Academic Psychiatry (2023) 47:640–641
https://doi.org/10.1007/s40596-023-01851-0

THE LEARNER'S VOICE

What Do We Consider as Treatment Success in Psychiatry?

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Received: 30 June 2023 / Accepted: 16 August 2023 / Published online: 27 August 2023

"Do you think we have fixed the problem that brought him in?"

I exchanged a hesitant look with the other medical students around me, unsure of how to respond to the attending's question. I was on my psychiatry clerkship rotation and the patient I had been evaluating and about to discharge had been admitted for suicidal ideations in the setting of methamphetamine use. On the one hand, I thought about answering yes—the patient's mood had improved as he cleared the methamphetamines and he was back on his medications. On the other hand, it seemed like the problem was much bigger. The patient clearly needed help for his substance addiction, but he did not want to attend a substance use program. We had "fixed" the short-term problem but long-term, it was clear that there was a risk of him going back to the same behaviors that led him to be in the hospital.

We were all still deliberating the best answer when the attending answered the question himself. "It does not matter for now…he will be back soon."

At the time, I was surprised to hear such a pessimistic view from a physician. I had come in with an idealized view of the treatment goals in psychiatry and the attending's response was not matching up to it. Was it not his job to "fix" the patient before leaving the hospital? Should he not have made more of an effort with the patient to help them get their life back on track?

Looking back, it is almost funny how naïve I was to believe it would be that easy. In psychiatry, the expectations of treatment goals are different from what we know and see in other medical specialties. In other medical specialties, most patients *choose* to come to the hospital to get the help they need, all the while being appreciative of their care and the medical team. In psychiatry, I had to get used to the complete opposite. Most of the time, I was interacting with patients who wanted nothing to do with me and who were likely being discharged from the hospital with the root of their problem still present.

Now, as a first-year psychiatry resident, I have seen the difficulty in offering medications to patients who do not see the problems they are dealing with. As physicians, our goal is to offer the best options for the patient. In psychiatry, this is made more difficult with the added layer of having to convince the patient to see our point of view. This inadvertently leads to the frustration of trying (and oftentimes failing) to have a patient realize their disease.

For example, I recently worked with a patient with paranoia and persecutory delusions but who possessed a logical thought process. She explained how she was being targeted by her sister for identity fraud and financial gain which led to her leaving the state. She only disclosed this information a few days into her hospitalization because she feared we would think she was "crazy" and delay her discharge. It was clear to us that, based on the additional collateral information and her current presentation, starting an antipsychotic was the appropriate step for treatment. When I recommended the treatment, the patient was rightfully hesitant. She could not understand why she needed to be on medication, especially when we told her it was to help with her mood and clear her thoughts. Why should she? She did not feel like her mood or thoughts had ever been a concern.

How does one tell a patient—let alone anyone—that they are paranoid and delusional? As we spoke, I could see the confusion, anger, and helplessness wash over her face. I knew I could not be upset if she refused the medication; the alternative of taking the medication did not mean she had come around to treatment. I knew acceptance of the medication would only be to appease the doctor and to show that she could comply in order to guarantee a quick discharge. She was in a locked unit, and she wanted to get out; her only salvation was to "play the rules" to gain her freedom.

The field of psychiatry does own up to this fear of having to work with patients that do not want the help. Tough

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decisions are made for the betterment of the patient, even if they do not see it that way. Sometimes, I find myself questioning my impact when caring for patients that do not have the insight into, or understanding of, their diagnosis. Without this foundational understanding, they are already at a disadvantage, and I am left with the expectation that many of the patients I discharge will be back in the hospital soon enough. While the attending psychiatrist's words on my clerkship rotation may have sounded callous, they were not an untruth given the reality of the profession we work in.

Yet, it is not always so bleak. There are many situations when a patient is compliant on their medications and have a support system (whether inside or outside the hospital) to continue to do well on their own. It is these patients that succeed in the hospital—despite all the odds seemingly stacked against them—that motivate me to see just how much and how far I can get through to the different patients I meet every day.

Acknowledgements The author wishes to thank Rawan Abdelrahman, BA, for their help and review in support of this manuscript.

Declarations

Ethics Approval This study was reviewed by the University of Illinois College of Medicine at Peoria Institutional Review Board and was deemed exempt on 7/26/2023.

Disclosures The corresponding author states that there is no conflict of interest.