A Psychiatric Resident’s Journey
Through the Closed Ward

by Tomer Levin

The article that follows is part of the Schizophrenia Bulletin’s ongoing First Person Account series. We hope that mental health professionals—the Bulletin’s primary audience—will take this opportunity to learn about the issues and difficulties confronted by consumers of mental health care. In addition, we hope that these accounts will give patients and families a better sense of not being alone in confronting the problems that can be anticipated by persons with serious emotional difficulties. We welcome other contributions from patients, ex-patients, or family members. Our major editorial requirement is that such contributions be clearly written and organized, and that a novel or unique aspect of schizophrenia be described, with special emphasis on points that will be important for professionals. Clinicians who see articulate patients with experiences they believe should be shared might encourage these patients to submit their articles to Schizophrenia Bulletin, First Person Accounts, EEI Communications, 66 Canal Center Plaza, Suite 200, Alexandria, VA 22314.—The Editors.

Prior to starting my residency in psychiatry, my world of medicine had been that of polished, tertiary referral centers where monitors hummed and nurses glided. Patients spoke in only subdued tones, their relatives and friends brought flowers and chocolates, and everything from bedpans to food was sterile or being sterilized. I wore my pressed white coat rather proudly—it symbolized my aspirations, labors, and achievements in high school, medical school, and my internship year. My stainless steel stethoscope hung around my neck almost casually, and my name tag was displayed prominently on my overstarched collar. Overstarched is how I was from head to toe—I was stiff and formal, overfriendly and overpolite; perhaps that is why I was attracted to psychiatry.

I remember the feeling of tranquility the first time I saw the expansive hospital garden, with its shady trees and lawns so spongy that my feet sank a few centimeters with each step. As chance would have it, I met the gardener, tanned and muscular, with a sweat-stained wide-brimmed hat. He made no comment about me trampling over his lawn, although he must have noticed the blush of guilt on my face. Like many people who work the land, he always spoke his mind with a minimum of words, hardly opening his mouth as he talked. He explained that his contribution to the patients’ care was his garden. Patients could relax in the shade of a tree or be alone with the flowers and the birds. As he pruned another branch without stopping the rhythm of his work, he added, “I’m no psychologist, but in my opinion you can tell a lot about a man by looking at his garden.”

That Welcome-to-the-End-of-the-World Feeling

Every psychiatric resident starts his or her specialization program on the closed ward. That feeling of dread started rising in my abdomen as I walked down the dimly lit corridor to where the ward was supposed to be, poked away in a corner of the sprawling hospital complex. The corridor was painted a sickly mustard yellow, and lining it was a series of doors. Only two bore signs. I felt an odd sense of danger and uncertainty (why were there no signposts?); my briefcase felt like a useless appendage hanging off my arm.

Posted on the first door was a small plaque: “ECT Room—Entry to staff only. Donated through the generosity of the Albright Trust.” It was not the most reassuring sign if you happened to be a patient or visitor on your way to the ward. If you happened to be passing at the right time of the morning you might catch a glimpse of a patient being wheeled into or out of electroconvulsive therapy (ECT), as there was no waiting room or recovery room. My mood turned somber. It seemed that the further I walked down this corridor, the less light there was.

The door opposite the ECT room was unmarked but could be identified by the sound of dripping water and the
The Language of Smoking

I banged on the metal door and waited. Thumping sounds echoed through the corridor. A clearly manic and paper-thin older lady flashed me a toothless smile and dashed off barefoot, returning after a few minutes with a burly, battle-wearied nurse wearing a flashy gold-plated necklace, a cigarette hanging out of the corner of her mouth. Keys were rattled with obvious effort and the door opened up without any words actually being exchanged. The first thing to catch my attention inside the ward was the ceiling.

According to local legend, the previous head of department had been a chain-smoking, dirty joke-telling, vodka-imbibing but much admired demigod. His word was law. One day he decided that the department was too noisy and that something had to be done. His solution to "the noise problem" was acoustic insulation.

As I walked into the ward, I looked up to see his creation. Cotton wool and glue had been applied to the whole ceiling of the department in what I imagine was a crude attempt to build an acoustic ceiling. Over the years it had acted as a giant, fluffy cigarette filter, absorbing every puff of smoke in the department, impossible to clean or paint. Apart from the unusual cumulus texture, it caught the eye because of its appalling nicotine discoloration. With the yellow cloud above and benches lined with puffers on either side of me, I made my way to the glass-walled nurses station.

It was an almost unbearable 15 meters. The department was pitifully small and overcrowded. On average, there were four to six patients to a room, and most mornings the rooms were locked so that patients would not sleep their day away.

Immediately, clamoring patients besieged me. One wanted to know who I was and where exactly I lived. He stared into my face at close range as a line of saliva dripped from the corner of his mouth. Another said that he was illegally interned in the hospital; he was sane, and it was the doctors who were cuckoo. A grossly overweight lady with three chins who was dressed in a gaudy floral skirt grabbed my arm. Without warning, she burst out crying. "Doctor!" she wailed, unsuccessfully trying to choke back a flood of tears and get out a few words, her face red and puffy from the sudden catharsis of sentiment. She was swiftly pushed aside by a sour-faced Russian man who barked in a slow bearlike voice, "Enough of that! Stop your wailing. She is always crying, Doctor. Take no notice of her. I need to speak to you urgently. I want you to authorize walks in the garden for me."

It was a relief to escape into the quiet of the nurses station. The intensity of the contact with so many psychotic patients in such a small physical space was overwhelming. The nurses station had a 180-degree view of the department. Within its glassed-in confines, I identified a resuscitation trolley and a drug cupboard, diligently filled with little glass ampoules and symmetrically arranged bottles of brightly colored pills, each labeled neatly. There was even a thoughtfully placed yellow plastic container for the disposal of blood-contaminated needles. The nurses station led to a back staff room, where, out of view of the patients, staff could have a cup of coffee, write up their nursing logs, or page through the newspaper surrounded only by blissful silence. I was momentarily reassured that there was order and sanity and sat down with a sigh.

Without warning, a stony-faced old man started banging loudly and relentlessly on the window. His face was expressionless, and his arms and legs were affected by a coarse tremor, a side effect of chronic exposure to psychotropic medication. The male nurse standing alongside of me, dressed in jeans and a white shirt, had been trying to ignore the rhythmic thumping on the window. Finally he succumbed.

"It's not time yet," he bellowed, without opening the window.

Without batting an eyelid or changing his expressionless stare, the old man turned around and faltered off down the corridor.

"Time for what?" I asked.

"Cigarette time. Every forty-five minutes we hand out cigarettes through the window. The patients aren't allowed to have their own cigarettes or matches. It's too dangerous. We light up for them."
I wondered how a lit cigarette could be less dangerous than a match, but nevertheless my curiosity had been aroused and I waited until 15 minutes before the hour. What I saw took me by surprise.

The toothless septuagenarian momentarily rested her manic outpouring of chatter and activity as she pensively drew in a lungful of smoke and elegantly puffed out small clouds. Mr. Saliva smoked Marlboro without drizzling, and the old, parkinsonian man inhaled deeply, filling every last alveolus in his emphysematous lungs with Time. The Russian, who had no family, was given an Escort, a notoriously coarse, government-issue cigarette issued free of charge to psychiatric patients. In the unspoken language of the ward, smoking Escort symbolized being down and out—having no family or friends that could come to the rescue and buy a pack of smokes for a miserable soul who had run out of luck. With an Escort in hand, the Russian sighed with relief, as if he was no longer alone, even before the nicotine had entered his bloodstream and hit the appropriate receptor. Seemingly oblivious to the lowly status of his tobacco, he waved at me through the glass as if I were an old comrade from the Red Army.

Every sick person wants attention. In the psychotic mist of the overcrowded department, there simply was not enough to divide up among all the hungry. Often the most regular and dependable positive affirmation was cigarette distribution every 45 minutes. It was accompanied by a sympathetic smile, as if to say, “Enjoy your smoke, you poor bugger. You don’t have much else going for you.” It was also a subtle way of rejecting the patient by in effect saying, “All you’re going to get out of me is a cigarette. Don’t expect anything else, and don’t bother me for the next 45 minutes.”

Almost everyone smoked, patients and staff alike. There were positive aspects to the smoking—staff and patients often shared cigarettes or lit up each other’s cigarettes, which resulted in a sense of camaraderie, a type of nonverbal common language. The smoking ritual served to break down interpersonal barriers and diffuse tension. There were times that I felt like a goody two-shoes being a nonsmoker—a squeaky clean crusader sitting on the bench. At other times I craved to light up, to feel the rush of smoke passing through my lungs, to casually toss my smokes onto the table or to offer them around to the doctors and nurses.

It is strange that smoking was so emotionally charged in what was in fact a hospital ward in the mid-nineties, when smoke-free working environments are the norm in most of the Western world. When at a staff meeting I suggested lightheartedly that in view of the dangers of passive smoking, we should put all the patients on nicotine patches, there was great uproar. This was more than a protest against my sense of humor; obviously, psychotic patients on the closed ward are not ideal candidates for a smoking cessation program. The nursing staff was especially opposed to my suggestion. They, perhaps unconsciously, anticipated a release of wholesale aggression every 45 minutes, 18 hours a day, when patients were robbed of their ritual (Pao 1970) and denied their smoke. Possibly they feared that a way of communicating nonverbally with patients would be cut off. Nonverbal channels of communication are important in regressed patients and in most “normal” people when emotions run high, as they almost always do in the closed ward.

The Language of Aggression

A month into my rotation I learned what it felt like to be hit by a patient. A paranoid 110-kilogram lady with evil, dark eyes and whiskers on her chin had “psychogenic polydipsia”: she drank huge quantities of water while simultaneously opening every tap in the bathroom, flooding the department. While she stood ankle deep in water, she would shriek a blood-curdling cry, bringing everyone within 300 meters of the ward running to see what had happened.

On one of these occasions, I asked empathetically “Anna, what’s the matter?” Without warning, Anna struck out viciously, delivering a stinging right to my face. I was so stunned that I did not know how to react. The nursing staff reacted swiftly and rushed to my aid. Within a few minutes Anna was safely tied to a bed with restraints on all four limbs.

Being hit by a person that you are trying to help arouses all sorts of feelings, including anger, helplessness, and frustration. I still remember the burning humiliation and patients’ worried faces as I groped for my glasses. Doctors are supposed to be omnipotent, immune to assault and illness. “Would the doctor, hurt by a patient, want to continuing treating his patients, or would he abandon them?” their eyes asked, correctly reading the “What am I doing in this profession?” that was plastered over my face.

So when I heard that the three-chinned, wailing lady had struck her therapist, I understood how he must have felt. As a “behavioral measure,” her rights to go on escorted walks in the garden were cancelled. One evening soon after, I was summoned to the ward after the three-chinned lady had upturned a table and had again been physically restrained.

Physical restraint is a necessary measure on a closed ward. However, it always involves a degree of force. It is unavoidable that the other patients will look on, horrified. There is an element of humiliation and degradation, even if it is not intentional. With a staff member on each limb,
the patient is laid down on his or her back, legs spread apart, and tied to the metal bed, which in turn is bolted to the floor.

When I arrived at the restraint room, the three-chinned lady was lying on her back, dressed in a pink hospital nightdress, her fat legs ungraciously exposed, with not even a blanket or sheet to cover her. She was crying uncontrollably. Between sobs she explained that she couldn’t take it anymore. There was no room to breathe in the department. She was the only one who did not smoke. No one paid any attention to her. She wanted to go into the exercise yard to get some air and a bit of peace and quiet.

It was not hard to empathize with her. What she was saying was in no way psychotic. When I left the room for 5 minutes, she suggested that a clock be put up in the restraint room, as she had no way of knowing when I would be back (or if I would be back). How true this was. I tried to imagine what it would be like to be tied down, alone in a room and not knowing how much time had passed, to see only the white walls and ceiling—to not know when someone would come and check up on me. In the restraint room, time too was put on hold.

I tried to remind myself that physical restraint is a therapeutic intervention, calming the disturbed psychotic patient and facilitating a forced rest. The patient’s emotion-laden memory, however, was of physical restraint as a nontherapeutic event. Patients would often remember the experience, even years later, as a terrifying and humiliating rejection by powerful transference figures at a time when they were psychologically most unstable. For me, there is no symbol of loneliness more tragic than a patient tied to a cast-iron bed in a whitewashed room, regardless of whether it is a necessary measure or not.

In contrast to the isolation of the restraint room, outside there was always frantic and anxious activity—the type that you find wherever there are too many people stuck in a confined space. There were always people milling about aimlessly or sprawled on the cold floor tiles. There was no recreation room. The dining room, which was really an elongated corridor, served as a multipurpose room, and the television always blared in the corner. If a patient’s behavior was unacceptable or uncontrollable, the doctor on call was summoned to intervene therapeutically.

Physical restraints could be used to knock-out injection. Physical restraints could be used to a sedating tablet or, for very uncooperative patients, a preventive rejection by powerful transference figures at a time when they were psychologically most unstable. For me, there is no symbol of loneliness more tragic than a patient tied to a cast-iron bed in a whitewashed room, regardless of whether it is a necessary measure or not.

A time-out room, had there been one, would have presented a good therapeutic alternative. Telling patients that they should rest in a stimulus-free environment until they feel that their behavior can be controlled allows them to preserve their autonomy and sense of control over their inner and outer worlds. Time-out is a readily understood concept that helps a person to calm down alone and helps avoid open conflict between staff and patient.

As the doctor on call, it was my task to handle the three-chinned lady’s crisis. I explained that I understood how frustrated she must feel and said that I would like to help. I suggested that I give her an anxiolytic tablet and free her from the restraints. She could then go back to her room and sleep it off. She agreed. Within 20 minutes she was sleeping soundly.

What was unexpected, however, was the staff backlash to my freeing the patient from her restraints. The nursing staff’s complaints went straight to the head of department, and the next morning I was promptly summoned to an angry audience.

“Half an hour of restraint is not enough—the patient was still potentially dangerous!” the department head said with contained anger disguised by a thin smile. I protested that the patient was practically anesthetized when I tucked her into bed. I tried to conjure up an image of this overweight, lonely person, who had spent most of her day crying, being a danger. I couldn’t.

“She has to learn her lesson! Half an hour is not punishment for the way that she upturned the department,” insisted the deputy head nurse dryly. The head of department nodded sternly in agreement.

Punishing mental patients is not a new concept (Foucault 1965). Throughout the Middle Ages, psychiatric patients were consistently punished, whipped into shape, confined, interned, banished, and so on in an effort to make them conform to cultural norms. In the late nineties punishment was still part of the way in which staff, unconsciously in my opinion, dealt with their patients’ incessant demands, aggression, and madness.

The staff was always very wary of aggression that might endanger the breast trying to soothe the baby. From their hypervigilance flowered a new concept: “preventive physical restraint.” This is a pasteurized term for tying patients down before they have actually done anything, on the assumption that they are close to physical aggression. The head of department explained that the nursing team spent more time with the patients than the doctors did and could better predict aggressive outbursts. It is in fact notoriously difficult to predict which psychotic patient will explode and when (Fottrell 1981).

The incident with the three-chinned lady created a measure of resentment among the staff. I was perceived as a non–team player and given the cold shoulder. This was characteristic of the way the ward dealt with dilemmas and conflict—splitting and projection, them and us. Staff meetings are the way that most organizations deal with such therapeutic dilemmas and interstaff tension.
On the closed ward, staff meetings were stormy affairs, as might be expected. Curiously, however, they never concluded with any definite decisions! I have never before seen a similar phenomenon, whereby staff are encouraged to ventilate their feelings, week after week, but no conclusions are ever drawn from the debate. This was abreaction in its purest form. Every second staff member was trying to get something off his or her chest, but rarely did it lead anywhere. Perhaps the department heads thought that clear policy decisions might act as an impetus for further disagreement and encourage interstaff divisions and aggression. Alternatively, it may have been an unconscious reflex. Whatever the impetus, very important issues, such as major staff conflicts, were often left suspended in midair.

Eventually this wore me down. Bouts of tension alternated with a gnawing apathetic indifference. I found myself thinking, What difference does it make? A bit of haloperidol to calm the patient and a quick transfer or discharge note. In medical colloquialism, this is referred to as buffing and turfing (Shem 1978); this was my function. Hopefully the patient would not bounce back and be readmitted during my rotation. The apathy penetrated into my bones, dulling my curiosity and enthusiasm.

At team meetings I would look over at the other residents and wonder how they were coping or if I was the only one on autopilot. The oldest resident among us was an introspective woman. She never uttered a word and avoided taking sides, hardly ever voicing an opinion. When the department head criticized or belittled her, she looked down at her feet, unable to open her mouth. Another resident took a more grandiose, hypomanic approach: denying his need for supervision, he maintained total independence by never consulting with others.

I shared an office with a dour middle-aged resident who had been trying to pass his final exams for years. He spent most of his day reading cheap novels and never saw patients except on his way to the ward to make a cup of coffee. For breakfast he brought along a mix of baby cereal that supplemented the snacks he kept in his briefcase. Dr. Morose never left the office except to eat. When I saw patients in the office it would always be with him sitting in the corner breathing heavily (I think he had an adenoid problem). Both the patient and I had to play the game of pretending that we were alone in the room.

My dominant mood while in the closed ward was one of indignation. The smallest injustice was enough to get me going. How could a psychiatrist be expected to see patients while sharing an office with a perspiring, choleric monolith nibbling away next to the pot plant in the corner! I went to speak to the department head. He explained, in the classic psychiatrist mode, that he understood how I was feeling but that there was a space problem on the ward and there simply were not enough rooms for everyone. I knew this was not exactly true, but there was nothing further that I, as a junior resident, could do. Defeated, it took me a month to activate my manic defenses and come up with a contingency strategy. I returned to the department head with a plan to renovate the department by closing off an alcove, thereby gaining two extra rooms! I was politely ushered out of his office just as I had been politely ushered in.

I did not cope with and had no way of dealing with the deep sense of humiliation that I constantly experienced. Instead of feeling, I reacted with a flurry of activity, organizing myself around lists of “things to do.” Deep down, buried beneath the “doing” and the indignation, real feelings started to poke their way through to the surface. I gradually started feeling depressed. I can even pin down the trigger to the whole affair, now that I look back in retrospect on my year in the closed ward: there was an obnoxious patient my own age who was suffering from a drug-induced psychosis.

His parents came from the same small town that my grandparents originally came from. Every week, I would sit for hours with his concerned parents, who reminded me of my own parents. The patient threw every possible spanner into the therapeutic works—he refused to be admitted voluntarily and escaped three times into the adjoining forest, resulting in dramatic police intervention. It took a whole month on haloperidol before he came out of the psychosis, by which time he was virtually frozen by side effects and had a perpetual dribble of spit coming out of the corner of his mouth.

I was trapped between the patient’s psychotic greed and aggression and my loyalty to his parents. Terrible guilt tormented me: the patient was not improving and, worse still, was suffering from the disfiguring side effects of the medication I was giving him. It was as if I had somehow disappointed my own parents. I found myself treating both the patient and his parents and trying to please everyone. This is, of course, an impossible situation. I started to hate work and to hate myself. My personal life was affected. I had sleepless nights. My supervisors irked me, and I seemed to irk them. There were long silences in my supervisions—the hour-long weekly meetings with a senior psychiatrist that were intended for discussing difficult patients. I had no idea what my supervisor expected of me. I tried to please him but to no avail. I secretly fantasized about brushing all the dandruff off his shoulders and pulling his beard sharply. Hardly anything at work was enjoyable.

No one, myself included, saw my depressed side. It was unconsciously translated into a hive of activity. I started a weekly case conference on the ward. I organized a small reference library for residents. I tried to write a
paper on drug-assisted interviews (a paradox within itself). And I typed up signposts for every unmarked door in the corridor. Intellectualizing and rationalizing, I overanalyzed even the simplest issues to death. My desire to bring about change on the ward was without a doubt related to the dejection that I felt inside. Is it a second year resident's task to bring about change in a large institution? Sorting out countertransference feelings, my inner world, and my downcast mood from the reality and depression of the closed ward was my major task as a psychiatric resident.

While I was functioning on autopilot, the most spontaneous and colorful place in the hospital, the visitors room, was right next door to my staid office. Perhaps paradoxical contrasts such as the cacophony of the visitors room with the spartan stiffness of therapists' offices are what make mental hospitals such peculiar institutions.

The Language of Visitors

"Psychiatric" visitors are locked into the dingy, stuffy visitors room, with its one small barred window, two crooked pictures, and noisy wall fan permanently stuck on high. How would I feel in a similar situation, being locked up with my "mad" relative and two other families and their "loony" relatives? Nervous? I would do exactly what my patients' families did—put on a brave face and stuff something into my mouth and the mouths of everyone around me. Denial and oral regression!

Huge quantities of food and tobacco were consumed in that oppressive and dirty visitors room. It could have been a family picnic in better days. Everyone was seemingly impervious to the location of the picnic spot, and with great gusto bottles of cola were brought out and cold cuts and salads were consumed on disposable plates. Within a short amount of time the whole room was filled with smoke, the aroma of garlic, and nervous laughter. When I passed through the visitors room I felt what it was like to be analyzed under the microscope, as half a dozen pairs of astute eyes dissected the "shrink." Sometimes I felt as if I was intruding, and other times I was made to feel like part of the family. Once a buxom aunt visiting felt as if I was intruding, and other times I was made to feel like part of the family. Often a buxom aunt visiting felt as if I was intruding, and other times I was made to feel like part of the family.

The Deficiency of Emotional Investment and the Rescue Fantasy

On the closed ward there was an immediate loss of autonomy. Everything was taken from patients, so that they could not harm themselves or others, and stowed away in a plastic bag. No matches or cigarettes were allowed. Belts were taken away. Patients were advised that if they had any valuables or good clothes that they feared might be lost or stolen, they should be sent home with the family.

Many patients wore the same clothes every day for as long as a week, or they wore the drab hospital garb. People use clothes and jewelry to express their identity. Take clothes and jewelry away, and you are robbing a person's internal being of its fragile wrapping paper. Upon arrival on the ward the patient's outward appearance was often disheveled, as one might expect from a person in crisis, but it was still an expression of that person. After a few days the patient was simply neglected, with many traces of originality missing.

At night when I did my rounds I would see patients sleeping in their clothes and even wearing their shoes. Some patients were afraid that their clothes would be stolen, but most were simply indifferent and apathetic. How should I have reacted to a patient sleeping fully clothed? Should I have encouraged the patient to put on pajamas or called for the nursing staff? I knew from bitter experience that one of my fantasies was that I could, in a fatherly sort of way, save the patient from a pitiless fate— that his or her future was in my hands.

One episode in particular made it clear that I had an unconscious rescue fantasy. I decided that a patient who had been readmitted through the revolving door of the hospital for the third time in as many months should be sent to rehabilitation, if there was to be any chance of saving him. The rehabilitation ward was at another hospital, and the patient had no way of getting there. I decided to take him in my own car, at my own expense.

Only when we arrived back at the closed ward did he tell me about the voice inside his head that commanded him to yank the steering wheel from my hands and crash
the car into the steep ravine that flanked the road to the hospital. I realized how close to disaster I had been. It was just good fortune that he had not acted on his hallucinations. This experience helped to make me more aware of my rescue fantasy, which had blinded me to the depth of the patient's psychosis.

The rescue fantasy coin has a flip side. Instead of a desire to rescue the patient, there is sometimes a deep sense of helplessness and indifference and a desire to get rid of the patient.

We described regressed patients with an adjective peculiar to the closed ward: "clingy." "Clingy" meant that they indiscriminately stuck to anyone, as a piece of chewing gum might stubbornly adhere itself to the first shoe that approached. It is hard to emotionally invest in someone who is clingy, dependent, and pathetic. It is a reflex reaction not to get too close to someone who wants more than you are willing to give.

Robbed of my rescue fantasy and not wanting to get too involved with patients that I perceived as greedy, I found that my thinking had been altered to a short-term wavelength—never going past tomorrow. The moment the department head's car approached the boom gate at 15:00 sharp (he never stayed a moment later than necessary), I took my cue and my car keys.

The problem with both doctors and patients thinking in the short term only is that time tends to catch up with you as apathy and hopelessness accumulate. Both patients and doctors ask themselves, "What is the bare minimum required of me?" It is unfortunate that as the months dragged on, I continued to think this way, avoiding emotional investment in my patients and in the department. Little was expected of me, and I could get by with a minimum of effort. I, like my patients, realized that compliance was the key to getting out.

Getting Out of the Holding Bay

One of my schizophrenia patients was particularly unstable and slow to react to medication. After considerable time and effort, I was finally succeeding in my efforts to reach into his inner world and build a relationship. This was what psychiatry was all about! I felt pleased with the results of my hard work and perseverance.

Without consulting with me, the department head decided that the patient was well enough to be transferred over to the open ward and informed me so post factum. I was indignant! I protested that this decision was rash and possibly damaging therapeutically; it should have been made with my consent, and the patient should have been given time to say his good-byes. Predictably, I was duly invited to the department head's office to be put in my place.

"We are a holding bay," he explained. "This is the closed ward; we cannot do everything. Our job is to stabilize the patients and move them out. Every day we have new admissions."

I think it was the holding bay policy of the ward that ultimately frustrated me the most. It was most unrewarding "stabilizing" patients pharmacologically and then turfing them just as the real therapeutic work had begun, but this was what was expected of me.

Patients too had to learn what the holding bay expected from them. Their mouselike task was to learn how to navigate the maze and get out.

The unwritten rules of the maze were as follows: on admission, patients were "confined to the ward." Only after it was apparent that they would not endanger themselves or others were they allowed "escorted walks" in the garden. If they passed this test, they were allowed to go out into the gardens with an "escorted group" of patients three times a day. Prior to discharge or transfer to the open ward, patients were allowed out of the ward on "limited unsupervised leave," with their only obligation being to report back for meals.

New patients soon realized that their name appeared in a notebook that was updated every day. It was of paramount importance to end up in the correct column. Not infrequently, a patient would badger every doctor in sight to be "put in the group" or to be given a "personal escort" even though only the patient's treating doctor could authorize changes in the patient's getting-out status. The main goal in ward life was to rise in the notebook hierarchy. Many patients, especially the more chronic ones, did not remember their doctor's name. Perhaps this was an indication of how important we residents were to them in the greater scheme of their lives or the number of different doctors that had already treated them through the years. I was often called by a generic name for doctors on the ward, Dr. X, the former head of department. The smoking, drinking, womanizing, fat psychiatrist had become an archetype doctor. Even though he had retired more than 10 years before, his spirit still lived on as the authoritarian paternalistic element split off and projected onto even the youngest and thinnest of doctors.

Names and notebooks aside, there were two ways to be discharged from the closed ward. The younger patients with better social skills soon learned that if they asked often enough, they would be transferred to the open ward. This department was renown for its psychodynamic foundations and extensive work with families. Patients were sent out to rehabilitation programs, a day care program was being developed, and there was a feeling of relative optimism. The chronic, no-hope patients were sent straight home from the closed ward. The open ward rejected them as being too old or handicapped.
If Only the Buildings Could Talk

Adding to the despair was the gross neglect of the facilities. I remember late one night trying to reassure two parents that admitting their psychotic son was the right thing to do and that he was in good hands. Sitting with them in my office, I looked around at the peeling paint, the torn curtains, and the two out of four fluorescent lights that were working. I wondered how much trust they had in me.

Was there a reason that the hospital was crumbling? Funding issues aside, was there some sort of psychological black hole that prevented the maintenance department from maintaining the hospital? The hospital administrator never popped over to the ward to see how things were going. It seemed to me as if the entire administrative staff ignored the clinical function of the hospital—treating psychiatric patients. It was as if the madness, aggression, and hopelessness of the department were safest if they were not dealt with but rather left behind closed doors.

I tried to get the intercom fixed and to have a sign put on the door of the visitors room. This was a lengthy process that involved filling out forms in triplicate, followed by making telephone calls, ambushting the maintenance man in the dining room, and faxing the hospital administrator. Needless to say, the intercom is still broken and the sign that I printed up on my computer out of desperation is still tacked to the door of the visitors room.

No one was ever accepted for rehabilitation straight from the closed psychiatric ward. As a result, many of the chronic “too difficult” patients joined the revolving door of despair, to be discharged and readmitted to the closed ward every 1 to 2 years. Chronic patients learned that the key question to ask was, “Doc, when am I going to continue getting my injections at the clinic?”

There was another group of leftover patients—those neither well enough to advance automatically to the open ward nor chronic enough to be sent straight back to their local community clinic from the closed ward. It was my task as their doctor to buff them up such that they presented an irresistible challenge to the staff of the open ward. Good selling points to emphasize included a family in crisis who were reaching out for help, a patient with overflowing motivation for rehabilitation, a double bind situation of any type, a schizophrenogenic mother, and a relative with clout. There were times that I felt like a salesperson, being false to both my patient and myself. I knew that if my patients were compliant and I was compliant, we would both find our way out of the holding bay.

The library, usually the academic heart of a hospital, was devoid of books and journals! The previous hospital head had transferred every one of them to the safety of his own office. He was worried that doctors would steal the books. This sort of paranoia could only be found in a psychiatric facility! Surely this was not the library of the largest psychiatric hospital in the city, affiliated with one of the most prestigious medical schools in the country? The hospital was an environment of suspicion, disorganization, and neglect—paralleling the real madness behind the closed doors.

Peculiarly, the hospital, like the unconscious, had no sense of past, present, or future—everything was mixed up in a temporal blender. Unlike most other government institutions, the hospital had few clocks. In 1994, when I started at the hospital, letters were still being typed up on an old manual typewriter. In retrospect, I should not have been surprised that I too was “forgotten” on the closed ward by the hospital administrator and served 2 months beyond my required 12 months.

Time passes. I am now a qualified psychiatrist. The three-chinned lady committed suicide. Anna Polydipsia was transferred to a distant hospital. The paranoid patient that wanted to run my car off the road married an equally unstable patient. He never made it to rehabilitation. My odd colleague who shared my office has still not passed his board exams.

In fairness, looking back, I must also state that I learned a tremendous amount about descriptive psychopathology, biological psychiatry, and the management of actively psychotic patients. The department head was willing and encouraged and invested in me. The nursing staff were an overall good-hearted and rowdy lot that cared for their patients within the limitations of the institution. I remember the annual staff barbecue—what a relief it was to see colleagues in an informal setting with a beer in one hand and a hot dog in the other. Dr. B wore his Donald Duck swimsuit, and even the most bitter of the nursing staff smiled warmly, a sharp contrast to the low-oxygen murkiness of the ward.

Still, the memory of a psychotic patient tied by all four limbs to a bed and soaked with urine, being helped to smoke a cigarette by a nurse dressed in white, is still vivid in my mind. A smoke is a smoke, and every patient deserves to have one every 45 minutes.

This article is an attempt to understand the overwhelming emotions and the often existential feelings that work in this holding bay aroused within me. I do not think that the closed ward was planned to be a place for profound psychological change in the residency program, but the intensity of densely compacted emotions...
enclosed within its walls affects every young doctor that passes through.

References


The Author

Tomer Levin, M.B., B.S., completed psychiatry residency training at Eitanim Mental Health Center in Israel and is currently a fellow in consultation-liaison psychiatry at Long Island Jewish Medical Center, New York.