My Patient and the Mouse

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SYNOPSIS

Sadly, there are many individuals who are in need of psychological help. Not all of these folk are committed to psychiatric units. Instead, some wind up as clinical supervisors. On some days, mine in particular might as well have been locked up on a 72-hour watch. She could blow hot and then cold, be mean and then happy, dominating yet inferior, insensitive and, then at times, overly caring. What? Yes... – it's true. But, within all of the chaos that I was about to experience, I was to find a special individual – a patient – who not only transcended her own disorder but helped me to realize that locked deep within her 'schizophrenic mind', was someone who understood something my supervisor was simply incapable of.

The following is a snapshot of my experience, during which time I was a clinical doctoral student, under the first-time supervision of a young and inexperienced clinical psychologist. Armed with a low sense of self-esteem but a high sense of superiority, this individual single-handedly changed the course of my professional career, yet, the reader should understand that this article is not about her.

Although a painfully emotional and ethical ordeal, the year I spent on the psychiatric unit allowed me to understand that there are many times that patients do not and cannot flourish, not because of an innate incapacity to express emotion, but simply as a function of the therapist's, or in this case my supervisor's, toxic personality. And yet, in spite of this, I learned that even a patient with the most chronic form of a debilitating psychiatric disorder was capable of displaying acts of compassion, gentleness, kindness and lucidity, that reached far beyond the clinical expectations that I was allowed to have of her. The most important of life's lessons was the one I was to receive from my relationship with my patient 'Carolina', and in spite of the overall outcome, I would never have changed the circumstances that occurred on this particular day.

Carolina

My task for the year was to learn about the clinical aspects of psychology. I placed my trust (and my externship) in Dr G's hands. As the days on the unit proceeded, I began to realize that something was drastically wrong. I found myself being reprimanded for saying 'Good morning' to patients that I would pass in the hall, for saying a few words to a patient in the dayroom, and for standing next to a patient while we looked out the gated window. The desk I was assigned to was in the corner of a room that I shared with three other clinical psychologists. By the third month, all three had witnessed Dr G's verbal aggression mixed with dismissive statements, condescending blank stares and an overall disgust because I couldn't recite the DSM. Although only a short time into the externship, I was a mess; flustered, insecure, anxious and nervous, I was determined to find a way to let her see that I had what it took to become a clinical psychologist. Every day when I arrived on the unit, I fought my intuition and ducked into the office when I saw a patient coming down the hall in the morning. I refrained from saying anything nice to patients in the dayroom and never stood by the window again. Although the other psychologists displayed care and compassion when Dr

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G forbade me from going to lunch with the group, I felt isolated and miserable, and so I went to the cafeteria and started reading up on the computerized rehabilitation training that I would soon begin with my patient.

In our office, one topic that was the center of discussion among the psychologists was that of 'touch'. The question was very simple; how ethical was it to touch a patient or be touched by a patient? We all agreed that it depended on the context of the situation. None of us saw anything ethically or morally incorrect with a friendly light tap on the shoulder or on the hand, if the situation warranted it. We agreed that it wasn't good clinical practice to do this often, but also understood that a patient's observation of our responses could significantly influence the delicate emotional state the patient was in. And so, here lies the context in which my own story begins.

I became involved in a project where I had to run subjects for a potential study that dealt with using a computerized program to assist in cognitive rehabilitation training (CRT). One of the patients that I was assigned to was named Carolina – a Hispanic woman in her mid-fifties. She was divorced from her husband with whom she had had a volatile relationship. She had been an in-patient on the unit for quite some time. Upon admission, Carolina had presented with severe and chronic paranoid schizophrenia, grandiose delusions, compromised thought processes and ideas of reference. Her insight and judgement were both impaired. Her chief complaint was that the medication was harming her and that vampires were leeching her blood. She was guarded, anxious, agitated and detached. She was poorly groomed and mal-odorous and suspicious of everything and of everyone. She was hostile and angry, and would not make eye contact. Dr G approached Carolina to ask if we may speak with her for a few moments, to which she agreed. Dr G held the door open for both of us leading into one of the small conference rooms. Since Carolina was in front of me, I motioned for her to go into the room with my left hand and gently placed my right hand on her left shoulder to guide her in. Little did I know how this small, seemingly innocuous gesture would not only change my professional career, but would also become one of the most important lessons that I've ever learned.

Don't Touch

The three of us took our seats, and Dr G explained to Carolina what to expect during the half hour that she and I would be working on the computer. After the meeting was over and Carolina left the room, I too got up to leave, but was motioned that I should remain seated. 'Rule number one', she said. 'You are to never touch a patient. This was the worst thing you could have done, Denise. Don't ever do that again. Do you understand?'. 'Yes... – but...', I responded. 'I saw that you put your hand on Carolina's shoulder; don't ever do that.' 'Okay... – but ...', I replied again. 'First', my supervisor reprimanded,

> for hygienic reasons. Carolina's dirty and she stinks, and secondly, because she is extremely paranoid. You never touch a patient for any reason whatsoever. You never know how they're going to react and don't, under any circumstance, ever let them touch you. I don't care what the situation is. Do you understand me, Denise? Do you? I never want to see this happen again.

I shook my head in dejected acknowledgment and left the room. I thought about the scenario for the entire day, and well into the evening when I returned home. I tried focusing on other things, but the impact that it had upset me to the point of nausea.

The Mouse

Soon afterwards, Dr G informed me that it was time that Carolina and I begin CRT. Because of Carolina's fragile psychological condition, I was once again sternly advised to proceed with caution, and strongly reminded to refrain from physical contact. During our first session, Carolina continued to display paranoia, ambivalence, physical withdrawal, poor eye contact, introversion, and an overall underlying sense of suspicion. I sat far away from Carolina (mostly because I was scared witless), yet close enough that she could hear me speak. I spoke gently and softly, afraid that a tone any louder than a whisper might excite her too much. By our third session, we began to establish a mutual foundation of trust and respect, so much so that

she allowed me to sit next to her, shoulder to shoulder.

Because Carolina was having difficulty in controlling the mouse, I made the clinical decision to show her how it was done. But how was I to accomplish that without physical contact? I was already comfortable in knowing that Carolina responded well to verbal encouragement, praise, support and genuine caring, but I felt that in order for her to really be successful at learning how to navigate a mouse, I was going to have to physically show her, and with Dr G's reprimand still burning my neurons, I was paranoid that there were little cameras in the computer room watching my every move. I felt so unnerved by what I was about to say to Carolina that all I could do was to take a deep breath and hope that Dr G hadn't secretly set up any microphones. 'Would you mind if I showed you how to move the mouse around?' 'No', she replied. 'But Carolina, you know that in order for me to teach you, I'm going to have to put my hand over yours to show you how to move the mouse around. Is that okay with you?' 'Yes', she said. 'Just to be clear, you're giving me permission to put my hand over yours so I can teach you how to do this?' '*Yes!*', Carolina replied again with a look like *alright already*.... 'Okay. Here we go.' And with that, I placed my right hand over hers and held my breath. I braced myself for some kind of an emotional outburst; a full paranoid tactile hallucinatory 'you should have never done that' response... – but nothing happened. Not only did nothing happen, but Carolina was visibly calm and thrilled that she was mastering control over the mouse – A MOUSE! – a simple computer mouse. Yet, I couldn't enjoy the moment because I was feeling guilty for thinking how, according to Dr G, having fun with a patient was simply prohibited.

The next morning I was informed that Carolina was looking for me. The tech stopped me in the hall and said 'Hey, doc – Carolina's lookin' for you. I think she needs her meds. She's all wound up 'bout a mouse or somethin' – says she wants to play with the mouse. I don't know what she's talkin' 'bout, but in the mean time I called housekeeping'. 'Oh dear', I thought... – 'What have I done...?'.

The Fall

One day, after Carolina and I spent an hour practicing (far more time than my supervisor allowed me to give her), I was shutting down the computer and printing out her scores. Carolina, who wasn't standing too far away, was patiently waiting for me to gather the last of my belongings. Already a half hour late for a meeting that Dr G was running and flustered about the wrath to come, I had somehow managed to get both my feet tangled up in the wires that were on the floor. Within a matter of seconds, I completely lost my balance and my face was heading for the edge of the table. It happened so quickly that I didn't have the time to brace myself for the fall and so, as if in slow motion, I closed my eyes and waited to feel the sharp edge of the table tearing into the side of my jaw.

But it never happened. I never felt any pain. Strange, I thought. I must have knocked myself out. As I slowly opened up my eyes, I realized that I never hit the table. Instead, I felt two arms around my waist. Carolina had caught me in mid-fall and placed me back on my feet within a matter of seconds. 'Are *you* okay?', Carolina asked. 'Yes... – I think so... – thank you, Carolina... – I'm okay now... – I think.' 'Are you okay?', I asked. 'Yeah', she responded, 'I was afraid you were gonna get hurt. I didn't want you getting' hurt. Are you hurt?'

What is going on here?!? Not only could I not believe what she was asking, but it was incomprehensible that in the moment in which she detected that I was going to be injured, it was as if she was transformed from a chronic psychiatric patient to this wonderfully caring person. In those seconds during the fall and then afterwards, all her symptoms seemed to have vanished; her paranoia disappeared, she was lucid, there were no overt behavioral signs of chronic schizophrenia, she wasn't afraid of reaching out to physically touch me, and most of all, she was able to express emotion. How did this all change so quickly? What did this all mean?

We walked to the elevator and just stood there; not speaking and avoiding direct eye contact. As we rode up to the unit, I couldn't stop thinking about how Carolina, in all her psychoses, saved me from a fractured jaw. This was just incomprehensible, but as amazing as this was, all I could think about was my supervisor finding out. Carolina broke the silence; 'They're going to take blood from me, you know.' 'Who?', I responded. 'The vampires that wait for me when I get off the elevator.' I looked at her and smiled, and knew that Carolina was now back to her 'normal' self once again.

The Change

I'm not sure how it happened, but eventually, Dr G found out. Perhaps Carolina told her when they discussed her CRT progress. I finished out the externship filled with anticipatory anxiety at what I felt was imminent, but at the same time grateful for my having met such a wonderful individual. The time came for my supervisor's written clinical evaluation that was sent to the university's doctoral committee. Not long after, I explained in detail

the year's events, but Dr G's assessment took precedence over any position that I had presented, and I was soon dismissed from the program. I left confused, hurt and depressed, but content in knowing I had shared an experience with a patient who was basically understood as 'unreachable'. I never gave up, though. Three years later, I was awarded my doctorate from another university and am now a theoretical psychologist.

Lessons

Unlike my supervisor's understanding, a patient is a real person; a person with a lot to offer, if only deeply hidden, distinct and separate from their diagnosis. Carolina, in her own way, was more of a mentor than Dr G could have ever hoped to be. She taught me that it was okay to not get caught up in protocol, and that somewhere deep inside, even the most chronic of individuals has the capacity to display kindness, concern and perhaps even love. She taught me that it was okay to be caring; that I could laugh with her and other patients, and at the same time deliver quality care without overstepping professional, therapeutic and ethical boundaries. Specifically, Carolina taught me that if a smile is the first thing a patient sees in the morning, that's not a bad thing, and that a walk down the hall before breakfast can change a patient's life – even if it's for a short time. Carolina told me that spending time away from the unit gave her a sense of 'feeling like a real person again'. She had once asked me what I would do if I were the one who had to stay while she got the chance to go home. That simple question changed my life. Although Carolina couldn't verbalize it, her question implied that the only difference between me and a psychiatric in-patient is genetic luck and a decent environment. I always kept that in mind when I would say 'goodnight' to my patients as I went home to sleep in my own bed. It was Carolina who really understood what appropriate behavior was, and I now keep her memory in my heart without ever again fearing that I will be reprimanded for an ethical transgression. S

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