Medication Effect Interpretation and the Social Grid of Management

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SUMMARY. This article reports on two research projects and argues that current medication management research and practice does not represent the complexity of community-based psychotropic treatment. Ethnographic findings are used to demonstrate that a social grid of management exists to negotiate medication 'effect' interpretation. Anthropological and semi-structured interview data are used to illustrate patient subjective experience of atypical antipsychotic treatment. It is argued that 'active' and 'passive' management relationships are produced by the myriad ways individuals manage the gap between the desired and actual effects of medication. It is shown that psychological and cultural 'side effects' are as common as physical 'side effects.' *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website:*

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INTRODUCTION

For many, psychotropics offer a panacea, the final scientific and technological solution to the human experience of depression, psychosis, or disabling anxiety. Yet the research on medication management points to relationships and compliance problems well beyond the scope of psychopharmacology. Some medication recipients, for example, are passive and readily defer to expert opinion and intervention, requiring the active involvement of practitioners (Ascione, 1994; Wells & Sturm, 1996). Not surprising, therefore, research has shown that for both practitioners and clients, there exists a continuum from activity to passivity (Chewning & Sleath, 1996; Chewning, 1997; Cohen & Insel, 1996; de Vries, Duggan & Tromp, 1999; Demyttenaere, 1997; Lipowski, 1997; Sleath, 1996; Sleath, Svarstad & Roter, 1997). These states, passive and active, do not refer to chemicals circulating in the blood. They implicate social positions, feelings, and interpretations of medication events and treatment experiences.

Moreover, dissemination of laboratory discoveries is increasingly recognized as the next step in pharmacotherapy research and practice. The translation of clinical-trial data for community practice raises questions about how practitioners and researchers include or exclude client beliefs and values in treatment decision-making (Chewning, 1997; Chewning & Sleath, 1996; Gournay, 1995; Hohmann & Shear, 2002; Morris & Schulz, 1992). As a result, management models have been proposed that seek active client participation (Cameron, 1996; Gerbert, Love, & Caspers, 1999; Warren & Lutz, 2000; Warren, 1999). Medication management research has shown how all participants differ significantly in levels of involvement about prescription, compliance, and symptom monitoring (Chewning & Schommer, 1996; Chewning & Sleath, 1996; Dowell, 1990; Jordan, Hardy & Coleman, 1999; Sowers & Golden, 1999). Consequently, no matter how hopeful we remain regarding the use of chemicals to relieve mental suffering, we inevitably

return to human relationships. In previous work (Longhofer, Floersch & Jenkins, 2003) we identified the social grid of medication management; here, we go further to argue that the grid exists to mediate the subjective experience of psychotropic treatment.

It is argued in this article, drawing from the management literature and from our own research, that a perplexing interpretive difficulty, what will be called a drug aporia, produces the 'activity' and 'passivity' characteristic of most medication treatment relationships. The aporia is an interpretive gap produced by the distance between the hoped-for 'desired' and the perceived 'actual' effect of psychotropic treatment. Sometimes, practitioners active in the aporia, interpret effects for clients; at other times they are passive. And many factors, including gender and ethnicity, influence the subjective experience of atypical antipsychotics (Jenkins & Miller, 2002). Much of management research has been limited to compliance and decision-making in physical medicine or to management of iatrogenic problems related to chronic mental illness (Boomsma, Dassen, & Dingemans, 1999; Bennett, Done, & Hunt, 1995; Gournay, 1995; Hamera, Rhodes, & Wegner, 1994; Roter, Hall, & Merisca, 1998; Steiner & Prochazka, 1997). Others focus entirely on the narrow problem (Atkin & Ogle, 1996; Berg, Dischler, & Wagner, 1993) of compliance and pay little attention to the complex divisions of labor resulting from deinstitutionalization; indeed, this division of labor–among psychiatrists, social workers, nurses, clients, and families–remains virtually unexplored (Jordan et al., 1999; and Longhofer et al., 2003 are exceptions). There is little interest in how compliance and related behaviors emerge from the subjective experience of medication effect interpretation and how the resulting aporia, in general, is negotiated through the *social grid of medication management*. Nor is there consideration of the deliberate and self-conscious nature of patient and practitioner interpretation of medication effects. In short, patient compliance is rarely psychologically or culturally analyzed; reasons, wants, purposes, desires, and intentions, the causes of compliance, are ignored, and their unconscious dimensions inevitably elided (Keat & Urry, 1982, p. 94).

Using data from two research projects, it is argued that current medication management research and practice does not represent the complexity of psychotropic treatment. While the broader process of managing medications includes the presenting problem, prescription assessment, delivery, monitoring for compliance and effect, and reporting (see Figure 1), this essay examines the roles of the case manager, the

work of case management in effect interpretation, and client subjective experience of medication. Indeed, effects are realized in the intensity and extensivity of monitoring for effects, and in the knowledge produced in day-to-day practices and interactions among the key figures: the client, case managers, pharmacists, nurses, and psychiatrists.

First, the study of community medication management and its contribution to psychopharmacologic research, the *social grid of community medication management*, is reviewed. Second, a case example from a study of atypical antipsychotic treatment is used to empirically ground the concept 'drug aporia.' Finally, in the discussion, it is argued that practitioners and clients use the grid to mediate interpretive dilemmas.

THE SOCIAL GRID OF MEDICATION MANAGEMENT

Methods

The social grid research (Longhofer et al., 2003), conducted in a community support service setting, used ethnographic methods to explore practitioner management of medication events. Narratives, culled from field notes and recordings, were used to specifically explore community monitoring for compliance and effect. Thirty-five managers were observed in weekly team and monthly clinical meetings; these, attended by team leaders, psychiatrists, nurses, and team clinical social workers, included lengthy deliberations of individual cases. Client medical records (n = 329 cases) were analyzed for the types of psychotropic medications prescribed and a synchronic analysis was conducted; during one week, medical records were examined to determine the frequency of medication type. These were studied to establish a rough measure of the intensity of interpretation in community medication management. At this particular site medications were monitored under the rubric of strengths case management, one of the most popular management models in the country (Rapp, 1998). The program offered services to approximately 400 clients. Unlike most urban community programs, this suburban location was rich in resources, evidenced by the manager's annual salary of approximately $35,000 (Floersch, 2002). All managers were required to take an in-house examination on psychotropic medications. Although the majority had bachelor's degrees, a few had post-baccalaureate training. Managers had about 5 years of experience (median) and the average caseload was fifteen (see Floersch, 2000, 2002 for a detailed discussion of methods).

FIGURE 1. The Social Grid of Medication Management

Elements of a Medication Event	Patient	Community Social Relations: Informal Supports (e.g., friends, family, pharmacist, employer)	Community Social Relations: Formal Supports (e.g., case manager, nurse, psychiatrist, nutritionist)
1. Presenting Problem	X	X	
2. Prescription Assessment			X
3. Delivery and Access	X		
4. Monitoring for Compliance and Effect	X	X	X
5. Reporting			X

X = Who in the medication grid does what?

Findings

Longhofer, Floersch, and Jenkins's (2003) analysis of a suburban community mental health center identified five elements of a medication management event; thus a single medication experience can be represented as a complex social division of labor. In Figure 1, the elements are represented horizontally and the social relations mediating them are represented vertically. Understanding management requires examination of who does what and why. Most research on medication management segregates one or another element; few examine the *totality* (Estroff's 1981 work on this subject is an exception). The grid represents the social relations potentially correlated with each element of a clients' medication experience and the overlapping roles and multiple sites for management. For whatever reason, those who lack the ability to self-monitor are confronted with 24 possible sites (a single site is represented as a cell in the grid) for determining *who* will do *what*. And the intensity of external (e.g., case managers, family, nurses, and psychiatrists) monitoring is determined, in part, by client capacity to act alone at each site. Power, consequently, is differentially distributed throughout the grid and depends on social policy (Cohen, McCubbin, & Guilhème, 2001), funding mechanisms, the organization of mental health services, and, of course, the client's unique life circumstances. Each service delivery setting and associated community (i.e., rural, urban, or suburban) will produce unique management of the elements. Settings dominated by medical practice, for example, will focus attention on psychiatrists and nurses. Realistically, however, case managers

play a pivotal role in monitoring medications for clients (Floersch, 2002).

Research by Longhofer et al. (2003) suggests that compliance is not one-dimensional or empirically transparent; in reality, compliance, like all events in the grid, is always in complex ways psychically, culturally, and professionally mediated (see also, Cohen, 2002; Conrad, 1985; Trostle, 1988). In the following compliance illustration, a manager reports her observation of client behavior to the case management team; she draws conclusions about failed and hoped-for medication effects:

> He had put one of his mattresses outside and it got wet from the snow and rain. It was ruined. I asked him, "why didn't you tell us? We could have found a home for it [the mattress]." It didn't cross my mind what might happen next. After I left, he went to the trash bin, got the wet mattress, and put it back on his bed. It was soaking wet! He is having a difficult time keeping the place clean. I chatted with him about his personal hygiene because he is getting a little stinky. In the way he was describing his routine, I do not think he is taking a shower. He told me that he doesn't want to take a shower because of the mirror in the bathroom. He may be getting paranoid. He so *high need* and so *low functioning* at times. Well, his shot is due soon.

It was irrational to place a wet, ruined, and foul-smelling mattress on a dry bed; it was read as a sign of disorganized thinking. The manager referred to the client as "*high need*" and "*low functioning*" because he received considerable help to clean, shop, pay bills, do laundry, and get medications. For team members this client was sometimes unable to understand or "*get it*." Floersch (2002) has shown how "get it" and "high need" are examples of situated or invented language that assisted managers in explaining client behavior when medication failed to produce desired effects. In the example above, the manager reasoned that the bathroom mirror was indicative of paranoia, which prevented him from taking showers. The medication's desired effect was captured in a typical manager oral narrative, "his shot is due." Managers often condensed complex compliance observations such as these into a single medication 'effect' interpretation. Here it was hoped that with the injection the client would take showers, clean his apartment, and demonstrate clear thinking. With respect to grid participant expectations of desired effects, Lorna Rhodes has identified the cultural implication behind the

metaphor "clear the mind," which was in common use among practitioners and patients in our study (Rhodes, 1984).

We found that practitioners seek desired effects and, of course, clients experience myriad actual effects. And all parties to medication treatment, aware or not, assess and monitor effects. Once in the body, crosschecking the medicine's desired effects with the actual required continued and active monitoring. Managers constantly observed changes in behavior or symptoms and reported these to others. For example, "he had an ER [emergency] med[ication] check yesterday. He was really frightened. When he hears voices, they are usually violent and aggressive. I think it was due to a decrease in his Haldol [conventional antipsychotic]. It looks like he will need both medications [Haldol and Lithobid (antimania)]" (Longhofer et al., 2003, p. 28). This example of effect interpretation–"it looks like he will need both medications," –involved reading multiple dimensions of client reality, including polypharmacy. In assessing the hoped-for desired effect, the manager used behavioral (reference to violent), emotional (reference to frightened), and cognitive (reference to hearing voices) referents to draw the conclusion that a medication change was needed. However, which medication category, antipsychotic or antimania, would produce the desired effect, less aggression and fear? This is of particular significance because it highlights the complexity of effect interpretation with polypharmacy (e.g., Floersch found in one study (2002) of 329 clients that 40 percent were prescribed three or more drugs). Behavioral, emotional, and cognitive factors combine to challenge practitioners to speculate about cause and effect across several dimensions of client experience. Was it the client's fear that caused aggression, which caused auditory hallucinations? Or, did auditory hallucinations cause fear? Moreover, what was the role of medication? The manager thought that increased fear, aggression, and auditory hallucinations were produced by a reduction in antipsychotic medication. Consequently, even under the best of consultation circumstances–which might include the presence of self-monitoring clients, the psychiatrists, managers, and family members–the above example highlights multiple dimensions of a single 'effect' interpretation.

Medication management interpretations, not always observable in the clinical or team meetings, could only be known in the ebb and flow of daily living in the community and in the occasional visits to the mental health center. Increased manic behavior, pressured speech, and exaggerated displays of anxiety made managers wonder, "are you taking meds," [compliance monitoring] or "perhaps there isn't enough in his

system" [effect monitoring]. Practitioners had no conceptual tools for undertaking interpretations, nor did they see the need to do so. Even though they consistently used a situated language (i.e., "his shot is due," "has the medication kicked in," and "it clears the mind") as a substitute for pharmacological interpretations, their invented language never became a conscious part of daily work.

Moreover, in medication case management, we saw that effect interpretation often spilled over into other life domains. In the next example, managers weighed client self-initiative, self-responsibility, and self-understanding alongside medication compliance and monitoring:

> *Case Manager 1:* We need to make a decision. His apartment looks awful. Trash is everywhere and he spills coffee everywhere. I don't know if he *gets it*.
>
> *Case Manager 2:* We are using $200 a month of our flexible money to subsidize his apartment living. I don't have a problem with $100 a month. I would like to write him a letter.
>
> *Case Manager 3:* I wonder if it is time to sit down with him and talk about this. I think we could tell him we would not subsidize a substandard apartment. He is never going to pursue working a little if we do not cut him off.
>
> *Case Manager 2:* What about meds? Did he do his labs?
>
> *Case Manager 1:* I think he did, but I don't know for sure. He likes Clozaril but if he isn't going to follow the protocol, then maybe we should change it.
>
> *Case Manager 3:* Maybe we should have a team meeting at his apartment. There are so many issues. Meds, money, and housekeeping–there are at least three issues. Let's talk to him, but separate the times and the issues.

In the statement, "we need to make a decision," we see the acknowledgement that client housekeeping was below the team's standard, especially irksome because the team subsidized his rent. A quid pro quo was expected: we finance your apartment and in return we expect it to be clean enough to avoid eviction. In this instance, no effect interpretation linked medication compliance with wellness. Rather, unpredictable

adherence was evidence of the client's lack of understanding ("I don't know if he gets it"). The client did not "get" that managers wanted him to see a relationship between compliance and "doing fine." In the query, "did he do his labs," managers commented on self-reliance. Intervention was considered when it was suspected that the client had not followed instructions, that is, Clozaril required weekly laboratory analysis to rule out serious side effects. Thus, when blood was not drawn for two weeks, Clozaril should be terminated. But before termination was considered, the team did *for him*–changed his medications–to prevent medication non-compliance. Here, the team feared that relapse and hospitalization would be the outcome of inadequate medication monitoring. In the above example, note in particular the complex relationship between compliance and effect interpretation: when the latter was ambiguous, the former became problematic. Was it non-compliance, failed effect, or unanticipated effect, or an even more complex dynamic among neuro-chemistry, intra and inter-psychic and social forces? The complexity was not sorted out but rather summarized in a situated, manager lexicon language: "he doesn't get it." (See Floersch, 2002).

Where self-monitoring is not possible, as in the example above, others in the grid share power or exercise it on behalf of clients, not always in helpful or caring ways. And the use of this power must be aimed at more than attempting to achieve behavioral outcomes. Throughout the life course of any specific illness, monitoring will be variably and complexly determined by a multitude of continuously changing conditions: course of illness, gender, ethnicity, social class, ability to work, family, community and cultural context, neighborhoods, quality of human relationships, emotions, social networks, type of medication, polypharmacy, and funding streams. Thus, with respect to practitioner and client management roles, we speculate that activity or passivity is dependent on (1) the level of a client's ability to self-monitor and (2) the ease of the effect interpretation. And, effect interpretation is extremely difficult when the gap between the desired and actual effect is ambiguous and open to multiple interpretations. Using client perceptions of treatment with atypical antipsychotics, we will illustrate the ambiguity present in medication effect interpretation.

CLIENT SUBJECTIVE EXPERIENCE OF MEDICATION EFFECTS

A number of ethnographic and qualitative studies have developed methods for investigating the relationships among an illness, a person,

and the person's lived experience (Csordas, 1990, 1994; Good, 1994; Karp, 1996; Kleinman, 1995; Strauss, 1994, Jenkins & Barrett, 2003). These studies include a notion of intersubjectivity alongside subjectivity, emphasizing the interactive zone of lived experience in which the self is dynamically and multiply constituted. Extending these insights into the world of medication research provides a doorway into how desired and actual effects are interpreted by the medication recipient. In research sponsored by the National Institute of Mental Health, "Culture, Schizophrenia, and Atypical Antipsychotics," Jenkins, Floersch and Longhofer are studying the subjective experience of atypical antipsychotics by incorporating the perspectives of anthropology, psychoanalysis, social work, and history.

Methods

Ninety adults (see Table 1) currently receiving outpatient treatment and management for either schizophrenia or schizo-affective illnesses (see Table 2) are included in the study. Standard research diagnostic assessments (SCID, BPRS, and SANS) have been completed on all subjects. And using the *Subjective Experience Medication Interview* (SEMI) instrument, patient experience of antipsychotic treatment and illness is examined. The SEMI tracks the multiple meanings of medication experience, which are often shifting, paradoxical, and sometimes contradictory. One focus has been the use of patient metaphors to describe medication experience. The SEMI is an open-ended anthropological interview guide designed to obtain illness and medication narratives; it queries participants about perceptions of antipsychotics. Among numerous SEMI questions and categories, those relevant for this case study are: "What do you think these medications are doing for you?"; "If you tried to explain to someone not taking this [these] medication[s] what the experience is like, what would you tell them?"; "How would you describe the effects the medication has on you?"; "What do you like about the effects of the medications?"; and, "What don't you like about the medications?"

Data analysis is currently focused on four thematic areas: (1) medication compliance, (2) emotional changes related to medication, (3) stigma linked to mental illness and medication, and (4) the usage of metaphorical language in articulating the experience of antipsychotic medication. Future analysis will investigate additional domains of gender, social relations, family life, work/employment, and experience of recovery from illness. Using a descriptive illustration, we identify the phenomenological

TABLE 1. Socio-demographic Characteristics of Participants (N =90)

	Number	Percent (%)
Gender		
Male	49	54.4
Female	41	45.6
Mean Age (s.d.)	40.7	(7.8)
Ethnicity		
European American	70	77.8
African American	20	22.2
Marital Status		
Single	74	82.2
Married/Partner	7	7.8
Divorced/Widowed/Separated	9	10.0
Living Situation		
Alone	24	26.7
Partner/Spouse	10	11.1
Relative/Parent	37	41.1
Roommate	5	5.6
Group Home	14	15.6
Have Children		
Yes	16	17.8
No	74	82.2

or interpretive gap (i.e., the medication aporia) as the paradoxical, contradictory, and ambiguous client feelings and perceptions of medication treatment.

A Case Illustration of Medication Effect Interpretation

New atypical antipsychotics have often been referred to as the "miracle drugs." Thus, each research participant was asked if their medication experience could be characterized as a miracle. In one case, the client replied:

> I don't know. I simply don't know. It's freed my anxiety level. The thing I don't know about the [medication] is that my environment has changed so many times since I've been on it. First I started taking it when I was [back east]. And then, when I came home [here] I

> was living with a guy . . . And then with two guys. So as far as the effects of the medications on me, it must be so complicated because there is an interaction going on between my environment and when I take the pills. So I don't know how to judge it.

In a follow up question–"since you started taking it, do you feel different in yourself in any way?"–the same respondent, with an upbeat tone, noted:

> I feel like a different person. I have self-confidence now. I dropped six pounds last week. And now I know I can do it because I play tennis and golf every Monday and Wednesday. . . . So [I] shower and shave and [get] out of the house at 8 o'clock, that's cool. . . . And now when . . . I hear words about the computer like upload and download and megabytes and modem and stuff that all [my] nephews talk about, I used to go to an anxiety state.

Continuing the interview, he was asked: "what do you want medications to do for you?" "I would want it to help with anxiety. And help me find a beautiful girlfriend." And, "what would you want a medication not to do?"

> I don't want it to make me gain weight. I've had enough of that excess salivation. I don't want it to make me sleep more. I don't want to feel lethargic. And I don't want tardive dyskinesia. I don't want any of the side effects to interfere with my life.

"What does the medication do best?" the interviewer asked. "One thing I've noticed is I'm losing weight slowly, that's good." With a tone of disbelief, the interviewer followed: "Because of the medication?" "Yeah, I think so. And I feel [that] my body [is] softer now." The interviewer's skeptical tone was understandable; minutes later, in the same interview, the respondent was asked, "out of the side effects that you've talked about (i.e., weight gain, drowsiness, and drooling) what bothers you the most?" Without hesitancy, the respondent remarked: "Weight gain. I don't wear the clothes that I wore during my younger days."

Excerpts from this interview demonstrate ambiguity, contradiction, and paradox. Ambiguity is evident in the respondent's indecision about the causal powers of medication: "so I don't know how to judge it." By not

TABLE 2. Clinical Characteristics of Participants (N = 90)

	Number	Percent (%)
Diagnosis		
Schizophrenic	73	81.1
Schizo-affective	17	18.9
Mean age at onset (s.d.)	20.6 (8.2)	
Mean years ill (s.d.)	20.6 (7.3)	
Mean admissions (s.d.)	7.0 (7.0)	
Out-patient treatment*		
≤ 5 years	32	35.6
6-10 years	33	36.7
11-15 years	22	24.4
≤ 16 years	3	3.3
Current atypical antipsychotic		
Clozaril/Clozapine	51	56.7
Risperdal/Risperidone	17	18.9
Zyprexa/Olanzapine	15	16.7
Seroquel/Quetiapine	6	6.7
Melperone	1	1.1

* for length of treatment at current clinical site

separating environmental from medication effects, this left the client's causal explanation in doubt and open to myriad interpretations. Yet, by pointing to a time without medication, the interviewer found the respondent felt like a "different person" since starting the medication. Indeed, there was the sense that he felt good (i.e., "cool") about waking early to exercise. Does this contradict the earlier statement about an inability to judge? To answer this question requires exploring the gap between hoped-for and actual effects. The client's hopeful medication effect seemed fantastic in the hoped-for "beautiful girlfriend." Were the girlfriend to be actualized, we do not know if he would attribute it to medication. What we do know is that he imagines the powerful possibility of medication; therefore, he opens up a very large gap between his desired and actual medication effect. In his actual dating experience, for example, how might he have claimed that medication delivered to him the hoped-for girlfriend? Even if medication could, how would the recipient know the

girlfriend had been delivered by the medication? A longing feeling, such as a "beautiful girlfriend," and "happiness," were common desires when respondents were asked, "if a medication could do anything you wanted, what would you want it to do?" Most stated very clearly, however, that medication would not make them happy. And most were fully aware that the absence of happiness was attributable to their illness; its lack produced a desire that something, perhaps a medication, could produce a miracle for them. In at least one case, the association between medication and happiness was so strong the client reported pasting smiley faces on each day of her medication box; she reported her compliance behavior improved by looking at the happy faces.

In the case example, was medication causing weight gain or loss? Interview responses suggested both. Because pharmaceutical companies have identified weight gain as a side effect, the respondent's reported weight gain and reduction, empirically real and experienced by him, had several interpretable causes. He reported exercising, which could produce weight loss, and he reported complying with a regimen known to produce weight gain. Consequently, the weight reduction remarks *did not* produce a contradiction; they were statements contrary to received opinion or belief, and contrary to what was held to be established truth–the prescribed atypical antipsychotic had not been shown to reduce weight; instead, the opposite had been established. Thus, it was not a contradiction but a paradoxical *feeling* the client was attempting to sort out. On the one hand, he wanted weight reduction and had experienced it. Yet, on the other, following medication compliance, he had experienced weight gain.

Although preliminary, this case example of paradox, ambiguity, and contradiction is likely to be experienced by many. This is so because of the interpretive gap between hoped-for and actual medication effects. The actual size of the gap is dependent on numerous variables not yet fully understood. Nevertheless, the presence of the drug aporia is evident when research methods acknowledge the paradoxical, contradictory, and ambiguous feelings that recipients (and practitioners) often experience.

DISCUSSION

A medication effect interpretation will always occur alongside at least one of the five elements of a management event; they are most prominent when compliance and effect monitoring and reporting are

unfolding. It is in this way that the 'activity' or 'passivity' of actors, clients or practitioners must be calibrated to careful interpretations of the reasons, wants, purposes, desires, and intentions of actors, sometimes including unconscious ones. Thus, a patient or client-centered approach cannot be predetermined and applied mechanically to any particular setting or person; this choice should be the outcome of careful, collaborative, and highly skilled medication management, not preconditions for it. Medication, rather than producing independent behavior, the intended outcome of most pharmacotherapy models, generates instead inseparable bonds between clients and managers (Floersch, 2002). Medication often becomes the crucial link and the central most important basis for establishing and maintaining a relationship. In short, in making effect interpretations practitioners evaluate the client's capacity to live in the community.

Monitoring and reporting *for* clients occurs not because practitioners do not hope for independent compliance behavior. Rather, the drug aporia requires that management participants (inter)dependently and (inter)subjectively resolve the ever-present 'effect' interpretations. In the earlier case example of a client's subjective experience of atypical antipsychotic treatment, there was no one interpretation that could finally settle his cause/effect dilemma: Is it environment or medication that produced change? Moreover, why not wish for a medication-produced girlfriend? The hoped-for or desired effect of medication has numerous permutations depending on the client's unique circumstances and social relations. Indeed, the social relations that constitute the client's grid (Longhofer, Floersch, & Jenkins, 2003) offer evidence for the importance of relationships in any pharmacotherapy intervention; the grid relations support the participant by managing the five elements (see Figure 1) of medication management. And as long as the gap between the desired and actual effect lingers–always present–the need for 'effect' interpretations will never disappear (see Floersch [2002] for examples of case manager ongoing 'effect' interpretations).

An example of physical medicine is instructive. When one takes aspirin and hopes that the headache will subside, and it does, the gap between the desired and actual effect is minimal; although rarely is it completely dissolved, perhaps, because simultaneously the person may have learned to associate relaxing with taking aspirin. Thus, we speculate that the extent to which the gap can be reduced to a minimum, for practitioner or client, doubt will fade as to the medication's lack of effectiveness. However, as long as a perplexing difficulty or aporia over assigning meaning to our subjective experience of medication exists, the resulting ambiguity and paradox will be negotiated by relationships in the grid and associated interpretations.

For community social workers and practitioners our findings suggest that clinical interventions need to help participants (1) understand how medications become meaningful; (2) acknowledge the existence and function of the grid; and (3) place medication interpretations at the center of therapeutic work. To bracket–set at the periphery–medication effects, as if they occur independent of interpretation, requires adopting a strictly technocratic and rationalistic practice. It is as if we imagine chemicals produce subjective experience without interpretation. Perhaps it is our anxiety over not knowing–and with precision–how to 'fix' mental suffering that we imagine that psychotropic effects are transparent. The drug aporia produced by psychotropic treatment is real, multi-dimensional, and must be researched and understood. To do otherwise is to retreat into a rigid mind/body dualism. Our empirical research on medication management and the subjective experience of clients puts into question dualistic thinking.

Finally, we are left with important questions about the cultural and psychological 'side' effects of psychotropic treatment. Are they not as significant as physical ones? If not, on what empirical grounds could this be argued? Indeed, pharmaceutical companies are required to list physical side effects and psychiatrists and doctors are instructed to inform their patients about them. Why would we not also consider the cultural and psychological effects in our warnings? For example, in hoping for an effect that medication *cannot* deliver, does this not constitute a negative psychological side effect? In *not* respecting cultural difference in how people make sense of medications, is this not a negative cultural side effect? If these are 'side' effects, then why are we not including psychological and cultural warnings in our routine informed consents? We may need dualist approaches in science for research purposes, but in the lives of the medicated our findings show that separating cultural, psychological, and bodily experiences will not adequately represent the medication experience. Consequently, practitioners and researchers need to take the drug aporia as seriously as they do symptom reduction and physical side effects.

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