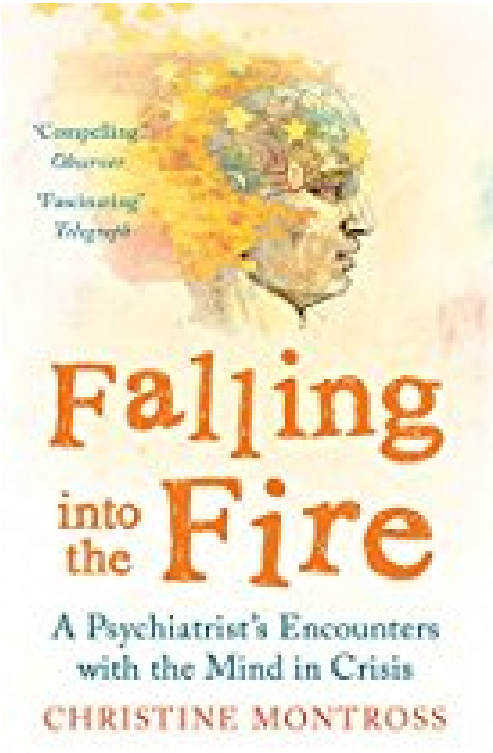

Falling into the Fire : A Psychiatrist's Encounters with the Mind in Crisis

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256 pages

Extrait

(AUTHOR'S NOTE)The names of all patients and certain details of their stories have been changed in order to preserve confidentiality. For the same reason, the names of some of my colleagues have also been changed. ()(PROLOGUE)BedlamCanst thou not minister to a mind diseased?—Shakespeare, *Macbeth*In early January, Charles Harold Wrigley, a twenty-two-year-old gas engineer, was brought by his family to the psychiatric hospital. "The patient is extremely depressed," the evaluating physician wrote. "He sat with his hand on his forehead as if in pain during my interview. He says everything he does is wrong and that he is very miserable." A second doctor's note adds, "I am informed . . . that the patient has suicidal tendencies and since he has been [at] this hospital has attempted to strangle himself." Notes like these are familiar to me. As a psychiatrist, I have seen countless patients in emergency rooms, inpatient units, and outpatient offices whom I might have described in nearly identical terms. This patient's symptoms are not striking; however, the familiarity of the description is, considering that Charles Harold Wrigley was evaluated and treated at England's Bethlem Royal Hospital in 1890.Before I became a doctor, I had more faith in medicine. I thought that medical school and residency would teach me the body's intricacies, its capacities to heal and to falter, and all of our various methods of intervening. Once I mastered these, I thought, I would really *know* something. That has turned out to be partially true. I know many more things about the body—its wonders and its failings—than I could ever have imagined. But as a doctor, I have emerged from my training with a shaken faith. If I hold my trust in medicine up to the light, I see that it is full of cracks and seams. In some places it is luminous. In others it is opaque. And yet I practice.At times this doubt is disillusioning. More often, however, I've come to view the questions that arise as a vital component of the work of medicine. My faith in medical knowledge has shifted into a faith that the effort—the *practice*—of medicine is worthwhile. I cannot always say with certainty whether the course of treatment I prescribe will heal; I cannot always locate with precision the source of my patients' symptoms and suffering. Still, I believe that trying—to heal my patients and to dwell amid the many questions that their illnesses generate—is a worthwhile pursuit.I have found that one of the gifts of medicine is that it allows those who practice it to participate in the purest and most vulnerable moments of human life. As doctors we share in the utter joy of birth, the irrepressible relief of a normal scan or a benign biopsy. We deliver earth-shattering diagnoses. We accompany people to their deaths. In these moments there is not much room for the protective or insulating layers that people—all of us—put upon ourselves in our daily lives. Joy is joy, and grief is grief, and fear is fear; and in the context of medicine, those emotions are often at their most primitive and raw. As an inpatient psychiatrist, I treat people who are in moments of profound crisis. The majority of them are hospitalized because they might not be safe otherwise. I do not lose sight of the fact that my patients come to me in these precarious states.I am a few years into my psychiatric practice. Relatively speaking, I am new to the job. Every day that I go to work on the inpatient psychiatry wards, I encounter people who are despondent, or terrified, or raving mad. I see people whose lives have been ruined by addiction. I hear unfathomable things that people have done to others, from familial betrayals to brutal attacks. I talk with people who, more than they have ever wanted anything, want to die. It is not a dull job.This book was written over the course of my residency in psychiatry and in my first years as an attending psychiatrist. As a resident, I worked in many different psychiatric settings, from prisons to outpatient offices to medical and psychiatric hospitals. These days I work as an inpatient psychiatrist on the locked wards of a freestanding psychiatric hospital. I wrote the book not as a sequential exploration of patients I have encountered over these years but rather as a visiting and revisiting of hard questions that emerged for me about patients, and medicine, and the mind. Questions that stayed with and gnawed at me. This book arose from psychiatry's mysteries and my own misgivings, from patients whose struggles I could not make sense of, from the doubts and queries that haunted me and kept me from sleep at night.• • •It was in my current job working weekends on the wards of the psychiatric hospital that I

met Joseph. On the weekends I cover an entire adult unit in the hospital, which means that on Saturday mornings I will have eighteen to twenty patients to see. Before I see them, I will have had a brief Friday sign-out on each patient from the weekday doctor. Sometimes this will be a conversation that spans a few minutes. Sometimes it is a phrase written beside a name: “resolving paranoia,” for example, or “manic, assaultive.” The nurse in charge of the unit meets me when I arrive and gives me pertinent information from the last twenty-four hours: vital signs, the degree to which a patient is participating in the unit therapy and activity groups, whether a patient is eating and taking her medications, whether a patient appears to be withdrawing from alcohol or from drugs. The nurse will also pass along anything the staff has noticed, either worrisome or reassuring. It is in this early-morning session that I hear about who wandered out of whose room naked and confused, who has gone two days now without talking to himself, who remains suspicious about whether her medications are poisoned, who was caught with cigarettes.If a patient has been admitted overnight on Friday, then I will have the record of his emergency-room evaluation, but I will be the first treating psychiatrist to see him. It will be up to me to learn how the patient ended up in the hospital and how his treatment on the unit should begin.This was the case for Joseph. When I walked onto the unit and saw his name listed as a new patient, I pulled his chart from the rack and flipped to the ER assessment: “42-year-old man with a history of depression who was referred by his caseworker after becoming increasingly depressed, not eating or drinking, not leaving his house, etc. Patient engages minimally with interview. States he wishes he were dead, but denies plan or intent to kill himself. Patient has been on antidepressants for many years, but recent compliance is questionable.”Because of Joseph’s “minimal engagement,” there wasn’t much additional information in the evaluation. Our records showed that he had been hospitalized here five times before, but his most recent prior hospitalization had been seven years earlier. That was before the hospital had adopted computerized records, which meant that Joseph’s records were entirely contained in paper charts, and those were archived. They could be requested, but it would require several days to obtain them. I needed to begin treating him now.From the nursing report, I learned that Joseph had arrived on the unit and gone straight to bed, where he had been asleep for the last six hours. When the report had concluded, I made my way to his room to see him. I knocked on his door, and no one answered. I pushed the door open gently and called, “Joseph? I’m Dr. Montross. Okay with you if I come in?” The room was dark; the curtains were drawn. I took a step in and immediately noticed the smell of a person who had not bathed in some time. As my eyes adjusted to the darkness, I could hear Joseph snoring loudly. It wasn’t unusual for me to find my patients asleep. I started rounding early. Some patients, like Joseph, would have come to the hospital or would have been transferred from another ER in the middle of the night. Not infrequently, at some point in the admission process, patients received medication that had the potential to sedate them. I tried again.“Joseph?” The snores continued. I turned and left the room. I’d give him some time to rest while I saw the other patients. If he hadn’t woken up by the time I came back, I’d have to awaken him. For now I’d let him sleep.I made my way around the unit, stopping into rooms to talk with the patients. I jotted down notes as to how they felt they were doing. I made myself a list of orders to write: medication changes for certain patients, additional privileges—like outdoor walks or permission to use their own razors—for others. I had met with about half the patients when Henry, an experienced nurse, pulled me aside, looking concerned.“Hey, Doc,” Henry said. “We’ve been trying to get Joseph up for his vitals. He’s not responding at all. I even gave him a sternal rub, and nothing. Can you come over and examine him?”I work with Henry frequently. He is easygoing and typically unflappable. Patients like him, I think in part because his demeanor is so even. Their worlds might feel chaotic, but Henry radiates calm. At this moment, however, he was talking quickly, and his tone was businesslike—a departure from his usual slow, unruffled jocularity. I took note immediately and followed him back across the unit toward Joseph’s room. As we walked, Henry anticipated all my questions.“I brought in the pulse ox and the manual cuff. His vitals are fine: one-eighteen over seventy-six, pulse of sixty-four. Oxygen saturation is ninety-eight percent on room air. But he’s totally unresponsive. I checked the admission paperwork,” he continued. So had I. “He blew a zero on the Breathalyzer when he came in, and he got no meds at all in the ER. He’s been with us eight or nine hours now, and he was at least with it enough to register and get oriented to the unit on the night shift without them

worrying he had a heavy dose of anything on board." We got to the door, and Henry paused. "I really dug my knuckles into his sternum, Doc."Sternal rubs are a seemingly vicious part of a neurological examination. People respond to different stimuli at different levels of consciousness. When afraid and alone in a quiet house, a person might be aware of the tiniest sounds or movements: the freezer's hum, the click of a thermostat, or the whisper of a single leaf fluttering outside a window. Adrenaline hones our senses and renders them keener. In contrast, in the depths of sleep I may not notice my partner's leg brushing up against my own. She may hear our daughter's single cough; I may not. There is a range of awareness. And yet the body's response to pain is preserved in these depths, for reasons that are evolutionarily obvious. Even in the deepest dream, a burning ember on your skin would wake you.A sternal rub consists of making your hand into a fist and grinding your knuckles into a person's sternum, or breastbone. Try it on yourself; it doesn't take much pressure until you want the feeling to stop. With patients who are sound asleep, or sedated, or feigning unconsciousness, doctors and nurses first try less painful means of rousing them. If the gentler methods yield no response, so-called painful stimuli like the sternal rub may be employed. When someone truly does not respond to painful stimuli, there may be real cause for medical concern.Most of us, as patients, are not entirely forthcoming with our doctors. We overestimate our exercise and round down on our junk-food consumption when we talk with our primary-care doctors. I generally tell my dentist that I floss more regularly than I do. The crass conventional wisdom in the emergency room is to use a formula when calculating the "true" amount of alcohol a person drinks: Ask patients how many drinks they have in a typical week. Then, if the patient is female, multiply the number by two. For men, triple it. For veterans, multiply the number by five.The true state of the psychiatric patients I treat may be obfuscated by a range of factors. Drugs—of both prescription and street varieties—are far more likely to be involved with my patients than with nonpsychiatric patients. Mentally ill people may be less able to accurately recount the symptoms they are experiencing or the drugs or medicines they have taken. They may be paranoid or angry and, as a result, refuse to disclose information that is important for me to know about their care. They may also—as in the case of suicidal patients who have intentionally overdosed—be less inclined to be forthcoming about what may have brought about changes in their condition or mental state. A pediatrician friend once joked that treating babies and young children can be like practicing veterinary medicine, since the patients cannot fully communicate with you. Sometimes psychiatry is similar; my colleagues and I must attempt to deduce what is going on when patients' explanations do not—or cannot—help.I knew so little about Joseph that I had to keep a broad range of possibilities in mind. And if a patient was not responding, emergent causes needed to be ruled out first. It was reassuring that Henry had reported normal vital signs. Patients who overdose on opiates or sedatives have suppressed respiratory rates—they take fewer breaths per minute than a nonsedated person would, and their oxygenation levels drop accordingly. Joseph's breathing rate was normal, and so was the level of oxygen in his blood. But other medical emergencies could cause an acute change in someone's ability to respond. A neurological exam—including response to painful stimuli—could help determine whether there was a physical cause in his brain. I needed to know whether Joseph could be having a stroke, for example, or an otherwise undetectable seizure."Joseph?" I called loudly as I stood by his bedside. He remained motionless in the bed. I took hold of his shoulder and shook it. "Joseph, I need you to wake up now," I said. There was no response. Not even the snoring I had heard from him earlier in the morning. "Okay, I'm going to examine you, Joseph," I said as I lifted his limbs one by one from the bed. His reflexes were normal. I lifted his eyelids and shined a light in his eyes; his pupils were the same size, and they shrank in diameter when the light struck them. All reassuring signs. I began thinking that maybe Joseph was ignoring me, simply refusing to engage. Then I remembered Henry's sternal rub. I took Joseph's hand in mine and held my pen crosswise against his thumbnail. Then I pushed down on it, first gingerly and then, when there was no response from Joseph, as hard as I could. He didn't even flinch. The sensation of hard plastic pressing against a nail bed is unpleasant at best, excruciating at worst. Before a clinical-skills exam in medical school, I practiced it on my partner, Deborah, right after assessing her cranial nerves and position sense. Not having expected what was coming, she almost punched me. Joseph's lack of response was meaningful. It made me nervous. I started to leave the room, resolved that I would send Joseph out to a

medical emergency room, but then turned back to him to try one last thing.Doctors have tests that are specifically designed to determine whether symptoms are truly neurological in origin or whether they might have psychiatric or volitional components. Some of these tests are meant to flush out people who are exaggerating symptoms for their own gain. Disability applicants, perhaps, or military draftees. Many of these tests take advantage of basic tenets of brain functioning that are likely unknown to the general public. For example, in all but the most profound losses of cognitive functioning, people who sustain a brain injury will retain elementary facts: that a dog has four legs, for example, or that the date of Christmas is December 25. Even people with near-total memory loss know their own names. Answers to the contrary raise a flag of concern for malingering or symptom exaggeration.Dr. Charles Scott, a well-known forensic psychiatrist, demonstrates the coin-in-the-hand test to uncover intentionally erroneous responses on testing. “You can’t imagine that anyone would fall for this,” he says. “It’s very obvious.” Scott puts a coin on his desk and then puts his hands out in front of him, palms up, facing the person he’s evaluating. Then he explains to the examinee that he’s going to ask him or her to select which hand the coin is in. With the person watching, Scott picks up the coin with his right hand, slowly puts it in the palm of his left hand, and closes both of his hands into fists. The hands never cross; they are never out of the person’s sight. “That’s it,” Scott says. Then, with all that in plain view, the examinee is asked to count down from ten to one and then say which hand the coin is in. Ninety-plus percent of nonmalingering examinees will indicate the correct hand, Scott explains. Malingerers, conversely, will choose the wrong hand more than 50 percent of the time. They’re trying too hard to look as if they can’t function.There are similarly cunning tests to assess pain, sensory loss, and paralysis. And as I turned away from Joseph, I suddenly remembered the arm-drop test. I stepped back to his bedside and raised his limp arm up above him until it was over his face. Then I let it drop. The arm flopped down, landing alongside Joseph’s body. I did it again, raising the limb, holding it directly above and in line with his face, then letting it drop. Again the arm flopped to Joseph’s side. Henry and I exchanged glances. The fact that Joseph’s hand had missed hitting his face—twice—made it likely that he was changing the trajectory of his arm to protect himself. He may have been doing it unintentionally or subconsciously, but if he were totally unconscious he would have been unable to redirect his arm.A group of internal-medicine doctors rotates through the psychiatric hospital early on weekend mornings to do physical exams on newly admitted patients and consultations for psychiatric patients who are medically complicated. I left Joseph’s room and told Henry that I was going to page the medical service to run this by them. Now that I had seen the results of Joseph’s arm-drop test, there was nothing else on exam that made me think he needed to be sent out to a medical hospital. Still, the lack of response to painful stimuli was unnerving. Henry agreed.When I got the medical doctor on the phone, he had already left the hospital. “Did you check his pupils?” he asked me. Yes, I told him, and his reflexes. And his muscle tone. Everything was normal except Joseph’s lack of reaction to pain and the fact that he seemed to be protecting his face from his falling hand. The doctor listened, then thought aloud, ruling out one medical cause after another based on my examination. Eventually he paused. “What about the gag?” he asked. “Did you check a gag?” I hadn’t. Lack of a gag reflex could indicate damage to the medulla, a critical part of the brain stem.“I’ll try it now,” I said.“Call me if you need me,” the doctor replied. I hung up and headed back to Joseph’s room with gloves and a tongue depressor. Henry met me in the doorway.“Still nothing, Doc,” he said. “I don’t like it, but then again, he doesn’t *seem* that sick to me.” I understood. Joseph’s motionless endurance of two painful tests was impressive, but it didn’t add up. I put on my gloves and went back to the bedside.“Joseph?” I said loudly. “I’m going to open your mouth to test your reflexes. This might feel uncomfortable. You might feel like you have to gag.” He remained stock-still and silent on top of his covers. I took his face in my hands and gently pulled his jaw open. I began to slide the tongue depressor into his mouth. Well before I was close to making him gag, Joseph let out a low moan. I paused and glanced up at Henry, who looked surprised. I withdrew the tongue depressor.“Joseph?” I said again. “Can you hear me?” The room was silent as Henry and I craned forward to listen for several long seconds. I began to convince myself that I had heard nothing and started to take Joseph’s chin back into my hands. Then, finally, there came the slightest of sounds from his lips.“*I’m very depressed,”* he whispered, motionless and eyes closed.I suddenly heard myself exhale, relieved by

Joseph's response. "Okay," I replied. "Okay. We had some trouble waking you up and had to make sure you were with us.""I know where I am," Joseph whispered, slowly and laboriously, "and I know who you are, and I just want to be left alone, because I'm terribly depressed."• • •It's tempting in situations like Joseph's to read a patient's lack of responsiveness as intentionally obstructionist, a manipulative trick. And yet the intersections between mind and body are so much deeper and more complex than that. My interpretation of Joseph's condition was that he had symptoms of catatonia.Though catatonia is most widely associated with images of schizophrenic patients who adopt bizarre postures for prolonged periods of time, unresponsiveness and a lack of withdrawal from painful stimuli are indicative of stupor, a principal feature of catatonia.Stupor illuminates a baffling intersection of the mind and body. Here psychic conflict can somehow interrupt a body's neural circuitry so as to render a person mute, immobile, or even impervious to pain. Psychiatry occupies just this kind of ever-shifting nexus of brain and mind. In terms of scientific disciplines, psychiatry bridges the territory between neurology and psychology. Like neurology (and unlike psychology), psychiatry is a medical discipline; practitioners of both disciplines must go to medical school, then train in a hospital-based residency program.Neurology claims the territory of the brain, the spinal cord, and the nerves that branch throughout our bodies. The neurologist treats the migraineur whose headaches will not abate, the stroke victim who comes into the emergency room slurring her words and unable to move an arm and a leg, the boy who dives into the shallow end of the pool and becomes a quadriplegic, the motorcyclist whose crash has left him comatose from a bleeding brain.Psychiatry, in contrast, is the science of disorders of the mind: when thoughts derail, emotions wreak havoc, or behavior destroys. In this book I have written five chapters about the mind and its mysteries. The first explores the struggles that doctors face in treating patients who intentionally and repeatedly injure themselves, by swallowing dangerous objects or by cutting and burning their own flesh; who undermine the very work their doctors do to try to help them. The second examines illnesses in which people are relentlessly tormented by their ideas about their bodies. Herein is a woman who nearly killed herself by picking at a blemish on her neck and a man whose earnest plea is for a surgeon to amputate his healthy leg. The third chapter centers on the legal ability doctors have to hospitalize—and sometimes medicate—a patient against his or her will. A patient claims that love emanates from everything around him. Is it ecstasy or psychosis? Do our current views of sanity allow for the otherworldly or divine experiences historically associated with saints or mystics? The fourth chapter grapples with the very real peril that patients face if their individual illnesses are not correctly defined. When a woman is admitted with repetitive thoughts of harming her child, her course of treatment—and her child's safety—depend upon whether she receives the correct diagnosis. The fifth and final chapter recalls Joseph and patients like him whose bodies are overtaken by the illnesses of their minds. How do we treat a woman whose seizures have no neurological cause? What possible explanation can there be when groups of men are convinced that their penises are shrinking into their bodies? The chapter asks how well we doctors, trained to act and fix, are prepared to sit with patients in—and accompany them through—the trials of their illnesses.Life, of course, changes how we see things. As I wrote this book, my partner, Deborah, and I were raising our young daughter and our even younger son. It turns out that parenting children and caring for psychiatric patients have their fair share of similarities. I mean that in all the ways in which that sentence can be interpreted: with love, and frustration, and gratification. With fear, and awe, and ineptitude.My children do not age sequentially in this book. My daughter may be four, and then she may be a newborn. I have found that I experience the pasts of my children in this jumbled way. A snapshot of a year ago and then a flowing current of their infancies and then today, with their book bags and lunch boxes and shoes that tie. I imagine that the memories will intermingle like this throughout their lives. Those memories, too, will shift with context. My son will become an engineer, and we'll nod knowingly, claiming to have seen it coming from the years of infinite Lego structures. Or he'll be a comedian and we'll say, *We knew because he always made his sister laugh.* Hindsight is powerful in parenthood, as in medicine.• • •In its quest for effective treatments of mental illness, the evolution of psychiatry has been characterized by both inspiring and inglorious moments.The Bethlem Hospital to which twenty-two-year-old Charles Harold Wrigley was admitted in 1890 was founded as a priory in 1247. It became a hospital in 1330 and took the first patients

classified as “lunatics” in 1357, making it the first and oldest recognized institution in the world to give care to the mentally ill. By the end of the fourteenth century, the hospital began to be used exclusively as a hospital “for the insane.” Over the centuries the hospital grew, as did the demand for the care it provided. But for nearly three hundred years, Bethlem housed only twenty patients at a time and operated as an institution for so-called short-stay patients.Today my colleagues and I use this term for hospital admissions whose duration is less than forty-eight hours. In the current state of health care, only the most severely ill patients are admitted to the hospital; even then the average stay is five days. Managed-care companies will phone physicians, sometimes daily, to interrogate them about their clinical decisions and treatment plans. If the insurance companies do not feel that the patient continues to meet their own narrow criteria for inpatient treatment, they will refuse to authorize additional days of hospitalization. Physicians have the right—indeed the mandate—to make clinical decisions based on patients’ needs rather than insurance companies’ pressures, but we are aware that unauthorized days in the hospital will result in staggering bills for our patients, many of whom are already in financial turmoil. If patients cannot pay, the costs of their treatments are frequently absorbed by the hospitals themselves—an obviously unsustainable practice. These factors combine to form the present reality: Today’s inpatient care is most often crisis management. Patients are discharged from our wards as soon as they begin to stabilize, once they are no longer acutely psychotic or no longer in imminent danger of harming themselves or others. This means that patients are often released from the hospital in a tenuous state of mental healing. In many cases their symptoms recur and they return to the hospital for another five-day effort at stabilization.In contrast, by early Bethlem standards a “short stay” was one in which the patient was discharged after twelve months or less. Even one year of treatment proved to be inadequate for many patients at Bethlem, as the hospital archives reveal. The hospital developed a means of classifying patients as either “curable” or “incurable.”“When a patient, after sufficient trial, is judged incurable,” an eighteenth-century hospital document explains, “he is dismissed from the hospital, and if he is pronounced dangerous either to himself or others, his name is entered into a book, that he may be received . . . [into] the house whenever a vacancy shall happen.” Despite the dangerous conditions that these patients were deemed to have, the number of patients in need of longer-term care far exceeded what Bethlem Hospital could offer. “There are generally more than two hundred upon . . . the incurable list,” the document continues, “and as instances of longevity are frequent in insane persons, it commonly happens that the expectants are obliged to wait six or seven years, after their dismission from the hospital, before they can be again received.”In response to this great need, Bethlem expanded yet again in 1730, adding two wings for the “incurables,” who were now permitted to stay until the moment when—or if—they recovered. One such patient was Richard Dadd, an artist who began suffering from paranoid delusions at the age of twenty-five. Dadd said he received messages from the Egyptian god Osiris and stabbed his father to death in a park, believing him to be the devil in disguise. The hospital documentation mentions that Dadd remained in Bethlem until his death, forty-two years after he was first admitted to the incurable ward.The expansion of Bethlem Hospital to treat—or at least contain—patients whose struggle with mental illness would be chronic and severe was not one entirely characterized by altruism. The sheer number and concentration of (often visibly) ill patients at Bethlem became a major eighteenth-century London tourist attraction. Visitors bought tickets from the hospital to gawk at the spectacles of both frenzied psychosis and the brutal forms of physical restraint that Bethlem employed. The tour began on the Bethlem grounds beneath two reclining sculpted figures called *Melancholy* and *Raving Madness* and then processed past the patients, some caged or shackled or with iron bits protruding from their mouths. Using Bethlem’s name, the witnessing public soon coined a new word for the conditions they observed: “bedlam.”In retrospect, “bedlam” seems an apt description both for the scenes of madness in Bethlem’s early halls and for the torturous range of “therapeutic” treatments whose efficacy was tested on the captive patients. Every spring, under the orders of one particular physician, there was a prescribed bloodletting for every patient in the hospital. At other times, depending on the psychiatric treatment currently in vogue, patients were restrained in submersible cages and then held underwater in the hopes that the near-drowning experience would shock the ill mind into a new outlook on life; they were strapped to seats that spun for hours at great speed, and treating practitioners marveled at how

well the induced nausea would calm the most agitated patients into more placid behavior.Even in that earlier era, a patient's finances could determine the treatment he received. Bethlem's eighteenth-century hospital physician, Thomas Monro, was called before a House of Commons committee to discuss the use of Gothic fetters—iron restraints to which hospitalized patients were frequently riveted. Monro reassured the committee that the fetters were "fit only for the pauper lunatics," explaining that "if a gentleman was put in irons, he would not like it."Though the treatments I can offer to my patients today are, thankfully, far more humane than those I find documented as I page through the nineteenth-century Bethlem casebooks, I am struck by the disquieting fact that Charles Harold Wrigley, with his exact symptoms and story, might as easily have been seen in one of the psychiatric wards on which I work today.I could likely guarantee Mr. Wrigley more dignity, more comfort, and more privacy than he received in 1890 in "Bedlam." I could prescribe him modern medications and offer him appropriate psychotherapy. But in spite of the surefire treatments that have been found in the last three centuries for countless *other* medical conditions, I could not guarantee that my treatment would bring him relief or cure.So, standing in the dark of Joseph's room, my mind returned to young Charles Wrigley, who was described as miserable and holding his hand on his forehead as if in pain. "I just want to be left alone," Joseph had labored to tell me from his impenetrable stillness when I began to test his gag reflex. "I'm terribly depressed."I sat down beside Joseph to ask him more questions, now that he'd broken his silence. "How long have you been feeling this way?" I asked. His eyes remained closed. He did not respond."Joseph?" I tried again. "I'd like to hear about what you've been going through so that I can help." He did not stir. I sat there beside him, the awkward silence in the wake of my voice hanging between us. I felt a palpable discomfort—my own inability to penetrate Joseph's misery, the paralysis of his suffering. I found myself thinking of a short-lived flirtation I'd had with Buddhism in graduate school, when I'd sit and reach for the meditative stillness the practice espoused only to find my mind wandering and waylaid, my body stiff or itching. "Joseph?" I said again. "Joseph?" Eventually I stood and left the room.Medicine asks its practitioners to confront the messy, unsatisfying, nonconforming human mind. As psychiatrists, we see the mind while it careens and lists, and we are not always sure how—or whether—we can right it. How do we respond when a patient's suffering breeds unbearable discomfort and unease within our own selves? What do we do when our patients' symptoms do not relent? When their experiences cannot be accounted for—or helped by—what we know about medicine, or the brain? *What then?*(CHAPTER ONE)The Woman Who Needed a ZipperThose wounds heal ill that men do give themselves.—Shakespeare, *Troilus and Cressida*Lauren's back again." The gastroenterology fellow groaned. "Lightbulbs this time." I was in my second year of residency training and had just started working in a major medical hospital as a psychiatric consultant for medical and surgical inpatients. I had no idea who the fellow was talking about. When I told him so, he began to laugh. "Oh, my God. You've never seen Lauren? Every time she comes in, the ER docs call us and we call you guys. We all give our advice on how to treat her, but you know what she really needs?" I didn't. "A zipper," he said. "See you in the ER."I was utterly confused. Lightbulbs? A zipper? Sounded more like supplies for a child's science project than relevant clinical information. My mind was spinning as I walked through the dingy hospital stairwell to the emergency room to meet Lauren. On the wall at the landing hung a faded hospital-benefit poster of a horse-drawn carriage in the snow and some lines from Robert Frost. When I walked by the poster, I was typically working an overnight shift, and so "miles to go before I sleep" had taken on a bleary, fluorescent-lit meaning quite detached from woods, "lovely, dark and deep." As I swiped my badge to go into the ER, the lines were still running through my head: *Between the woods and frozen lake / The darkest evening of the year*.Lauren was in a room across from the nurses' station. The ER rooms had three walls; the "fourth wall" was a pink-and-tan curtain that could be drawn for privacy or pulled back to enter or exit. Lauren's curtain was wide open, and a security guard in a navy uniform sat in a plastic chair at the foot of her bed. I took a look in as I walked by. Given the gastroenterology fellow's dramatic reaction to her presence, I expected her appearance to be notable. It wasn't. She was sitting glumly on the bed, upright, in a hospital johnny. She was thin. Her dirty blond hair was a little mussed. She was twenty-five, but she looked slightly older. Otherwise, there was not much about her that was remarkable. I continued walking by; I wanted to take a look at her chart before I

went in.As I pulled Lauren's chart from the nurses' station, one of the nurses seated there glanced at my name tag. CHRISTINE MONTROSS, M.D., it read. PSYCHIATRY."Aha!" The nurse smiled and in a singsong voice added, "I know who you're here to see.""The woman in 2B?" I asked. "You know her?"The nurse nodded and laughed, surprised. "You don't? I thought everybody knew Lauren. Have fun!" She winked and handed me a folder with the patient's ER paperwork in it. "Oh, Doc?" she called as I walked away. "Don't lend her that nice pen of yours."I opened the chart. A sheet of Lauren's orders was on top. Along with the ticked boxes indicating the conventional laboratory studies for ER patients were a few additional specifications: "Finger food diet only," read one line. Beneath it: "**NO** objects to be left in room—SEE BEHAVIORAL CARE PLAN." I couldn't be sure how to interpret these orders, but from them I surmised that Lauren must be either suicidal or homicidal. Patients who were relegated to finger-food diets were those who could not be trusted with utensils.Beneath the orders page was a sheet of Lauren's lab values. I quickly scanned it, looking for the typical irregularities of psychiatric patients: elevated blood-alcohol levels, a positive drug test, subtherapeutic medication levels, thyroid abnormalities, infection. With the exception of a toxicology screen that was positive for her having smoked marijuana sometime recently, nothing stood out. Her complete blood count and electrolytes were totally normal. Her pregnancy test was negative. Chest and abdominal X-rays had been taken; the results were pending.I flipped through the remainder of the paperwork and found that Lauren was already slated for admission to a bed on the internal-medicine service. The admitting resident had seen her and written a note. I deciphered the scrawled shorthand to read: "This patient is a well-known 25-year-old female with extensive psych history and multiple previous intentional ingestions." Usually an "intentional ingestion" meant that someone had drunk bleach or eaten rat poison or overdosed on pills as a suicide attempt, but the meaning was different here. Lightbulbs. Suddenly keeping utensils and objects and nice pens out of Lauren's reach made sense. Nobody wanted her to swallow them.I walked past the security guard and into Lauren's room. Before I could introduce myself, she glared at me and said, "Let me guess, you're the shrink, right? I can always tell you guys—you're all nicey-nice handshakes and dipshit smiles." The security guard, who had doubtless seen a number of ER psych consults, stifled a chuckle and put his fist over his mouth to hide a grin."Sounds like you've pegged us," I answered, reaching out my right hand in a nicey-nice shake. "I'm Dr. Montross.""Yeah," replied Lauren, glowering at my hand without taking it. "I can read your fuckin' name tag, *Christine,* but unless you are going to get me something for this pain, I'm not in the mood for a conversation."I turned to the security guard. "Would you mind letting us talk alone for a minute?" I asked."Whatever you say, Doc." He shrugged. "I'll be right outside if you need me." He stepped out and drew the curtain closed behind him when he left. I slid his chair to the side of Lauren's bed and sat down.Lauren pulled the hospital blanket up to her neck, lay down against her pillow, and rolled onto her side, turning her back to me. "Jesus, you people don't *listen.* I wasn't kidding. Unless you give me something for my pain, I'm not talking.""Since I'm meeting you for the first time, it's hard for me to know about your pain. If you tell me about it, maybe we can come up with a way I could be of help," I offered. It was a stretch—she was talking physical pain, and I was going to try to access her psychic pain—but it didn't feel like a lie. I knew I wasn't going to write her an order for pain medication—that was the territory of the ER and the medicine teams—but I needed an entrée, and I hoped that asking about her pain would soften her defensive stance. Or at least encourage her to roll over and look at me. "What's going on that you've ended up in the emergency room?""Read. The. Chart," Lauren intoned, not making a move."I've looked at it a bit already," I said, "but I'd actually rather hear from you—""Well, I'd rather be left alone," she interrupted."Fair enough," I said. "Let me just read you what I've got here, and you tell me whether that sounds about right, okay?" I opened the chart to the admission note. Lauren was silent. "It says here that you were feeling upset and that you swallowed some pieces of a lightbulb. Is that right?"Lauren scoffed, then abruptly turned toward me, angry. "Yeah, 'upset.' That's one way to put it. See? That's why I don't talk to you people. I'm in the hospital three days ago, you all decide—you shrinks and the surgeons and the GI docs—you all decide to kick me out even though I'm telling everybody *I'm not ready to go home,* and then some intern writes that I'm 'upset.' Well, fuck yeah, I'm upset. I'm upset because I told you I wasn't ready

to go home and no one listened to me. So pardon me if I don't really buy that you're so *interested* in my side of things.""What happened with the lightbulb?" I asked."Lightbulbs," she said."Okay, what happened with the lightbulbs?""I was pissed. I crushed them up and swallowed them," she said matter-of-factly. "Not the metal part, just the glass and wire." I nodded. There was a moment of quiet between us. Then she spoke. "Now do you believe me that my stomach fucking hurts?"I left Lauren and went off to write up my evaluation and recommendations. The surgical team to which she would be assigned consulted the psychiatry service for help in managing her psychiatric medications while she was hospitalized. The team's larger hope, of course, was that we would be able to provide some sort of intervention that would break the pattern of Lauren's swallowing, or at least lengthen the periods of time in between her intentional ingestions. To better understand the medications she had been on and the psychiatric treatments she had tried prior to this admission, I pulled her old charts from medical records. She had stacks of them, some of which were more than four years old and so had been archived. I looked up the most recent admissions that had taken place in the last four years; there were twenty-three. Her hospitalizations had been prompted by her ingestion of the following:ninety screwsAA batteries and paper clipstwo knife blades and four fork handlesfour candlesfour metal spoon handlesthe screwdriver from an eyeglass-repair kita knife and six barbecue skewersa bedspringthirteen pencilsa knife, a knife handle, and a mercury thermometera box of three-inch galvanized nailsa screwdriver, a ninja knife, and a knife bladea steak knifea razor and five penstwo knivesscissors, pins, and a nail filefour four-inch pieces of curtain rodscissors, a drill bit, and a pena six-inch piece of curtain rod and a seven-inch knifea knife, three spoons, and some copper wiretwo six-inch steak knivesa pair of scissorsa four-inch metal blade, three spoon handles, and a nail clipperOver and over, Lauren would swallow potentially dangerous objects in the context of stress. She swallowed the screwdriver, the knife blade, and the ninja knife when she learned that her uncle was terminally ill. The two knife blades and four fork handles were a response to learning that her sister had hepatitis. The box of nails was after a fight with a neighbor. Each time she said she felt better after she had swallowed something and then brought herself to the emergency room for treatment. Over and over, doctors performed endoscopies, threading a camera and tools down Lauren's throat with a tube to try to get the objects out before the things she had swallowed inflicted damage on her esophagus, stomach, or intestines. Only once, after she'd ingested a single spoon handle, was endoscopy deemed unnecessary. "She had some discomfort," the discharge summary read, "but the spoon passed normally."In contrast, once, when an eight-inch knife blade was too dangerous to pull back up through her esophagus and out of her mouth, Lauren's abdomen had to be surgically opened and the knife removed. Many times, multiple endoscopic attempts were required to "retrieve" the same object. One endoscopy note read, "Four approximately 4-inch-long sharp pieces of broken curtain rail were found in the gastric fundus. Removal of two was accomplished with a snare. The other two could not be removed. They kept holding up at the gastroesophageal junction despite two hours' manipulation." If objects could not be extracted, more experienced doctors were brought in for additional attempts. A senior physician developed a reputation for being able to retrieve items Lauren had swallowed when others had failed to do so. Once, during a hospital meeting that had specifically been convened to discuss Lauren's care, an administrator asked the gathered group of clinicians for ideas about a systematic approach for treating her during her recurrent admissions. A GI fellow piped up from the back, "If at first you don't succeed, try, try again. If you still don't succeed, call in Dr. Friedrichs."Not infrequently, once awake and recovering back on the floor, Lauren would swallow something in her hospital room and require further treatment. Several times she swallowed the handles of spoons from her meal trays. Once a pencil. Once she broke fragments of wood from the frame of her room's window and ate them. One night in the emergency room, she removed and swallowed a metal piece of the gurney.The doctors charged with Lauren's care had no choice but to treat her when she came to the emergency room. Each time her actions were potentially life-threatening. To deny her care not only would be ethically incomprehensible but could also be medically catastrophic. No one could suggest that doctors should refuse to perform procedures on her, even if the procedures themselves were somehow reinforcing the maladaptive behavior, even if Lauren might swallow something as soon as she awakened from an endoscopy that had narrowly averted disaster. And yet the frustration of the surgical staff,

who once during a consultation expressed their shared wish to “let her experience the consequences,” was only partially an emotional response to her flagrant self-injury and misuse of their expertise. It was also a manifestation of the fact that they felt they were contributing to this young woman’s demise. “It doesn’t matter that she’s the one that swallowed the razor,” one surgical resident said to me. “If I have to operate, I’m the one that’s cutting her open, exposing her to the dangers of major surgery, giving her a belly full of scar tissue. . . . I might fix the emergency, but beyond that, none of what I’m doing is going to help her in the long run.”Many surgeons differentiate their field of medicine from others by their ability to perform a procedure that fixes what’s wrong with the patient. Surgeons realign the broken hip and remove the cancerous breast; they repair gunshot wounds and replace burned skin. One particularly brazen surgeon with whom I trained as a medical student would routinely wait for his patients to awaken from anesthesia and then come to the bedside, look them in the eye, and announce, “I cured you!” This was all the more disquieting to observe given that some of his patients were terminally ill, and his role—to remove a cancer-ridden lobe of the liver or extricate a tumor-infested loop of bowel—might well have been only palliative in nature.Revue de presse
'Montross explores the practical, emotional, and philosophical challenges of working with patients whose illnesses of the mind are often intractable and deeply disturbing'(*The New Yorker*)

'A piercing portrait of psychiatry... Montross seamlessly weaves together history, reportage and memoir while reflecting on the difficult questions that arise as she digs into psychiatry s past.'(*Los Angeles Times*)

'An absorbing glimpse into the darker rooms of the human mind. Christine Montross offers a personal guided tour through fascinating case histories and reveals how very much our minds are our selves, and not always operating in our own best interests.'(Andrea Gillies, author of Keeper and The White Lie)

'A mind-boggling inventory of psychiatric pathologies... Dr Montross, an award-winning poet before attending medical school, is passionate about her work and her patients plight... The book emphasizes neither their madness nor our sanity in the face of mental disease, but our fragile and shared humanity.'(*New York Times*)

'*Falling Into the Fire* is as good an account of the labyrinth of mental health care as you re likely to read. [Montross s] work in critical care psychiatric settings is the source material, and she launches from discussions of clients into larger questions about the nature of psychiatry and of mental health. Montross writes beautifully about the deep-seated illnesses that challenge therapist and psychiatrists.'(*Daily Beast*)

'Montross exposes and explores the challenging, sometimes paradoxical role of psychiatric professionals... Her intriguing analysis is anchored by [a] humble and empathetic voice.'(*Publishers Weekly*)

'Her poetic insights into how tragedies may be understood stir empathy, as Montross delves into the details of the history of her patients... This beautifully written book doesn t offer answers but rather encourages compassion.'(*Library Journal*)

'Montross writes of [her] encounters with a dramatic flair, ever empathetic but unsparing of occasional negative feelings, fears and frustrations... As an antidote to her daily coping with extreme behaviors, Montross writes serenely of a home life with her family. No triumphs of modern psychiatry on display here, but rather a sympathetic portrait of seriously ill patients that could guide future practitioners on the art of helping, if not always healing, the sick.'(*Kirkus Reviews*)

'These stories are fascinating in the macabre way that psychiatric case studies can be, but *Falling into the Fire* is not a mere catalogue of human oddities... Her patients' neurons are certainly misfiring, but these

individuals have just as certainly led beleaguered lives with fractured relationships... Powerful.' (*Washington Post*)

This account by a practising psychiatrist is the kind of confession doctors aren t supposed to make: that they don t always know what to do, and they may spend their entire working lives learning on the job... revealing.'(*Independent*)

'Fascinating... [Montross] is very good at exploring the ethical issues raised by her practice... that there are no certain answers to these questions only makes them more absorbing... Montross writes beautifully.' (*Telegraph*)

'Christine Montross is the latest recruit to our distinguished line of literary psychologists... Montross goes into a great deal of interesting detail.'(*Daily Mail*< --*The New Yorker*

Compelling... Falling into the Fire is a fine addition to a body of writing including the work of Paul Broks, Kay Redfield Jamison and Oliver Sacks. (Observer) --Observer

Lucid, fluent [and] absorbing... nestles into a burgeoning genre of mental health books focusing on individual patient experiences rather than self-help prescriptions (*Sunday Business Post*) --Sunday Business Post Présentation de l'éditeur
A woman habitually self-harms, eating light bulbs, a box of nails, zips, and a steak knife. A new mother is admitted with incessant visions of hurting her child. A recent university graduate, dressed in a tunic and declaring that love emanates from everything around him, is brought to A&E by his alarmed girlfriend. These are among the patients new consultant physician Christine Montross meets during rounds at her hospital s locked inpatient ward as she struggles to understand the mysteries of the mind, most especially when the tools of modern medicine are failing us.

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