

# The Psychiatric Medication History: Context, Purpose, and Method

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**SUMMARY.** This article presents *The Psychiatric Medication History: An Interview Schedule*, a 30-step semi-structured protocol designed to help practitioners understand how clients manage their psychotropic medications and interpret their effects. The critical perspective leading to the design of this interview schedule, its purposes for clients and practitioners, its divergence from traditional treatment histories, and its uses and limitations are discussed. The author contends that, in a safe space, taking a psychiatric medication history according to these suggested guidelines offers clients an opportunity to construct an independent, evidence-tested personal narrative about their medication use. To practitioners, taking such a medication history offers a person-in-environment point of entry into the psychopharmacology scene. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2003 by The Haworth Press, Inc. All rights reserved.]

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Within the mental health system, the place of medication is pivotal and in everyday discourse the word “treatment” is synonymous with “medication.” In the West, for the past half-century, there has been systematic use of about one hundred psychotropic drugs. Hundreds of millions of people have been prescribed these drugs for dozens of emotional/behavioral states. Thousands of scientists have investigated the drugs’ effectiveness. As a result, colossal revenues have been generated for drug manufacturers. Still, no current data shows even modest improvements in the incidence or prevalence or prognosis of *any* condition routinely treated today with psychotropics, including schizophrenia, bipolar disorder, and depression (Cohen, 1997a; Healy, 1997; Research Triangle Institute, 2002; Whitaker, 2002). Nonetheless, prescribing psychotropics to more people, to younger people, and for longer periods, is continually increasing (e.g., Zito et al., 2003), and expansions of coercive psychiatric interventions (such as outpatient commitment) appear intertwined with the popularity of drugs.

Two decades ago, practicing social workers merely referred patients for medication. Today, social workers may be involved in many more medication-related tasks. These tasks include recommending that physicians prescribe drugs to clients, monitoring medicated clients’ states, persuading or coercing clients to follow prescribed drug regimen, facilitating clients’ understanding of drug effects, and assisting clients to stop taking drugs. Case managers of clients diagnosed with severe mental illness and residing outside hospitals may count and sort medication boxes, bring drugs to clients’ homes and watch while clients take them, and drive clients to and from clinic appointments where medication is the overriding issue of interest (Floersch, 2002). These activities of case managers literally make possible the taking of medications by clients within a service system arguably revolving around “medication compliance.”

Few textbooks on social work and psychopharmacology have been published, and courses on this topic are the exception in social work curricula. Most social workers receive only cursory training in this area, which suggests that they are not provided with the opportunity to evaluate their involvement critically. One can speculate that where social workers take part in medication-related activities, training is on-the-job: guided by the requirements and the short-term goals of the service, provided by a multidisciplinary team or medical professional, or using information and guidelines from one’s employer. This is not to suggest that practitioners blindly follow dictates to monitor drug treatments without grappling with the significance of these treat-

ments in their clients' lives and in relation to their helping strategies. Indeed, in the only detailed narration of case managers' work on a daily basis in mental health settings, Floersch (2002) reveals subtle processes of managing medications and interpreting their effects. However, Floersch's analysis confirms that such processes become visible and intelligible only if the observer attempts methodically to uncover them. In this effort, he or she must be guided by various conjectures and hypotheses about the observed situation, including a critical understanding of the goals of the treatment system.

In this vein, this article presents *The Psychiatric Medication History: An Interview Schedule* (see Table 1). This schedule was designed to help practitioners obtain information from their clients to help decode their clients' procedures of managing medications and interpreting their effects. The schedule grew out of interviews the author conducted as advocate, medication consultant, researcher, and therapist with adult users of psychiatric drugs. It was further developed in group meetings and workshops with such users. The schedule is part of this author's effort to assist social work practitioners and students to emancipate from the domination of the medical model (the view that people who behave in ways unapproved or unacceptable have something wrong with their genes/brains and that this problem needs to be fixed physically). The schedule may also help to ground some social work interventions on an independently-arrived-at knowledge base, explicitly guided by the intention to minimize iatrogenic harm and redress power imbalances between clients and professionals (Cohen, 1988, 2002; Cohen & Jacobs, 2000). Finally, the schedule fits in the author's broader attempt to formulate a critical, constructivist, and systems framework within social work to conceptualize and study medication use in individuals and societies (Cohen et al., 2001).

The article is structured as follows: in the major portion of the text, some critical conjectures and observations shaping the author's perspective on psychiatric medication are outlined. Next, to provide contrast and additional context, literature bearing on treatment/medication histories in psychiatry is analyzed. Finally, uses and limitations for social work practice of *The Psychiatric Medication History: An Interview Schedule* are discussed.

## ***CRITICAL THINKING ABOUT PSYCHIATRIC DRUGS***

A pressing task facing mental health professionals today may be analogized to a "detoxification" process: identifying and examining

TABLE 1. The Psychiatric Medication History: An Interview Schedule

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*Baseline*

1. Ask subject to describe his/her most important current difficulties.
2. Ask subject to describe what he/she believes would be the most helpful intervention (resource, person, skill, thing, etc.) for him/her at this time.
3. Ask subject to identify what he/she believes are the main obstacles to getting this help.  
Names and instructions
4. Record names and dosages of all drugs currently taken by the subject, including prescribed medications and licit or illicit drugs.
5. Record any name given to each drug by the subject (e.g., "tranquilizer," "little red pill," etc.)
6. Ask subject to explain why each drug is taken, and for how long each has been taken.
7. Ask subject to describe any instructions received from physician or nurse regarding the taking of the prescribed medications.
8. Ask subject which side or adverse effects, if any, he/she has been told to expect or has discussed with health professional. When did these discussions take place, and how often?

*Compliance*

9. Inquire about the regularity of drug consumption (continuous, intermittent, idiosyncratic, etc.) and adherence to physician's instructions.

*First Use*

10. How does subject describe his/her difficulties when prescribed drug use first started? Inquire into the particular circumstances and events immediately preceding drug use.
11. How does subject describe the *initial* effect of drugs on the above difficulties? Inquire if and how the use of drugs modified the circumstances and events.
12. Inquire into subsequent episodes of drug use if the initial drug taking was discontinued.

*Effects*

13. How does subject describe the current effects of medication on his/her functioning?
14. How does subject think the drugs act upon his/her body or mind?
15. How does subject describe the effects of medication on interaction with other people, general well-being, looking for employment, reading, writing, remembering things, working and being attentive, interacting with his or her family?
16. How does subject describe the effects of medication on sleeping and waking, sexual desire, lovemaking, urinating and having bowel movements, sweating, sensitivity to light?
17. Ask subject to name the distinctive "psychological" effect or effects of their medication. If subject had to give his/her own descriptive label to the medication, what would it be?
18. Ask subject to name the distinctive "physical" effect or effects of their medication.
19. Ask subject whether drugs consistently have the same effect on him/her.

TABLE 1 (continued)

*Non-drug solutions*

20. Ask subject if and how current difficulties are similar to difficulties leading to original drug use.
21. Ask subjects if other solutions besides drug use were attempted, and if so, with whom and with what results? Ask subject whether/what lessons were gained from these attempts.

*Withdrawal*

22. Ask subject to describe any attempts made to reduce dosage or completely cease taking medication. Inquire into why subject acted and whether these attempts were discussed with others.
23. Ask subject to describe as precisely as possible the withdrawal schedule used.
24. Ask subject to describe what occurred during and after withdrawal.
25. Inquire about the negative and positive effects of the withdrawal experience.
26. Ask subject if and how much of the withdrawal experience was discussed with health professionals. Ask subject whether/what lessons were gained from these discussions.

*Social network*

27. Ask subject to describe the attitudes of family members about his/her medication use.
28. Ask subject to describe the attitudes of health professionals about his/her medication use.
29. Ask subject to describe the last three different conversations he/she had with anyone about his/her medication use.

*Conclusion*

30. Ask subject what he/she wishes to understand better about his/her medication use.

some deeply held or “simply held” ideas and deciding whether or not one should continue to hold them (Cohen, 2001). The reason to do so is that most ideas (hypotheses, theories) and their associated interventions (technologies, practices) representing reform, progress or enlightenment at one moment in the history of mental health interventions were later repudiated as misleading or damaging (e.g., Braslow, 1997; Johnson, 1990). Proponents of these ideas were leaders and practitioners of the mental health professions and their allies. Those who suffered from the adverse consequences of these ideas were individuals and families seeking help from officially designated experts.

This realization imposes upon practitioners the duty to choose carefully which ideas and practices merit our allegiance, and to be sensitive to the harm that may result from them. This constitutes the generic process of “critical thinking,” which encourages us to step outside dominant ways of viewing something and to submit it to logical, ethical, and historical scrutiny (Gibbs & Gambrill, 1999; Paul & Elder, 2002). With respect to developing a critical perspective on the use of psychiatric

drugs, helping professionals might wish to reflect on some basic questions. Some of these questions, and answers this author has developed for them so far, follow.

### ***What Does Biological Psychiatry Rest On?***

Does the popularity of biological psychiatry rest on its success in providing validated answers to age-old conundrums about mental suffering and healing? For this author, the popularity rests on the simple facts that many people like to use drugs for reasons that are important to them, and that biological psychiatry provides fresh, culturally acceptable justifications for this use (Fancher, 1995). Using drugs to alter consciousness, to ease pain, to induce sleep or maintain wakefulness are universal and ancient practices. Biological psychiatry exploits these ordinary desires with a medical/scientific rhetoric, currently that of the “biochemical imbalance.” On radio and on television, in newspaper and magazine articles, and in doctors’ offices, people hear, read, and are taught that psychotropic drugs are prescribed for them because their brain functioning is defective. For examples, laypersons and professionals come to believe and repeat that hopelessness and depression result from inadequate serotonin neurotransmission which is remedied by serotonin reuptake inhibitors (Johnson, 1999), or that restlessness and inattention in millions of American school children result from frontal lobe shrinkage and that stimulants help the brain to grow (Kurth, 2002). The reality is of course more complex: people experiencing psychological distress take drugs because they want to, or because others want them to, or because alternatives to drugs are expensive, time-consuming, demanding, and less easily available.

Part of the problem with reductionist biological explanations is that they are commonly presented as obvious scientific facts although *none has been demonstrated* (Mental Health, 1999). In this way, their resemblance to now-discarded dogmas is striking. Earlier explanations, such as the all-powerful but undetectable unconscious, were initially useful to promote professional interests, scientific purposes, and humane reforms. However, as these constructs came to fashion entire societies’ outlooks on deviance and distress, they only served to constrain intellectual and therapeutic innovation, and worse (Dolnick, 1998; Torrey, 1992).

### ***How Do Psychotropic Drugs Produce “Therapeutic” Effects?***

No single theory in psychopharmacology addresses how drugs produce “therapeutic” effects. Neither the 1090-page *Textbook of*

*Psychopharmacology* (Schatzberg & Nemeroff, 1998) nor the briefer classic *Primer of Drug Action* (Julien, 1992) discusses any theory of “drug response.” This illustrates the unacknowledged fact that the perception of a drug effect as “therapeutic” depends on social context and human motives (Cohen & Karsenty, 1998). How abnormal movements of patients on neuroleptics were initially labeled (or even noticed) depended on expectations of clinicians and inmates in mid-20th century mental hospitals (Cohen, 1997b). Whether sedation from temazepam is called a “main effect” or a “side effect” has nothing to do with the pharmacology of benzodiazepines and everything to do with what participants consider desirable (and at what point in the treatment). Whether indifference and euphoria in a formerly depressed patient taking fluoxetine is labeled as “improvement” or “frontal lobe damage” depends on how long and how closely the patient and the clinician have been interacting (Hoehn-Saric, Lipsey, & McLeod, 1990). Whether submissiveness and cognitive overfocusing in a child taking stimulants is seen as “effectiveness in reducing off-task behavior” or “an expression of the continuum of stimulant toxicity” depends largely on teachers’ expectations of children in a structured classroom.

Numerous hypotheses exist to describe how drugs circulate throughout the central nervous system (CNS) and produce cascades of physiological alterations. However, short of postulating a pre-existing (but undetected) “chemical imbalance” that causes undesirable changes in mood and behavior (the “mental disorder”), and that is in turn “corrected” by drugs, the conclusion seems inescapable: most prescribed psychotropics serve as non-selective CNS depressants or stimulants (to use Julien’s expression). If that is so, it is unrealistic to expect drugs not to impair or blunt higher human functions including emotional responsiveness, social sensitivity, and judgment. With prolonged use, as the exquisitely integrated brain alters its functioning and structures to adapt to the persistent disruption of neurotransmission by drugs, emotional/cognitive/behavioral/physical impairments can become extremely complex (Breggin & Cohen, 1999). In the extreme, these impairments lead to “iatrogenic denial and helplessness”—a process in which the patient is rendered less independent and discerning, and patient and prescriber work together to deny the damage inflicted (Breggin, 1983).

Pharmacology might indicate how drugs trigger emotional/behavioral states, but it cannot answer questions such as: (1) How do non-specific psychotropic effects come to be desired or shunned, studied or ignored, categorized as “therapeutic” or “adverse”? (2) How and why

do conceptions and definitions of therapeutic or adverse effects of particular drugs change over time? (3) How and why might different participants in the prescription situation hold differing views on what should count as a “therapeutic” or “adverse” effect? Some light may be shed on these issues by means of a “person-in-environment” perspective. These issues could be at the core of an independent understanding of medications by social workers.

### ***Does Prescribing Drugs Represent Progress in Mental Healing?***

Perhaps the most natural way to comfort someone in distress is to touch that person, or give that person something to swallow. Many professionals might view prescribing or taking a mood-altering drug with the approval of an officially designated helper as a modern or scientific way to treat emotional distress, but the practice can also be seen as a primal custom that resonates with our earliest experiences as powerless infants.

Throughout the ages, recognized and illegitimate healers have used licit and illicit substances to treat all types of ailments. In parallel, sick and distressed people have long claimed benefits from using substances whether or not medical science could validate the claims. For centuries, bleeding was sought by sufferers and administered by physicians. Today, medicine understands bleeding to have been extremely harmful. These examples suggest that: (1) there is nothing inherently progressive or enlightening about the drug treatment of psychological distress; and (2) individuals’ experiences of medications as genuine palliatives or curatives illustrate a dimension of healing that may have no reliable relationship to the properties of the particular medications.

### ***What Are Drugs?***

Psychotropic drugs are material substances that are ingested inside the body and, according to current ideas in neurophysiology, exert effects on the brain to alter feeling, behaving, and thinking. Drugs’ material properties are essential for any understanding of drug effects. Yet, emphasis on material structure impedes discerning much of the significance of drugs in people’s lives: their power as *symbols*. From an anthropological perspective, drugs might be seen as “charged objects” (like talismans or amulets) laden by humans with powers, hopes, and fears. Like diamonds reflecting light, the “essence” of medications changes depending on one’s standpoint.

Cohen and colleagues (2001) have proposed that medications can appear in numerous forms: (1) the primary strategy to treat disease; (2) an interface between patients and physicians; (3) triggers for personal change, leading some users to radically reinterpret their very sense of self; (4) tools of social control; (5) causes and consequences of medicalization; (6) reservoirs of badness (“dangerous drugs”) or goodness (“approved medications”) for mainstream society; and (7) vectors of globalization, given how few developed countries sell most of the world’s medicines to all the rest of the world’s countries. One could characterize medications in other ways, none of which would account for the totality of their effects, but each of which would add to our understanding. In sum, drugs are powerful material objects as well as socially grounded phenomena that are highly responsive to culture and history, producing “effects” that reverberate within and outside individuals’ bodies to shape social relations in families, in groups, in institutions, and in societies (Cohen et al., 2001).

### ***Are Some Drugs Better than Others?***

From a pharmacological point of view, one cannot explain why various drugs are approved or disapproved, available legally or not, considered beneficial or harmful, promoted or prohibited, available by prescription only or over-the-counter. For example, it is impossible to account for the fates of two stimulants with virtually identical neurochemical effects: methylphenidate (Ritalin) and cocaine (Vastag, 2001). One is prescribed to millions of children, the other is cursed as dangerous for any human being and its mere possession carries heavy legal penalties. Similarly, amphetamines were rejected decades ago by medical and law enforcement authorities as likely to trap users into patterns of substance dependence and to trigger psychosis and violence after prolonged use at high doses (Grinspoon & Hedblom, 1975). Yet today, after antibiotics, the mixture of pure amphetamine salts marketed as Adderall appears to be the drug most prescribed to American children.

These and many other examples suggest that the fate of a psychotropic drug in society has little to do with its known and predictable effects and much to do with how legal and medical authorities choose to treat it. Furthermore, these authorities change their minds frequently on these matters, sometimes every decade. That a drug is approved by the Food and Drug Administration (FDA), prescribed by doctors, promoted by manufacturers, and praised by clinicians and patients says *little* about the drug’s “safety” or its “effectiveness.” It says even less about

how future observers will judge how the medication genuinely impacted those who took it regularly.

### ***Drug Effects: Attributes or Properties?***

Students of the history of drug use might observe that various names used to describe or classify drugs are metaphorical and change along with sociocultural transformations. These names may be called attributes: ascribed characteristics or qualities. "Consciousness expanding" (ascribed in the 1960s to "psychedelic" drugs) now stands out as a notable example of a drug attribute. Less obvious but no less valid examples include "antipsychotic," "antidepressant," "mood stabilizer," "cognition enhancer," "addictive," and of course "medication."

Other drug appellations resist linguistic fashion, and may be called "properties." Properties refer to objectively validated drug effects ("sedative," "antiemetic," "anticonvulsant," "myorelaxant," etc.) that pharmacologists usually discover within weeks of systematically screening a given substance for the first time. Properties rarely vary under typical conditions or across different animal species. Undoubtedly, most people, and many experts, confuse attributes and properties. It may be that many individual and societal struggles with drugs stem from a tendency to treat attributes of drugs as if they possessed concrete existence, while neglecting or dismissing the actual properties of drugs.

### ***Drugs or Placebos?***

Modern medications are put forth as sophisticated products of rational and technological design, but they cannot detach themselves from their shadow: suggestion. The world's highest enforced scientific and regulatory standards (e.g., those of the FDA) used to classify a compound as an "effective medication" for a given condition may involve nothing more or less than comparing it to a pharmacologically *inert* substance, a placebo. That is because placebos seem to act as vehicles for humans' powerful, innate potential for self-healing and repair.

When primed only with information (including deliberately deceptive information), a person can sincerely report as much or more improvement in symptoms of major depression while taking a yeast pill than while taking a centrally active drug (the composition, effects, dose and administration of which have been studied for years). In re-analyses of the very best clinical trials of seven modern SSRI "antidepressants" (trials submitted to the FDA by manufacturers to gain approval to mar-

ket the drugs), Kirsch, Moore, Scoboria, and Nichols (2002) have demonstrated barely noticeable advantages of drugs over placebo. Antonuccio, Burns, and Danton (2002) believe that "It could be argued that the patients randomly assigned to placebo are the lucky ones, because they derive a benefit virtually comparable with the medication condition without the associated medical risks." *Mental Health: A Report of the Surgeon General* (1999) states a contrary view: "The evidence for treatment being more effective than placebo is overwhelming" (p. 65). The *Report* does not acknowledge that little evidence exists that any drug used in psychopharmacology will actually surpass an active placebo (a substance that exerts some noticeable physical effects, such as increased heart rate or sweating) in reducing "target symptoms." It may soon become well recognized that, as Fisher and Greenberg (1997) put it for antidepressants (and Thornley and Adams [1998] argued for antipsychotics), "the potency of any [psychotropic medication] is typically inverse to the degree to which the drug trial in which it was tested was adequately controlled" (p. 362).

The placebo effect (simply defined as the patient's expectation) remains possibly the single most important factor in any self-reported positive medication-induced change. However, because it is not directly visible and is completely unpretentious (and unpatentable as placebo), its benefits can easily be claimed by competitors. In the clinical situation, awareness of the placebo effect should compel us to ask how much of a "medication response" truly has anything to do with the "medication."

### ***How Is Knowledge About Drugs Constructed?***

The pharmaceutical industry is the most profitable industry in the United States (Fortune, 2000), more than the oil or automobile industries. Like "scientific" knowledge about oil and automobiles, "scientific" knowledge about medications is socially constructed and extremely receptive to the influence of money and power (Safer, 2002; Schulman et al., 2002). Many individuals, failing to discern this system's operations, labor tirelessly and sincerely to concoct inappropriate trial designs, to ignore blatant confounds, to write obscure prose, to publish unfounded claims about the medications they study, and to ignore conflicts of interests. Many journal editors work just as tirelessly to accept these products and pass them off as exemplars of scientific medicine (Relman & Angell, 2002). Other researchers within this system are acutely aware of the bankruptcy of the "business-as-usual" style

of psychopharmacotherapy studies but downplay their critical observations, wary of negative repercussions on their careers and livelihoods (Healy, 2002). The activities of other stakeholders and participants in the life cycle of medications, such as manufacturers, regulators, and consumers are also important, if more or less visible.

Under such circumstances, it would be dangerous to believe that the legitimate construction of knowledge about drugs should be the province of officially designated experts. Recently in the case of prescribed psychotropics, and in no small measure because of the advent of the Internet, such knowledge has to accommodate the voices of consumers in areas that psychopharmacologists have consistently ignored or downplayed, such as withdrawal effects (Breggin & Cohen, 1999). This is why it is desirable for a profession professing concern for the powerless to encourage the creation of knowledge among the presumed beneficiaries of drugs, who are often the least powerful in society.

This task takes on increased importance because of the recent return, after six decades of outlawing, of direct-to-consumer advertising of prescription drugs. The modern marketing of Ambien and Adderall, Paxil and Prozac, or Zyban and Zyprexa illustrates that prescribed medications are no longer exclusive tools of medical practice: medications can now be sought or declined on the basis of *consumer preferences*. And, given how such preferences are instilled and shaped in this advanced age of advertising (Cross, 1996) and pharmaceutical industry agenda-setting in mental health (Gosden & Beder, 2001), it is reasonable to expect that in the not-too-distant future, admen, not doctors, will serve as the true intermediaries between us and our drugs.

### ***THE MEDICATION HISTORY FROM A CRITICAL PERSPECTIVE***

The preceding discussion hints at some concerns one might have when interviewing a client who takes or considers taking psychotropic medications. These questions should direct practitioners to undertake at least four tasks.

First, they guide practitioners to nourish, as an empowering methodology for their clients and themselves, a critical (questioning, skeptical) attitude toward medications.

Second, they direct practitioners to understand how clients actively construct—through language, expectations, beliefs, and social interaction—their entire medication experience.

Third, they lead practitioners to explore how their clients' medication use interacts with other systems of managing problems and issues in their lives.

Fourth, they suggest that practitioners carefully assess potential adverse effects that prescribers might be prone to miss or dismiss and that clients may sense but may not associate with their medication use.

In addition, from the perspective sketched above, practitioners are urged to take responsibility for their education in medication-related matters. Non-medically trained or psychopharmacologically naive practitioners can be optimistic about their ability to reach novel or useful understandings of medications. How do these suggested tasks of a medication history compare with those discussed in conventional psychiatric literature? A brief analysis of some relevant sources follows.

### ***The Medication History in Psychiatry***

A search of the Medline database using the keywords "medication history" yielded only three articles with any relevance to the topic. However, none discussed how such a history should be taken (Gettman, Ranelli, & Ried, 1996; Klungel et al., 2000; Lau, Florax, Porsius, & de Boer, 2000).

Professional or teaching manuals on clinical interviewing constitute another appropriate source of guidelines on taking a psychiatric medication history, and probably no manual better illustrates the current approach in psychiatry than *The Clinical Interview Using DSM-IV-TR—Volume 1: Fundamentals* (Othmer & Othmer, 2002). In it, the "Treatment History" is discussed in a single page of the 547-page volume. The authors identify three purposes of "a detailed history of treatments and treatment responses" (although the discussion focuses almost exclusively on *drug* treatments): "1. . . . to reconstruct what . . . diagnoses another psychiatrist may have entertained if records are not available . . . 2. . . . to help identify responsiveness to certain treatment modalities. . . . 3. . . . to confirm your own diagnosis" (p. 266). A terse clinical example explains each purpose. Here is the entire example for purpose number 2:

For instance, Keith reports: "I took Wellbutrin for 3 months, and then Serzone for 4 months, and I didn't get any better. My mother went to Dr. J., who switched her from Serzone to Paxil when she didn't respond. Paxil really helped her." Not only disorders but also response to medication may be partly genetically determined.

Entertain a treatment attempt with a specific serotonin reuptake inhibitor such as paroxetine (Paxil) for a patient like Keith. (p. 266)

For purpose number 3, Othmer and Othmer mention a chronically mal-adjusted person with periods of increased energy followed by social withdrawal. The clinician notes that the person does not fulfill diagnostic criteria for bipolar disorder and decides to prescribe lithium. Two months later, the patient returns and reports great improvement in his relationships and behavior. Exemplifying the logical fallacy of deducing the nature of a problem from the treatment response, Othmer and Othmer write: "Such a response, even though not treatment specific, may for practical purposes confirm your impression that the patient had a bipolar disorder NOS" (p. 267).

Another expert source touching on the contents of the medication history is entitled *Practical Psychiatric Practice: Forms and Protocols for Clinical Use* (Wyatt, 1998). This manual includes dozens of detailed forms itemizing virtually all possible information from and about patients that psychiatric experts recommend practitioners to collect in order to practice psychiatry. Three different forms are meant to contain information relevant to the patient's history of substance use. In the first, *Self-Assessment Form*, the patient is asked to answer the following question in writing, before the first visit:

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them. (p. 10)

This same form queries the prospective patient to answer checklist questions about drinking, smoking, and use of illicit drugs. The clinician can choose to record these data, and those obtained from a personal interview, in a second form, the *Initial Psychiatric History and Examination*. It contains a section on the use of caffeine, alcohol, and illicit drugs, but none pertaining to previous prescribed medication use. According to Wyatt, "When completed, the document is a record of the patient's history, mental status examination, the psychiatrist's diagnostic impressions, treatment plans, and recommendations." Of note, "as much as possible, the form was designed to allow the recording of facts

with a check mark” (p. 21). The third and final relevant form in Wyatt’s volume is the 10-item *Patient (Medication) Information Documentation Form*. It asks the clinician to answer (by checking “yes” or “no”) whether the patient, and the patient’s family, know “the name(s) of the medication(s) the patient is taking,” “what the medication is intended to treat (i.e., the disorder itself or side effects of another medication),” “how to determine if the medication is working,” “what to do when a dose is missed,” “the name of the disorder for which the patient is seeing you,” “the major risks of the disorder and its likely course,” “when the patient should take the medication,” “how long it should take before they can expect the medication to work,” “the most important side effects and what to do when they occur,” and “the possible effects of the medication on potentially hazardous activities” (p. 47).

The above sources illustrate that in conventional clinical psychiatry, the over-riding functions of taking a medication history are to help the clinician determine a DSM diagnosis and prescribe a medication. In Othmer and Othmer (2002), the examples of suggested clinical reactions to patients’ information deny that psychiatrists are expected to engage in sophisticated or even somewhat individualized biological reasoning when making prescription decisions. In the entire Wyatt (1998) manual, the only question dealing specifically with “medication response” is asked of the patient *in writing*, before the initial visit. Viewed from the critical perspective sketched in this article, these guidelines are superficial and miss the point of taking a medication history of people who seek mental health services. The author would not use these sources as positive pedagogical aids for students, and there is evidence that similar guidelines and training, based on DSM-categorizing and prompt drug treatment, do not impact young residents in psychiatry positively. (For some critical opinions on this matter by psychiatrists, see Kemker & Khadivi, 1995; Smith, 2001; Tucker, 1998; see also Luhrman, 2001). It is difficult to see how such guidelines could help clinicians to reach an understanding of how patients respond to medication, how they interpret its effects, and how medication affects them as biopsychosocial beings. Similarly, it is difficult to see how taking the treatment history within the clinical approach delineated by Othmer and Othmer (2002) and Wyatt (1998) would help patients to make sense of these issues, thus increasing patients’ insight, autonomy, and power.

### ***The Psychiatric Medication History: An Interview Schedule***

The PMH is designed for use by any helping professional with any clients (except children), in an individual or group format. It may be used for information gathering in the assessment process, in the context of an ongoing counseling or psychotherapeutic relationship, or as a self-help tool for consciousness-raising. Its 30 questions/instructions represent 30 steps in the assessment of medication-related matters, meant to focus on why and how a person uses medication and meant to assist the participants understand the effects (in the biological, psychological, and interpersonal realms) of psychiatric medication. The client's answers can help the practitioner to form opinions on some of the following questions: How is medication "helping" the client? Should the client be referred for specialized assessment to properly diagnose subtle or gross adverse effects? Should the worker consider the possibility that the client would be better off with less of or without the medication? What is the client's potential to undertake a prudent withdrawal? What is the potential of the client's network to support such an endeavor? The PMH is merely one set of guidelines to enter the terrain of medication use and effects: it cannot account for the numerous styles of medication use but it can assist to identify them. What meaning and intelligibility these styles come to have for client and practitioner lies beyond the use of any semi-structured questionnaire.

The overriding task of the person taking such a history is to create a safe space wherein medication-related matters can be examined and discussed without the pressure to diagnose or medicate. A tool such as the PMH is not meant to be used with an involuntary client, as involuntary treatment is inimical to the ideal sort of relationship—voluntary and contractual—that should exist between participants in a helping (educational) encounter. This instrument is not meant to be used in an "emergency" situation, when clients, families, or employers are pressuring practitioners to *do something*. Finally, as discussed in Jacobs and Cohen (1999), there are valid reasons to believe that a proper assessment of medication effects is never complete until the client is able to reflect on the drug experience retrospectively, *from a drug-free standpoint*. Any instrument or interview relying solely on information obtained while the client is medicated will carry this important limitation.

For a practitioner functioning in a multi-disciplinary treatment team that expects a prompt assessment or review of "pertinent facts" in order to dispose of a case, the instrument will be inappropriate. The PMH is probably not meant to be used in a single session, although all the steps

can be covered in reasonable detail in a session lasting 75 to 90 minutes. This initial history may be augmented and modified with future probes. During the first interview, the issues are stirred and the client usually raises them later with more curiosity. This links the issues to the client's life, circumstances, problems, strengths, and challenges, and contributes to a proper understanding (assessment) of the client's overall situation. Use of the PMH is not meant to be an end in itself, unless for specific instructional or research purposes clearly explained to the subject and their informed consent obtained. Students in this author's graduate courses regularly use the PMH in course assignments.

Nourishing in clients a critical perspective about medications can be accomplished only if the attitude of the practitioner taking a medication history is one of respect for the client and curiosity about the client's thoughts and beliefs. Neither the most seemingly outlandish responses nor the most "erroneous" interpretations of clients need to be "corrected," at least initially. They can be treated as personal beliefs with which we need not agree but should treat respectfully and, if possible, seek to understand. In the presence of clients in distress, our own prejudices can become blatant, but least of all to ourselves. Thus, respect for and interest in the client's "lived reality" (Farmer and Bentley, 2002) provides the form within which the medication history can properly be taken. One tries to understand this "lived reality" through the client's verbal and non-verbal communications. One might then communicate back to the client what one has understood. One could then engage in a process of gentle challenge of *all* the client's ideas about medication (not simply the ones we find unreasonable), to discover how the client has come to hold them.

Different sections of the PMH explore different themes. Each is briefly discussed below.

*Steps 1-3: Baseline.* The first three questions on the PMH serve to establish a baseline for the client's problems and idealized solutions. For example, the client has been prescribed medication as a means to suppress painful or undesirable symptoms, to cope with an unpleasant reality. However, the practitioner is led to question whether this solution is uniquely suited to this client's needs, whether it has been implemented after a proper understanding of the clients' context, and whether it incorporates information that the client wished he or she had before undertaking drug treatment. Obtaining clients's present perspective on their difficulties, on what they believe is needed to resolve these difficulties, and on what they see as the main obstacles ahead is done *before* exploring drug-related matters. Indeed, the latter can easily distract or seduce client and helper away from arriving at a fresh understanding of *what is the matter (the problem) and what to do about it from now on.*

After taking the medication history, client and practitioner should find it useful to return to these original questions and to pose them in light of the newer understandings that might have been reached because of the focused exploration of the medication history.

*Steps 4-8: Names and instructions.* These steps direct the practitioner to list names (including idiosyncratic ones given by the person) and posology of all drugs prescribed/taken, and to gage the person's understanding/memory of the instructions that he or she might have received relative to the taking of medications. This includes asking about which beneficial and adverse effects were mentioned by the prescriber(s) or other health care provider(s). Clients may be asked to bring their medication boxes, bottles, or labels, so that exact information can be obtained. When initially discussing medications, this author has found it useful to have the "actual things" visible. In the peculiar (safe but formal) environment of the consulting office, this paradoxically encourages both an immediacy and a distance from the objects, that is, a perspective, which may otherwise be difficult to create in the abstract.

*Step 9: Compliance.* This question is meant to gage the person's regularity of drug consumption. Most people do not take medication exactly as prescribed. Individual patterns of consumption vary enormously, and each pattern may have an interesting or revealing justification.

*Steps 10-12: First use.* These three steps focus the interview on circumstances surrounding the first remembered use of prescribed psychiatric drugs (or the one that the client seems most concerned about). Instances of acute psychological trauma (the sudden loss of a close relative, an episode of psychological or physical abuse, a painful divorce) typically lead people to consult physicians, implicitly or explicitly requesting medications. Whether the consequences of such trauma could or should have been dealt with differently than by a prescription, why they were not, or why other options were tried and abandoned are questions of interest. With prolonged drug use, various other problems, including drug-induced problems, may have papered over the initial difficulties. How drugs actually made a difference during the initial crisis, how this was evaluated, and for what reason they are still taken weeks, months, or years after the initial crisis are critical matters that require exploration.

In contrast to the clinical psychiatric suggestions reviewed in the previous section of this article, the client's DSM labels are not of interest here, besides providing some idea why other clinicians might have prescribed a certain medication. DSM labels cannot make up for the

first-person story, which connects events, circumstances and history from the person's perspective to the person's emotions, thoughts and actions (Jacobs & Cohen, in press).

*Steps 13-19: Effects.* This section guides the practitioner to ask general and specific questions concerning what and how the client thinks the medication(s) is affecting him or her. One should cover at least as many areas (physical, cognitive, emotional, practical, social) as are suggested, because unless queried specifically most people do not typically make connections between their medication use and various emotional and behavioral states. Depending on the practitioner's level of knowledge of how drugs impact the body and how bodily organs impact drugs, questions can focus on some of these issues. Conversely, depending on the client's answers and the practitioner's knowledge and observations, other questions can explore medications' effects on processes such as emotion regulation, social sensitivity, short- and long-term memory, attentiveness to detail, ability to monitor one's psychological state, and concern for other people. Two additional questions ask the client to name any distinctive (characteristic, singular) psychological and physical effects of the medications. For example, some people taking "antidepressants" or "mood stabilizers" would not describe their distinctive psychological effects in these words, if asked in the context described above. These queries help clients to use their own language to produce a more "valid" (i.e., experience-tested) description of the medication.

*Steps 20-21: Non-drug solutions.* Here, the person is asked to describe other informal and formal attempts, besides taking prescribed medication, that may have been pursued to solve their problems: how serious were the attempts, what were the results, and what lessons were learned.

*Steps 22-26: Drug withdrawal.* Whether examined from a pharmacological, emotional, psychological, or familial angle, the issue of withdrawal from psychiatric drugs remains complex. The effects some people experience when they stop taking their medications, or merely reduce the dosage, or skip a few doses can be the most significant of their entire drug taking episode. However, such withdrawal effects are not acknowledged by many practitioners, and even less so in the published literature. What is more, unpleasant effects which are likely to abate with a truly gradual taper of medications may be described to patients by health professionals as evidence that the patient "needs" to remain on the medications indefinitely. Because many stakeholders in the mental health system are invested ideologically and emotionally in a

view of medications as the essential intervention, rational discussions about drug withdrawal rarely take place. Nevertheless, they may rank highly on clients' agendas. In sum, an "unbiased" discussion of the client's experience of stopping to take medications and reinstating them should be an integral part of any medication related discussion.

*Steps 27-29: Social network.* These questions are aimed to understand to what degree the client's current medication use might respond or conform to, or fail to meet, others' expectations, especially family members, friends, and health professionals. Question 29 asks the client to describe the last three different conversations about his or her medication use.

## CONCLUSION

Clients seeking or receiving mental health services today have many reasons to be wary of the *zeitgeist* of the times. From this author's perspective, there have been several worrying developments during the last two decades: rampant biologization of distress; overemphasis of drug treatments at the expense of every other sort of intervention; increasing adoption by psychologists and social workers of biomedical models of categorizing distress and intervening with clients; decreasing privacy within the therapeutic relationship; and increasing social acceptance of involuntary psychiatric interventions. These and other trends highlight the importance of creating safe spaces where clients and practitioners can critically explore the issue of psychiatric medications.

For clients, discussing their medication use along the guidelines suggested in this article could provide an opportunity to construct an independent, evidence-tested personal narrative about their drug-taking. It could serve to uncover some otherwise unarticulated impacts of medications on their lives, including the extent of psychological alterations brought about by centrally acting substances. It could help to clarify their representations of medications, medication effects, and mechanisms of drug action, as well as the origins of these representations. It could help them to discern how taking medications might be structuring some of their interpersonal relationships and activities, and how, in turn, these relationships influence their medication use. It could assist in articulating clients' desire to stop taking medication and entertain other options to manage their distress.

For practitioners, the PMH offers a person-in-environment point of entry into the psychopharmacology scene. Conducting ten or more of

these in-depth histories with different clients will provide any social worker, regardless of their current knowledge level, with a wealth of information and hypotheses about the social and behavioral effects of psychotropic medications. Much of this information is simply unavailable in published works. This information can be systematized, tested, and shared with colleagues and students. Taking a psychiatric medication history can help practitioners to understand their clients' experiences and can assist clients to develop conscious ways to integrate or exclude psychiatric medication from their lives.

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