

Back Ward

When I began my new job as the director of a large State Hospital inpatient unit I thought that I was prepared for anything. Like many young physicians I was idealistic, energetic, and pretty filled up with myself. I had received wonderful training at a prestigious Ivy League mental hospital and had taken a special interest in the care of people with chronic schizophrenia. Two years of experience with acutely disturbed patients at a busy county hospital and a year of working at an HMO clinic had, I thought, fully rounded out my clinical experience. But nothing could have prepared me for what I was about to become immersed in.

My new Unit was what used to be called a “back ward”. Most State Hospitals of the time had them. These were places for patients that had to be confined indefinitely, usually due to the severity of their symptoms or a history of behavioral problems which would make a return to community living impossible. The name comes from the fact that these wards were usually located in parts of the hospital that were as far away from the other patients- and the eyes of visitors - as possible. We had forty-four patients on The Unit and they had stayed there anywhere from one year to a high of 48 years. In the first two years that I worked there the *average* person who was discharged had been on the ward for over eight years.

The atmosphere of this place is hard to describe in words. “Crazy” or “chaotic” are fitting terms but hardly begin to do it justice. Perhaps “jaw-dropping” comes the closest. There were severely psychotic people everywhere. Everyone was doing and saying crazy things. Violent altercations were an everyday occurrence. As I listen to tapes I made back in those years, though, it is the sound of the unit that is so striking. Patients were constantly yelling at each other, screaming out insane gibberish, or moaning in despair. In my therapeutic zeal I had insisted that my office be located right on the ward, so these sounds were a constant part of my life. I soon learned what noises spelled trouble and which could be safely ignored. Over time I even became able to identify patients by their knocks at my door.

Drawing on my experiences in training at a hospital that had always been at the forefront of the “humane treatment of the mentally ill”, I quickly set out to make some changes. I tried to see each patient each week, alone, for a decent length of time. Since I wanted the patients to address me as “Doctor Turnquist” it only seemed fair that I would address them by their title and last name as well. They had always been referred to by their first names previously and that relationship imbalance had never been questioned.

Other changes included trying to give each person as much freedom to come and go as they could handle. If it was necessary to deny them this privilege we tried to explain why this was done and what they would have to do to regain their rights to freedom. The intake of caffeine had been totally prohibited (for patients - not for staff) for the entire hospital for many years. The staff had been convinced that the patients would become violent if allowed

to drink coffee. A successful campaign was launched to restore the right to drink coffee to the patients.

Perhaps most puzzling to the long - time staff members was the attitude that psychotic symptoms, no matter how bizarre, contained some effort on the patient's part to communicate something. To express some part of themselves, some hidden wish or fear perhaps, that they could not deal with in any other way. Over time a new attitude emerged among many of the staff members. They began to look at the patients with increased curiosity and tolerance. Eventually the ward's atmosphere began to include the sound of laughter.

The previous psychiatrist on the ward had not seen things in quite the same way. The majority of the patients were taking very large doses of the powerful antipsychotic Haldol. They usually received that by monthly injections, along with lithium and Tegretol (an anti-seizure drug that was typically given for behavioral control) by mouth. Many of these patients were experiencing tremendously uncomfortable side effects from their medications, and those side effects, e.g. restlessness, agitation, apathy, confusion, etc. were usually interpreted by staff as symptoms of the mental illnesses themselves.

Setting out to minimize medication exposure, eliminate side effects, and simply keep people as physically comfortable as possible went a long way towards building good relationships with my new patients. Listening to them was helpful in this regard too. Many especially liked my belief that we could both teach each other things. I was fortunate to find so many people who were willing to try to explain to me what their mental illness was really like for them, to let me into their internal world. The education that they provided was truly invaluable.

Of course everything did not go smoothly. As psychotic people will do, some people distorted their representation of me in all sorts of ways. Many reacted to me as though I was a sadistic tormenter, regardless of how kind I tried to be to them. And my one unpardonable sin was that I had been given the charge of eventually discharging these people from the strange but familiar place that had been their home for so long.

What follows will be an attempt to tell the stories of some of these people, to provide some insight into what this ward was really like. Things have changed in the ensuing years. Better medications are now available to reduce psychotic symptoms in people who had previously been unresponsive to any treatment efforts. In our present budgetary situation we no longer can afford to house patients in expensive hospitals for decades on end. The community has become at least a little better at providing care for some of these folks. A ward like this one may never exist in quite the same way again.

Needless to say, the identities of these individuals will be disguised. I will use invented first names for them and change any facts that could lead to their identification. Many of the

elderly patients, and some of the younger ones, have been dead for years now anyway. Strangely enough, though, I think that few of these people would have objected if their identities had been made known. As bizarre and seemingly different from other humans as these people were, many had a wonderful heart underneath it all. Most would gladly do what they could to improve our current mental health system or to bring a chuckle to those who study it.

A famous psychiatrist named Elvin Semrad was once asked “how do you help your schizophrenic patients to recover?” Semrad replied, “Why you fall in love with them, of course”. By those standards I clearly failed these people miserably. Most of these patients that I will describe came to have somewhat better lives over time, I think. All of them were eventually able to leave the State Hospital. But very few experienced any sort of complete recovery from their illness. While I’m sure that I did not love any of these people enough, I hope that the glimpse into their inner worlds that follows will be, at least, a loving and respectful one.

You Couldn’t Make This Stuff Up

Lois was 72 years old when I met her. She had spent the last 12 of them on The Unit. She had been an attractive woman in her youth but decades of schizophrenia and the attempts to treat it had changed all of that. She was quite overweight from the starchy hospital diet and the medications that made her so hungry. She only bathed in response to a show of force. Her hair and her eyes were wild. Like many State Hospital patients of the era, all of her teeth had been removed. Sometimes this was done to control biting but more often, as in Lois’ case, it was simply cheaper and quicker to deal with infected teeth by removing them entirely. The image that Lois presented was, quite literally, akin to the picture that comes to mind when children think of “witches”.

Occasionally psychiatrists encounter memorable patients that seem to embody every symptom that the Doctor has ever learned about- and more. Lois was clearly such a patient. Her incessant screams were typically driven by genuine terror. Oftentimes she would lay on the floor of public areas and yell about the terrible things that were being done to her. This was particularly common if visitors were on The Unit. When nurses tried to move her to a bed or quiet room she would go completely limp, resulting in frequent back strains among the staff. Very few of the staff were kindly disposed towards Lois. She never appreciated anything that they tried to do to help her. To make matters worse, there were no single rooms on The Unit. And Lois had a particular talent for getting her roommates stirred up. It quickly became apparent that the staff were going to look at the ways in which I dealt with Lois as the ultimate test of whether all of my new ideas actually had any merit to them.

Lois reluctantly agreed to come to my office during my first day on the job. Her room was right across the hall from me so it wasn’t a long walk. As respectfully and gently as

I could, I invited her to meet with me so that we could get to know each other a little bit. I explained that since I was going to be her new psychiatrist it would only make sense for me to know her so that I wouldn't make mistakes out of ignorance. I was quite encouraged when she agreed to meet with me as she had always refused to meet alone with anyone.

Within moments of sitting down in my office she made it clear that she "already knew me". She explained that she had been "found in a garbage heap" and begged me not to read her mind. When I tried to protest that I did not have mind reading talents but thought that my job would be tremendously easier if I did her demeanor shifted.

"You're just a little quack Doctor", she snarled. "You're the one with the long black tail. You saved the witch and you wouldn't save me. Now you're breaking up everything inside of me and making me change into all colors. Some Doctor you are. I will never meet with you again". With that she stormed out of my office and it was several weeks before I could persuade her to return. Her screams and crazy statements only increased. The nursing staff was quickly convinced that all of this talk about "understanding people" was only, as they had suspected, going to make all of the behavior problems on The Unit get worse, and that their firm way of dealing with Lois had been the only way possible.

Eventually Lois did return to my office and, over time, she gradually began to reveal her inner world. The fragility of her sense of self was overwhelming to observe. She really could not tell where she left off and the outside world began. Like many people with schizophrenia, she had difficulty distinguishing between the three great classes of things: Human, Alive But Not Human, and Inanimate.

Lois often complained about her bed. Many times she would go for weeks sleeping on the hard linoleum floor. She believed that her bed was becoming smaller and smaller and that it was able to read her mind. She believed that "two men with poles lived inside her mattress". Once she revealed that she had "an Anastasia bed". Such a bed could take her to different places and times, without her awareness or control, only to "dump her off". Perhaps most terrifying was her belief that she was actually "becoming her bed". She meant this in the most literal way.

It turned out that much of her aversion to bathing resulted from the terror that she experienced when forced to shower. She complained "if I go into a shower I may never be able to get out of it". Similarly, she was afraid of pots, pans, and other cooking utensils. She always feared that kitchen equipment "could cut her legs off". She believed that some sort of "thing" lived inside of her and controlled all of her movements.

Her lost beauty figured prominently in Lois' delusions. One morning I heard a

bloodcurdling scream that was of unusual intensity even for her. When I rushed over to her room, thinking that there must have been some sort of fight, I found her on the floor sobbing. She pointed to her legs and said "someone came in last night and cut off my beautiful legs- they replaced them with these fat ugly ones. You have to do something".

Lois believed that the nursing staff had a special machine behind the nursing station. The only purpose of the machine was to "make patients homely". She was absolutely convinced that the nurses were jealous of her because of her beauty and took all sorts of steps to destroy her appearance. She would wail " I was so beautiful -now they've turned me into this stretched out old thing".

One of the old conceptualizations of schizophrenia took special note of patients' "ambivalence" - their inability to decide between two opposing views of things. This was especially notable in her relationship with me as it developed over time. The dreadful accusations never did go away completely. "You just electrocuted me you fucking bastard ... You just tapped into my water supply!" she'd complain. Eventually the other side of her feelings for me began to surface, often in odd metaphorical ways. Once when I came into her room to invite her to my office she asked "aren't you afraid of burning up in here?". She refused to come to my office on one occasion because "there are too many drills in your bed". As she began to become more connected with me I commented once that "she seemed to have trouble deciding whether she wanted a lover or a servant". With a lewd smile she responded " well, I'd like both".

In keeping with my inflated view of myself back then I , like most humans, believed that I was probably pretty good looking compared with the average person. So I was a bit taken aback when she looked at me sincerely one day and said " You know, I'm really sorry about the way you look- I like you anyway, as a person". She suggested that I should find out what medicine she was taking and take that so that I could "become a little better looking.". Another time, immediately after a barrage of complaints about how I "turned people into hamburger" she paused, cast a knowing glance at my crotch, and smiling a toothless grin said " I'd be happy to suck that for you". Thanking her for her "incredibly generous offer" was difficult. Sometimes people say things that are so hilarious and unexpected that it's pointless to even try to keep from laughing.

Returning from a walk one time she smiled sweetly and said " Be careful, we might fall into each other's arms". One of her cleverest attempts at seducing me came the day she whispered "you know, my brother owns a rubber factory". I was touched one day when I met her usual stream of indefensible accusations by gently asking her "what is it that you really believe that I've really done to you?". For just a moment a tear came to her eye as she replied "you married someone else".

Like many severely psychotic people, Lois had a number of theories about what had

happened to leave her in such a state. She believed that she had come from a wonderful, caring family. Her father was described as “the richest person in the world” and “the Heavyweight Wrestling Champion of the World”. She thought that something had happened to her at about the age of 17 that had changed everything. My attempts to educate her about the onset of schizophrenic illness seemed to go nowhere. Her theory was that she had been “adopted by Adolph Hitler” and later “kidnapped to the North Pole”. At times she was convinced that Satan lived inside her or that she had married him. Once she revealed that she was “stuck in a movie that never stops”. She insisted that she “needed a new head” and that her existing head was going to fly away entirely. Sometimes her strange experiences were attributed to “the rays that come up through the floor and go right through me”.

Whether it was due to our work together, the reduction in her medications, a better environment, or other unidentified factors, Lois eventually became much more pleasant and “manageable” on The Unit. Most of the screaming behaviors stopped and she began to talk with other people in more rational ways. Of course this “clinical improvement” brought with it the new threat of discharge from the hospital. She was not enamored with the idea of leaving. She said that she’d be happy to look at other places to live- right after I had all of the buildings on our large hospital campus painted orange. Once, in a candid moment, she protested that she could not possibly go to a nursing home to live because she “would have to act up too much to get attention”. But she was finally discharged to a community nursing home anyway and never returned. I was genuinely sad to see her go.

Mark was one of the “wandering paranoids” that would come through our system every now and then. These people always believed that their demons were a part of external reality, rather than a personal creation that they would always carry with them wherever they went. They assumed that if only they could find that safe place where their tormenters could not find them they would be OK. In Mark’s case that safe place was hiding under a stairwell at the airport. When security officers discovered him he was wearing only a pair of sox. Huddling in an airport stairwell wearing just sox will get you a psychiatric evaluation nearly anywhere. It was hard to maintain my composure when he revealed that he was fleeing “Richard Nixon and Valerie Bertonelli” (a now obscure actress who had once starred in a show called “One Day At a Time”). Apparently the two were in cahoots and had been chasing him for years. They each spoke to him in a threatening manner. Sometimes their voices would merge so he couldn’t tell which was which. At times Mark was forced to conclude that Mr. Nixon and Ms. Bertonelli were actually one and the same person.

Selma's appearance was unusual, even by The Unit's standards. She always walked in an odd, hunched over fashion. Sort of like a bad Groucho Marx imitation. But Selma did not take on her strange gait for laughs. She sincerely believed that she was carrying Satan on her back. It looked like he was quite heavy. She had always tried to get out of

her required yearly physical exam but one year the nursing staff persisted and she reluctantly consented to be examined. The physician was amazed to find that she had two imitation pearls jammed deep into her ear canals. They seemed to have been there for a long time, perhaps years. When asked why she had the pearls in her ears Selma explained that they were "hearing aids".

Strangely enough, those pearls might have been hearing aids, after a fashion, for Selma. A common symptom among people with schizophrenia is "hyperacusis". In this condition ordinary sounds can be experienced as though they have been amplified manyfold. Even a quiet sound that is barely perceptible to others may seem incredibly loud and unnerving. So perhaps the pearls were just what Selma needed to survive on the noisy Unit. But then again, she might have been becoming hard of hearing and actually believed that those pearls would help. She never would explain how those things worked.

Monty was a man who was brought in after what was assumed to be an unsuccessful suicide attempt. He had jumped off a bridge that crossed the Mississippi River. People die jumping off this bridge nearly every year but somehow Monty had survived. Of course we tried to determine what would prompt him to do such a thing. It was a conflict over cigarettes. Cigarettes are the most important thing in the day to day lives of many people with severe schizophrenia. An aid at Monty's nursing home had threatened to take his cigarettes away if he didn't correct some behavior or another and it was more than Monty could stand for. Amazingly, Monty consistently maintained that his several hundred foot jump into the Mighty Miss was in no way to be understood as an attempt to kill himself. Far from it. This was a part of his new plan "to live underwater". He said that he had it all figured out. He would have unlimited water to drink and plenty of fish to eat. There would be no meddling staff members to answer to. He became very annoyed, however, when I gently asked how he was going to smoke in his new home. "You Doctors are all alike" he snarled. "You all think that jumping off a bridge is some sort of big deal". Years later I was sad to learn that Monty had drowned after wading into a different river. Apparently some ideas are just too good to let go of.

Marie was convinced that she came from a long line of "Russian Nobility". She knew beyond any shadow of a doubt that she didn't belong on The Unit. She "wasn't like these people". Marie had been committed after throwing her television out the window of her seventh floor apartment. As often happens in schizophrenia, the people on TV spoke directly to her. Every sentence carried a special meaning for her alone. And that day she just didn't like what they had to say.

Leonard might never had come to psychiatric attention if he hadn't started calling his local police station asking them to leave him "a wake up call".

The clientele on The Unit had trouble adjusting to the new telephone system. Previously

there had been two old fashioned pay phones that required a dime to make a call. Back then the public rate was a quarter but the hospital had tried to give the patients a break by keeping the cost down. Of course, even that dime was a hardship for many of our folks so we were delighted when the pay phones were replaced by two new "princess" style phones that would allow local calls to be made for free. Within a few days, however, one of the new phones was inoperative. Before the phone company was out to fix the first phone the second one had died as well. The telephone repairman was surprised to find that each of those phones was filled with dimes. Since there was no longer a slot to put the dimes in people had jammed them into the opening next to the lever that the handset rested on. We had to put up signs saying "No Dimes Required" after the phones were repaired.

Benny was another man who totally lived for his cigarettes. He had lived on The Unit for over six years by the time I met him. In those days cigarettes were generally doled out on the quarter hour, for those lucky enough to have them. Benny would smoke his cigarette in the smoking room- which was usually so dense with smoke that actually having a cigarette seemed almost unnecessary- then immediately get in line for his next cigarette. Like many of the patients he was taking a large dose of long-acting injectable Haldol each month but was having a hard time with it. His entire body shook incessantly and he could rarely sit still for more than a few moments at a time. He could not light a cigarette on his own because of the tremors - the nurses always had to do this for him. It had been over a year since he had stepped foot off The Unit. Of course we felt that he was severely addicted to nicotine and speculated that he also smoked so much because he was extremely nervous and this was his best chance of relaxing for a minute or two.

We didn't know back then that cigarette smoke increased activity in the liver enzyme system that was responsible for breaking down Haldol. So Benny's smoking was also driven by his unknowing attempt to reduce the level of Haldol in his bloodstream and the uncomfortable side effects that he was experiencing from it.

Back then the McNeil Corporation that manufactured Haldol was trying to advance the idea that their product was far superior to everything else. A "pure dopamine blocker" they claimed, plus the convenience of once monthly injections. They had hired a couple of nationally known shills- a psychiatrist and a psychopharmacologist who are still prominent in the field today - to make the rounds of the State Hospitals explaining why Haldol was the best thing that we could offer our patients. The only place for Haldol's older competitors was "on the pharmacy shelf", the psychopharmacologist boldly stated when he met with our medical staff. Of course similar claims had been made for centuries about all sorts of other wonderful treatments for schizophrenia but we still fell for the claims back then. And the process still goes on with each new drug that is released.

It would have been hard to convince Benny of the wonders of Haldol. He was

tremulous, stiff, and severely restless. He suffered from constipation, dry mouth, and was having trouble urinating because of the side effect reducing meds that were given along with the Haldol. To add insult to injury, he was every bit as psychotic on the Haldol as he was without it. The only discernable “benefit” was that he was more docile and manageable on The Unit than he had been in the community. He had no prospects for ever leaving The Unit unless something changed significantly.

Benny was slowly switched over from Haldol to a modest dose of Serentil- one of those older antipsychotics that “belonged on the shelf”. I learned that he had enjoyed playing pool back before the onset of his illness and eventually persuaded him to accompany me to a distant building on The Campus where we had an old pool table. His game was pretty terrible by then. I began to assess his clinical condition by whether he could remember if his balls were the “stripes” or the “solids”. I’d know it was a bad day for Benny if he neglected to remove his heavy winter gloves while we played. Over time we formed some sort of relationship but it was hard to say just how this looked from his end. He did begin to look forward to our games and even requested them at times. His side effects came under much better control and it was a big day for him when he could finally light his own smokes again. He began to spend time in the day room watching television with other patients. This does not imply that his schizophrenia had gone away though. He was still terribly anxious and much of what he said did not make sense to us. When he was upset for one reason or another he would voice his displeasure by urinating on the floor outside my door. The slope of the hallway always brought the flow right into my office. In those days it was a common occurrence for me to come to work and notice that “The River Benny” had overflowed. A visit to the nurses station to find out what had upset him usually followed.

Benny was afraid to leave The Campus to look for another place to live. Eventually we were able to locate a half-way house in his home community that was willing to take a look at him. In order to persuade him to “interview” at the facility I had to agree to drive him there personally. We brought his belongings and arranged for him to be able to stay if the interview went OK. The drive of over a hundred miles was agony for both of us. He never said much of anything that I could decipher and I doubt that my comments registered with him much either. Saying goodbye was hardly a “Kodak Moment” but as I made the long drive home I suspected that we would each miss each other in our own ways.

Scientists are trying to understand the powerful link between schizophrenia and smoking. An estimated 90 % of people with schizophrenia smoke cigarettes, despite the fact that smoking typically uses up almost all of their very limited disposable income and has all of the known health risks. There are now suggestions that schizophrenia is associated with abnormalities in neurotransmitter systems that are related to nicotine. Smoking may help to stimulate brain areas that are under-active as a result of the illness itself.

The fixations on cigarettes could get pretty extreme. Many patients scoured the ashtrays for butts that still had tobacco in them. These would be relit if they were big enough. The smaller ones were collected and rolled up into pieces of paper from magazines. One young man had dispensed with the whole business of lighting the cigarettes. He simply ate them. One day he was being escorted to another building on The Campus. His propensity for picking up cigarette butts and eating them was well known so staff had restrained his hands behind his back prior to the walk. Even that strategy failed when he saw a butt resting on top of a snow bank. Before the startled staff member could react the man dove into the snow head first, neatly grabbing the smoke in his mouth before he sank into the snow. He had eaten the butt before he was pulled out.

Vladimir had been on The Unit for seventeen years. He had assaulted a policeman because of some paranoid ideas involving his wife. The charts indicated that Vladimir spoke only Ukranian. No one had been able to talk with him in the entire time he'd been on The Unit. My own attempts to speak with him were always unsuccessful. I didn't know if he was actively crazy or had a dementing illness. Since he rarely got out of bed and never interacted with anyone it was impossible to tell what his internal world was like.

Finding a person who could speak Ukranian was the obvious solution, but this had never been seriously attempted. One of the social workers was given the task of finding a translator. After a couple of months the big day arrived. A Russian Orthodox priest came to The Unit, wearing robes and all. We went down to Vladimir's room to ask him some questions. When the Priest asked his first question- in Ukranian- we were stunned when Vladimir answered him in English.

Erika was an older woman with a thick Austrian accent. She sounded much more like the typical caricature of a psychiatrist than I did. She'd been committed after assaulting her husband with a duck. She had a longstanding "erotomaniac fixation" on her outpatient psychiatrist and had become furious when her husband refused to drive her to the psychiatrist's home so that she could deliver a love letter to him. The problem was that she'd gotten the duck from her freezer so it was a potentially dangerous weapon in the eyes of the court. Like many women with Bipolar Illness you could sort of judge how manic she was by her jewelry. When Erika was wearing two or more rings on each finger you knew she was going to be difficult to deal with. Her other clinical indicator was whether she was wearing shoes. Years earlier Erika had made a suicide attempt during one of her depressive episodes. She had laid across the railroad tracks near her home but as the train approached she had a sudden change of heart. She almost got out of the train's way except that it neatly severed the big toe on her right foot. Amazingly, she incurred no other injuries in the incident. In the years that I knew her, when she was shoeless and showing the missing toe that was another sure sign of trouble.

Laura was another of the Bipolar patients that would come to us as a result of her mania. When her mania had reached a sufficient level she often concluded that she was pregnant. For some odd reason manic women often conclude that they have many fetuses in them. Some claim to be carrying ten or more babies at once. This happened often enough that I began to call it "the litter delusion". During this hospitalization she had decided to take some contraceptive measures to keep yet another litter from developing. She was wearing a moist bath towel wrapped around her head when I came to see her. She explained to me that she had a large hole in the top of her head. The towel covered it up but had to be kept moist "for protection". When I asked what she needed to be protected from she whispered "air born sperm".

One young male manic was severely "hypersexual". His efforts to copulate with every female on the ward - staff and patients alike- had finally resulted in his being put in a seclusion room. There was a small window, maybe five inches square and at eye level, that allowed staff to observe the patient that was in seclusion. For several days that young guy tried to expose himself to every woman that walked by. "Hey, Hey" he'd yell, trying to get ladies to look at him. He jumped up and down like he was on a pogo stick as he tried to get his penis in front of that little window but it was just too high off the ground for him.

Shortly before I left The Unit we joined the computer age. An old desktop that had become too obsolete to be used somewhere else in the State bureaucracy was delivered to my office. Of course the patients had a variety of reactions to the new machine. "There are heads in there with squashed down brains in them- I used to make those things" one elderly man claimed.

Gigi was another patient who had managed to stay on The Unit- over her bitter protests- for many years. Part of the strategy in staying in a State Hospital for years on end involved convincing staff that you hated it there and wanted desperately to leave, then acting in a way that made it clear that discharge was impossible. Gigi had not left the unit for even a brief walk in years, even on the occasions of rare visits from family.

Gigi was in her seventies when I met her and had had a unique delusional system for several decades. No treatment had ever shaken her core beliefs. She was totally convinced that all humans had "39 brain cells" and that a single one of hers had "turned irrational". As she once put it, "I have had that sick cell in my body since I was seven months in utero...it directs me and talks to me...That's why I must rock back and forth...I have heard it speak at times- it has a very weird voice". Unfortunately Gigi's "sick cell" had told her to kill herself on occasion and we knew of at least two serious suicide attempts. Once she had taken a potentially lethal overdose of medications. Another time she had driven her car off a bridge.

Like many people with schizophrenia, Gigi evidenced no concern whatsoever for

personal hygiene. Oftentimes it isn't like they make a conscious decision to neglect their self-care. Its more like the matter doesn't even come up on a neurological level. Their brain may not attach any importance to the way that they actually look or how others might view them. Gigi's hair was matted down and she wore the same tattered housedress every day except when the nurses insisted that she finally had to surrender it for laundering. She had a few teeth left but they were dark and twisted. She had come from a wealthy family and was convinced that she was a genius.

It is always a temptation for even trained mental health professionals to try to rationally persuade psychotic people that their delusional beliefs are false. I fell into the trap early, showing her atlases of neuroanatomy, quoting her estimates of how many billion nerve cells were actually in the human brain, and so on. Of course this did no good whatsoever. 39 billion brain cells is what humans were born with and any competent physician should know that. By definition, a person with delusions believes that their beliefs are true. They can quite literally decide that the person who doesn't agree with them is crazy when their beliefs are challenged. Plus, by the time they come to psychiatric attention patients like Gigi have usually had all sorts of well meaning people try to point out the errors in their thinking. So I should have known better. Gigi quickly became convinced that I was both ignorant and "an alcoholic". She became resistant to meeting with me and was often quite hostile and demeaning.

Eventually Gigi consented to brief meetings with me again when I suggested that I'd be an even worse psychiatrist for her if she wasn't giving me input into her treatment. I decided to focus on getting her to tell me her life story rather than eliminating her "symptoms" and she did enjoy talking about her past. At times we'd laugh at my foibles or those of the nursing staff- there was plenty of material to chuckle about. This was back in the days before Clozaril had been introduced so there weren't a lot of good medication options when patients didn't respond to the usual drugs. In Gigi's case it turned out that she had had a good response to lithium many years before. So we tried adding a low dose of lithium to her antipsychotic medication. As occasionally happens, the lithium seemed to "augment" or turn on the action of her antipsychotic medicine in a dramatic way. Long standing delusions rarely disappear quickly or entirely. Instead they seem to lose their emotional emphasis in the person's inner world. This was the case with Gigi. She never believed that she had been wrong about that 39th brain cell that had gone rogue on her. But the cell gradually became less bothersome and she was able to think about other things at times.

As Gigi's condition improved we had to face the inevitable prospect of her discharge. Fortunately there was a nurse who had known her throughout her long hospital stay and had somehow managed to form a decent relationship with her. That nurse was finally able to persuade Gigi to go for walks to the hospital store to buy cigarettes and coffee. Then the big day came where Gigi agreed to go to downtown Minneapolis with

her nurse "to see how the city has changed". Her reaction to the trip was striking. We tend to focus so much on the aberrations in meaning that people with psychosis attach to things around them that it is easy to forget how strange things can be for them at the more basic levels of perception. When she related how the city had changed since she last visited she was quite focused on a new skyscraper that had been constructed. " You wouldn't believe it", she said, holding her thumb and forefinger about an inch apart. "Those morons built a beautiful building but the windows on the upper floors are only this big!" Later she referred to the "miniature helicopter" that she had seen flying over the city. Despite everything that I thought that I knew about schizophrenia I was stunned to learn how different that the picture of the world presented to her by her nervous system really was. The fact that objects look smaller at a distance was no longer a part of her perceptual universe.

Emily lived alone and missed her children terribly, although she missed them in her own unique way. Rather than feeling the pain of longing for her grown up kids (who wanted nothing to do with her in reality) Emily decided that her children visited her regularly. It's just that they assumed the form of squirrels when they came to see her. She would leave nuts out to entertain the kids when they visited. On holidays and special occasions she'd put out a little bowl of Jack Daniels. Her social worker asked that I come meet with her in an attempt to persuade her to take the antipsychotic medication that she apparently needed. I was pretty pleased with myself after our meeting, as she did consent to taking some medicine and was already becoming less disorganized. Within a few weeks, however, she decided to stop the medicine again and, surprisingly, was claiming that it was me who had instructed her to do so. It turned out that I had been "speaking to her through her grapefruit juice" every morning since we'd met and was now finally giving her the sort of advice that made more sense to her, i.e. "don't take any more of that medicine - it's poison".

Hannah was trying her best to maintain a dignified front in commitment court. All of a sudden, in the middle of her attorney's attempt to plead for her release, Hannah let out a loud scream and fell writhing on the floor. The court deputies and I rushed to her assistance, fearing that she'd had a heart attack. "Cosmic rays" she gasped. "The rays got me". Her attorney's case did not go well after that.

After we'd talked for a while Alma indicated that it was now safe for her to leave my office. " I'm pretty sure that my feet will keep me on the ground now", she said with obvious relief. "They are a lot heavier now". I was pleased to learn that I could have that sort of effect on a person's relationship with gravity.

Our clientele on The Unit was by no means limited to severely psychotic people with schizophrenia. All sorts of brain problems could get a person admitted to The Unit. The key factor was whether they were too confused, vulnerable, or unpredictable to be cared for in the other wards of the hospital.

Tommy was a man who had suffered a brain injury in a motorcycle accident. He was the exception to the general rule that brain trauma magnifies or worsens preexisting personality traits. Before his injury Tommy had been quite nasty and ill-tempered but now he was relatively pleasant and docile. In fact the few family members that visited found that they liked the brain damaged version a lot better than the old Tommy. Unfortunately, his new found tranquility was accompanied by a profound memory deficit and almost total absence of problem solving abilities. One day I saw him walk towards a drinking fountain on the way to the smoking room, carrying a cigarette and lighter. I turned to my medical student and predicted " He'll never be able to handle this- it'll be too complex for him". Sure enough, Tommy stopped before the fountain and looked at it with puzzlement. He finally figured out that he needed to push the button to get the water to come out but when it did he placed his cigarette under the stream rather than taking a drink. "Aw fuck" he yelled, throwing the soggy cigarette to the floor. The student looked at me in amazement and asked " how did you know he'd do that?" Of course I didn't know that he'd put his smoke under water. I just knew that the complicated process of taking a drink while carrying a cigarette would be beyond his capacities.

Robert was an elderly man who had been an alcoholic for many years prior to falling and hitting his head on some concrete steps. The resulting brain injury changed his personality, leaving him very suspicious and irritable. Despite the seemingly clear relationship between his suspiciousness and the head trauma, he had been on The Unit for several years with the diagnosis of "paranoid schizophrenia" and was treated with antipsychotic medicines. Robert had the peculiar habit of writing down just about everything that he saw or thought about in little notebooks. He'd follow me around the ward, pushing his notebook at me, insisting that I read what he'd written down- which was all basically nonsense. It turned out that what Robert actually suffered from was "temporal lobe epilepsy", a peculiar seizure disorder that had resulted from the head injury. One of the odd symptoms of his disorder , in addition to the personality change, was "polygraphia". Polygraphia means essentially "too much writing". Once we got Robert off his antipsychotic medicines, which were making his seizures worse, and on to a medicine to tame the seizures he improved significantly. His drive to write down every little injustice faded away and his mood improved. He left us to live with a daughter in a distant state.

Leona had suffered brain damage as a result of strokes and had one of the worst memories on record. I could talk with her for a while, leave the room for thirty seconds, and when I returned she could not recall having ever met me before. One day she had a visit from family and when they left she became quite agitated, screaming loudly that someone had stolen her wallet. She did not actually have a wallet with her but her brain was somehow aware that something important had been there previously and had been taken away from her. Reassuring her that it was her family- not her wallet - that had

departed did little good. She did not remember that her family had been there just minutes before. Of course she forgot about "the wallet" in a few moments too so everything was quickly back to normal for her.

Martin had the same sort of brain injury that Leona had but his presentation was different. "Multi-infarct dementia" results from a series of strokes and the location of the strokes largely determines what the resulting symptoms will be. Martin was a Native American man who had a history of alcoholism and uncontrolled hypertension. The strokes had left him with a severe memory loss, an aphasia (an inability to speak) and tremendous difficulty controlling his basic impulses.

*Sometimes life imitates art in funny ways. I knew Martin for several years and, like everyone else on the staff, was convinced that he was completely mute. I had managed to locate a sign board that is used with deaf people and he'd communicate by pointing at symbols on the board or by writing me simple notes. One night I came to The Unit in the wee hours of the morning and was shocked to see Martin talking on the telephone. Of course the character of "Chief" in *One Flew Over The Cuckoo's Nest* came to mind immediately. He smiled sheepishly when he knew I'd found him out. The movie analogy didn't hold exactly though. Martin's speech was very clumsy and difficult to understand and it was clear that some genuine aphasia was indeed present.*

It wasn't his speech problems or even his memory deficit that had left Martin locked up for so long. It was his problems with impulse control - especially sexual impulses. Martin would try to have sex with just about anyone who was willing or had just been left unattended for a few moments. Gender was of no consequence. It was just a part of everyday life on The Unit to walk down the hall and see Martin with a big grin on his face and his organ out for everyone to see. He'd sidle up to unwary patients, staff members, and visitors, trying to rub himself on them for a little while before being driven off by the predictable screaming.

Martin was pretty clever for a demented person. He had somehow learned how to pick the locks to The Unit with an old credit card and was always trying to escape. One time he made it as far as the parking lot and managed to get a worker's truck started. He might have gotten away except for the fact that a can of motor oil in the truck captured his attention. Martin had drank over half of the quart of Quaker State before staff members caught him and returned him to The Unit.

Martin was another person whose behavioral problems were clearly going to make discharge impossible unless something drastic was done. I began to look into the possibility to reducing his excessive sexual drive with "antiandrogens". There was a small literature on using Depo-Provera (a female hormone often used for birth control) injections to accomplish this. We discussed this with Martin (to the extent possible), his wife, and the hospital ethics committee. The entire medical staff reviewed the issue.

Martin and his wife consented to have him start the injections. Baseline measurements of the testosterone in his bloodstream were taken and we finally began to inject him with Depo-Provera each week. As his testosterone levels came down so did his sexual drive. He stopped exposing himself and no longer tried to mount everyone. He gained a little weight but otherwise seemed to tolerate the injections quite well. Within a relatively short time it became possible to discharge him to a nursing home much closer to his wife and family.

While there are all sorts of legal and ethical issues around a treatment like Depo-Provera injections, which essentially represents "chemical castration", this seemed to represent the only way that Martin would ever be able to return to a non - hospital setting. We made every effort to obtain truly informed consent from he and his wife and had a lot of opinions on the table before proceeding with this. One wonders why this type of treatment is not routinely offered as a voluntary option to incarcerated sexual offenders who clearly cannot control their sexual impulses and have no other prospect of ever returning to live safely in society.

The Unit used to get patients with Alzheimer's Disease but something else usually had to be going on with them for them to come to us. They had to have other problems, e.g. paranoia, medical problems, hitting, or other behavior issues that no longer made living in regular nursing homes possible. In Dan's case it was that he was just too confused to get by anywhere else. When he came to The Unit he was wearing two pairs of trousers- with his underwear on the outside of them. One time I saw him walking down the hall with a tattered garbage bag pulled over one leg. He was very serious as he struggled to keep the bag pulled up with both hands as he walked. Later he was seen in the smoking room wearing four baseball caps on his head. I was surprised one morning to see him pushing his entire bed down the crowded hallway. If there was an underlying reason for these odd behaviors I never could figure out what it was. Perhaps these things made sense only in the reality that Dan was now living in.

The Alzheimer's patients were hard for us to deal with. They tended to die within at least five years of the onset of their illness and most of them were already in the advanced stages of it by the time they came to us. Sometimes tiny doses of antipsychotic medications made them more comfortable and manageable but otherwise we didn't have a lot to offer them. By definition, they had terrible short -term memories so any sort of attempts at talk therapy would be quickly forgotten. Most of them did maintain some memories of their more distant past though. I always tried to impress upon the medical students - that were a constant part of life back then- that just taking the time to listen to the stories of their past was sometimes the kindest thing that we could do for these demented people.

Mary had been hit by a car years earlier and had never recovered her ability to make new memories. One of the things that she could never remember was that she wasn't actually pregnant. Her belief that she was pregnant was so powerful and complete that

her body actually looked exactly like she was about 26 weeks pregnant. Her presentation was so convincing that she'd had a number of expensive obstetrical work - ups when she went to Emergency Rooms complaining that "something's not right with the baby". Mary was another patient that frightened us by running away. She'd given her social worker the slip when they stopped for gas on the way to an interview at a nursing home. She hitched a ride and eventually ended up somewhere in rural Tennessee. When she was finally found by their police and transported back to The Unit I was surprised to learn that she had acquired a pronounced Southern drawl. Apparently she couldn't remember that she did not usually speak with a southern accent. Her old way of speaking slowly returned over the next couple of months that she was on The Unit.

About a year after her discharge Mary was returned to The Unit on another mental illness commitment. Since she arrived without cigarettes we went for a walk to the hospital canteen to buy some. I was surprised that she remembered me. As we caught up I asked her "do you have any memories of that time you took off to Tennessee and came back with that southern accent?" She didn't recall much of the trip. The amazing thing was, though, that as soon as I reminded her of that accent it returned in full force. This time it didn't stick around as long- only a couple weeks. But I never could figure out how that accent had come back. I was convinced that there was nothing volitional about it on her part.

Few conditions are harder for a hospital ward to deal with than "screamers". These were patients that yelled incessantly. The Unit had two of them and they were both world class at what they did.

Andrew was a man in his twenties who had had no psychiatric problems at all until he suffered brain damage in an automobile accident. He was in a coma for nearly two months and when he woke up he woke up screaming. He basically yelled every moment that he was awake. "Help me", "I'm hungry" and "my butt hurts" constantly resounded through the halls of The Unit. He often couldn't remember that he had eaten just a few moments before. Andrew could walk with the assistance of two people so we tried to get him up and about to maintain whatever strength and coordination were left in his legs. Since I was one of the few male staff members on The Unit I'd often help out with trying to get him walking. Andrew taught me a great lesson about never letting your guard down with a brain-damaged person. They are often so confused and impulsive that you can't predict how they'll respond to a situation.

One day as we were trying to get him walking he suddenly grabbed my testicles in, what seemed to me, to be a death grip. It took two of us to get his hand unclawed. This may have been the longest minute of my entire life. Another time he suddenly struck out as I was standing behind him, catching me square in the mouth with his fist. On neither occasion had he even seemed angry beforehand. Andrew also had the habit of reaching

back into his soiled "Depends" and throwing feces at people who entered his room. He did not seem to have any animosity to any of us as individuals. He just seemed so terribly-and understandably- upset about what had happened to him that his anger would come out when we would not expect it.

Ironically, Andrew was responsible for getting the patient who had proven the hardest to discharge to finally leave The Unit. Maureen was a very frail woman in her early eighties. She had lived on The Unit for some 48 years. Records indicated that she had become convinced that a neighbor was responsible when Maureen's mother had died of natural causes. Maureen had calmly walked next door and killed the man with a pistol following her mother's funeral. The Unit had been her home for a long time and she would have absolutely nothing to do with me since I was someone who clearly had the agenda of discharging her. To compound matters, Maureen had a "Conservator of Person" who had the legal right to approve or disapprove any proposed community placements. The Conservator would not approve any place unless Maureen wanted to go there. And Maureen let us know that she wasn't going anywhere.

When we'd had Andrew on The Unit for a while it suddenly occurred to me that he could help us. I arranged for Maureen to be transferred to the room directly across the hall from Andrew's. After a couple weeks of hearing "my butt hurts" for hours on end the idea of living in the State Nursing Home began to look more attractive to Maureen. We always made a point of mentioning how "quiet and peaceful" the place was. Her conservator approved the transfer and, after 48 years, Maureen left us to live in a quieter place. The story ended sadly, however. Maureen had insisted for years that she would certainly die if she lived anywhere else besides our weird, chaotic Unit. We received word a couple months after she left that she had, indeed, passed away. Sometimes your beliefs can kill you.

Martha was our other screamer and in many ways she was more difficult to deal with than Andrew. One of the biggest problems was that her room was two doors down from my office. She had had a series of strokes that left her blind, unable to walk, with memory impairments, and in constant physical and emotional pain. In contrast to Andrew, she could carry on a rational and polite conversation. What she absolutely could not tolerate was being left alone, even for a moment. As soon as a staff member left her room the screaming would begin. This was a shrill, high pitched "help me" that carried an amazing distance. On a summer day with the windows open I could easily hear her in buildings on the other side of the campus- a good 300 hundred yards away.

This was another situation where the patient's symptoms were quickly equated with the psychiatrist's skills. Only now the entire hospital seemed to be cursing me under their breath every time that nerve wrenching "help me" started up again. We tried everything we could think of to quiet Martha down. I even arranged to have her room lined with acoustical tiles in an attempt to soundproof it. Nothing worked. She had already been

tried on just about every class of medications that one could think of and nothing had put a dent in her screaming. Major tranquilizers, minor tranquilizers, antidepressants, lithium, antiseizure drugs, even some of the blood pressure medications that occasionally calmed people down were of no apparent benefit. The only option left- and one that was heavily favored by staff throughout the hospital- was to keep her so heavily sedated that she would not have sufficient energy to speak, much less scream. But there were some touchy ethical and quality of life issues that made that option hard for me to exercise.

Two basic things seemed to turn things around for Martha. One involved talking to her very candidly about how her various negative and demanding behaviors- which were by no means limited to the screaming- made it hard for people to be around her. We arranged for contact with staff to be limited if she was yelling. As she tried to be a little easier to deal with we tried to get the staff to seek her out and spend more time with her when she was "being good". Pretty basic behaviorism-reward the good behaviors, try to ignore the bad ones. The other involved opiates - perhaps the one class of medications that had not been tried with her. The idea was that maybe the multiple strokes had also damaged the pleasure systems in her brain, resulting in her seemingly constant agony. This was another case for the hospital Ethics Committee (which I chaired in those days) to review. Since the other members of the committee had also had to deal with Martha's screaming, albeit from a greater distance, and given the fact that nothing else had worked for her, the request to use opiates in her care was quickly approved. Martha, herself, was all for the idea. Opiate addiction seemed like small potatoes compared to what she was already forced to deal with.

We were surprised when Martha didn't really take to the painkillers as we'd anticipated. She used them only rarely but seemed to appreciate knowing that they were available if she was having a particularly rough day. The Unit became a much more pleasant place for everyone as Martha became more quiet and comfortable. When the time came to transfer her to a community nursing home we sent our Behavioral Analyst and Martha's primary nurse along to help teach their staff how to best deal with her. This was a discharge that we did not want to go sour. The prospect of having her returned to us in a decompensated and screaming condition was more than any of us could bear.

Bart was a man that did take to painkillers in a big way. He had an advanced case of Huntington's Chorea, a dreadful genetic illness that robbed him of his muscle control and turned his body into a never - ending series of involuntary spasms. The Huntington's was slowly taking away his mind as well. Bart was one of the many people that had been sent to Minnesota from a neighboring state because of the fact that our mental health system, dreadful as it was, was so much better than that available back home. He'd had problems with a back injury years before and had developed a fondness for Percodan- an opiate based painkiller. As he was clearly dying it seemed that addiction to opiates should not be a concern. We let him titrate a different opiate

(Percodan's dosing was limited by the amount of aspirin in it) to a level where he felt relaxed and comfortable. Bart was quite appreciative. Yet every time we tried to discharge him to a nursing home a new psychiatrist in the community would take away the painkillers. Bart would become pretty upset about that and act up so that he'd be returned to us in short order. He knew that he'd have his painkillers resumed. We could never understand the problem with giving a dying man with an incapacitating disease the pills that made him feel better.

Psychiatrists have no problem with the idea of removing symptoms but when it comes to use our medicines to provide some degree of pleasure to people - even those whose brains are damaged in ways that keep them from experiencing good feelings - we show a wide range of opinions.

We had a number of Huntington's Chorea patients on The Unit over the years but none of them rivaled Mabel's story. Mabel had been on The Unit for over thirty years with the diagnosis of Huntington's. The nursing staff was terrified of her because of her history of violence. Mabel had had all of her teeth removed after biting off the tongue of a man who had been foolish enough to French kiss her. She'd also had two frontal lobotomies to control her aggression. When I met her she lived her waking hours in a "Geri chair"- sort of a wheeled lounge chair that you could be locked into. She was in that wheeled chair so much that I once suggested that in her next life she would come back as a golf cart. Mabel had the most pronounced movement disorder I'd ever seen. Her body was in constant motion, with snakelike movements of her limbs and continual facial grimaces. As I sat with Mabel and came to know her it became apparent that there were two parts of her clinical picture that did not make sense. She did not show the progressive dementia that Huntington's patients inevitably experience as their brain essentially rots from the inside out. Mabel still followed the soap operas and could remember the story lines in detail. When I looked into her family history, she did indeed have Huntington's disease throughout her mother's side of the family. But her mother herself was in her eighties and did not have the illness. So she couldn't have passed it on to Mabel. It turns out that what Mabel had was perhaps the world's worst case of tardive dyskinesia. Her nonstop involuntary movements were not a result of an illness, but of the medication (Haldol again) that had been given to her in an attempt to keep her calm and manageable. She had been treated on The Unit for over thirty years for an illness that she didn't have.

Lewis was a young man who had gotten into a fight and had been severely beaten with a baseball bat . He was so confused when I met him that I decided to give him my "cigarette test". He was given a cigarette and lighter to see what he could do. Any long term smoker has their cigarette habits pretty much ingrained after a while. I knew that we were in for a rough ride when he looked at the cigarette with puzzlement, then put the lighter in his mouth sideways.

Lewis' s purposeless and unpredictable assaults on staff members, myself included, were so severe that he had to be kept in a locked seclusion room. One day, after several particularly trying months, I was observing him through the small window of the seclusion room door. I was strangely delighted by what I witnessed that day. Lewis had defecated in the corner of the room, as he often did. But on this occasion he picked up the turd and carefully placed it on a radiator. At that moment I knew that we had turned the corner in his treatment. That one little purposeful behavior, that attempt to make his environment better, was something that we could not have imagined for him previously. The prediction did prove to be accurate. Over the ensuing weeks he began to show more awareness of himself and was able to walk on The Unit with a couple staff members that found a way to get along with him. The assaults faded away. Several years later we learned that he was living in a supported apartment.

The brain's plasticity, even in the face of severe damage, can be a wondrous thing to behold. Recovery from brain injuries can go on for at least two years after the damage is incurred. So you never can tell exactly what deficits someone will eventually be left with. But sometimes we have to look extra carefully to find those glimmers of improvement that can make the work with these patients seem worthwhile. If someone had told me during my residency that I'd be thrilled because a man picked up his own feces I would have never believed it.

Brad was a deeply schizophrenic man who was catatonic when he came to us, barely moving or responding to his environment at all. But we were surprised to learn that even in the midst of his catatonia Brad was still a collector. The problem was that he was collecting his own feces. A nurse had noticed a strange odor emanating from Brad's dresser and was surprised to learn that he had carefully packed each of his bowel movements into plastic bags, bags that were apparently too valuable to discard.

Susie was another collector but her specialty was used tampons. The nurses were always finding them stuffed into her dresser. One day I was trying to talk with her about why she would save things of this nature. She became very indignant with me. "They turn into babies if you just let them be", she cried. "What kind of Doctor doesn't know that?"

Chuck suffered from both mental retardation and schizophrenia. He had lived in the community his entire life, with the assistance of a brother. Once the brother died, Chuck could not manage on his own but it took a while for him to come to the attention of authorities. When neighbors' complaints finally brought in the Housing Inspector the condition of Chuck's home was truly appalling. The basement was flooded with water. An enormous hole ran through the kitchen floor so that you could see through to the flooded basement below. But it was the cats that really made the place uninhabitable. Dozens of cats that were barely alive and many dead cats were scattered throughout the house. Cat feces were everywhere. His freezer was filled to the brim with

the remains of other cats. Chuck was convinced that modern science would soon be able to bring the dead cats back to life so he would never dispose of their bodies.

As far- fetched as Chuck's delusional system was, is it really more bizarre than the story of Ted Williams' remains?

Lucy was another favorite. She was the patient who "died" nearly every night, only to be reborn as "an atom bomb", "John F. Kennedy", "The Blessed Virgin Mary" or Satan. She was still a relatively young woman but did not have a single tooth left in her mouth. This left her with an odd appearance and limited her diet so I decided that we would take whatever steps necessary to get Lucy some dentures. It took a lot of work to prepare her- and the dentist- for the ordeal involved with examinations and fittings but after some months the big day arrived. When Lucy put in her new dentures she looked like a different woman- at least ten years younger and dramatically more attractive. The staff and myself were thrilled by what we had accomplished for her. Lucy, however, was less impressed. Within a week the dentures had gone through the laundry in the pocket of her jeans. Soon afterwards we were surprised to see that an elderly woman on The Unit suddenly had teeth, when she had had none before. Lucy had traded her dentures for a pack of Marlboros.

More than money, cigarettes were the unit of trade on The Unit. Just about anything could be purchased if you had enough smokes. One day we were saddened to learn that one of our women had prostituted herself to a male patient for one cigarette. To make the story even more tragic, when the act was completed he refused to pay her, saying that "she wasn't worth it".

Ginger was a large, powerfully built woman who split her time between Minneapolis and St. Louis. When things got rough for her in either city she would always manage to get herself admitted to psychiatric hospitals, where she knew that she would be cared for and she wouldn't need money. In fact sometimes she got herself admitted to the State Hospital to make money. She would quickly show that she was on her best behavior so that she'd earn passes into town. Once she had the freedom, her coffee smuggling business kicked in. She'd make over a hundred dollars per month selling coffee back in the days when it was banned on The Campus. Patients would make slurries of instant coffee and water from the drinking fountains. A few bypassed the adding water step and simply ate their coffee. The staffs efforts to keep coffee away from the patients were never successful, nor could they be.

Ginger had two preferred ways of getting into psychiatric hospitals. One was swallowing foreign objects. She'd swallow anything from marbles to razor blades. One time after she'd swallowed a number of coins she had to laugh when I said "remind me not to ask YOU for change for a dollar".

Once she'd swallowed several large paper clips that would have to be surgically removed. The young surgical intern patiently explained the endoscopy procedure that Ginger would have to undergo, then offered her his clipboard and pen so that she could sign the necessary consent form. To his horror, she quickly swallowed his pen.

Ginger's other ticket to admission involved cutting her throat. She had done this so many times that there were multiple rings of scar tissue visible at the base of her neck. She had always managed to cut herself severely enough to need stitches- and to shed an impressive amount of blood- but had yet to nick a major blood vessel. It seemed to be just a matter of time before she'd kill herself by accident.

As it became obvious that Ginger was in no way ready to give up these long standing behaviors our attention shifted to finding a way to get her what she wanted - psychiatric hospitalization - without having to go to such dangerous extremes to get it. We looked at various options before settling on the "Benadryl Overdose Strategy". In this maneuver when she wanted to get into the hospital she would take a few Benadryl capsules, wait until she was getting pretty sedated, then go to the emergency room saying that she'd taken an entire bottle of Benadryl. Blood tests would, of course, be positive for the drug. She would be viewed as a person with suicidal intent and a lethal plan, without having to truly endanger her safety as she had so often with her other ploys. I had some ethical issues around this early "harm reduction approach" but ultimately came to believe that it was the best that I had to offer Ginger. There was an unanticipated benefit of this approach. She was sufficiently touched by the fact that I'd go to this length to try to help her, without insisting that she change her way of operating, that we developed a close relationship.

"Harm Reduction" is a popular concept in the Chemical Dependency Treatment field these days. The idea is that maybe everyone is not able to make the jump to total abstinence from drugs and alcohol, so just getting them to cut back, or to reduce the harmful consequences of their addictions, can be a worthwhile goal. Of course this makes perfect sense in some cases. And who says that our goals for people, be they "total sobriety" or whatever, should be the goals that they will truly hold for themselves? Many of us who work with severely mentally ill people had been familiar with a "Harm Reduction Approach" before the concept ever had a name. There was often nothing else that we could offer.

When someone can see you for who you truly are and can still tolerate you, warts and all- or better yet can actually like you- it has subtle effects on the way you think about yourself. This is one of the major, but often unrecognized, benefits of all psychotherapies.

Stanley became quite agitated one day as I walked by. He began to rant and rave about "all those bastards in business suits". I explained to him that I was wearing a suit that day (a very rare occurrence on The Unit) because I had to go to court and didn't want the judge to think that I was disrespectful. Stanley's demeanor quickly shifted and, out

of the blue, he asked " Who's the Champion anyway, The Crusher or Nick Bockwinkle?". I explained that to the best of my knowledge both of these gentleman had retired from wrestling well over a decade ago. Stanley shook his head and replied "They must be wrestling in Milwaukee".

When I asked Stanley to come to my office he replied that it was too far to walk. "I need a wheelchair" he said. " Electric. Battery operated. Twelve volt. Dry cell". When we got to the office he asked where my secretary was that day. This puzzled me, as I did not have a secretary, until I realized that he was referring to my medical student Trish. I explained that Trish was on vacation, touring Greece and Italy. Stanley replied that there was "nothing left to see in Germany or Italy". He then demanded that I "give him a form". I was at a loss to understand what he really wanted. I brought out some of the various forms that I had to complete as part of Unit business but they didn't interest him. What he had wanted was the manila folder that I kept some of the forms in. I found a blank folder and handed it to him. At that point he got up and left my office without a word.

Psychiatrists use the term "Thought Disorder" pretty loosely these days. Technically there are two main types of thought disorders: Thought Content and Thought Form Disorders. Thought content obviously refers to the things that people think about, the content of their beliefs. Thought form refers to the thinking process itself. Many psychotic people demonstrate what is called "loosening of associations" or "derailment" of their thinking. They embark on a train of thought but each thought fragment calls up other associations so they skip from topic to topic in ways that may only be understandable to them. Stanley was a master of another type of thought form disorder called tangentiality. Entirely new topics could spring up without any seeming relationship to what was going on just a moment before. An attempt to engage him around any particular topic or question was usually met with a totally unrelated response.

I was always looking for ways to find some common ground with these unusual people. In Stanley's case we finally settled on cards. He said that he liked to play but it turned out that the only game that he knew was "War". He wouldn't consider learning any other games, no matter how simple. So I'd hear this faint knock on my door and it would be Stanley, looking to play cards. War is, of course, the most basic of children's card games. You each turn up your cards and the high card wins. Stanley tried to cheat on many occasions but I'd never let him get away with it. It didn't matter anyway. In over two years of playing war with Stanley we never came close to finishing a single game. Right in the middle of the game he'd just get up and leave the office. It didn't make any difference if he was winning or losing.

Malcomb was a man who made Stanley look accessible by comparison. Young, strong, and quite autistic, he seemed to live entirely in his own world. He almost never spoke except to mumble "Popeye". Being a cartoon fan myself, I tried to engage him in

conversations about Popeye, Miss Olive Oyl, Brutus and other characters from the show. When that failed I tried talking with him about Underdog, The Flintstones, Yogi Bear- essentially any cartoon that I knew about, I'd talk about. I had learned that sometimes I could wear mute people down. If they wouldn't talk I would, babbling one inanity after another until they couldn't take it anymore and had to either correct me or tell me to shut up. Nothing reached Malcomb though. Then one night he managed to get one of the nurses alone in the hallway. After wrestling her to the floor he had tried to get his fingers into her eye sockets to remove her eyes. Fortunately another patient heard her screams and was able to pull Malcomb off even before the other staff members arrived- and before any permanent damage was done. "Popeye" had meant something entirely different to Malcomb than had ever occurred to me.

At our most basic levels of perception our brains often have to choose between "same" or "different". Its a decision that we take completely for granted until we see that people can guess wrong on the issue. All sorts of strange things can happen when they do. Sometimes even standing up or shifting position in one's chair can lead a psychotic person to conclude that you are now a different person. If one thing changes, everything can change. Similarly, if two people or things have a single attribute in common the brain can decide that they are identical.

Steve was my very first patient with "Capgras Syndrome". This is a belief that people familiar to you have been replaced by identical imposters. In Steve's case it was his parents. He'd lived with his parents all of his life but was now convinced that that his "real parents" had been abducted to California. The beings that he shared the house with were, he was certain, "computer generated images". As psychotic as he was, Steve was way out of my league when it came to playing chess. I could never come close to giving him a good match so he basically just toyed with me. I was the guy with the medications and authority, though, so he rarely dispatched me as quickly as he could have. After several months of taking antipsychotics Steve returned to his family home to live. He was still convinced that he was living with computer -generated images but he decided that they were actually pretty decent "images" to live with after all.

Alice had a similar syndrome. De Fregoli's Syndrome this one was called. As we talked in our initial interview it soon became apparent that, as often happened, Alice thought that she had known me before. Slowly it dawned on me that it wasn't really me that she thought that she knew. She believed that I was actually a nurse (a female at that) from a hospital that she had stayed at previously. She thought that this nurse was able to physically transform herself into other shapes. This time she believed that the nurse was assuming the guise of a psychiatrist. I knew Alice for over a year but she never seemed convinced that I was the person that I claimed to be.

Rebecca may have taught me more about mental illness than any other single person. She was my "psychotherapy patient" at Cornell. She had been tried on all of the usual

classes of medications and had underwent a trial of shock treatment but nothing had worked. Severely catatonic, she lived almost entirely in her inner world. She didn't speak for the first month that I knew her. Didn't toilet herself. Didn't walk. About the only time she'd move was to dig her fingernails into her face, leaving deep scratches. The nurses used to wheel Rebecca into my office in a wheelchair. There we'd sit for 45 minutes, three times per week. The silence was probably more painful for me than it was for her. I, after all, felt a responsibility to somehow change her. She seemed only dimly aware of my existence.

Eventually I began to speculate out loud about what it might be like to be her, locked up in a psych ward and having an attempt at psychotherapy inflicted upon her by a young know it all. When she couldn't take any more of my mistaken speculations Rebecca would mumble corrections. This formed the early foundation of our relationship. Over time she told me a great deal about what her reality was like. One event stands out in my mind. About six months into our therapy Rebecca was walking down the hall of the hospital. She was panic stricken when she saw a woman wearing a turquoise necklace that looked identical to the one that Rebecca was wearing that day. Although their appearances had little else in common, Rebecca had concluded that the other woman was Rebecca herself. One thing was identical- the necklace- hence they must be identical people. So Rebecca believed that she was approaching herself in the hallway and it was too much for her to deal with.

Rebecca improved pretty dramatically over the year that I treated her. While this goes against the prevailing beliefs of modern psychiatry, her recovery took place without the use of any medications. When the time came for me to leave the hospital that she was living in, she regressed dramatically. By the time that I departed she had become catatonic again. Several years later I heard from the therapist that had assumed her care. Rebecca had pulled out of that catatonic episode pretty quickly. She had eventually left the hospital and had recently married.

George was stuck. He had rubbed his hands through his rats-nest of a beard and a long hair had come out. As he held this single hair out in front of him I could see his anxiety mounting. He knew that he had to do something with it but his brain would not cooperate with the process of generating options and selecting between them. When I finally said "why don't you just put that hair in the ashtray" he was visibly relieved.

When George was a little better he began to tell me what it had been like to be deeply psychotic. He had been sure that if he ate the flesh of an animal he would, quite literally, turn into that animal. "I used to fall for that one all the time", he said, as though the idea was just waiting out there for anyone to trip on.

Samantha was yet another obese woman with only a few remaining teeth who had suffered from schizophrenia for many years. She told me that when she had tried to live

by herself it had just been too much for her to handle. Samantha was absolutely convinced that people came into her apartment at night and cut pieces of meat off from her to sell at the neighborhood grocery stores or fast food restaurants. "Oh Dr. Turnquist, when I'd go by a Wendy's I'd just shudder" she exclaimed.

Samantha also believed that she "grew extra arms out of her back" each night but was sure that the people who lived in her mattress cut them off. She always complained that her medication caused her to have yellow snakes living inside of her. Her poor dentition was nicely handled through her delusional system. Not only did she have teeth- she had lots of them. In fact she believed that she had three complete sets of teeth waiting to come in. She said that the third set was a full six inches long. I tried to figure out with her exactly how far up in the skull a set of six inch teeth would have to extend but that line of questioning went nowhere. Her delusional system was so complex and entrenched that putting a dent in it seemed impossible.

Like other people with schizophrenia, Samantha had some peculiar tastes in fashion. While she weighed at least 250 pounds she would somehow manage to squeeze herself into size 8 shorts. The effect was striking, to say the least.

I've been surprised to see a similar style taking hold among the non-mentally ill young women of today. The idea of wearing clothes that are so tight that bulges of fat explode from gaps between shorts and tops seems to be catching on. Maybe Samantha was on to something...

One time Samantha "eloped" from the hospital . Elopements were a big deal back then. You never knew when or how these people would turn up, or what sort of things might happen to them in the community. We sent out a Missing Persons report to the police but she wasn't located. A week passed and I'd just about given up on ever seeing her again. Then, on a trip to court in Minneapolis, I happened to be looking down into the central commons area of the county government center. There was Samantha, sprawled out on a chair and smoking a big maduro cigar. I brought two deputies downstairs to help apprehend her, anticipating that she might put up a fight. She didn't seem at all surprised to see me there and came along willingly. I think that her "vacation" had gone on long enough and she'd gone to the one place where she knew that she would be "caught" and returned to The Unit. Of course, these days smoking a cigar in the government center would be looked on as a much more serious offence than running away from a psychiatric hospital.

It was common back then for me to write bogus Doctor's Orders for "cosmetology consults". So many women with disorganized schizophrenia would wear absolutely garish make-up in a sad but often comical attempt to be beautiful. One woman was always ripping up the seams of her dresses and reconnecting them with the pull tops of soda pop cans. But one of the finest beauty statements of all was made by a VISITOR to

The Unit. A young woman came in to see her boyfriend, who had been recently committed to the hospital. There was something striking about her appearance so I had to go into the smoking room for a closer look. To my amazement I found that she had Superglued a stone to her cheek, right underneath her left eye.

Beauty is, indeed, in the eye of the beholder. But some of those eyes are connected to the rest of the brain in strange ways.

Georgia was another woman with unique fashion sense. Her peculiar fashion statement was to wear summer clothing throughout the winter and vice versa. In the summer it was painful to watch her wearing a heavy coat and hat on stifflingly hot days. The Unit was, unfortunately, not air conditioned.

Georgia was incredibly hard to form a relationship with. She had somehow maintained an ability to play the piano but attempts to engage her around music went nowhere. Eventually it dawned on me that what Georgia absolutely could not stand was me looking at her. Many of these folks are overcome with self-consciousness, even self loathing. Being scrutinized by others, especially those in authority, can be too painful for them to bear. Gradually we fell into a pattern where we could sit together for at least a few minutes. Rather than sitting across from her I'd arrange the chairs so that we'd be sitting side by side, looking out at the world together through the windows. I made a point of never glancing at her for more than a second or two. That seemed to go a long way in terms of making my presence more tolerable for her.

While Georgia had been extremely disorganized for many years, she began to improve significantly when the new antipsychotic medicine Clozaril was introduced in the early 90's. In fact she was one of the first patients that we had on that medicine. As her thinking began to clear she tried to make some sense of what had happened to the previous twenty years of her life. One day she revealed her theory. "I think what happened was that one day I went on a trip to California- and I never came back" she explained. What a wonderful metaphor for losing one's sense of self, even though she meant this quite literally.

The version of our own lives that we create for ourselves via the memory process is always subject to distortion, whether we suffer from a mental illness or not. My own recollections of who I was and how I treated people back then are relatively unchanging. The rare therapeutic successes are given much more emphasis in my memories than are my many disappointments. But even I must admit that there were some patients who, despite my best intentions, seemed to despise me and everything that I stood for. In some of their realities I was a demon, a tormenter, or worse.

Bubba wasn't even one of my patients. He was treated by one of the long series of other psychiatrists that I partnered with on The Unit. But Bubba hated me nonetheless.

“Here comes Hitler’s son” he’d yell whenever he saw me in the halls. He was an elderly man (with no teeth, of course) but he’d still get rambunctious on occasion. For some reason when he’d “go off” I was his favorite target. Before I got to The Unit his aggressive behaviors usually were met with “take downs” in which a number of staff would rush him, bring him down to the floor, and then inject him with tranquilizers. He would then be strapped to a gurney and transported up to one of the seclusion rooms upstairs, where he'd remain as long as necessary to calm down. To their credit, the staff had the art of the “take down” down to a science. Take downs were a regular part of life on The Unit.

When Bubba would come after me it was an easy matter to stay out of his reach. He had to be at least seventy and wasn't in the best of shape. If I walked at even a brisk pace I could easily stay a few steps ahead of him. The whole take down, injection, and seclusion routine was not one that I was comfortable with so I'd just let Bubba chase me for a minute or two until he'd blown off some steam. For some strange reason though, I used to get the giggles when people were really angry with me. So a common sight on The Unit involved Bubba chasing after me, cursing and flailing his arms wildly, with me giggling like a madman a few steps ahead of him. He never did lay a finger on me, although I'm sure that there were times when he could have caught me by surprise. By the end of my stay on The Unit we had gone from secluding someone on nearly a daily basis to averaging about one seclusion per year.

Sophie was another woman who detested me. Her standard greeting was “ who let you out of Stillwater Prison you fucking asshole?” Many times she would loudly command her hallucinated allies to come after me. “ Get that motherfucker. Kill him. Cut off his head and shit down his neck” she’d cry. Even though I was pretty sure that she was the crazy one of the two of us it was still a bit disconcerting to hear her commands.

LuAnne came through The Unit several times. When she was stabilized on medications she was quite sweet-natured and friendly with me. When she was off of her medicine and decompensated she was about as vile as a human could be. One day I heard that she was coming back in. She had rushed out to her sidewalk and clotheslined a seven year old girl who was innocently riding by on her bicycle. I heard LuAnne well before I saw her. “Where is that horse-piss Ethiopian Doctor?”, she hollered. “Wait til I get my hands on that German-Catholic son of a bitch”. Her rants about people being “German-Catholics” were pretty standard for her but thinking that I was “Ethiopian” came out of the blue. As much as she despised me, I must reluctantly admit that I liked the nasty, demeaning version of LuAnne better than the syrupy sweet person that she presented herself as when she was “better”. Maybe it was that she was more genuine and authentic when she was ill. Perhaps her negative distortions of me were easier to dismiss as “crazy” than when she saw me as much better than I actually was.

Whenever a patient was put into seclusion it was the psychiatrist's job to see them and to fill out a form justifying the fact that they had been secluded. Whether we agreed with the decision to use seclusion made little difference. If a Doctor didn't back up the decisions of his nursing staff there'd be hell to pay. Nurses can make a Doctor's life about as miserable as they want to, when it really comes down to it.

During my first weeks on The Unit Greg, one of the younger male patients with disorganized schizophrenia, had made a clumsy sexual advance towards one of the women. In fact, "clumsy" would be a generous characterization of his actions. He had simply walked into her room as she lay in bed and laid on top of her. No attempts to grope, fondle, or even kiss her were involved. He just laid on her. The nurses reacted to her resulting screams in a predictable way. This was seen as a sexual assault and met with the standard take down, Haldol injection, and trip upstairs to a seclusion room.

By the time that I arrived at the seclusion room Greg was completely calm and a little embarrassed about what he'd done. I decided that rather than give him yet another lecture about how "inappropriate" his behavior had been (the nurses had more than covered that territory) I'd talk to him about how his strategy with the female in question had been doomed from the start. I explained how women liked to be treated with respect, how he should try to show some interest in her as a person if he really wanted to have a relationship with her. "Besides", I added with a grin, "I've tried that strategy of just laying on them many times. It never works for me and I'm sure it won't work for you either". Greg was forced to smile at the image of me trying his strategy and I think that he got the points that I was trying to make. He came back to The Unit with me and never tried anything like that again. Upon return to The Unit, however, I was shocked to learn that the seclusion room upstairs was wired for sound. The nurses on The Unit had all heard the way their new Doctor had dealt with Greg's misbehaviors and were doubled up with laughter.

When the weather was cooperative I tried to give my patients a choice of where we'd spend our time together. Some preferred my office, others liked to go for walks. Many of the older folks liked to sit on the porch outside of The Unit. Elmer was a terribly anxious old widower who really didn't want to face leaving. I had sat on the porch with him on many occasions, talking about the loss of his wife and what his life might be like when he went off to live in the nursing home that was being arranged for him. Somehow, in the days prior to his departure he managed to get out onto the porch by himself. Someone must have left the door unlocked. Elmer decided that he would make his best bid to stay. A nurse came running down to my office and exclaimed "Elmer's on the porch-he says he's going to kill himself". When I got there he was hanging from the railing with both hands. "I'm gonna jump- I swear I'll do it" he said. It was a serious moment and his emotions were very real to him yet I had to struggle to keep from laughing. Elmer's feet were hanging less than a foot off the ground. As many

times as he'd sat out there he apparently had never realized that the porch was only elevated about six feet.

Gene was brought to psychiatric attention after shooting at a neighborhood teenager with his twelve gauge shotgun. As I tried to figure out why a crusty old bachelor would suddenly start shooting at the neighbor kids a bizarre delusional world emerged. Gene was certain that the neighbor boy was shooting at him with a bow and arrows. While he had never actually seen one of these arrows, he "sensed them" as they went by. Any suggestion that they might not have been "real" was regarded as nonsense. But the invisible arrows weren't even the real problem.

Gene believed that someone was causing him to have a tickling sensation in his rectum. He didn't come right out and say it but I was pretty sure that this sensation had an erotic quality to it. His tormenters somehow managed to do this to him with their television remote controls. Gene lived at least a quarter mile away from his nearest neighbor. Discussion of the actual range of these devices, and their inability to travel through solid walls, was unproductive. But he was interested in my questions about how and why this "tickling of his buttock" was still continuing. This was the third psychiatric facility he'd been in since the police removed him from his home and the tickling sensations had never stopped. How, I wondered, had his tormenters managed to track him around the entire State? Gene motioned for me to come closer and whispered "Depth Finders".

Another man was absolutely convinced that he was being "followed by a Lazy Ike that meant to kill him". To the nonfishermen, a Lazy Ike is a fishing lure that is about four inches long and known for its side-to-side wobbling action. How or why the lure was following this gentleman may never be known.

Cynthia complained that "people keep talking to me in foreign duck voices". "I'm a hundred and eighty years old" she said. "If I took off all this Vaseline you'd see all of the wrinkles". "That psychologist of yours almost killed me to death". "I won 100 million dollars doing a crossword puzzle- I made my whole neighborhood rich!". She also said that she was rich as a result of an accident in Florida in which she was "run over by a train and killed". Cynthia demanded an immediate discharge one day. "The notary public signed the forms - once a notary signs something it is the law" she claimed. One hot day in June she was wearing a leather coat and gloves. She explained that the gloves were necessary "because there are things coming out of my fingers".

Cynthia was hard to confront about any behavioral problems. When I once tried to tell her how loud and disruptive she'd been on The Unit that day the excuses came faster than I could address them. "I was hypnotized in the bathroom...I have to be loud - it helps my neck...I was in the choir... most of my family is deaf...I had to be loud for my thyroid". Finally she said "Why should I change? - it works".

Occasionally we'd have police officers on the ward , usually for security reasons but sometimes to serve warrants or to transport people to court. " I'm going to be a policeman again someday". Cynthia exclaimed. "I'm going to really kick the shit out of some people".

We used to dread the Publisher's Clearing House sweepstakes. They used to mail out official looking letters to just about everyone in the country. The letters announced that the recipient had won huge prizes, prizes in the millions of dollars. Of course if you read them carefully they actually said that you won IF you had the winning number. But for our folks that sort of careful scrutiny was impossible. They simply concluded that they had won the sweepstakes and were now millionaires. They wanted to get on with the business of spending their winnings as soon as possible. One gentleman had plane tickets to Hawaii hand - delivered to The Unit. Our unpleasant task involved having to go over the forms with them to explain how it was that they really hadn't won. Predictably, some people thought that we were lying to them so that we could keep their Publisher's Clearing House money for ourselves.

Wishes, conscious or otherwise, often provide the seed that delusions crystallize around. Sometimes the wishes are pretty transparent.

Luke had been a puzzle to the neighbors in his apartment building. They would often see what appeared to be trash outside the door to his apartment. After a while, though, they realized that it was always the same things that he'd leave there. Empty beer cans and empty cigarette packages. Luke was convinced that if he wished hard enough some benevolent force- perhaps part good fairy, part deliveryman - would refill these empty containers. His frustration mounted as time went by without his ever receiving a refill visit.

Luke's delusion was pretty easy to understand. What child hasn't wished for some magical being to bring them the sorts of gifts that they would get all of the time if only the grown ups would appreciate them more? Tooth Fairies, Easter Bunnies, Santa Claus. These are all a part of the reality that many of us live in as children. Sometimes we carry these ideas on through adulthood but the topic gets a little sensitive when it is our adult beliefs that are scrutinized.

Is the standard image of "Santa Claus" really that different than that of "God" that most Westerners carry around with them? Older white men with gray hair and beards that makes wishes come true if you're good- and if you believe. One is thought of as chubbier and more likely to wear red than the other but there are a lot of similarities. Once again an objective visitor from another planet might be forced to conclude that the differences between "normal" humans and those with mental illnesses are not quite as great as the

“normal” humans would like to believe.

Monica’s wish was easily visible to me but completely out of her awareness. She came to The Unit only after extensive efforts to have her sent to a specialized “hypoallergenic porcelain environment in Texas” had fallen through due to financial issues. Monica was billed as having “environmental allergies” of the most severe kind possible. She had become “allergic” to just about everything. Her allergies in her home had become so severe that the family had shelled out big dollars to have the entire house treated with ozone in a strange attempt to neutralize the allergens. Then she became “allergic” to everything that the ozone had touched. Since this entailed the entire house and all of their belongings there was no way that she could safely live in her own home.

She literally could not tolerate being in the same room with me. She always complained that I must be wearing “hair tonic” or other such chemicals because it was hard for her to breath whenever I tried to interview her. Monica insisted that she could not sleep in a regular bed and certainly could not tolerate roommates. The only foods that she was not allergic to were walleyed pike and brown rice. Neither of those showed up regularly on The Unit's menu. The nurses were certain that Monica would starve to death if we didn’t somehow arrange to get her “safe foods” brought in for her.

I was pretty convinced that despite what her various “allergists” had found, Monica’s problems went a little beyond allergies. The certainty with which she clung to her beliefs seemed to reveal their psychotic nature. I arranged for her to be faced with choices. She could choose between the regular hospital bed that she was “allergic” to or she was free to sleep on the two hard wooden chairs that she said were the only “bed” that she could tolerate. Similarly, she could try to avoid eating except on the rare occasions when her fish and rice were brought in by her family. In our meetings her complaints of allergies were given little attention. We both agreed that I, as a psychiatrist, would be generally useless when it came to dealing with complicated things like allergic responses. Instead we would talk about how the rest of her life was going.

What Monica really was wishing for, and communicating so effectively via her symptoms, was to be away from her husband. The children had recently left the nest and some of the long neglected relationship problems had begun to surface. The husband was too powerful and rational to be dealt with directly. So she became allergic to everything that he had ever touched. It was later revealed that she believed that she had even become allergic to his person. When the house had become off limits as a result of the ozone treatments she had lived in her car for a while, then decided to go stay at a family cabin. As she approached the cabin, however, she became increasingly anxious and short of breath. She knew that her husband was there waiting. Ultimately she came to the conclusion that her allergies made it physically impossible for her to come within a two mile radius of the man.

Within a short time of arriving on The Unit Monica was eating regular foods and sleeping in a bed again. The complaints of allergies cropped up regularly, but weren't as severe. In addition to her odd ideas and relationship problems, she had a full fledged Major Depression. As depressions sometimes do, hers had also made her psychotic. Treating her depression with medicine and talking to her about the new phase of her life that she was entering seemed to produce some benefits. But even as she improved she did not want to return to her family home. The chaos on The Unit, even Martin trying to hump her in the hall one day, did nothing to ready her for the return home.

Many of us psychiatrists are experts at claiming responsibility after the fact when our patients improve. Maybe it is our medications, perhaps the insightful things that we say, but we can usually convince ourselves that we were the difference. The facts that most of these illnesses will sometimes get better without treatment and that people do have recuperative powers of their own are often overlooked. When the patients don't improve we can always fall back on the idea of "The Negative Therapeutic Reaction". That theory holds, in essence, that our therapy is so good that the patient is not ready to handle all of the resulting improvements. So they get worse.

In Monica's case it was probably not anything that I said or did that convinced her that it was time to get on with her life. That turning point occurred the night one of the crazier female patients snuck into her room. Monica awoke to find the woman trying to jam some feces - soiled toilet paper down her throat. The allergies were better but this was clearly more than she could handle. Within a week she was home with her husband, along with a referral for marital counseling.

It doesn't show up in the literature much but a lot of psychotic people have trouble with mirrors. Our nervous systems are so attuned to human faces that all sorts of problems can arise around them, even our own. Many people with schizophrenia can look at their own face in a mirror but distort their reflected images. The image in the mirror is often experienced as alive in its own right and may move, grimace, change shapes, or even speak.

Calvin would help me to teach the medical students about mirrors. We'd walk down to the end of the hall, where someone had mounted a full length mirror for some reason. He'd stand motionless before it for a few moments, then exclaim excitedly, "see, see, there it goes". He'd point to the parts of his face that were changing. Of course there was nothing to see from our vantage point. But Calvin would see his face changing to that of Marilyn Monroe or another actress named Samantha Eggars. Perhaps related to the peculiarities of his own experiences with faces, Calvin would often greet me in an odd way when I'd come to The Unit. "Hi Doctor- Its me, Calvin" he'd say. Even after I'd known him for two years he still introduced himself to me in that manner. "Of course it's you Calvin", I'd sometimes reply "who else would it be?"

Sometimes we'd see patients sitting in front of those mirrors for hours at a time. Years

earlier an outpatient had told me "sorry I'm late Doc- I got stuck in the mirror". At the time I hadn't known just how literally he had meant this.

The extreme importance that our nervous system places on human faces comes out in other funny ways. Most of us have had the experience of *physiognomization*. This is our tendency to see faces even where they do not exist. Children may "see" Abe Lincoln in a cloud. Patients may see faces everywhere, in the textured patterns of their walls or ceilings or in a flickering fire. Psychotic people may see human faces distorted to look like the faces of animals. And the task of correctly deciphering emotional expressions on human faces may be an impossibility for some patients.

Stella came to The Unit during my eighth year there. She couldn't have come at a better time. By then I was growing tired and a bit jaded. A couple of unexpected patient deaths had taken their toll as well. I was coming to believe that I had heard just about every crazy idea a person could have. "Rays", demons, witches, computers, spies, Satan, bodies that wouldn't stay together properly- they were all just sounding like variations on familiar themes that I'd heard too many times before. Stella reminded me that there is simply no limit to the realities the human mind can create.

Stella had a special thing about bears, especially white bears. One day as we sat on the porch she looked up at a cloud overhead and said "there's a bear right there... you have to shoot 'em - you just have to.. I've been shooting those things for ten years. If you don't shoot them they die and rot and the blood falls all over you". Stella believed that she and I were not strangers to each other. We had lived as disembodied heads on the tongue of a giant white bear for some 63 years, she said.

Stella believed that there were special "holes" to be found throughout the earth. Those "holes" were tricky, she explained. You could fall into one and come up in China or other exotic places. And the giant snakes that lived in the holes were always a potential problem.

On one occasion I was feeling pretty puzzled as we'd been together for almost ten minutes and there's been no talk of the bears. She motioned me closer and explained "There was more than one Hitler, you know. He had a family. They changed their names but they're still around."

Once Stella calmly told me that "her body had been replaced". "The new one likes to eat all the time" she complained. "They put a pig's nest in me but maybe my brain and eyes are worth saving". Stella said that she was in a State Hospital in Africa. "A spirit came into my head and made me a scientist" she claimed, then without a pause, she looked at me quizzically and asked "why did you put that rope around the baby's neck?". She accused me of "reading her mind and controlling the weather". Her comments often seemed like they must have some symbolic meaning for her but as soon as I would start

to speculate about what that meaning might be something else would come up. Stella could always disarm me by producing a nonstop barrage of bizarre comments.

My notes from one session with Stella report that she had left me with my head shaking and my jaw agape. She had stared by telling me that she'd like to go home as soon as possible. I'd asked if she felt that it would be safe to go home.

"Well, it might not be that safe... there are a lot of bears in the neighborhood - I might have to do a lot of shooting to protect myself. I was a sheriff in Oklahoma and I came across three men who had killed each other so I took their guns...a lot of the neighbors give me guns too. I have a whole cabinet full of them. You need a lot of guns when there are so many bears around". The bears of this day were described as being "about twelve feet tall with big scary brown eyes". She said that she had fallen into a hole in her back yard and there were more than 5000 bears underneath her property. Stella explained how tightly packed these bears were, standing up to demonstrate that they had to keep their arms held tightly against their sides and how they could only step forward a few inches at a time.

"They're packed in so tight they have to sleep standing up... when I fell in there I had to sleep on their heads. Usually I slept on the bigger ones. I was in a fire in a nursing home and it turned my skin completely black. The only thing that made my skin white again was sleeping on those bears. I used to work with a woman named Lola. Lola's skin was black too. But she got some piss on her and it turns out her skin wasn't black after all...

My understanding was that Stella had lived with a husband and a son but she maintained that the people that she lived with were not related to her in any way. I asked how many children she had had. "They're all dead" she replied. I don't remember half of them. I had 45 of them. It was hard to feed them all so we'd just pump their stomachs up with air so they wouldn't have to eat."

Stella mentioned that she had had her head cut off when she was ten years old. "I've had four or five bodies since then - some of them have been men...the right side of my head is actually a man named Bob... A man with brown eyes came into my room last night and pulled at my tit with a pliers". She looked at me earnestly and asked "well, don't you think that would have to be a bear?" I always imagined that, for Stella, the bears were a symbolic representation of the men that she actually lived with.

Dangerous, cruel brutes who were too mean to be human. Creatures that she would, at one level, destroy if she had the means to do it. But she was totally uninterested in my insights. For her, the bears were not something that symbolized someone or something else. They were completely "real". If I couldn't see that then I must be crazy.

People that haven't spent a lot of time with psychotic people often have a hard time with stories like those related here. They assume that the person cannot truly believe things that are this bizarre and outlandish. " They've got to be putting you on", they'll argue. "How could anybody actually believe that that is true?" Or they will reluctantly conclude that the patient is telling the truth as they see it but focus on the fact that people with mental illnesses are just qualitatively different than other humans. People who have been in the business, though, know that these are the realities that truly exist for these people. Many also become aware that, as strange as these patients seem, their struggles and emotions are the same ones that all humans must deal with at some time and in some way.

Derrick was a very religious man. In fact he talked to God regularly and directly and God talked back. Derrick's world was populated by demons too. Sometimes God gave him commands about what he must do to prove his basic goodness, to show that the demons were not winning the battle for his soul. Unfortunately, one of God's commands was that Derrick must remove one of his eyes. Something about having seen something offensive was involved. So Derrick removed one of his own eyes with a pencil. As I was sitting with him one day, trying to understand how he could do something that horrible to himself, Derrick looked down into the cup of coffee that I had given him. Floating on the surface was a tiny piece of ash from his cigarette. He looked at me calmly and, pointing at the bit of ash, said " why there's a demon right there". He explained that if God commanded him to remove his other eye in order to prove that he was not allied with the demon in the coffee cup he would do so without any hesitation whatsoever. I knew that he was telling me the truth.

We psychiatrists are reported to have one of the highest suicide rates of any of the professions. There are a lot of reasons for this. Having to make reasonable predictions about what psychotic or disturbed people are likely to do next is a hard business. We are often in the position of having to determine if it is safe to return these people to the community and, by their very nature, the severely mentally ill are often quite unpredictable. There are never guarantees that how a patient behaves in the hospital will correlate with their behavior after they've left. So disaster is always lurking around the corner in the form of suicides, violence, or psychotic decompensations. If negative outcomes occur there is always the chance that the psychiatrist will be blamed or sued, in addition to the guilty feelings that we inflict on ourselves. This would wear on anyone. And has been emphasized elsewhere, prolonged exposure to stress hormones frequently leads to brain changes that cause depression and anxiety. Just because we know about these emotional reactions doesn't mean that we're immune to them.

The more significant reason for our elevated rate of killing ourselves is more complex. When one is around psychotic people long enough it becomes apparent that each and every one of them creates their own individual reality. Of course all humans do this. It's just that the process becomes more visible when the realities that are created are so different. Being experienced in so many vastly different ways by so many people is hard on the

psychiatrist's self-image. Strangely enough, being seen in a very negative and distorted way is easier to deal with emotionally. If someone believes that we are Hitler or an agent in the "British Secret Service" those distortions are easy to dismiss as the output of a disturbed mind. It is when we are seen in inflated terms, as better than we actually are, that the resulting emotions become harder to deal with.

All of us, whether mentally ill or "sane", must deal with the idealized version of ourselves that we carry with us at all times. Throughout our lives we form an image of what we should be like. What we should look like, how we should conduct ourselves, what we should accomplish, and where we should rate in comparison to other humans are all ongoing creations of our nervous system. The inevitable comparisons of our actual selves to the inflated version are a major source of the pain of being human. Psychotic people may try to solve this problem by simply disavowing any parts of themselves that don't match up to the ideal. They can truly believe that they are beautiful, powerful, loved, or important in the face of massive evidence to the contrary. It is harder for the rest of us.

When patients, staff, or families react to psychiatrists as though we are wiser, more humane, or better healers than we actually are (and that is a daily occurrence for many of us) those distortions resonate with our grandiose versions of ourselves. These positive distortions are much harder to dismiss since they are so concordant with our secret views of ourselves and what we should be.

The disparity between what we are actually capable of doing to help people and the expectations that are held for us-by others but especially by ourselves- can become too painful for us to deal with. Suicide, substance abuse, and a desire to minimize any contact with patients are common outcomes for psychiatrists that cannot effectively come to terms with the fact that we are far from being the superior humans that we believe we should be. Yet without that naive sense of grandiosity we may not have the energy or the will to make the attempt to help others in the first place.

So perhaps when we look in the mirror and see a larger amount of arrogance, ineffectiveness, or self-importance than we'd like to we can somehow forgive ourselves these limitations. After all, rising above our primate natures in an effort to care for other humans is-at a most basic level- a stunning achievement for any person. If we are successful in helping even a handful of other humans to have a richer, more satisfying time on this planet doesn't that make our own lives worthwhile?

Hurling through space at mind-boggling speeds without any real sense of where we're going or why can be nerve-wracking for any human. It's even worse when we expect that we should be able to make some sense out of something far beyond the reach of our capacity for comprehension. Just doing the best we can in spite of our limitations is about the most we can expect of ourselves- or anyone else. So, like all humans, we shrinks really should lighten up a bit and enjoy the ride.

