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Jessica Hahne

Yale University, jessicamariehahne@gmail.com

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Self-medication and “Personal Medicine” as Alternatives to Pharmaceuticals Among American Young Adults with Mental Health Conditions

Jessica Hahne, *Master of Public Health Candidate*
Yale School of Public Health

Background:

Many studies have documented high rates of non-adherence to prescribed psychiatric medications among individuals receiving mental health services. Few studies have sought to understand how young adults with mental health conditions who are not consistently connected to mental health services view psychiatric medications, or what types of self-directed symptom management strategies they might prefer to psychiatric medications.

Methods and Results:

This secondary analysis on 11 pairs of semi-structured interviews with young adults (aged 24-28) used a grounded theory approach to elucidate common themes in self-management of mental health symptoms. Many participants described alcohol or marijuana use as preferred strategies for symptom management, perceiving these substances to be less addictive than psychiatric medications, to have preferable effects, and to be expressions of self-control compared to psychiatric medications signifying a lack of self-control. Other participants expressed similar reasons for psychiatric medication aversion, but also rejected self-medication, and instead relied on spiritual or wellness practices to manage symptoms.

Conclusions:

The findings on self-medication shed light on a need for interventions against self-medication with alcohol or illicit drugs. Given inconclusive knowledge on the effects of marijuana, further research on potential risks and benefits of marijuana as an alternative treatment is needed as legality and social acceptability of marijuana increase. The findings on spiritual or wellness practices shed new light on how “personal medicine” (non-pharmaceutical, self-directed symptom management strategies) might complement or replace psychiatric medications as part of a process of shared decision-making between clients and mental health care providers.

Background

Psychiatric medications are considered a frontline treatment for many mental health conditions. While patient involvement in decisions about medications is often emphasized in clinical practice guidelines (APA 2016; NICE 2009), individuals who use mental health services have frequently reported feeling a lack of agency in the decisions made about their medications (Adams, Drake, & Wolford, 2007; Read,

2009). Many individuals with mental health conditions simply choose not to take medications. A recent review of studies involving individuals connected to mental health services estimated medication non-adherence rates of 20%-50% for bipolar disorder, 20%-72% for schizophrenia, and 28%-52% for major depressive disorder (Julius, Novitsky, & Dubin, 2009). As these wide ranges suggest, non-adherence to medications is notoriously difficult to estimate with precision, given the different limitations of research methods such as patient self-report or use of pharmacy data (Julius, Novitsky, & Dubin, 2009). Furthermore, mental health recovery is a complex process that varies across individuals, often begins before mental health services are sought, and happens largely outside of the clinical setting, in the activities of daily life (Biringer et al., 2016) (Borg & Davidson, 2008).

For many individuals, the experience of mental health conditions starts early in life, with little connection to clinical services. Although 75% of all lifetime mental health conditions begin before age 24 (Kessler et al., 2005) only about one-third to one-half of US children and adolescents with mental health conditions receive any form of professional help (Costello et al., 2014). Many early onset cases of mental health conditions go undetected for several years, into young adulthood (Costello et al., 2014). Although medication non-adherence among service-connected individuals is well-accounted for in the literature as described above, much remains to be understood regarding aversion to psychiatric medications among individuals who are not connected to mental health services—including the estimated many young adults with mental health symptoms whose conditions began in childhood or adolescence.

Historically, psychiatric research on mental health clients' non-adherence to medications has framed the trend as an issue of compliance, with research oriented toward increasing rates of medication adherence. Recent years have seen an increased shift toward an alternative paradigm of shared decision-making for psychiatric care (Deegan & Drake, 2006). While the compliance model assumes that the provider knows what is best for the client, even if the client does not agree that psychiatric medication is an effective option for them, the shared decision-making model proposes a greater valuation of the client's perspective on what their recovery process should look like, in addition to valuing the evidence-based treatment recommendations of the provider (Deegan & Drake, 2006). The goal is to bring these areas of expertise together to shape a client's care plans and work toward a mutual vision of recovery (Deegan & Drake, 2006).

Deegan (2005) presented the concept of "personal medicine" as a key consideration in shared decision-making models for psychiatric treatment and recovery. Personal medicine may be understood as any "self-initiated, nonpharmaceutical strategies, to improve wellness and avoid unwanted outcomes, such as hospitalization" (Deegan and Drake, 2006). The concept of personal medicine may shed light on motivations for non-adherence, as individuals who find the effects of psychiatric medications to support personal medicine tended to adhere to prescriptions more consistently—whereas individuals whose medications inhibited their ability to practice personal medicine were more likely to stop taking them (Deegan 2005). Examples of personal medicine described by Deegan (2005) included both activities that promoted self-care such as exercise and roles that gave

life meaning and purpose such as mothering. Along similar lines, a recent review of 20 qualitative studies found that individuals with mental conditions perceive a wide variety of non-clinical strategies to be helpful in managing symptoms, ranging from creative activities, to structured routines, to spirituality (Lucock et al., 2011).

A more potentially harmful method of self-initiated coping with mental health conditions that has not yet been extensively explored under the shared decision-making model is chronic use of alcohol and illicit drugs. A national survey in 2014 estimated that 7.9 million adults in the US had co-occurring mental health and substance use disorders, with the highest rate of co-occurring past-year serious mental illness and substance use disorders observed among young adults ages 18 to 25 (SAMHSA, 2014). Research has linked the co-occurrence of mental health conditions and abuse of alcohol and illicit drugs with higher rates of psychiatric hospitalization (Haywood et al., 1995), as well as higher likelihood of other negative outcomes such as violence (Cuffel, Shumway, & Chouljian, 1994), homelessness (Caton et al., 1994), incarceration (Abram & Teplin, 1991), and risk for serious infectious diseases (Rosenberg et al., 2001). These outcomes may involve the direct effects of drugs or alcohol, or may also be explained by the lower likelihood of compliance with psychiatric treatment that is observed among individuals with co-occurring substance abuse (Strakowski, DelBello, Fleck, & Arndt 2000).

One prominent hypothesis to explain high rates of co-occurrence of mental health conditions and substance abuse is the self-medicating hypothesis, which posits that some individuals with mental health conditions choose to use alcohol or drugs to relieve symptoms of their mental health conditions (Khantjian, 1997; Chilcoat & Breslau, 1998; Strakowski & DelBello, 2000). Although many studies have supported this hypothesis, much remains to be understood regarding the subjective perceptions of individuals with mental health conditions who use alcohol and illicit drugs and are averse to using psychiatric medications. Exploring such perspectives could help build providers' understanding of how to approach shared decisions about mental health treatment when clients have a history or are engaged with harmful patterns of self-medication.

This qualitative analysis aims to build toward a deeper understanding of the self-described reasons why some young adults who are not consistently connected to mental health services may reject psychiatric medications in favor of self-medication or "personal medicine." This analysis draws from in-depth interviews with 11 young adults (ages 24-28) with a self-reported history of stressful life events—which may be associated with both substance use and onset of mental health conditions (Low et al., 2012). Participants for the analysis were sampled from the original study based on the criteria of having discussed, in their interviews, experiences of substance use (either their own, or that of social connections). All participants in the sample described either past or ongoing experiences of mental health symptoms, and a majority of participants expressed aversions to psychiatric medications, in favor of self-medication or "personal medicine" in the form of spiritual or wellness practices.

The design of this analysis offered the particular advantage of interviews taken at two time points. Given that many participants experienced significant changes in relationships, employment, and even perspectives on their mental health

conditions over the course of the two-year study, having interviews at two time points allowed this analysis to take those changes into account for a more complete picture of participants' experiences.

Methods

Study Design and Sample

We analyzed in-depth, semi-structured interviews conducted with 11 young adults (ages 24-28) at two time points (2013 and 2015), a total of 22 interviews. The interviews were part of a sociological study on human resilience and flourishing (Mooney, forthcoming). This study recruited 26 young adults who had originally participated in the National Study on Youth and Religion (NSYR), a nationally representative study on youth from various regions of the US that began in 2002. The primary study selected participants who had self-reported on NSYR surveys having experienced one or more stressful life events. The study author conducted all interviews in-person, using a standard interview guide including questions about relationships, life goals, values, and motivations. When necessary, the interviewer used probes to encourage participants to elaborate as needed.

For this secondary analyses, we referred to interview memos from the primary study and used purposeful sampling to select young adults from the larger study sample who mentioned either their own or their social connections' substance use. For each individual selected, we included both interviews (2013 and 2015) in the analysis.

Sample Characteristics

The sample included 7 men and 4 women, between the ages of 24 and 28 at the date of the first interview. One limitation of the sample was a lack of heterogeneity in the race/ethnicity of participants, with 9 White participants and 1 Black participant selected. However, participants represented various regional subcultures of the US, with 6 participants from the West, 3 from the South, and 2 from the Northeast.

Data Analysis

The research protocol for this secondary analysis was approved by the Human Subjects Committee at Yale University, New Haven, Connecticut. Our analysis followed a grounded theory approach, as described by Strauss & Corbin (1998). Throughout the process of reading transcribed interviews, we developed codes (labels denoting meaning to excerpts) inductively to reflect the data, and wrote memos to reflect emerging concepts. This process allowed for continual shaping of the research question to incorporate ideas emerging from the data. From an initial broad interest in young adults' self-described motivations for using or not using particular substances, the story of self-medication versus personal medicine

as primary strategies for mental health symptom management emerged from the data.

Reading through the first few transcripts, the primary author created an initial coding scheme. After reviewing these preliminary codes alongside memos, the primary author developed a focused codebook in consultation with secondary authors. The primary author then coded all remaining interviews using the finalized codebook, constantly comparing the application of codes across interview transcripts to check for consistent application of each code to similar data. The primary author then extracted a number of codes related to mental health experiences, substance use, and attitudes toward psychiatric medications, to analyze the application of these codes across interview transcripts, frequently returning to the full interview transcripts to reread coded excerpts within the context of participants' overall narratives. The primary author continued to write memos throughout the analysis of coded data, to refine and better understand the relationships among concepts, in continual consultation with secondary authors. We used the online software program Dedoose throughout the analysis for data organization and retrieval.

Results

Many participants expressed reasons for aversion to psychiatric medications and described alternative methods of coping with symptoms. Many participants described self-medication, mainly with alcohol or marijuana, as a strategy for symptom management. Three main concepts emerged from these participants' narratives: concerns about addiction to pharmaceutical drugs, a preference toward the effects of marijuana or alcohol in contrast to the side effects of psychiatric medications, and an emphasis on self-control in decisions to use marijuana or alcohol and not to use psychiatric medications. Each of these themes is explored at length in the first three sections that follow. The fourth and final section explores the perspectives of participants who rejected both licit and illicit drugs as options for managing symptoms, in favor of spiritual or wellness options that might be described by Deegan (2005) as "personal medicine."

"The whole concept of having to take a pill": Associating dependence on psychiatric medications with addiction to pain medications

Many participants either had a history of abusing prescription pain medications, or knew of people in their social networks or wider communities abusing prescription pain medications. Impressions of the effects of prescription pain medication abuse were overwhelmingly negative, and the perceptual lines between psychiatric medications and pain medications were often blurred in the minds of participants who saw all pharmaceutical drugs as substances likely to elicit abuse or addiction.

One participant, "Alex," (age 26, from the South) grew up in a single-parent home and went on to experience other breakages in close friendships and mentorship relationships as an adolescent. He describes this relational instability as

leading into a “negative lifestyle” from age 10 to age 20, abusing alcohol, marijuana, and pain medication, along with frequent partying and petty crimes. Along the way, he was diagnosed with several mental health conditions: ADD, ADHD, bipolar, and schizophrenia, for which he took multiple medications.

Alex entered young adulthood with the desire to start living a more sober lifestyle, “laying down” his marijuana and pain medication habits. Although this shift to sobriety did not encompass alcohol—he still drinks moderately as a social activity—it did provoke him to stop seeking mental health treatment, including his medications. He states:

I left the whole mental thing alone [...] because I didn’t want to have to keep the whole concept of having to take a pill [...] If I would’ve kept taking those pills that I knew were meaning to help me, I would want to take pills that would intoxicate me and I couldn’t do it no more.

For Alex, mental health medications have the potential to become a gateway drug, with the very behavior of taking a pill threatening to trigger old habits of abusing other pills. He claims in both interviews that he no longer experiences the symptoms that used to make him dependent on medication—which he attributes in the first interview to an answered prayer from God, and in the second interview to keeping his “mind busy” in the midst of unemployment, doing car repairs and other odd jobs for friends.

Other participants were immersed in communities with widespread prescription pain medication abuse. Laura (age 24, from the South) experiences bipolar and depression. When her 1-year-old baby daughter drowned in her backyard five years ago, her daughter’s father spiraled into a state of abusing prescription pain medications, among other drugs, while she was pregnant with their next son. Together, her daughter’s death and her ex-boyfriend’s drug abuse made her depression debilitating. She also works as an assistant at a pharmacy in a neighborhood with pervasive drug use. Discussing her job and her community during her first interview, she states:

Around here, prescription pain medicine is very bad, you know, everyone is addicted to Oxycodone, and all that stuff, Methadone, Xanax, that kind of stuff. I can kind of tell the people that are using it right and the ones that are not because I’ve seen it actually on the streets. [...] The pill, like I don’t know how they do all that, but they would shoot ‘em up and I would see these people all strung out and I’m like that’s not my environment, like I don’t do any of that. Like I don’t, I don’t think that it’s right. I mean it’s medicine from FDA and all that, that’s why I get my, that’s how people are getting addicted and that’s how people are living around here, like they’ll get more than they need, and then they sell them [...].

Although Laura starts out saying that prescription pain medications are abused widely, her list of drugs also includes Xanax, a psychiatric medication. She also implies a distrust of the FDA as the source of pharmaceutical drugs that feed

addictions. Both of these patterns surface in her second interview as well, in her discussion of methadone use in her community:

It's a whole circle with the FDA. More money. They prescribe you some. You're addicted to heroin. You go into a methadone clinic. You get addicted to methadone. [...] it's a legal opiate because you can get your prescription. I say that, but you can pay a doctor and he'll write you what you want. There're doctors around that will do that. It's like, here's a stack of money. Write me a script for, you know, three Adderall, or—

Laura's inclusion of psychiatric medications in discussions of drugs she associates with abuse has implications for her own medication preferences. After her daughter's death, she began using marijuana to cope with her depression, but she was soon caught in possession of marijuana, sent to drug court, and prescribed psychiatric medications. Although she was taking medications at the time of her first interview, she stopped taking them and began taking marijuana again by the second interview, citing similar reasons having to do with addictiveness and wariness toward pharmaceutical drugs:

Basically if you put people on prescription drugs they get addicted to them. Marijuana is not addicting at all. You can stop. You might sweat a few nights, you know, but you're okay. When you detox from pills and stuff, you feel like you're going to die. [...] So they keep feeding the habit. You don't do that on marijuana. You just stop. [...] It's an herb. It grows naturally. You plant a seed and it grows, right? It's not chemicalized. You don't put—you usually don't put chemicals in it. You know, you just water it, sun, and it grows. And the other stuff, it's chemicals, and chemicals eat your body, and stuff like that.

Another participant, "Jessica" (age 27, from the West) had a mother who had recurrent cancer and became addicted to pain medication. Although her mother hid her addiction for years when Jessica was a teenager, telling Jessica's father that she was using money to treat recurrent cancer, Jessica knew her mother was really using the money to buy pain pills. Jessica's resentment toward her mother came to its height when her parents told her she couldn't go to college, because she needed to stay home and take care of her bedridden, often demanding mother, who eventually died from a pain medication overdose.

Jessica attributes two perspectives on substance use to her experience with her mother: a period of heavy alcoholism from age 18 to 21 (which now continues at a more moderate level, as she goes out frequently to drink with friends), and a lasting distrust toward all other drugs, licit and illicit. She expresses a general wariness held by her whole family toward even minor pain medication because of what they have seen it do to people:

My brother is a doctor, and he still doesn't take medicine. You know? I and my Dad don't take medicine. I mean, antibiotics, but I don't Ibuprofen or anything [sic]. I try to rely on more natural remedies than try to put

something in my body that, you know —I see—I don't understand drugs that have only been tested 10-20 years. [...] I feel like that they turn people into things that —well, things people wouldn't be without it, you know? It's like all of a sudden they lose reality of who they are, and what they're doing, and they're only goal is to, I don't know, get more drugs and sleep.

Although she was diagnosed with bipolar and depression around age 16, her discussion of why she no longer takes psychiatric medication to manage her symptoms lapses into the same general wariness toward pharmaceutical medicine:

They started putting me on Zoloft and I don't know, the thing that I've learned with medicine is that it makes...it doesn't make you feel the bad parts, but it doesn't really make you feel the good parts either. It's kinda like one of those things, and I...me and my dad we're just really...I don't take medicine. I don't take; I don't even take aspirin or ibuprofen. I don't take vitamins. I'm really not, I'm one of those people like, I do like organic type of stuff and home remedies and aromatherapy and the different soul cleansing things like that, but I'm not big on being medicated.

"I did it for me to feel like a person": Preferring the effects of marijuana or alcohol to the effects of psychiatric medications

Jessica's last quote above highlights another theme that ran through many participants' discussions of psychiatric medications: the unpleasant side effects of psychiatric medications in comparison to preferable effects of alcohol or marijuana. Her suggestion above that medications numb both bad and good feelings contrasts her positive description of using alcohol to cope: "A lot of people that are bipolar or depressed, they usually turn to drugs and alcohol to deal with it. [...] It just makes me feel happy, have a good time out with friends and laugh a lot. [...] I am like more socially open when I drink, I guess." In Jessica's mind, alcohol not only preserves the good feelings that psychiatric medications would numb; it has enhanced those feelings and served a secondary social function.

Both Jessica and Laura (introduced above) describe the effects of psychiatric medication as feeling "like a zombie." Jessica states, "You kinda just feel like a zombie, like you're just going through the motions rather than actually enjoying it." Her mention of lacking enjoyment at the end recalls her opposite depiction of alcohol making her happy. Laura states: "They [medications] made me feel like a zombie. I stopped halfway through it. Halfway through drug court [...] I wanna feel, you know? [...] it makes you not feel like you're a person. You just sit there like you're a zombie." Explaining her decision to use marijuana instead of psychiatric medications, she states, "I did it for me to feel like a person." While committed to taking psychiatric medications during her first interview, she describes marijuana as a therapy that helped her not only to be functional, but happy:

It was, you know, I didn't do it all the time, like I would smoke it twice a day, you know in the morning and then at night because it would help me sleep

also, and in the morning I was fine. I could do what I had to do, I was happy until I got in trouble and now I have to do the whole medication thing because I've tried without medicine and without that and I'm just a complete wreck. [...] I'm emotional, I'll cry for everything.

Although she does note at this point in the interview that the medication she is currently taking is an improvement from a more debilitating medication she was prescribed previously, she only mentions feeling an enhanced sense of happiness when she talks about using marijuana—which may offer a partial explanation for why she resumed taking marijuana in the place of psychiatric medications by her second interview date, as stated in the above section.

Even participants who have never taken psychiatric medications themselves found the descriptions that other people gave of the side effects reason enough not to take them. “Evan” (age 28, from the West), grew up with an abusive father and a mother who died of cancer when he was 20. Looking back, he believes he developed depression and anxiety around age 14 when his mother was first diagnosed. He started smoking marijuana with his friends at that time, progressing to the point of using it 3-4 times a day. He also went through a period of daily drinking and infrequent experimentation with other drugs. Although Evan knows his parents used psychiatric drugs for their mental health issues, he has never taken them. He states:

I don't like the way mental health medication works. It's like - my mom described it to me when she was doing it. It regulates your serotonin in such a way that it takes out the highs and the lows, is the way she described it. It's like—it's called an SSRI because it's a serotonin inhibitor and it keeps the flow of serotonin so steady that you don't have mood swings, is what happens. [...] I don't know what that would do to me emotionally.

Like Jessica and Laura, Evan dislikes the idea of taking medications that would numb good feelings along with symptoms of depression and anxiety. Despite the similar mechanism by which the THC in marijuana affects levels of neurological chemicals, Evan shows markedly more suspicion toward the mechanism by which antidepressants act on the brain. Like Laura, he presents marijuana as a milder, more favorable alternative: “You can, I mean with pot, I can still feel so I wasn't completely numb and I could tell what I was doing.” Although a scientific explanation is part of his opposition to psychiatric medications, his favoring of marijuana as a therapeutic option draws wholly from experience.

Although Evan decidedly prefers marijuana to psychiatric medications, his description of using marijuana to cope is not always framed in a positive light. Recounting his heavy use as a teenager, he states:

I completely blew off high school myself in the first place. But that depressed me for a couple years. And I started smoking a lot of pot and stuff and trying to make up for the lost time and stuff, which was not the greatest move.

In fact, many participants give mixed portrayals of the stability of alcohol and marijuana as methods of coping. Alex (introduced above) describes his state of being at the height of his alcohol and drug abuse as a “total migraine, body ache, soul ache,” elaborating:

Just because your body ache, your soul is just ache because your soul just get tired of just not doing nothing and stuff, I mean it just...you're mentally just shut down maybe eventually and so. [...] You just feel blah. You just don't wanna go anywhere, you don't wanna do anything; your soul is just, you might think you're just dead in a way, like you're dead on the inside and not doing anything anymore, so. [...] You would want to try to do something differently and then it's just gone, it's just dead.

Although Alex does not link this “soul ache” directly with the mental health diagnoses he mentions at other moments in his interviews, the description he gives of losing all drives and desires may suggest that his heavy use of substances, including alcohol and marijuana, exacerbated his depression.

Multiple participants also nuance the positive social portrayal of alcohol given by Jessica. Alex describes one occasion during his heavier drinking days when drinking caused him to express false affections that he later regretted. Although Alex has such a high degree of conflict with his mother that he describes her at one point encouraging him to commit suicide, he describes one occasion when he was drinking heavily and told her impulsively that he loved her. He qualifies, “But that was because I was drunk, I mean honestly. And it came out, and I actually thought about it the next day, I was like did I really just tell her that?”

Similarly, “Joey” (age 25, from the Northeast), a participant who experiences depression and drinks and smokes marijuana often, describes a recent occasion when alcohol led him to speak impulsively and cause a woman he was romantically interested in to lose her job:

It's my fault. 'Cause I opened my mouth. It was after my finals, I had a couple drinks in my and start mouthing off [sic]. And then, shit hit the fan, fast. So, I've been trying to deal with that all week. It hasn't really made me feel like a good person, 'cause, I don't like to cost people, anybody, their jobs. Or quit because of my stupidity. So, I kinda learned, I think I hot rock bottom with that.

Despite hitting “rock bottom” with the negative social consequences alcohol can elicit, Joey continues to drink moderately after this occasion. In the same way, Evan continues to express the intention to smoke marijuana, and Alex continues to drink moderately despite limiting his use of other drugs. As stated above, Evan and Alex have no interest in taking psychiatric medications as an alternative to their substance use—their aversion to psychiatric medications appears to be stronger than any negative feelings associated with their experiences of alcohol and marijuana. Joey's attitude toward psychiatric medications will be explored at length in the next section.

“I personally feel safer being able to back off than having a pharmacist”: Tension between self-control and social influences in the framing of self-medication with marijuana or alcohol

Joey began using alcohol and marijuana during a period of depression following his parents’ divorce the year before his first interview. Like Evan and Alex, Joey’s aversion to psychiatric medications outweighs his doubts about using alcohol and marijuana. He has never taken medications for his depression, and he states in reference to psychiatric medications, “I feel like that’s kinda like a scapegoat. I can do it myself. [...] I know people who have antidepressants. But I feel like the mind, it’s a strong thing in this world. Mind over matter.”

The frame Joey presents, of psychiatric medications as a weak excuse not to exercise mental strength, is voiced by other participants as well. Evan uses similar terms in his consideration of psychiatric medications: “I feel like it’s a really cheap answer. I’d rather get over it myself.” Both Joey and Evan acknowledge experiences of mental health conditions, constituting a problematic task to “do” or “get over,” but they also value a sense of self-control in facing those conditions that they feel would be denied by the choice to depend on psychiatric medications.

Evan goes on during his second interview to make a direct comparison between dependency on alcohol and marijuana and dependency on psychiatric medications:

I just feel like I can stabilize myself and stop it and stuff. [...] It’s not something I want to do for the rest of my life, especially not the way I did it in the last year. But I personally feel safer being able to back off than having a pharmacist, like paying for a drug dependency on a schedule basically.

Evan suggests a greater sense of personal control with the option of alcohol and marijuana, using the phrase “stabilize myself,” a sense of agency that does not show up in his description of psychiatric medications. The distinguishing factor that seems to take away this sense of agency in the case of dependence on psychiatric medications is the third party involvement of medical providers that would be monitoring his drug use. He associates the greater sense of agency involved in managing his own alcohol and marijuana use with a sense of control over when and how much he uses—“being able to back off” if he wanted to. However, even in the midst of making that point, he seems to have conflicted feelings about that sense of control, suggesting that his drug use was at a heavier level than he would have wanted it to be “in the last year.”

Evan described himself during his first interview as “a sober man.” But by the second interview, ongoing family conflict led his father to kick him out of their house. He moved in with a group of people who were heavy drug users, nudging him into a six-month period of relapse on alcohol and other substances. He describes how it was difficult to quit using alcohol, until he was able to remove himself from the situation and convince his father to allow him to move back in: “It was a rough period, trying not to drink too much. Like everybody’s drinking. I was trying to quit

smoking. Everybody's smoking, that kind of thing. I was just so depressed, but I kept smoking and kept drinking [...]" At the time of the second interview, he expresses a desire to be completely sober again, at least for a time, but he continues to struggle with not drinking at all, especially given that his best friend has heavy drinking habits.

Despite this recent period of difficulty controlling his substance Evan perceives a greater sense of agency over his self-medication than he would over pharmaceutical medication use. Despite his earlier admission that his social environment made it hard for him during a recent time to stop drinking during a period of depression, he also implies that he has only found certain substances to be addictive in his experience:

I think it just comes down to the person. Because I've done other drugs where I was like, this could be an everyday thing if I didn't care about my life. This is something I would be interested in doing all the time. I didn't really feel that way with heroin. But I've seen people try coke for the first time, and talk about it like it's the greatest experience they've ever had. I personally, when I did it, I wasn't enthralled at all. [...] For me, pot was a huge deal in high school. The first time I smoked, I was like, well, I'm only going to do this once, and I got high off it, and I was like, I don't know if I could ever follow that now. Because I was really, really fascinated by the feeling. For some reason, my psychological or biochemical makeup is more in that direction.

Evan identifies himself as someone who tends to be less "enthralled" by harder substances like heroin or cocaine, but there are certain drugs he could see himself using every day—perhaps marijuana, which he finds more "fascinat[ing]"—if he "didn't care about [his] life," a phrase that implies awareness of a tendency toward self-medication during hard times. Thus, in his earlier quote, when Evan implies being able to "back off," he seems to be referring to times when he has used harder drugs and been able to quit.

Evan's relative lack of interest in illicit drugs with more addictive potential shapes his narrative framing of alcohol use as well, in a moment of reflection on when his dad kicked him out: "It would make sense if he thought I was abusing drugs or something, which I wasn't. I drank and I smoked [cigarettes] when I was [with] him, and he was just fed up with that." He suggests that his father's demand that he move out was unreasonable, given that he could have been using worse drugs than alcohol.

Just as Evan and Joey present a common frame for psychiatric medications, this "could-be-worse" frame for alcohol and marijuana use is a continuity between their interviews as well. Joey states: "Yes, I drink, I smoke weed, but that's not the worst thing in the world. Some kids who I went to school with are just either dead or just more just, they're drug addicts. It's sad." Having grown up with many friends who went on to use more addictive illicit drugs, Joey justifies his chronic alcohol and marijuana use as a less harmful habit. But like Evan, there are also moments where Joey is conflicted between describing the boundaries of his alcohol and marijuana

use as a matter of self-control and conceding that there are also social factors at play:

I know what right from wrong is, I know what, I'm not letting pills and drugs take over me, I do drink and smoke weed, but they're not the worst things in the world. I have a good support system. I have great friends, great family, so I know I'll succeed.

Joey repeats the phrase “not the worst things in the world” to describe alcohol and marijuana and also makes more explicit here his sense that he exercises self-control in limiting his substance use to these less addictive drugs—“not letting pills and drugs take over [him]. Joey and Evan both emphasize confidence in their sense of independent self-control as reasoning for avoiding psychiatric drugs and for continuing to self-medicate. But like Evan acknowledging that living with others who had heavy drinking habits made it difficult for him to quit drinking, Joey suggests that his supportive social connections play a role in his ability not to become more dependent on illicit drugs. At another moment during his interviews, he focuses even more acutely on the importance of social support in limiting his self-medicating substance use to alcohol and marijuana:

I could've done the hard shit, I could've done heroin, cocaine, pills, and everything, but I didn't. [...] 'Cause they [certain acquaintances] went through tough situations and they couldn't get out. [...] I'm thankful that God had led me that way and my parents and my friends have kept me straight forward.

Joey suggests that some people he knows have used illicit drugs with heavier effects to cope with “tough situations,” but that he has been able to limit his own trajectory to alcohol and marijuana because of his social support network. Another factor nuancing his self-control as a driving force when it comes to his substance use, is his mention of God as a leading agent in his life who has kept him “straight forward.” This idea of God as a guard against certain types of substance use that are perceived to be worse than alcohol or marijuana was prominent in other participants' narratives as well, such as Alex's assertion, mentioned above, that prayer helped him not to be dependent on psychiatric medication. Even though Laura also believes that God is not “100 percent there,” considering her baby daughter's sudden death, she believes He has protected her from falling into addiction to the injection drugs that are prevalent in her community:

Yea, like he'll protect because I've been around people that do bad drugs, like and that's not for me. I see them, and that's where I think he protects me; like I don't want to do that stuff, you know; and every time I was in that kind of position I ended up, I had the strength to leave, and I feel like, you know, he showed me the worst of how you can be.

For participants like Laura, Alex, and Joey, spiritual forces can be reconciled or even aid their decisions to self-medicate their mental health conditions while maintaining

the substance use boundaries they prefer. The next section will give voice to other participants who saw spiritual or wellness practices not as relatively minor supplements to self-medication, but as their primary or exclusive framework for conceptualizing and coping with mental health conditions.

*“You know, it’s always a funny sight to see someone trying to meditate inside of a bar”:
Spiritual or Wellness-based Alternatives to Chemical Dependence*

Some participants described similar reasons for aversion to psychiatric medications to participants who self-medicated, but rejected either licit or illicit drugs as a primary means of coping with symptoms. By contrast, these participants engaged with spiritual or wellness practices that not only helped them cope with symptoms, but for some participants also laid a foundation for reframing experiences they identified at the root of their mental health conditions.

James (age 27, from the West) has experienced dyslexia and a mild form of Asperger’s Syndrome from a young age. Beyond early social challenges at school, he identifies an incident at the age of 14—in which he was hospitalized for months with a nearly fatal infection—as the primary trigger for the anxiety symptoms and panic attacks he continues to experience now. Following his hospitalization, he began taking anti-anxiety medications:

I was on anxiety meds for a while and then eventually I was just like, “Screw this. I can’t live my life this way.” [...] Because I was at the point where I was anxious when I had to take my pills because it reminded me of why I had to take my pills. Because I had anxiety. And why did I have anxiety? Because I almost died. So it was twice a day being slapped in the face with it. So we went and my mom had me work with an alternative therapist up in Boulder, who really worked more on trying to help me develop spiritually and helping me accept. Not forget; not block out. None of that, but accept that it happened.

Similar to other participants’ negative association of psychiatric medications with experiences of substance abuse, James found psychiatric medications to hold negative symbolic value. Although James does mention an acquaintance at one point who uses medical marijuana to cope with anxiety, he does not discuss having ever considered marijuana or other non-pharmaceutical substances as an alternatives. Furthermore, his aversion concerned the act of medicating in general, which reminded him of the traumatic experience at the root of his anxiety without doing anything to address it. While medication felt like an attempt to “forget” or “block out” his traumatic experience, the alternative of talk-therapy brought him to “accept” it.

During his period of illness, James also read books about various religious and philosophical perspectives on suffering. Taking an interest in Buddhism, he began practicing a self-taught form of meditation—at first to cope with the physical pain of his illness, and then even after his hospitalization, to help him manage his anxiety during high school. During college, he met a Tibetan Buddhist master, who

taught him about the philosophies of Buddhism, refined his practice of meditation, and introduced him to a small community of others who practiced meditation. He now continues to practice meditation daily, as well as using it in moments of need to manage anxious thought patterns and social anxiety:

If I start feeling the wheels spin, I'm like, "Okay, I'm aware that this is what's going on in my head. I have a couple options right now. I either stay on the wheel and I lose complete productivity and functionality for the next hour or so. Or I can sit here and I can get off. It's not necessarily an easy thing, but I can step off of it. I can breathe, I can refocus, and I can move on.

If I'm around a lot of people, my friends will notice that I'll sit there and my hands will usually be like this, which is my index fingers laying against each other and my thumbs touching and the rest of my fingers interlaced. And I'll just be standing there and my hands will just be in front of my body, and nothing super obvious, but I'll kind of straighten up my back and I'll breathe, and my friends will start laughing and be like, "Are you all right?" I'm like, "Yeah." And they're like, "Okay. You know, it's always a funny sight to see someone trying to meditate inside of a bar."

Although he acknowledges "it's not necessarily an easy thing," meditation has become a mainstay of his ability to cope with anxiety. However, the role of Buddhism in James' life also goes beyond using spiritual practices as a tool for wellness. He describes his initial steps of self-taught meditation as having "got into Buddhism ass-backwards"—now seeing meditation as a facet of a larger philosophical perspective that shapes both his inner life and the outer decisions he makes—such as deciding based on Buddhist values of the common good which companies he will work with in his consulting business.

Renee (age 26, from the South) describes a similar process of trauma leading not only mental health symptoms, but to existential questions demanding deeper answers than symptom management. She traces the beginnings of her depression and anxiety to growing up in a stressful home environment. After her parents divorced when she was young, her father remained emotionally and physically distant through her childhood, and her stepfather molested her for a period of four years until she was 13.

Renee began engaging in self-mutilation, heavy alcoholism during the time when her stepfather was molesting her. She also developed arthritis at this time, as a physical manifestation of chronic stress. She attempted to take anti-depressants, but found—like many of the participants who self-medicated—that the side effects posed a barrier:

I stopped taking it [an antidepressant] because of the medicines reacting with my arthritis medicines, combined making me sick and just keeping me down, so they [doctors] had to take me off one, so they decided to take me off the depression at that point.

For Renee, it was not so much the numbing side effects of psychiatric medications, as it was the sickness from drug interactions “keeping her down” that overruled any potential benefits of taking psychiatric medications. Through high school and a few years afterward, Renee continued to drink heavily and experiment with drugs, using “anything [she] could get [her] hands on.” When her father died three years ago, Renee hit “rock bottom” with depression. Having grown up in a Baptist Church, she turned to God as a last resort before attempting suicide:

I had actually been drinking, all day drinking binge [...] By the time I woke up and then it was night time and I was in my room [...] and I just said Lord I know you're real, but I need you to prove yourself. Make yourself real to me personally or I will succeed in killing myself [...] And sure enough, he did. I had a family friend contact me the next day, we had been connected for years, saying “the Lord laid you on my heart. What's been going on?” I remember saying, “this is an answered prayer.” [...] And she just started loving me and inviting me to church, and I started going back to church and just experiencing the love of God again.

Identifying with a spiritual tradition was a turning point in Renee's mental health. Over the next three years, she became heavily involved in the Pentecostal Church and is currently going to school for Christian ministry. She now speaks of her mental health conditions in the past-tense: “I was tormented in the areas of my mind, I never slept, I was super fearful of man, suffered with extreme anxiety and depression. I believe in a moment that was all broken. I experienced the presence of God.”

Like James, Renee's spiritual experiences enabled a shift in her perspective on her past suffering, in a way that medication did not: “I can go back and see those times when I was just really depressed and angry, and then how things are now, just positive, full of love and faith. Saying, ‘God, you are real and you are good.’ Super grateful for everything, past and present.” Although she describes freedom from anxiety and depression happening “in a moment” in the above instance, at other times, she admits a need for frequent spiritual practices manage recurring mental health symptoms, similar to James' use of meditation to pull himself out of anxious thought cycles:

There's a lot of, it's a lot of talking to yourself telling your mind to shut up. And to renew yourself in the word of God and to just remind yourself what he says. Not to worry, He's the provider, He's faithful, He's near. Those scriptures and then everything else fades away and you forget what you were struggling with.

Renee admits that she still does sometimes struggle with symptoms of depression and anxiety, but emphasizes that they now lack the power they used to have, stating, “It's just that I'm not led by those [emotions],” and describing her ability to “overcome them with the word [of God].”

A third participant, Sherry (age 25, from the West), came to believe in a higher power through the height of her experiences with trauma and mental health conditions, but has a less defined religion or philosophy in her ongoing spiritual practices. Sherry has had a serious heart condition since the age of 9, and for many years during her childhood, she was admitted to the hospital on a weekly basis. She had experienced OCD, depression, and anxiety from a young age, and she believes the stressful experience of her heart condition exacerbated her depression. Although she does drink occasionally, Sherry has never been able to abuse illicit drugs because of the danger they would pose to her heart condition. The one time she did try an edible marijuana product, it immediately stopped her heart, and she had to be admitted to the emergency room.

When she was 13 years old, Sherry's depression and anxiety came to a height, and she attempted suicide twice. This prompted her mother to take her to receive psychiatric care, and she was prescribed heavy medications for depression and anxiety. Although she disliked the numbing side effects like many of the participants who self-medicated, she had additional reasons for stopping medications around age 17:

Well, I just didn't feel like emotionally I wasn't experiencing that much. I didn't have that natural range and progression and I just didn't like it. [...] Well, the reason I went off it was I started to have like kidney problems and liver problems because [...] I was also on medication since I was nine for my heart.

Like Renee, Sherry experienced physical side effects from her psychiatric medications that outweighed the benefits of taking them. But since the age of 13, her experience of her mental health conditions has also included a spiritual perspective. During her second suicide attempt, Sherry believes a higher power suddenly broke through to her and stopped her from committing the act, and she states she has "never felt alone since then."

Although she has thought through popular religions like Buddhism and Christianity and does not identify with a particular religion, she continues to take purposeful moments that she describes uncertainly as something between prayer and meditative thought: "If I'm feeling stressed I just take moment to like appreciate all the things that I have, and kind of [...] put in perspective like where are you at, be grateful for what you have and just kind of remind yourself of that." At another point in her first interview, she describes how hiking or running in nature similarly helps her "reconnect with what's important."

By her second interview, however, Sherry began to experience heightened stress at her job as a waitress, to the point of having frequent nightmares about conflict with customers. She describes how she has become so stressed that she can't spend time alone, even to do some of her activities that usually help her manage stress:

I've been kind of avoiding alone time like I won't really take those walks or do this little kinds of inner reflection anymore, I'm kind of avoiding that just

because I'm so stressed out about everything and I'm not really happy where I am so I feel like when I do have that alone time I'm overly stressed and it's more in my head and it goes the reverse.

The nature of this decline in Sherry's ability to rely on spiritual practices for mental stability points to a noticeable difference between Sherry's spiritual narrative and those of James and Renee: the absence of a spiritual community. While James has a connection to a group of people who trained in meditation under the same Buddhist Master, and Renee describes learning doctrine and worshipping at her church as spiritual activities that happen within community, Sherry consciously defines her spirituality as an individual practice: "I kind of want to it to be a personal thing I guess like I don't really need the social aspect of it or community aspect of religion or spirituality and so I think that's something I want to do internally and kind of more do internally and kind of privately." Because none of her spiritual practice happen outside of her alone time, her inability to spend time alone by the second interview means an end to her spiritual practices as well.

Another distinguishing factor between Sherry's narrative and those of James and Renee was the role of counseling in relation to both mental health and spiritual practices. James' process of "accept[ing]" his trauma involved reframing his experiences in a more redemptive light—a process that began with counseling and continued with his gradual conversion to Buddhism. He reflects back on his experience with the alternative therapist:

And she [the therapist] was the first one who asked me why it was a good thing. [...] She was like, "So what did you get out of this?" [...] And that was horrible, absolutely awful. I was, at that time, 15. I had to sit there and write a reason that I was thankful that I almost died. [...] And then, suddenly it was really genuine. And I'm really thankful for it. [...] And then eventually I found a Buddhist philosophy that's, "Let us rise up and be thankful for we learned a lot today. And if we didn't learn a lot, at least we learned a little. And if we didn't learn a little, at least we didn't get sick. And if we got sick, at least we didn't die. And if we died, we're no longer suffering. So let us all rise up and be thankful."

James describes how the process of trying to find positive aspects of his near-death experience was frustrating at first, but then became an effective first step in changing his perspective from one of continuing anxiety to thankfulness. When he began practicing Buddhism in the years that followed, he went on to ground this new perspective on his trauma in a larger philosophical tradition that gave him words to express it more fully.

Renee's narrative involved a similar pattern of mutual reinforcement between counseling and a deeper philosophical perspective. Her experience of connecting with her family friend who first brought her back to church involved an element of counseling, as she describes telling this older woman "everything that had happened with [her] dad." Her ongoing training in Christian ministry also

includes connection to an ordained minister who serves as “a voice that speaks into [her] life.”

Sherry was the most consistent of all participants in seeking counseling for her mental health conditions, having gone to counseling for on-and-off periods since the age of 13. But although she believes in a higher power and has spiritual practices, there were no particular overlaps between the topics of spirituality and counseling in her interviews. This lack of a deeper shift in perspective may be one reason for the contrast in long-term stability between Sherry’s reliance on therapy and spiritual practices in comparison to Renee and James.

This is not to say the only time counseling helped to alleviate participants’ mental health symptoms was as a supplement to a spiritually integrated perspective. One particularly notable example of a counselor’s role in symptom improvement lay in the background of Laura’s narrative. Although Laura did return to using marijuana, she used it much less frequently by the time of the second interview compared to the first (about two times per week versus two times per day). In the first interview, Laura describes how her ex-boyfriend still lives with her and has become emotionally and physically abusive since their daughter’s death. However, when Laura was caught using marijuana, she was assigned a counselor as part of the drug court process, and this counselor became an advocate that helped her force her ex-boyfriend out of her home by the time of the second interview. Given what Laura says about the stressfulness of living with her ex-boyfriend—“[...] when I’m with him it’s more difficult, like stressful and you know, just hard”—her change in living situation may have been part of her decrease in dependence on marijuana.

However, there seem to have been more than a spiritual narrative lacking in Sherry’s experiences with counseling. She describes feeling frustrated with an inability to find a particularly helpful counselor: “I need someone that’s not going to take my controlling the conversation [...] And I just haven’t found one that’s like forceful enough with me yet (laughs).” In the midst of her inability to spend time alone on spiritual practices and her continued dissatisfaction with counselors, Sherry is considering an attempt to take psychiatric medications again:

I don't like the idea of taking medication at all. That's why I stopped it when I've been taking it a while before but it's starting to interfere with my day-to-day [...] so I think it's one of those things kind of talk to my doctor and see if there's like maybe with mild that I could take that kind of helps me not be so stressed.

Sherry turns to anxiety medications again only as a last resort, now that her anxiety is becoming severe enough to “interfere with [her] day-to-day”—but she does not appear to be fully resolved in her decision to try medication again, given that she still adamantly dislikes the idea of depending on it.

By contrast, James’ process of reframing his perspective on the trauma at the root of his mental health conditions seems also to have reframed his perspective on taking medications for part of his symptom management. Although he mentions meditation much more often as a means to managing symptoms, he also describes

now using mild medications to a limited extent to help him manage one of his more severe symptoms:

If I have a really bad panic attack, I go nonverbal. That part of my brains just shuts down, which is scary. It happens once a year, maybe. I've now started taking mild antianxiety medication if I know I'm going to be in a situation where that might happen. So I head it off and do a little proactive treatment on that.

James' empowered narrative of using psychiatric medications at times as a "proactive treatment" presents an interesting contrast to the kinds of narrative frames used by participants like Joey and Evan, who saw psychiatric medications as an option that would compromise their agency or imply a lack of self-control. Although medication once felt like a superficial attempt to block out deeper issues when it was his sole method of treatment, he has now found a way of using it as a more minor supplement to the philosophy and meditation that orient his life and wellness more directly.

Renee holds a more decidedly negative view on psychiatric medications, but exhibits a similar freedom from dependence as a result of a deeper perspective shift. She now sees both licit and illicit drugs as negative dependencies that she has now overcome by the love of God. Despite years of drug and alcohol abuse, she describes freedom from the desire for drugs and alcohol as a rapid change that occurred with her conversion: "About two months after I started going to church, [...] the need for drinking and to find satisfaction in drugs, just completely stopped. [...] Just every old desire was completely struck out of me."

On the topic of psychiatric medications, Renee states: "If there's somebody that doesn't know the Lord that is dependent on those things [antidepressants] like I remember what that's like, but there is hope. We have hope to overcome [...]." Although aversion to the idea of dependency on psychiatric medications echoes other participants, Renee presents a unique example as someone who turns away from dependence on substances in favor of direct dependence on a higher power—whereas participants like Evan and Joey, and perhaps even James, seemed to be more motivated by self-reliance.

A final continuity between James' and Renee's stories is the natural desire they both have to share the healing aspects of their spirituality with others. During her first interview, Renee talks about her "heart" to "minister to" adolescents who have experienced difficult home lives and gotten into substance use, a clear parallel to her own story. By her second interview, she had just returned from a mission trip to India, where she worked with an organization that helps women who have experienced physical or sexual abuse—another parallel to her own story. She describes her motivation as a compulsion: "the need there to just go and love on these women," talking throughout her interviews about her desire to "share the gospel" with all people now that she has experienced it.

Although James remains the only philosophical Buddhist among his group of friends, he has shared his meditation techniques to help a friend with a stutter:

I'm the only Buddhist in my group of friends. I have a buddy who has a stutter, and I've taught him mindful meditation, just with breathing techniques and things like that, because it allows him to regulate it easier. [...] He's now starting to meditate. But as far as reading kōans [Zen Buddhist texts] or really being interested in the philosophy and things like that, I'm the only one.

Though he does not necessarily desire to see others adopt the whole spiritual philosophy that he follows, he does show a natural desire to share the practices that have helped him. He mentions at another moment that his father, a Vietnam Veteran with PTSD, has also begun to try Buddhist meditation techniques. In contrast to the pattern of participants like Evan having heard negative reviews of psychiatric medications from people in his social network, James and Renee desire to share the aspects of their spirituality that they have experienced to be healing. When Renee connects with individuals who medicate or self-medicate for mental health conditions, she feels moved to state:

I was there, so and so years ago [...] I was doing the same thing you were doing, but there is hope. [...] [It's] not so much this is what you need, or you're an idiot. [...] I would never approach somebody and say that, but it's more building that relationship with people and sharing my story and saying it could be your story too if you would allow it.

Discussion

Many of the young adults interviewed for this study rejected the idea of using of psychiatric medications to manage mental health symptoms that were triggered or exacerbated by stressful life events. Reasons for being averse to taking medications ranged from associations with experiences of pain medication abuse, to disinclination to the numbing effects of many medications, to opposition to the idea of dependency on medication and medical providers to recover from mental health conditions. Many participants perceived marijuana or alcohol to be alternative ways of coping that alleviated each of those points of opposition. Other participants rejected chemical symptom management altogether and depended primarily on therapy or spiritual practices to cope with symptoms. More so than participants who self-medicated, participants who engaged in therapy or spiritual practices addressed not only symptom management, but also social factors and perspectives on past trauma that exacerbated symptoms.

Over the last few decades, there has been a growing shift in psychiatric care toward the concept of shared decision-making, which takes into account both the professional expertise of providers and the personal values of individuals with mental health conditions. Much remains to be understood regarding the perspectives of individuals with mental health conditions on different treatment options—particularly individuals who are not connected to mental health services and have been less represented in the existing literature. The design of this analysis

offered the particular advantage of a general population sample, including some young adults who had connections to mental health services and some who did not.

The design of having a non-clinical interviewer facilitating data collection could be seen as an advantage of this study as well, particularly for the self-medication section, as some literature suggests substance users may be more prone to use language of powerlessness and help-seeking when talking with clinicians, which can bias findings (West & Brown, 2013). The design of the original study being focused more broadly on relationships, life goals, values, and motivations also allowed for an arguably more authentic finding of continuities across young adults' experiences managing their mental health conditions than if the interview guide had been more targeted toward this area of inquiry. Although limited by certain factors such as low racial/ethnic diversity among participants, this study represents important preliminary findings on how some young adults describe their decisions to reject psychiatric medications in favor of self-medication or "personal medicine."

The finding that young adults in this sample associated psychiatric medications with drug abuse and addiction is consonant with the literature on psychiatric medication use suggesting that fear of addiction to medication is a main reason for noncompliance (Mibei 2013). Our analysis was unique in the finding that the root of that association for these young adults was often experience with pain medication abuse. Particularly for participants like Alex, whose prior opioid addiction made him averse to the behavior of taking a pill for fear of triggering relapse, this finding highlights the potential utility of screening psychiatric patients for history of prescription medication abuse. If the behavior of taking pills is a particular barrier because of substance abuse history, patients might be counseled through treatment or offered non-pharmaceutical treatment alternatives to the extent that it is possible to manage symptoms through alternative means.

The idea that side effects pose a barrier to psychiatric medication compliance has been widely represented by psychiatric research findings (Mibei, 2013; Perkins, 2002), including a study that examined barriers to compliance for psychiatric patients with comorbid substance use disorders (Magura, Rosenblum, & Fong, 2011). The interview participants in our study not only presented negative perceptions of psychiatric medication side effects, but in some cases directly presented the effects of alcohol or marijuana as preferable alternatives. This not only supports the self-medication hypothesis, but suggests that some individuals with mental health conditions may perceive alcohol or illicit drugs as direct substitutes for psychiatric medications. Although there is some literature emerging on the phenomenon of substituting marijuana for both licit drugs (Lucas et al., 2015) and illicit drugs (Swartz, 2010; Reiman, 2009), few studies have specifically investigated the substitution of psychiatric medications with marijuana.

It is well established that alcohol dependence can result in worse outcomes over the course of mental health conditions such as depression and social anxiety (Sullivan, Fiellin, & O'Connor, 2005; Terra, Figueira, & Barros, 2004). Educational and outreach interventions should aim to dissuade substituting psychiatric medications with alcohol. The question of whether marijuana might be effective as an alternative mental health therapy is controversial. While some studies have suggested marijuana use can make psychiatric symptoms worse (Degenhardt et al.,

2007), a recent systematic review noted that the studies with strong findings on this association neglected to control for other important factors such as baseline illness severity and alcohol intake, concluding that there is not a strong enough body of evidence to claim confidently that marijuana use worsens psychiatric symptoms (Zammit et al., 2008). As access and social acceptability increases with the legalization of marijuana in an increasing number of US states, future research should evaluate more clearly both the prevalence and the efficacy or harms of marijuana as a substitution for psychiatric medications. Since many participants in this sample notably used marijuana in combination with other substances such as alcohol or illicit drugs with stronger effects, future research should also evaluate the effects of such patterns and propose policy guidelines for controlling potentially harmful substance mixing in the context of legal marijuana prescriptions for mental health conditions.

The finding in our analysis that some participants framed psychiatric medication use as an admission of lack of self-control may be linked to findings in prior studies suggesting that using psychiatric medications is associated with fear of dependence (Givens et al., 2006). The opposing frame of marijuana or alcohol use as reinforcing a sense of self-control was complicated at times by participants' discussions of potential addictiveness and instability experienced in relation to marijuana and alcohol use. Future research should investigate how the addictiveness of marijuana compares to the addictiveness of psychiatric medications that was mentioned by many participants as a barrier, in the first theme discussed.

The results of this analysis provide insight into the perspective of individuals whose primary framework for recovery is spirituality. Some participants, like Sherry, had narratives that aligned with the concept of spiritual practices as "personal medicine" in the sense of self-care. Other participants, like James and Renee, saw their spirituality as the other type of personal medicine described by Deegan (2005), as activities that gave their lives meaning and purpose. Our findings add to the understanding of how this latter type of personal medicine may operate, particularly for individuals whose mental health conditions were exacerbated by stressful life experiences. James and Renee experienced their spiritual traditions as life-orienting narratives that helped them reframe the past experiences at the root of many of their symptoms, rather than simply as tools to manage symptoms.

While Sherry, James, and Renee all sought counseling as another aspect of mental health recovery, James and Renee experienced spirituality as mutually reinforcing with the spiritual narratives through which they reframed their past, whereas Sherry saw her spirituality as a set of individual practices and sought counseling as a separate, more clinical aid to recovery. Future research might explore how clinical counseling, particularly for individuals with a history of stressful life experiences, might aim to aid individuals in exploring sources of larger life purpose and philosophical understandings of suffering beyond the clinical setting—as in the case of James' alternative therapy experience. Although none of the participants in this sample described experiences with cognitive behavioral therapy or other motivation- or narrative-based forms of therapy, future research

might explore how such interventions might also be integrated into shared decision-making models of psychiatric treatment and recovery.

While Sherry was opposed to the idea of taking psychiatric medications, her inability to use the “personal medicine” of wellness activities by her second interview left her feeling obligated to seek a prescription once again for at least mild anxiety medication. The contrast between Sherry’s feeling of obligation to take medication and James’ more positive feeling by his second interview that medication can be a “proactive” part of his recovery process again raises implications for shared decision-making. In Sherry’s case, effective care from a provider might include counseling to reframe medication as an active choice that can be integrated with other practices like her wellness routines, rather than replacing wellness options with a chemical dependency.

Many of the experiences of participants in this sample implied the influence of daily stressors on individuals’ attitudes toward medication and self-medication. For example, Sherry’s anxiety was heightened by stress at work, Evan’s self-medication escalated during a time of conflict with his father and living with other substance users, and Laura experienced decreased dependence on self-medication when her drug court counselor helped her remove her ex-boyfriend from her home. Laura’s story in particular underscores the importance of emphasizing in the training of mental health providers not only to consider shared decision-making, but also to look beyond the clinical setting to address stressors of daily life that affect mental health recovery as much as, or even more than, treatment regimens.

Future quantitative studies should seek to evaluate the prevalence with which young adults use self-medication or “personal medicine” to manage mental health conditions and whether similar trends might be observed in other age groups. This analysis also points to a need for further qualitative understanding of how these self-directed forms of symptom management might be addressed by shared decision-making with providers, in a manner that both intervenes with potentially harmful self-medication patterns and complements more constructive forms of personal medicine.

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