

Madman

Strange Adventures
of a Psychology Intern



John R. Suler

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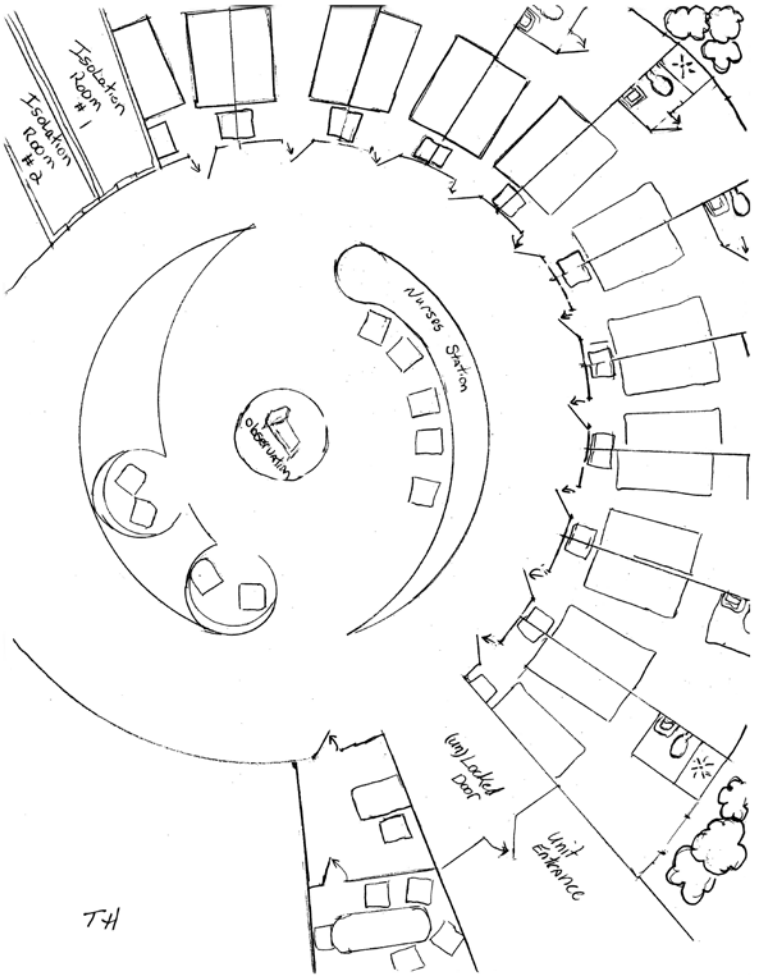
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— *For Debra, Asia, and Kira*

With gratitude for my mentors and teachers:
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CHAPTER 1



— Up —

I SHIFTED THE OLD NOVA into second gear, splashed it through a muddy puddle, and started up the hill. Weary from many years of loyal service and abuse, the rusty hand-me-down gasped for more fuel to grapple with the climb. My prayers that it would not stall — a recent symptom of its senile rebellion — would be answered today. The road curved gracefully around the hill as might any scenic route through these mountains, but this path bore a more serious and practical intent: to guide the faithful to the Medical Center at the top. Midway up I caught a glimpse of the distant city through a brief clearing in the late autumn trees. Snuggled into the valley that stretched to the edge of the horizon, the city glowed unnaturally in the oblique rays of the early morning sun, singled out from the wooded landscape by a stream of light descending through a small, temporary break in the overcast sky.

Despite the scenic beauty, that familiar tiny feeling of depression seeped into the back of my head — an almost imperceptible affect nagging for attention. I searched for its source and settled on an explanation: the long day ahead of me.

Internship. Doesn't "intern" mean "to imprison?" We're expected to work our butts off, all in the name of Training. It seemed more like a grueling rite of passage than anything else — the establishment's last chance to test the limits of the student's psyche before welcoming him to the club. I thought of Dr. Hapling, my psychopathology professor at graduate school, with his tenured feet perched atop his desk and a smile of retrospective content spread across his face. He offered his rationale, "I went through it too. We all did."

Do unto others as was done unto you.

Even graduate school was easier than this internship, and those four years at the university were no picnic. Blockbuster courses that terrorized and infantilized us; comprehensive exams that roused suicidal panic; slave labor as research assistants to tenure-hungry faculty; and, of course, the interminable dissertation, the final hurdle, the last of the Herculean tests of one's determination to overcome all the eccentricities of the academic system and its faculty. Not to mention the frustrations of dealing with professors who had complete power over the student's destiny, who with a casual comment in faculty meetings could inflate or pop a student's reputation. Then, of course, there were the nightmarish stories of the doltish professors who purposefully undermined students who were smarter than they were, or the narcissistic, fame-crazed superstars who sucked students dry and then tossed them aside, or the sleeze-buckets who subtly hinted that you had to sleep with them to graduate. The real horror show occurred when you put several of them together on your dissertation committee. Meetings became a game of "can you top this" where the most important objective was not the candidate's work — and the need to graduate — but rather proving who was smarter than whom. Select the wrong mix of professors for your committee and the group dynamics grind you to bits.

Graduate school was a real education.

I looked at myself in the rearview mirror. “Oh, aren’t we the cheerful spirit today, Tom? Are we the runner-up for the Norman Vincent Peale Award?”

After all, there was a positive side to graduate school. Some of the professors actually were Teachers in the truest sense; they cared about your personal and professional development. And we students did secretly find satisfaction in the bohemian student lifestyle of impromptu partying and discussing psychology over bottomless cups of coffee at the all-night diner. Despite all the work, there was some freedom to be unconventional and slightly irresponsible — wearing thread bare jeans to every social event, using a fruit crate as a coffee table, catching a matinee movie. We guys could let our hair and beards grow without anyone blinking an eye. Come to think of it, almost everyone grew a beard at one time or another. It was an unconscious homage to Freud, maybe even an unconscious requirement to receive your Ph.D.

Of course, there were positive aspects to this internship too — new people and new ideas, the excitement of working in the Real World of Medicine, a steady supply of tongue depressors.

I love my work. I hate my work. There it is — that Old Ambivalence, the never-ending toss-up between contradictory feelings, the weighing of the positives and the negatives, the to-be-or-not-to-be’s that trouble us all. Life could be so much more enjoyable, so much simpler, without the crippling “but.” Exceptions and qualifications. Are animals so indecisive? Is a frog ever conflicted about diving into a pond? Do geese draw up a mental list comparing the pros and cons of flying south for the winter? Only humans seem to be tormented by the powers of reason and self-awareness that knot our will and make us waver between this and that. There is no escaping

ambivalence. Freud said that opposites lie close to each other in the unconscious: love and hate, pleasure and pain, desire and fear. The healthier of us are aware of our contradictory feelings, can accept and verbalize our conflicts. We try to smooth over the internal brawl and heave our will in the chosen direction. Often, we're only partially successful. The only solution may be to force the conflict out of our mind, leaving conscious the tolerable half, burying the other. But buried ideas and feelings don't lie dormant. They creep and crawl in darkness; they go bump in the night. They seek out the cracks in our armor and make our lives miserable in disguised ways. For some poor souls, the conflict tears open the psychological gut — and out spills madness.

Why are we humans so afflicted and unhappy? It's sort of pathetic. What did we do wrong to deserve this? Is it the accumulation of bad karma? Is it payback for having picked the sacred apple, or for knocking off the Neanderthals?

The Nova started to gasp and shudder as the incline became more steep. It needed more power. I realized I was going uphill in fourth gear. Duh! As I tried to downshift, and momentarily took my eyes off the road, something swept passed the front of the car. I slammed on the brakes while swerving towards the inside of the hill. Did I hit it? Was that a thud? The car stopped short and I banged my head on the steering wheel. I looked around, but didn't see anything. My hands shaking and heart pumping, I reached for the door handle and quickly got out of the car. There was nothing there — uphill or downhill. A bird sitting on a nearby tree branch stared at me curiously, "What's the problem, human?"

Dare I look under the car? Scared about what I might find, I got down onto my hands and knees and peered below... Nothing. Rubbing my bumped and now puzzled noodle, I stood up and leaned back against the car door. I could have

sworn I saw something in the road and would have pondered this mystery a bit longer, if not for the fact that something was pulling steadily at the back of my pants. I turned around, half expecting to catch some practical joking person or animal in the midst of giving me a wedgie — but I was greeted by something a bit more alarming. My belt loop was caught in the door handle of the Nova that had now begun to roll slowly backwards down the hill. As the car began to pick up speed, with me being half dragged and half running backwards alongside it, grabbing unsuccessfully to free my pants, the insight suddenly struck me that this could be a serious situation. What if the car rolled right off the side of the hill, yanking me with it down onto the rocky terrain below? The bird, still staring at me from its perch, quizzically cocked its head.

You would think I would have panicked and screamed like a lunatic, or been catapulted into one of those superhuman adrenaline highs in which I could have lifted the car right off its wheels. But I just laughed. It's called dissociation, old boy. "This is ridiculous," I said to the bird while trying to control my backward stumbling prance. "I'm going to be wedgied to death."

Suddenly, the car came to an abrupt halt, sending me into a reverse somersault onto the grassy shoulder. Green and cloudy blue chased each other round and round for a moment or two, until I finally tumbled to rest in a seated position at the rear bumper of the car. The Nova was only a few feet from the edge of the hill and from my precipitous fate, but there was nothing else there — no tree or rock or guardrail that could have stopped the car's rolling. What the hell? I stood up and looked around. Just me and the car standing there in the middle of a patch of grass alongside the road. "I guess there really must be a God," I said jokingly to the bird — but my little cohort was gone.

When I got back into the car I just sat there for a minute. Did that really happen? After taking a quick inventory of my now trembling body, I realized I was uninjured — not even a grass stain on my clothes. But on second examination, I did discover one sequela. The belt loop on the back of my pants was torn. “Well, we’re off to a good start today, aren’t we?” I pronounced unconvincingly to the sky as I gave the broken loop a quick tug and started back up the hill.

Finally, despite fate’s warning to the contrary, I reached the top, where the residual anxiety from my comical near-death experience began to fade. Slowing down at the gate, I spotted Jon sitting in his booth, his nose pressed into a paperback book, probably some sci-fi novel like “The Attack of the Cabbage People.” He consumed these stories like the rest of us drink water. Technically, he might be labeled as a schizotypal personality. He was eccentric, superstitious, pre-occupied with peculiar topics, interpersonally odd. In plain English — a Space Cadet. Tall, thin, with stooped shoulders and a slightly too large head, he perfectly fit Sheldon’s body type of the “ectomorph.” The Hospital Rules of Convention, as he called them, forced him to wear a uniform — white shirt and dark pants — but with those pink high-top sneakers and a green paisley tie pulled to a mutated 45 degree angle from his midline, you knew from a mile away that it was Jon.

He was totally oblivious to my car idling no more than four feet away, so I tapped the horn. He nearly fell off his stool. Some security guard.

“My word! A rude awakening! How are you faring this fine day, Dr. Holden?”

If you didn’t know Jon, you would swear that he was being cynical, or mocking you with such formal expressions — which would be consistent with his history as a former Berkeley philosophy student, counterculture radical,

and perpetual intellectual prankster. He once stole the department chairman's favorite book — Aristotle's *Metaphysics* — replaced the entire text with blank pages and returned it to the professor's shelf.

But he was sincere, even when he was joking.

"Well, actually, coming up the hill I almost hit a ghost... and a miracle saved me from being dragged over a cliff by my car."

"Hmm, I'd say that kismet is on your side." He seemed only mildly surprised, as if these sorts of things happened in his world all the time. "Which reminds me..." He paused and cautiously looked from left to right, as if someone might overhear our conversation out here in the middle of the road! Tilting precariously on his stool, he leaned towards my window until his back curved into the shape of a question mark. His eyelids drooped slightly, covering half his pupils, giving him that quasi-conscious, burnt-out look so typical of those sensation seekers who dropped a few too many hits of acid during their college days.

"Officially, it is quite impossible to get a staff sticker for the A-lot up here at the top of the hill. But I have some underground connections. I might be able to get you a visiting clinician sticker. As long as you don't park up here every day, they probably won't notice."

"That'd be great, Jon. But if you're gonna get into trouble doing it, please, don't take the risk."

For a moment his eyes opened wide. "Risk? I am thoroughly enamored of risks, especially when it involves stratagems to thwart administration. It's my most preferred avocation."

"Just be careful, Jon. Someday they're going to catch you and they'll force you to reveal all your escapades — and all your secrets."

His body straightened up to military attention. “Not even if they locked me into a room and forced me to listen to cable news!”

“O.K. Just trying to look out for you. After all, if you were fired from this job, when would you find time to read?”

Jon laughed. He leaned towards me again and spoke in a whisper, “If I lost this position, I might have to become a psychologist, read their science fiction, and trick my patients instead.”

I never could outwit him. He was the master of passive-aggressive joking and one-upmanship. It was his sense of humor, as well as his offbeat mind, that I enjoyed most about him.

“Very funny, Jon. See you later.”

“Before you go, Dr. Holden, I have a riddle for you. What happens when you mix a dyslexic, an agnostic, and an insomniac?”

I reflected on this for a moment, but nothing came up, except a brief thought of what it would be like flying through the air while shackled to my car. “I give up.”

“You get someone who stays up all night worrying, ‘Is there a DOG?’”

I laughed. “Your mind is not normal, Jon.”

“Thank you,” he replied, pleased with himself.

As I drove away he called out to me, “Dr. Holden, bid my fond greetings to Barb!”

“Will do,” I shouted back.

I parked near a black Jaguar, which probably belonged to some surgeon, in hopes that it would catch the security patrolman’s eye and divert his attention from my decrepit Nova. A very long shot, but I was willing to try anything. I couldn’t afford any more tickets. Parking in P-lot at the bottom of the hill and taking the shuttle bus up — the only

alternative — was extremely inconvenient. Even chief residents were forced to ride the shuttle from P, or “Peon” lot as we affectionately called it. Being allocated a sticker to the upper lots required payment with your testicles or your firstborn child. Only one other privilege was considered more precious by the hospital staff, a privilege for which some would lie, cheat, and steal: an office with a window.

I leaned forward, reached behind me, and felt the broken belt loop. My heart started racing again. I can't afford that right now. Can't dwell on it. Got to get going. Three deep breathes — and onward.

As I walked towards the medical center I forced my mind to focus on its architecture. Constructed of steel and mirror-glass that distorted the nearby trees, its two front surfaces swept away from the main entrance in graceful curves suggesting a large circular structure. Yet the impression of size and circularity was deceptive, for just beyond the edges of the building, out of view from the front entrance, the walls turned sharply inward and ended abruptly. An illusion of grandeur. No doubt this location was also chosen to magnify the building's visual impact. Perched on top of a hill amidst rural surroundings, it seemed to herald the power of medical knowledge rising above the untamed wilderness. If only they could keep the mindless geese from shitting on the sidewalks, it would all be so perfect.

I leaned against the rails of the escalator that sympathetically carried me up to the third floor. At the end of the hall stood the gray metal doors with wire-mesh windows that marked the entrance to the inpatient unit. In such a modern and esthetically designed building, these institutional looking doors were an anomaly. Why not wood, or even a pleasing coat of paint on the metal? The patients were rarely violent, so there was no need for wire mesh to guard against projectiles. The doors, in fact, were never locked. Nevertheless, this

ominous entrance stirred the almost palpable sensation that something dangerous lurked just beyond: the nightmare of insanity, the bedlam of the present-day possessed, the horror of souls gone awry. I suddenly remembered my old high school friends and our favorite joke as we drove by the antiquated mental institution just outside our small hometown. It was a huge gothic building with smoke bellowing from tall brick stacks. “How many do you think they’re burning today?” I laughed off my medieval thoughts, but as I approached the entrance to the unit, I noticed again the tension in my throat and accelerated heart rate that betrayed anxiety. Summoning up a half-hearted confidence, I pushed through the double-doors and strode onto the unit.

CHAPTER 2

— Changing of the Guard —



THE PSYCHIATRIC INPATIENT UNIT looked futuristic. The room was circular, with the exception of the entrance hallway that briefly disrupted its continuity, a short stem reaching to the outside world. The ten patient rooms — each containing two beds, a small bathroom, and a tinted window overlooking the countryside — were lined up around half the circumference. The remaining half consisted of a dining area and recreation lounge, a large room for group meetings, the two isolation rooms, and the director's office, one of the privileged few to have a window. A green-carpeted walkway formed a ring that followed the contour of the circular wall. Dim track lights in the ceiling created a feeling of twilight, of being enclosed and contained. Two apostrophe-shaped counters were located in the middle of the unit, their outer surfaces paralleling the walls of the circumference, their inner surfaces perfectly positioned so that the bulbous portion of one counter fitted neatly into the tapering tail of the other, like two fish swimming gracefully around each other. One counter contained the nursing station,

strategically located to allow the staff an unobstructed view of the entire unit. Windows looking into each patient's room also gave the staff visual access to activities inside, although patients were allowed to close their curtains at night and while dressing. The other counter contained two small cubicles for conducting therapy and psychological testing. They were often referred to as the "libraries" because their shelves were stacked with a collection of miscellaneous paperback books donated by the staff over the years.

At the focus of the circular room, located between the two counters, in the very heart of the unit, was the slightly elevated Center Circle. If necessary, suicidal, obstreperous, and unpredictable psychotic patients could be seated there so the staff could keep an eye on them. A preliminary precaution. The last resort for dealing with a dangerous patient was Isolation — a locked room containing only a mattress. Most patients never required these features of the unit's clever architecture, although people suffering from agitated depression would take advantage of the unit's circular design by pacing around and around on the outer walkway. Manic patients liked to jog, sometimes fully attired in sneakers and sweat suits.

If, by magic, an unsuspecting citizen was swept off the streets and popped onto the unit, he might not even realize he was standing in a psychiatric ward. Very few psychiatrists wore the traditional physician's lab coat and none of the nurses wore the standard white uniform. The patients seldom acted bizarrely, or became violent, or actively hallucinated, thanks to the miracles of modern medications. If the visitor spoke to the inhabitants, he would not suspect them mad. After several minutes conversing with a schizophrenic, he might feel uneasy about the unusual quality of his acquaintance's ideas or manners, but he probably would not realize the person was

schizophrenic. Most people, even some mental health professionals, tend to underestimate psychopathology. It would take a while for our visitor to catch on; he might even mistake his surroundings for an innovative hotel for the eccentric.

Because the unit was a short-term facility, patients stayed only two to four weeks. Symptoms were treated swiftly, if possible. Patients who were severely disturbed, dangerously suicidal, or violent, were taken by ambulance to more secure institutions and involuntarily committed. They might stay there for months, years, or in the case of some schizophrenics, a lifetime. The financially distraught state institutions and the maximum security hospitals for the criminally insane were places you would rather not visit — and where you would dread to live. Simply mentioning these hospitals to unruly chronic patients, who knew the system inside and out, would snap them into compliance. To them, “We’ll have to send you to Elmcrest” was like saying “We’re sending you to the Black Hole of Calcutta.” By contrast, the medical center was the luxury edition of medical treatment. So pleasing were the accommodations, so helpful and supportive were the staff, that many of the patients from poor neighborhoods balked when it was time for discharge. They never had it so good.

As I walked onto the unit I glanced at the clock. Three minutes to eight. Still enough time to skim through the charts to see how my patients fared through the night. I had learned one lesson on this internship: Always be prepared for morning report. Getting caught off guard without an explanation for setbacks in a patient’s progress, even in your absence at night or on the weekend, was an embarrassing faux pas. Any reasonable explanation would do. Even all-purpose buzzwords like “regression due to family conflict” or the handy “discharge anxiety” were better than saying “I don’t know.” That was the equivalent of saying, “My brain

is mush and I don't know what I'm doing." When confused, in doubt, or just plain ignorant, a doctor nevertheless must speak with unswerving conviction.

A tap on my shoulder pulled my attention out of the stack of progress notes. It was Marion. She smiled warmly — a spark of youth lighting up her aging, wrinkled face. "Sorry to interrupt. I just wanted to congratulate you for the fine job you did with Elizabeth. She made so much progress while she was here."

"She worked hard," I replied, "and really responded quickly to medications. And thanks to your work with the family, her husband finally realized how he contributed to her depression."

"True," she answered gently as she touched me on the arm, "but don't forget to give yourself a little credit too. See you inside." Hobbling, but in her strangely graceful way, she hurried off to the group room. Thank God for Marion. She was the old mother hen of the unit — warmhearted, caring, nurturing — attributes that did not exactly flourish among some of the other staff members. Somehow the training of social workers like Marion spared their humane, down-to-earth qualities, rather than effectively stamping them out as in the highly intellectualized education of the psychologist, or in the medically mechanistic shaping of the psychiatrist. In her forty years as a social worker, Marion had developed a different kind of knowledge, a quiet but hardy wisdom gained through a lifetime of work with the sick and poor.

I checked the time. Thirty seconds to 8:00. All the staff members were converging on the door to the group room, as if someone had tilted a chess board and all the pieces, big and small, were sliding toward one corner. I quickly popped the charts back into the rack and plunged towards the meeting, lest I be the one who was embarrassed by arriving late.

Suspecting I was the last in, I quietly closed the door behind me and slipped into the nearest chair just as the head nurse began her report of the previous night's events. The usual stuff: a few patients requested some sleeping pills, Mr. Pinkton had an upset stomach, Mrs. Watts again was repetitively packing and unpacking her suitcase while sleepwalking. As I had deduced from the absence of new entries in the charts, my two patients had slept through the night without mishap. I felt spared, and grateful.

Safe, at least for the moment, I sat back and observed the ritual of morning report. During this transition from the night to day shift, the staff passed along information according to a strict protocol as orchestrated by Fred Cooling, the chief resident, also known as the "Chief." At the head of the room he sat tall, straight-backed, with squared off shoulders, like a true warrior presiding over the rituals. He deferred only to Dr. Stein, the director of the unit, who sat quietly off to the side, brushing and straightening his Armani ritual dress. He was the Really Big Chief, the keeper of the sacred bones of psychiatric wisdom. He also possessed more gold than anyone in the room.

I imagined an anthropologist from the 24th century, sitting behind the one-way mirror, watching us, writing notes for a thesis about primitive tribal rites. The medicine men wear stethoscopes rather than bone necklaces, and they quote the Diagnostic and Statistical Manual of Mental Disorders rather than chant lyrics about spirits in the trees and sky.

And how could the ritual be complete without the caffeinated sacrament to wash away the sins of physical and mental lassitude? Some say the western world runs on oil, money, or the narcissistic quest for power. Wrong. The life blood, the source of all energy and motivation, is coffee. I looked around the lopsided circle of staff members. Everyone was holding

a styrofoam cup. The Chief drank several quarts of the stuff each day. He had a cup pinned to each sleeve and embossed into his favorite mug were the words “Caffeine Psychosis.” No doubt the lining of his stomach looked like the inside of his mug — brown and crusty.

Not that I’m being critical. I too would have been quietly quaffing if I had had a few more minutes before morning report to suckle at the pot. How many businessmen and professionals would be thrown into a state of uncontrolled panic if coffee mysteriously vanished? Without its grounds, western civilization would collapse. And it’s because the stuff is more than just a stimulant to gear-up the mind and body for work. Coffee is a social lubricant. Just think of all the conversing and laughing around the coffee pots of the world, or about the unspoken sense of community among people who imbibe together. Coffee means group cohesion. Let’s also not forget how it lends emotional support. When in doubt at work or in a uncomfortable social gathering, when you don’t know what to do or say, when you’re feeling insecure, you can always pause to take a sip; or simply stare into the cup, as though an answer might appear in the floating artificial creamer.

Coffee helps us feel complete.

Let me put it this way. Our early social training, when we are one or two years old, leads us to think we reside within the boundaries of our bodies. “Me” is everything from the skin and in. “Me” is mostly organic tissue with some mental and emotional stuff clinging to the inside. Rarely do we consider that our identity, both psychological and physical, projects outward beyond our mortal frame, how it is connected intimately to the material world around us. Coffee may seem like a silly example, but it’s not far off target. Consider your feelings about your very first car, or why you just can’t bring yourself to throw away those old

clothes, or the house where you grew up as a child, or why humans since the dawn of time have been possessed with producing artistic and scientific doodads that will live beyond them. The traditional psychoanalyst would say that such possessions are hypercathected with libidinal energy; more contemporary theorists would call them “selfobjects.” The basic message is the same: We surround ourselves with satellites of our sense of self, each an external manifestation of some crucial aspect of who we are. We cling to them because they wield the power to make us feel more tangible, real, complete. They soothe our inner confusion as we struggle to stand on the shifting sands of our identity.

When I was in high school I had a small note pad. I used it to jot down homework assignments, ideas about class projects, and miscellaneous reminders to myself. One day I discovered it was gone! I turned my locker and every pocket inside out, my anxiety mounting with each passing minute that my search failed. I retraced my steps of that day, but to no avail. Ironically, only when I accepted that it was really, truly gone, forever, did my panic fade. Cold reason gave a helping hand, because, logically, it was no great tragedy. But on a deeper level there was a relentless feeling of loss. Something had been torn away. A piece of me had been squirted out of the universe, unexplainably. For other people it might have been a set of keys, a wallet, eyeglasses. In each case the anxiety about the lost object would signify the same predicament: a hole in identity that longs to be filled.

I forced my attention back to the meeting. One of the medical students was finishing up his sweaty explanation of why Mrs. Watts again was packing and unpacking her suitcase in the middle of the night. The Chief looked displeased with the student’s rationale. He looked towards Dr. Stein, who was

either bored or indifferent. He sat quietly on the outer edge of the circle of chairs, working at his fingernails with a gold file. Sensing that he was up the medical creek without a tongue depressor, the medical student looked down into his styrofoam cup. His two peers sitting next to him, similarly dressed in white shirts and ties, simultaneously raised their cups to their lips. I could swear their hands were shaking. Having admitted patients the day before, they knew they were next at bat.

“That’s enough,” the Chief grumbled, “let’s talk to Mrs. Watts during rounds and find out what’s going on.” Fred set his stopwatch to zero and looked up. “The admission summaries have been running overtime. Let’s keep them down to exactly three minutes.” He paused his index finger over the start button and looked out across the room with an automated expression. “Rachel Finski was admitted yesterday.”

The second medical student sprang to life, as if the Chief’s announcement punched a button hidden somewhere on his chest. He straightened his spine and firmly gripped the clipboard on his lap. In a crisp, dry voice he read his admission summary.

“Rachel Finski is a 30 year old, single, white, unemployed female. She has had numerous hospitalizations in the past. This is her second hospitalization here. Her presenting complaints included feelings of depression and thoughts about suicide. Although suicidal ideation was present, no specific plan was mentioned. There was no homicidal ideation. Some of the vegetative signs of depression were hyposomnia, including early morning awakening, a decrease in concentration and memory, and a recent increase in appetite resulting in a slight weight gain. No significant psychomotor retardation or agitation was noticed. On the mental status exam the patient showed adequate remote and recent memory; judgment and abstraction were good; attention and concentration were somewhat

impaired since the patient had difficulty with serial 7's but not multiplication or serial 3's; insight was fair; her salient thought content centered on suicide. The patient appeared to be above average in intelligence and she demonstrated considerable knowledge about psychiatry. A significant thought disorder was indicated by her thinking that was often tangential and circumstantial. Her ideas were bizarre and delusional. She believes her outpatient therapist was plotting to kill her and that she has been poisoned by contaminated tap water. The physical exam was unremarkable. Two years ago at the state hospital. . ."

The budding psychiatrist. I imagined what it was like being in his shoes, being a medical student, learning the ropes of the medical world. The psychiatrist's training is quite different from a psychologist's. It focuses on biological treatments of mental disorders, especially psychopharmacology. For that reason, when you ask the average person about the difference between a psychiatrist and a psychologist, the light bulb flashes and they answer, reflexively, "A psychiatrist can prescribe drugs." Very true. But people suffer from the mistaken notion that this privilege is icing on the cake for the psychiatrist, all other things being equal with the psychologist. The truth is that psychiatrists do not have the same expertise as psychologists plus more. Psychologists too have their own unique skills. Their training in graduate school emphasizes statistics and experimental research. They are the masters of diagnostic testing, including intelligence and personality tests. And unlike psychiatrists, they hold an academic degree, which means they have been doused with theories from a variety of fields in psychology — cognition, perception, memory, learning, personality, development, social processes, biopsychology — to name a few. They are expected to think like scholars. Perhaps that's why some mental health

professionals perceive psychologists as overly intellectual and analytical. They're probably right.

Psychologists and psychiatrists often find themselves mired in professional competition with each other. Who is more qualified to do psychotherapy? One particularly sore spot concerns the coveted access to the secrets of psychoanalysis. Since the time of Freud, the psychiatric profession has jealously guarded this territory. Many orthodox analytic institutes, which are, supposedly, the most elite bastions of training in insight-oriented therapy, once refused to accept psychologists into their programs. Why? Because psychologists have no medical background. Other institutes have a more lenient philosophy and greater financial crunches: they welcome psychologists and even social workers into the fold. But the elitist medical analysts from the big-time schools consider these institutes watered-down imitations of the real thing. Only when pressured by the goliath American Psychological Association in an emotionally charged and historic lawsuit, did the orthodox institutes finally relent and open their doors.

Ironically, Freud, the founder of psychoanalysis and a physician himself, believed that of all the people seeking to be analysts, physicians are probably the least qualified. Why? Because they are too biologically-minded. Those with a liberal arts background, Freud suggested, can resonate better with the psychological, emotional, and interpersonal issues that make up psychoanalysis. Somehow many medical analysts have forgotten the great master's opinion. They have substituted other rationales. They claim that physicians, having worked with people who are ill and dying, better understand human suffering and loss. I wonder about that. If anything, their training may push their heads into the sand so they don't acknowledge suffering, especially death. Death is defeat, failure. And that rubs the M.D.'s omnipotent ego the wrong

way. When Elisabeth Kübler-Ross, the renegade physician who pioneered the study of death and dying, asked her colleagues about patients who had passed away, some denied that anyone in their hospital died!

There's a parable about a peasant who pleaded with a guru to cure his grief over his wife's death. The guru agreed, but insisted that the man first find someone in the city who had not experienced the loss of a loved one. The man went from door to door, family to family, but every household had its own tales of death and bereavement. Finally, the peasant realized that he was a member of the universal community of human suffering. That was his cure.

That familiar demanding voice reached into my mental diatribe. I was just barely conscious of it: "Elizabeth Baso was discharged yesterday". Someone's elbow surreptitiously jabbed my forearm. A bolt of panic shot through me. "Elizabeth Baso was discharged yesterday," the Chief repeated, now with a distinct tone of irritation.

"Oh!" I crackled. Instinctively, I raised my hand to bring a coffee cup to my mouth. I needed to wash the frog — and the anxiety — down my throat. But there was nothing in my hand. I didn't have a cup of coffee! I cleared my throat and faked a confident voice.

"Elizabeth Baso was discharged yesterday after spending four weeks on the unit. Many of the vegetative signs of her depression were cleared by Prozac during the hospitalization. Family therapy was successful in clarifying some of the family dynamics that contributed to her depression. Her follow-up treatment will be individual psychotherapy with Dr. Benjamin Levinson, a private psychiatrist in Flemington. Family therapy was strongly recommended and the patient was given a referral to the Carrington Clinic."

“Thank you,” the Chief sighed. “The new admission today will be Richard Mobin. I’m assigning him to Dr. Holden. From what his parents told me on the phone, it sounds like a psychotic episode. He might be suicidal. His mother will be bringing him in sometime this evening.” He paused to scan the room. “Are there any other issues or questions?”

The staff looked at each other, then turned towards the director sitting in the back of the room, slightly outside the circle of chairs. He was clipping his nails and did not look up. There would be no pronouncements today.

“Right,” the chief resident tossed into the silence. He glanced at his watch and tried to suppress a smile of satisfaction. We were on time. “Let’s get on with it.”