The gift of misery

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On the first day of my psychiatry clerkship, I sat at a table with another student, 2 residents, and our attending physician. This wasn't my first clinical rotation, but it was my first formal exposure to psychiatry, and I was excited and a bit anxious because I was considering psychiatry as an area of specialty training for myself. I'd been assigned 1 patient that morning: a 42-year-old man admitted for alcohol withdrawal. Our team, the psychiatry consultation-liaison team, was asked to evaluate the patient's depressed mood in the context of withdrawal. As I began to present the patient's story, I spoke of how terrible this man's life had been, and how depressed he had recently become; this depression, I said, was likely exacerbated by alcohol use, but he was dealing with his depression by drinking more. He now wanted to quit for good. My attending, whom I had just met, interrupted me: "Misery," she said with an intense look, "is a gift to an addicted person."

I have ruminated on those surprising words ever since, and in that time I have begun to understand something about misery through the eyes of my patients. Sick people often are miserable; physical ailments can wreck hopes and plans and suck the joy from seemingly everything. Individuals who are ill or in pain often are suffering psychologically as well as physically. This suffering has been especially apparent to me in patients withdrawing from addictive substances: alcohol, cocaine, heroin, nicotine. I have been begged, cursed, praised, thanked, and more based on my ability or inability to relieve someone's suffering caused by the lack of a certain substance: *Please, just one cigarette. Please, something for this pain. Please, something to drink.* As a medical student, I did one of 2 things: stood there helpless, or promised I would do the best I could, knowing my resident or attending would likely tell them no.

Withdrawal from addictive substances is, unsurprisingly, not pleasant. Alcohol withdrawal is one of the few that can be fatal, due to its ability to cause autonomic instability and seizures. Withdrawing from alcohol is also unpleasant due to hallucinosis and tremors, on top of the very real cravings for the substance itself. My patient knew this; he had withdrawn from alcohol in the past. As he talked to me, though, it became clear he had finally decided this was the end. In the past, others encouraged him to stop drinking; this time he was doing it for himself. His life had become so dismal that he was willing to undergo the agony of withdrawal to be free from his addiction.

Was his suffering, then, his misery, a gift? As I came to know my attending better, I also came to understand what these jarring words meant to her. They were her version of the old adage: It's only when you hit rock bottom that you can start climbing back out.

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It isn't the misery of withdrawing, but the misery inflicted by the substance that might provide an unexpected opportunity to start fixing things. For my patient, this particular trip to the hospital—which happened to intersect in space and time with me, a third-year medical student keen to learn and to help—was rock bottom, and he knew it. His life had been destroyed by his addiction, and here, at this intersection, the destruction was so great that he was finally willing to make a change for the better.

It is counterintuitive to think of misery as a gift, but then again, this patient—and more broadly, all patients whose lives are tormented by addiction and substance abuse—are often on the receiving end of counterintuitive advice, and it is frequently the only way to enact lasting change. Consider, for example, Alcoholics' Anonymous, which works for far more individuals than one might expect. It does not seem possible that a small group without formal training could keep people sober simply by talking openly about their struggles; yet every day throughout the world, it does just that.

Patients struggling with addiction—labeled as addicts and drug-seekers by most of the world—are often written off as "difficult patients." Perhaps because of my inexperience, I didn't see this man as difficult, or as just another case of alcohol withdrawal. Although it may often be easier to define someone by his or her disease, I believe in choosing to see the human underneath the label. To me, these patients are not difficult; they are broken and miserable, and they desperately need help. Knowing this, I am forced to consider just how bad things have gotten for them, and how hard it must be to make a change. Their brokenness may be an opportunity to start down a new path, but only if we extend that invitation. Such an invitation may be the first step to turning genuine misery into a gift.

When I'm asked why I have chosen psychiatry, willingly entering such a "difficult field," I think about my experience on that consult service and this patient. I know that I'm still just beginning my journey, and that even more difficult moments and patients lie ahead. But difficulty depends on one's perspective; certainly that patient, trying to free himself from addiction's grasp, was "going through a difficult time." This is of course a platitude; the word "misery" gets much closer to the truth. I usually answer with some variation of the following: Medicine, especially psychiatry, is about caring for those who need it most: hurting, vulnerable people rejected by friends, family, and society. Our business is misery; sometimes we track in the broken, the beat down, the rock bottom. We get down in the depths with our patients to offer comfort and hope. We look at an addict, but we see a human being. We try to see the world from his or her perspective. This isn't always pleasant—sometimes, it's downright miserable—but to see the world through the eyes of another is, always, a gift.

Clinical Point

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