Shirley A. Smoyak, RN, PhD, FAAN, Editor, interviewed Daniel B. Fisher, MD, PhD, to learn, first-hand, about his experiences as a provider and consumer of mental health services.

Overcoming Schizophrenia

"The most difficult thing I confront is the coercive nature of the mental health system."

Fisher at the NEC

SMOYAK: We think that it's very important to provide our readers with first-hand accounts of professionals who are also consumers, and their work. Please talk about your work in the field of mental health.

FISHER: I agree, and that is why I now disclose my history of mental illness. I would divide my work in mental health into at least two sections, timewise—before and after deciding to disclose.

The first period of my work was when I didn't disclose, and I think disclosure is really a watershed, in a way. Before I disclosed, I really had to be much more cautious about how outspoken I could be. As a result, I was under a lot more tension. I couldn't reach out and get supports from other people. I couldn't speak up in a direct way if I heard someone discriminating against another consumer.

What I especially couldn't do was influence policy in the way and in the directions that I wanted to, because I was afraid I'd be found out.

SMOYAK: Would you please back up just a minute and say where medical school came in this process for you?

FISHER: I never disclosed in medical school. I was certainly very quiet about any of my experiences.

SMOYAK: Your onset of illness was before medical school?

FISHER: 1969 was my first hospitalization, and I was 25. I already had a PhD in Biochemistry at the time, and at that time had no thought of medical school. It was actually my experiences as a patient which led me to decide to become a psychiatrist.

SMOYAK: Where had you been headed with a PhD in Biochemistry, before your break?

FISHER: It's kind of ironic; I was trying to find the chemical solution to schizophrenia. I was looking for the biological link, or answer, to what was wrong with people who were diagnosed with schizophrenia.

SMOYAK: What set you on that path?

FISHER: There were people I knew who had emotional problems. It was sort of a mission to cure them or help them. But I think this work drove me partly crazy! I believed so thoroughly that these emotional problems were caused by biological imbalances that I took it to its logical extreme.

I became convinced that we were all basically machines—that I was a machine, and that led me down the path of psychosis. I no longer thought symbolically that we were machines; I moved over to thinking we really were. That was extremely frightening.

Daniel B. Fisher, MD, PhD, is Executive Director of the National Empowerment Center, Wakefield, MA.

Dr. Fisher is a provider of mental health services who overcame schizophrenia. He is one of the few psychiatrists in the country who openly discusses his recovery. His life dispels the myth that people do not recover from mental illness.

Dr. Fisher received his AB from Princeton University, his PhD in biochemistry from the University of Wisconsin, and his MD from George Washington University.

I found that I could come back to my very ordinary, day-to-day life, by taking medication, and not thinking those thoughts. But this really didn't work for me.

After my first hospitalization, I went back to the laboratory and tried to work again, but the same delusion persisted. I had to be hospitalized again, because I couldn't function.

During the second hospitalization, I decided that I should go to medical school.

This decision came to me while I was in seclusion. It was partly motivated by wanting to change the system, so that people wouldn't have to be put in seclusion when they needed help. That was 1970.

SMOYAK: Did you apply to medical school right after discharge?

FISHER: Actually, no. I first applied to social work school. I took the Miller Analogy Test and did well, and had done well all through college, graduating cum laude, had written a lot of papers and had been a successful biochemist. But I was turned down for admission to social work.

SMOYAK: Why?

FISHER: Well, the reason they gave was that they had never admitted anyone with a PhD in biochemistry.

They said I should go to medical school, and be a psychiatrist.

I wonder, even today, if they found out that I had been hospitalized. I don't think I was presenting myself as that far off at the time. I was in therapy, and was back to reality, more or less.

But the rejection was a shock to me. So I applied to medical school and got into George Washington University.

Then the stress and pressure of the first year of medical school caused me to have another episode or breakdown. It wasn't just the ordinary pressure, because I was trying to get through faster.

SMOYAK: Because you were a PhD already?

FISHER: Yes, so I thought I could get a year off, for good behavior, so to speak, but as it turned out, they only gave me credit for one course, biochemistry! Even for that, they wanted me to take a test!

SMOYAK: Well, those admissions committees can be tough.

FISHER: How well I know. So I had to take double the course load that first year.

> "I fantasized that I actually was the enzyme I had been working on—I was the hydroxylase."

SMOYAK: You probably didn't have human anatomy and physiology and all that . . .

FISHER: That's right—actually I took histology over the summer. But the double course load wasn't easy. And I once again got off to this other reality, with all the pressure I felt.

I in fact fantasized that I actually was the enzyme that I had been working on—I was the hydroxylase. I was it, and could actually feel the molecules coming at me.

I actually took the dictum of biochemical research to an extreme—to get into the problem. Well, I did! I was doing good research, getting into my subject and it got into me. I could draw these little molecules advancing. The boundary between me and my work completely broke down. And also between me and the reality around me.

SMOYAK: Did you have this break while you were actually in school, in classes? Did people around you know what was happening?

FISHER: Well, I don't see how they could not know, but I don't think they knew. I just stayed away from school. I'm not sure if the school was notified or not.

SMOYAK: Was the timing such that this occurred at a break, or semester's end?

FISHER: No, it was right during the semester. I missed a lot of classes, but people didn't seem to notice. This was another kind of remarkable thing—I still was able to take tests well, and had classmates who supported me by giving me lecture notes and filling me in on things. I studied them, and the week after I got out of the hospital, we had final exams. I passed them, and that was a miracle.

I considered leaving school. Another significant factor was the support of my parents. When I said I was thinking about leaving school, they left it up to me—no pressure to stay, or finish, or do what they thought was right. They had been in therapy themselves, and understood that the decision had to be mine. They recognized that my happiness was more important than my accomplishments. They said, "Do whatever will make you happy."

SMOYAK: And, obviously, you made the decision to stay.

FISHER: Yes, I decided to continue. Because it was my decision, I persisted. I think what helped me a lot during medical school was supports outside medical school. I tried not to become overly immersed in my work; that over-

involvement in work was what led to my previous breakdown. So I joined a square-dancing group, which was very, very helpful. Those folks became a sort of community; I'm still in touch with some of them.

SMOYAK: So, all through the four years of medical school, you didn't disclose and just made your way through the requirements.

FISHER: Basically, yes. Although one thing did happen that was pretty significant.

This, of course, was pre-ADA [Americans with Disabilities Act]. I was accepted into medical school, but the dean of students called me in, and said, "You're accepted, but I have one question. Were you ever hospitalized?"

I was dumbfounded; I had no idea about where or how he had gotten this information. I said, "Yes, I was." But I asked him what prompted his question.

He said that I appeared to be in good physical health, but had been in therapy. One of my references noted that while my work at NIMH [the National Institute of Mental Health] was very good, I accomplished it in spite of being sick several times.

So he concluded that I had been hospitalized. He told me that if my psychiatrist wrote a note and said that he thought I could meet my educational goal that they would accept me.

SMOYAK: Not a note from your Mommy and Daddy, only your psychiatrist.

FISHER: That's right, and they did let me in. The psychiatrist was actually quite helpful through this whole thing.

When I told him that I wanted to go to medical school, I was not in good shape at that point. I was barely going to work, and was in and out of what was real and what was not. He said he would come to my graduation, and years later, he did, even though I wasn't seeing him any more as a consumer.

The big challenge, actually, was residency. That was an awfully big challenge. Luckily, I was guided at that time to what was possibly the best residency program for me, which was Cambridge Hospital in Massachusetts. It was a liberal-oriented place, where they were very progressive about working with the community; they were very noncoercive. And they seemed to like me.

SMOYAK: That helps!

> "I was very upset with the way that they were coercing people to do this and that, especially over being admitted to the hospital."

FISHER: At the time, I was into wearing these rather strange hats, some of them crocheted, with bright colors. I crocheted one, myself.

SMOYAK: Sort of like Dr. Seuss?

FISHER: Yes, that's it! Like the Cat in the Hat; it was green and red and strange. I wore them all the time, and they just took this with a grain of salt. No big problem. But I did not come off as a doctor; let's put it that way.

SMOYAK: How did you dress?

FISHER: I didn't wear suits; I didn't wear a tie. I was rather casual, you might say, but that was OK with them. It was a casual kind of place.

They did supervise me very closely; we all had supervisors who were very in tune and attentive. There was only one episode which almost resulted in their kicking me out; it was over a treatment issue. This remains the most problematic aspect of being a psychiatrist when you are a consumer, even today.

SMOYAK: What was the clinical conflict about?

FISHER: I was a first-year resident, and I was very upset with the way that they coerced people into doing this and that, especially into admission to the hospital.

There was one particular woman who had been my patient in the state hospital. She was in her early 40s and was a mother, and she'd been repeatedly hospitalized on an involuntary basis, admitted about once a year. She would become mute, and then would gradually come around and leave the hospital, and be home for about a year, doing OK. So I knew her from that context. And then after I'd been at Cambridge for about six months, I was working in the community hospital, and was called as part of the crisis team to respond, to go see her.

She had thrown her television set out the window; this was a pattern with her, when she was starting to become psychotic. I could relate to this, by the way, because I had had the symptom of the TV talking to me; I knew that one very well. So I talked her into a voluntary admission. I said to her, "Look, we'd like for you to come in on a voluntary basis, into the community hospital, instead of being involuntary at the state hospital."

She wasn't talking, but she was obviously listening, and I knew she knew me. I also knew, from my own experience of being in a psychosis, that one can hear and take in more than the observers imagine can be the case. One can hear and process a great deal, even in these states; I knew this first-hand.

Resources from the National Empowerment Center

The National Empowerment Center (NEC), a nonprofit organization run by consumer-survivors, provides a number of resources. They also have an information and referral service to provide information about consumer-survivor resources, and selected topics such as holistic alternatives to symptom management or how to form self-help or mutual support groups.

Videos offered through NEC:

Self Managed Care
by Daniel Fisher, MD, PhD
This video provides suggestions on reducing overall health care costs, promoting recovery rather than dependency, using peer support, and encouraging the use of complementary medicine approaches.

Recovery Is for Everyone
by Daniel Fisher, MD, PhD
The values, philosophy, and practices that have enabled the author and others to recover are delineated in this video, which presents the story of his personal experience with mental illness and recovery.

Recovery as a Journey of the Heart
by Patricia Deegan, PhD
In this video, a provider-consumer of mental health services shares her lived experience of mental illness, the recovery process, and how professionals, peers, and friends can help.

Printed media offered through NEC:

On Our Own
by Judi Chamberlin
A compelling case is made for patient-controlled services, an alternative to institutions that destroy independence, in this book, written by a former patient of public and private American mental hospitals.

Coping With Voices: Self-Help Strategies for People Who Hear Voices That Are Distressing
Developed by Patricia E. Deegan, PhD
This self-help guide teaches patients specific techniques to gain control over or eliminate voices that are distressing.

Many other articles, books, and audiotapes are available from NEC. For a complete listing, contact the NEC at 20 Ballard Rd., Lawrence, MA 01843; 800-769-3728.

Others think that you can't think at times like this, but in actuality, you're thinking double time.

So I said, since she wasn't violent with anyone, that we would admit her on a voluntary basis into the hospital. We would not force medication on her, as long as she wasn't violent to anyone, or herself. She nodded in agreement.

She came in as a voluntary patient. But the staff was very upset about this. She was mute, and she had to be fed, or encouraged to eat.

They would not do it, because they were afraid of her, because she wasn't talking and was clearly in her own world. So I went in every day, and got her to eat whatever she would eat—milk, jello—I drew her blood, and showed them that these things could be done.

They still didn't believe she should be there. Every morning, for the next five mornings, the chief resident would come to her, as we did rounds, and he'd say, "Dr. Fisher, why isn't this patient being medicated?" And I'd say, "Because she's not ready to take medication yet." And he'd say, "Well, the treatment of choice is 400 mg of Thorazine; you should force the medication." And I'd say, "I made an agreement with her. I'm trying to develop her trust in us, and in me." He laughed and laughed. He pointed at me, and jeered, "He's concerned with trust, with someone who's psychotic!" At that point, I was ready to walk.

But I had a good therapist; I was in therapy again at that point. This therapist, himself, had been through some of these experiences. I told him how angry and upset I was at this chief resident, and how I felt that I really couldn't oppose him or talk back to him. So the therapist put his fist on my chest, and said, "I'm the chief resident, so what are you going to do?" I said, "Get your fist off me." "That's puny!" says he. So I reared up and yelled, "Get your fist off!" That helped me to get my voice out.

So the next morning, at rounds, I was ready in a new way. Again, the same question, "What are you doing about medicating Mrs. X?" This time, I lowered my glasses, looked out over them, and very decisively said to him, "Don't ever talk to me about her in that way again! I have my plans."

But it was only temporary, because he called on the assistant director of the department of psychiatry, who came up and I said, "This is illegal. Not only is it unkind and immoral, but there's a lawsuit, contesting medicating patients against their will." The assistant director responded, "The day that the law tells me how to practice psychiatry, that's the day I take my shingle down!"

SMOYAK: What's he doing today, with behavioral care managers telling everybody what to do?

FISHER: Beats me. But every period has its issues and concerns. Today, for me, the issue is community commitment. I've accepted that at certain times, I need to commit people to a hospital. The way I worked that out was to decide that I wanted to practice more than I didn't, so I did certain things I did not want to. I reasoned that I wanted to stay and to be there, to lend support in situations where maybe the support would not be there otherwise.

So I've accepted that from time to time, I have to commit somebody to a hospital. I'll beat the bushes and do everything possible to avoid this, but sometimes it just has to happen.

I do draw the line, however, on outpatient commitment. Just this week, it was brought up again at a meeting. "So-and-So is not taking his medication, and he's in the community, and he should be. In order for him to stay in the community, he's got to take it." I thought about it; should I bring it up again?

In this case, I've disclosed; people know me and my background. I've been open. I've got all the cards going for me, and still it's hard. I've been public about my position; at this point, everyone knows. I have a support group, a peer support group, who are survivor-providers.

Still, the most difficult thing I confront is the coercive nature of the mental health system. I fail to understand why professionals think that they need to force people to take their medication. I constantly hear stories about how money is withheld from patients unless they take their medication.

SMOYAK: I sidetracked you earlier when I asked you about medical school. Would you talk about how you decided to disclose after your residency?

FISHER: You know, there is voluntary and involuntary disclosure. First there was involuntary disclosure. Somebody did tell somebody else back during my residency. I was never really sure who knew and who did not know.

SMOYAK: This goes back to the dean of students?

FISHER: Well, I don't know. I was in a support group, MPLF (Mental Patients Liberation Front), a patient's Civil Rights group. I wanted to be a member of that group, but they wouldn't let me be a direct or core member, because I was a psychiatrist. I could only be a Friend of the group.

In that group, there was a woman whose therapist was the head of the Department of Psychiatry, and she told him about me. I was very upset. I immediately went and talked to him. This was my second year of residency. He said it was all right with him, but acknowledged that it would not sit well with others in the Department.

> "I fail to understand why professionals think that they need to force people to take their medication."

SMOYAK: So you were able to contain the event . . .

FISHER: So far as I know. I still don't know—then or now—who knew and who did not. The problem with not disclosing and being secretive is not knowing who knows what. I didn't feel secure enough at the time; I didn't feel that I had enough of a power base to disclose.

SMOYAK: When did you feel that you had enough of a power base?

FISHER: Once I got out of my residency. In fact, I did a very, very public disclosure the year after I finished my residency. I went on TV, on "People Are Talking." I was asked who I would like to have on there with me, another doctor. I said. "The chief of my residency program."

SMOYAK: That should have been fun.

FISHER: Yes, but as it turned out, I was a bit infuriated at him, still. As we were walking up to the podium, I told him that I was going to talk about being hospitalized prior to my residency, and he commented, "Oh, that's very much in vogue these days, to have been in a psychiatric hospital." I just wanted to belt him.

One other thing I wanted to mention. He was the doctor in charge of the residents, and after that medication issue that I described, he called me aside and said, "I don't know if you're right for this program. I think we have a pretty fundamental, philosophical difference of opinion here." I said, "I agree, we certainly do have a philosophical difference, but I want to try to continue in the program anyway." He said he'd try.

As I look back over this, I wish that I had insisted on a more in-depth discussion with him, about just how it was different. That sort of epitomizes how things go. I continue to have a basic philosophical difference with the mainstream mental health culture writers.

SMOYAK: Pat Deegan calls them "traditionalists." Do you use that term?

FISHER: Yes, I guess that's one term for them. Another is mainstreamers. The dominant ideology at the time. The medical model. Paternalism. All these positions or factors that I feel work against people, and not for them. They work against their deeper recovery.

SMOYAK: Was there a moment, after your residency, when you said, "OK, this is the day that I'm going to do it, to go public"?

FISHER: No, the opportunity actually came when Judi Chamberlain asked me to be on the TV show.

SMOYAK: How did you know Judi?

FISHER: I met her during my residency, at one of the consumer meetings. A lot of the consumers knew who I was, but the school didn't know.

I had written to the MPLF and introduced myself. They said I could come as an ex-patient, but not as a psychiatrist, and I didn't know what that meant. What it meant was that they didn't consider me a "core" member.

Some of the consumers at the hospital where I was working as a resident would come up to me and whisper, "We know who you are." Another time, a woman gave me a form, and inside it was a flier for Judi's book, *On Our Own*. She also said, "This woman would like to meet you." That's how it happened. That was about 1978 or 1979. We have worked together ever since.

> Right now, I'm working to change the culture of mental health and of the general public so that people with mental illness are seen as people."

Right now, I'm working to change the culture of mental health and of the general public so that people with mental illness are seen as people. The mental health system must recognize the need not only to listen to people, but to encourage them—and to do this encouraging actively.

The mental health system needs to allow the expression of their voices, individually and collectively. I do this through my work as the Director of the National Empowerment Center and through talks and workshops.

SMOYAK: How much of your time does the National Empowerment Center take up?

FISHER: I work here about 30 hours, and another 16 hours a week at the Mental Health Center, as medical director, and community psychiatrist. That adds to more than 40, doesn't it?

SMOYAK: Yes, and then you speak and write and travel...

FISHER: Yes, but I'm trying to classify those speaking and writing things as part of the Center's work now. Every honorarium and all royalties I get go into the National Empowerment Center. I've done some videos recently. One is on how to manage managed care—each individual becomes his or her own manager.