some of psychiatry's most devastating diseases will be to afford those patients the opportunity to struggle along with the rest of us.

Having returned to what both she and the doctors agreed was her baseline, Ms. Ross left after three weeks. Her room was taken by a short, overweight man in his 50s with crooked glasses named Billy, who apparently had just been discharged from the unit only a few weeks before. He hardly said a word, but from the moment he arrived he walked the halls constantly with small, shuffling steps that could be heard faintly in the background throughout the day.

As the month had progressed, I found myself spending much of my free time with Phillip, one of the social workers. He had known most of our patients on and off for years, and while the resident and senior physician took phone calls and dealt with paperwork, I asked him questions and listened to his stories over a soda or cup of coffee.

The day Billy arrived I asked Philip if he knew him from before.

"Oh sure," he said, "Billy's a regular. One time, years back, he was so depressed he walked around until his feet bled. They got infected and he had to go down to internal medicine."

"Depressed?" I asked, "I thought that slowed people down."

"Sometimes," he replied, "sometimes not."

At that moment we passed Billy's room on the way to Philip's office. It was empty, of course, and I noticed that Ms. Ross' name was still on the whiteboard. I stopped and rubbed away the writing with my hand, sparing the green flowers that, at one point, had been drawn in below. Then I took the black marker stuck to the side of the board by a strip of Velcro and removed the cap.

"Hey Phil, what's Billy's last name?" I called after him as he continued down the hall.

"McCrae," he said, without turning around.