

OUTSIDE THE BOX: A PERSONAL MEMOIR

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The author discovers that a surprise perk to providing temporary services as a locum tenens psychiatrist, the stranger who appears and lends a hand and then quickly leaves, is the unstated writ to think and even act outside the box.

"I'm afraid she'll kill herself out there," her doctor announces, putting a name to the elephant in the conference room. After that, there is nothing further to be said. Now it's time to interview Ms. Drum.

Today is my first day back at this state hospital as a *locum tenens* or temp-doctor, my final career incarnation after having been dismissed several years before from my psychiatric clinic and replaced by a nurse practitioner, a cost-saving measure. (I initially thought I'd retire at that unexpected and undignified close to my professional career, but that was before discovering that occasional assignments as a temporary psychiatrist, helping out at clinics and hospitals around the country, is a source of unanticipated enrichment and even inspiration for me and for my wife who accompanies me.)

I've just been given keys to my new office and an ID badge. I've met staff and am now invited as an observer to today's Patient-At-Risk-Committee meeting. Ms. Drum won't be under my care officially until tomorrow, but I am being forewarned and brought up to speed on her case.

"She's the most difficult patient on the Unit," more than a few sympathetic nurses have already whispered to me during my orientation.

Ms. Drum is a hot-button case. The threat of suicide is at its center. The likelihood of her suicide is apparently high and, of course, the risk of her doctor being blamed should that happen, very high. What surprises me at this meeting is not the pervasive sense of paralysis and discouragement in the room

about the case but my reaction to it. I'm feeling unexpectedly at ease and unruffled even though I'll own it all in the morning.

When the Treatment is Toxic

The conundrum is the usual one. A patient with out-of-control behavior finds the offered treatment, the usual and appropriate methods of behavior control, toxic and reacts to that treatment with even more out-of-control behavior that, in turn, predictably evokes even more of this toxic treatment, and so on in a vicious cycle. Neither can disengage from the other for the obvious reason. The irresistible force meets the unmovable object; the state hospital's policies and procedures meet the imperatives of a desperate and impulsive character-disordered person.

The case details are scary. A court sent Ms. Drum to this hospital because she'd tried to kill herself in prison. She'd been serving time for violation of a Restraining Order that she stay away from her substance-abusing and abusive boyfriend. Once she was safely hospitalized for a while, the skittish court, not surprisingly, deemed her confinement "time served" and declared that the remainder of her sentence need only be probation. Unfortunately (for the hospital), this meant that sending her back to prison with its structure and controls wasn't a discharge option any more. This hot potato was now the hospital's to hold, suffer the scalding, and pray it could somehow be made to "cool down," so to speak, before any release into the community could be contemplated.

Ms. Drum's court ordered commitment to the hospital is up at the end of this, my first week. This means that when she returns to court and they set her free, any subsequent antisocial behavior, including suicide, will be the hospital's fault or, more accurately, my fault because we were the last to "own" her. The hospital, thus, has four days to decide what shall be our recommended discharge plan, and thus this Patient-At-Risk meeting. Whatever plan is selected has to have, at very least, the appearance of being appropriate and responsible. Naturally, it has to succeed.

The odds of the hospital devising such a discharge plan are terrible. Having recently attempted to strangle herself over restrictions for having been caught smoking on the Unit against the rules, Ms. Drum is still on one-to-one (1:1) supervision, her attendant sitting at her door at all times, not taking eyes off her. Her collaboration on any discharge plan is surely as unlikely as it is imperative and thus, this meeting.

An aide goes to bring Ms. Drum to be interviewed, and I hurriedly review the discussion that has just taken place, puzzled, naturally, by my lack of distress. "Is it because I'm in denial," I wonder, "or is it because I'm now beyond any fear of losing my job?"

The Downside of Trying to Control the Outcome

The discussion, I recall, had been dominated by the usual subtext: the hospital seeking maximum control over the outcome to ensure there will be no suicide in the community. This, naturally, generated the two options before us, both tightly bound to this subtext but differing in severity. The first is to invite the patient to return from court *back* to the hospital as a *voluntary* patient to continue this treatment. She'd then transition gradually into the community, contingent, of course, upon her manifesting good self-control. The other is for us (me) to petition the court for an *involuntary* return (as dangerous to self) and

to continue this treatment and then transition her gradually into the community as she manifests good self-control.

"Kelly will continue to regress if we bring her back here *involuntarily*," someone had argued. "She'll get swept up again in the rules and restrictions, everything will be a control issue, and she'll keep upping the ante and she'll never get out. She has to come back *voluntarily*."

"But if we re-admit her as a *voluntary* patient," another argued, "and she spends her days in freedom in the community, when she comes back here to sleep she'll have the same problems with the second and third nursing shifts. It won't work. Kelly will go AWA (*absent without authorization*) and if she doesn't hurt herself, she will return from AWA and be restricted all over again per our rules."

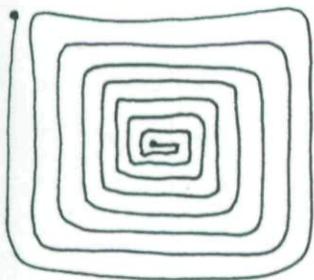
"According to her history," said another, "it's only in hospitals and prisons that she threatens suicide. In the community she's the most functional. She's held a job and driven a car. We have to let her succeed and be discharged and show we have confidence in her. That means she has to come back under a *voluntary*."

"But she always returns to the abusive boyfriend and she'll end up having problems with him and hurting herself, but it will be on *our* watch. Shouldn't we keep her from going back to him?" someone else asked.

"I'm concerned that, however we let her go, Kelly will feel abandoned by us. For me, at least a petition for an *involuntary* commitment will show we care," one participant declared.

A show of hands, however, indicated the committee was evenly divided between a voluntary and involuntary re-admission, a deadlock. It was then that the treating psychiatrist confessed, "Any way that we do this, I am worried about suicide."

The interview with Ms. Drum, a large and unkempt woman of 39 years, begins. Unfortunately, it does nothing to dispel the



group's angst (or stir any in me), let alone bring Ms. Drum on-board, as the expression goes. Actually, it goes as well as can be expected for a person that carries the character tag, "borderline." After a perfunctory assurance that everyone present wants to help her and the expected reference to the current restrictions placed on her, Ms. Drum is prodded gently.

"Might your *behavior* have something to do with your predicament of restriction to the Unit?"

Ms. Drum bristles, scornfully lets the doctor interviewing her know where the dog died, and pronounces the interview at an end.

"Clearly nobody intends to listen to *me!*"

"I think we're off to a bad start. Let's start again," the flummoxed interviewer hurries to declare. "We're all here to help you find a way to successfully integrate yourself back into the community." But it's too late. Ms. Drum is excused and discussion resumes and the same arguments are repeated.

At this point I inexplicably violate the first rule for newcomers, everywhere and in all settings: Don't speak unless spoken to. I not only share my outsider's view but offer a suggestion as well (that I promptly regret inasmuch as both are seized upon, a quick show of hands formalizes my suggestion as The Plan, the meeting breaks up, people scatter, and now I have become the official bearer of the group's angst). Uneasiness surfaces in me at this point, but it is not because I can't determine whether I'm meant to be the Messiah or the Jonah here. It's because I've placed myself in the crosshairs ahead of schedule. Beginning now I shall be the target for any future legal action.

I meant what I'd told them, though. Ms. Drum and the staff are trapped in a destructive embrace, each clasping the other in the deadliest of grips and both are spiraling downwards towards a sure if uncertain disaster and there is no map of a way out. I suggested that she be discharged at week's end *outright and unconditionally*. When

control isn't an issue, I was thinking, she functions in the community and makes no threats of suicide. Let her go.

Following the meeting I tell my new patient this discharge plan and share my assessment that the hospital is, for her, toxic and she must *not* come back, either voluntarily or involuntarily. She makes no comment. At issue, of course, is whether her *behavior* will, as before, make it impossible for me to discharge her back to her independent life and oblige me to arrange that she be returned here from court as an involuntary patient for more of the same "treatment."

Doctoring and Manipulating

"Can I smoke?" Ms. Drum asks when she sees me the following morning, her first words to me since I broke the news and caught her unawares.

"Aren't you permitted?" I ask (feigning ignorance that, as a court referral, she not only is ineligible for a pass to leave the Unit inasmuch as smoking is prohibited on the Unit, but that she had been living with those restrictions since her admission *six months earlier*).

If the first issue with me, I think, is to be one of control, it is vital that I commandeer that control issue from the very start. (My course, at that moment, becomes as obvious as it is paradoxical and unorthodox.)

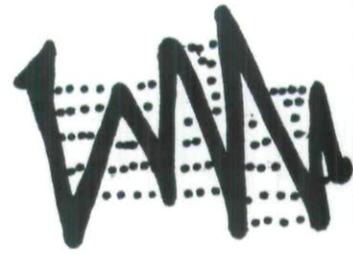
"No! They won't let me!" she loudly exclaims. "They won't let me smoke!"

"They won't?" I respond, forcing myself to sound surprised and indignant and raising my voice even louder than hers. "Let *me* look into it," I insist, "*right now!* Not letting you smoke doesn't seem right!"

I hurry off with a determined expression on my face.

Several hours later I seek her out and manage to look upset.

"They tell me there's a rule," I complain to her, "and that doesn't seem fair. You hang on and let me see if there is a way around it, okay"



"Okay."

Off I dash once again.

Several hours later, in the early afternoon and after I discreetly confirm that she has been controlling herself (and knowing that the nicotine withdrawal had been completed four months earlier and so any urgency about a smoke now would be bogus) I return to her.

"My God, you are right!" I blurt out in disgust. "This place is impossible! Everything is controlled by rules!" (Ms. Drum seems pleased to hear that I am now the one who has an issue with hospital controls *just as I am genuinely pleased to have thus manipulated her into transferring this issue of hers over to me.*)

"But, I'm going to find a way," I persist, forcing myself to sound flustered as well as dogged in my determination. "I'm going to talk to some senior staff I know. You hang on." (*And, of course, she does.*)

For the rest of the week I manipulate her in this way into manifesting the sort of self-control and appropriate functioning that not only signals clinical stability but will ensure her unrestricted discharge into the community at week's end, my *pseudo*-indignation over hospital controls effectively checking her habits of *pseudo*-losing control; my *splitting myself* from the staff, in this way, allowing respite, if not temporary healing for her own *inner* splits.

"Now I know why you want to leave," I confide to her at one point. "I got nowhere with administration. But Thursday I'll be meeting with lawyers." I pause and look concerned.

"It must be awful not being able to smoke. You sure you're OK?"

"Yes," she tells me reassuringly.

"I don't know how you can stand it here," and I'm off again.

Outside the Box

Ms. Drum, off restriction and 1:1 supervision, is discharged at week's end and without incident. She had been in good control

these four days, following the rules and with the follow-up connections that she'd asked for (and there is no grumbling or dissension on the treatment team or by the nurse staff, the different shifts, the administration or among the Patient-At Risk-Committee members). She had been clinically stable and manifesting her optimal personality functioning. Ms. Drum stops at court where she is assigned her terms of probation and, without incident, goes to her Section 8 apartment and returns to her life and outpatient treatment, and stays away from her abusive boyfriend. During the remaining months of my assignment she requires neither hospitalization nor police intervention.

In retrospect, I wonder if we all didn't share a bit in Ms. Drum's liberation from her entrapment on the Unit. I did. I learned, for example, that I could move beyond the tried and true (and ineffective), even if it is to something unorthodox, and move beyond the safe and customary (like not speaking until spoken to, as a newcomer), and even beyond the politically correct, to something ultimately effective and helpful. Doctors, for example, have been uncomfortable with the "manipulating" connotation to their name for forever, it seems, and "staff splitting" has been a bad thing for all the years I've ever worked as a permanent staff member. But this needn't be so.

Ms. Drum taught me that the fetters some of us shed on that occasion of her release were not only some old and familiar institutional ones, especially those of iatrogenic import; they were also some of our own making. Mine were.

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