Author(s): Harper, David J.
Title: When the drugs don't work
Year of publication: 2002
Citation: Harper, D.J. (2002) 'When the drugs don't work'. *Open Mind,* 114, pp.8.
Link to publisher site:
http://www.mind.org.uk/campaigns_and_issues/report_and_resources/openmind

When the drugs don’t work

Dave Harper

Harper, D. (2002). When the drugs don’t work. *Open Mind, 114*, 8.

It is clear that medication for mental health difficulties does not produce anything like a cure.[1] Taking medication is no guarantee that one will never relapse or experience a symptom again. This poses a problem for the over optimism of some biological psychiatrists. I became interested in responses to this problem during some research[2] in which I interviewed users of psychiatric services, GPs, psychiatrists and CPNs. Throughout these interviews I encountered the same common explanations for why medication hadn't worked: the patient is a non-responder; is chronic; is on too low/high a dose; is on the wrong drug/too many different kinds of drugs; has not been compliant with their medication; has been wrongly diagnosed; some of the patient's problems are due to manipulative behaviour; there are odd exceptions.

Rather than discuss whether these explanations are 'true', I want to look at how they are constructed and their effects. For example, they could be seen to justify certain actions (increasing the dose of a drug) and they could lead to the construction of certain kinds of identities (of the patient as 'resistant'). I drew on discourse analysis (a qualitative research method) to understand how these explanations are used.[3] When apparent drug failure was discussed, it seemed often that blame and responsibility were implied and that this was being shifted away from professionals and medication and onto the service user or their problems. Sometimes this was explicit and at other times more subtle. One of the more subtle was to use the notion of 'chronicity' to emphasise the permanence and severity of symptoms and illnesses, usually based on assumptions about the biological origin of problems within the person. We can see how this emerges in one of the interviews:

Psychiatrist: But, you get in schizophrenia, there's gradual deterioration and at times the s-, symptoms persist, you know, they've got residual symptoms.

Interviewer: Uh-huh.

Psychiatrist: So the delusions or hallucinations kind of ease off but they persist in between episodes as well.

Interviewer: Right.

Psychiatrist: And then, er, er, when the patient has the next episode, after that it will be even worse you know. Gradually the patient deteriorates and some of the residual symptoms persist. So in, in that case, with chronic, er, schizophrenia or this kind of schizophrenia where there's no, no complete remission.

Interviewer: Uh-huh.

Psychiatrist: The pers-, the delusions can persist

Chronicity is signalled here by mention of'deterioration', the persistence of symptoms and 'residual symptoms'. The latter are usually defined as symptoms remaining after drug treatment, but in this account the term is used almost as a new diagnosis. It is implied that the symptoms persist because they are 'residual symptoms', which is rather circular.

What are other effects of the chronicity narrative? First, the problem is located within the patient (the 'patient deteriorates') and the symptoms are given agency; they are invested with a life of their own, unlinked to the person or their life circumstances. Second, by implying that the problems are permanent and inevitable, responsibility for the explanation or treatment of problems is shifted from the professionals onto the problem itself, and a category ('residual symptoms') constructed that makes it look as if this is something to be expected. Once the problem is located within the service user, there is then some ambiguity about whether responsibility lies with the problem or the person - and indeed psychiatric discourse often contributes to this confusion by identifying people with their problems (e.g. as a 'schizophrenic').

I don't want to be critical of the speaker or speculate about their 'intentions'. I'm much more interested in the effects of language: here, how psychiatric language becomes all-encompassing. Professionals and service users can become caught in these language traps. Becoming more aware of them and seeking to avoid them may lead to more collaborative working. I see a role for research such as this in training service users and professionals to work more collaboratively. Mental health professionals need to become more open and pragmatic -especially given the trial-and-error nature of much medication use - in developing alliances with service users in order to think together about the most helpful uses of medication:[4]

1. Holmes, G. and Newnes, C. (1996)'Medication-the holy water of psychiatry', *Openmind,* 82: 14-15.
2. Harper, D. J. (1999) 'Deconstructing paranoia: An analysis of the discourses associated with the concept of paranoid delusion', unpublished Ph.D thesis, Manchester Metropolitan University.
3. See also Harper, D. (1999) Tablet talk and depot discourse: Discourse analysis and psychiatric medication', in C. Willig (ed.) *Applied Discourse Analysis: Social and Psychological Interventions,* Buckingham: Open University Press.
4. Randall, R, Wood, R, Day, J., Bentall, R. R, Rogers, A. and Healy, D. (forthcoming) 'Enhancing appropriate adherence with neuroleptic medication: two contrasting approaches', inT Morrison (ed.) *A Case Book of Cognitive Therapy for Psychosis,* Brighton: Psychology Press.