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As Ice Is to Water

Anonymous Three*

Dedication: With special thanks to KK, WE, AB, JDM, JS, and AGK for help with revisions. Dedicated to AS, TM, and GJ, who heard the first several hundred “drafts” of this work. And with special love for AGK, who visited me in the hospital with chocolate.

It is funny how a psychiatric ward looks exactly how you think it would. The off-white walls, thin blankets on hard mattresses, dayroom TV blasting reruns: it is mistakable for neither a hotel nor a prison, but resides in an uncomfortable spot between the two. There are differences. The fear of passing through the locked door, unable to leave, is far closer to prison than any hotel outside of a horror movie. And the emotional upheaval of psychiatric admission may outstrip what even a prisoner feels upon arrival.

There are similarities, too. Lovers behind a “Do Not Disturb” sign, a prisoner in solitary, someone half-dead with craziness: each experience bears little resemblance to stereotypes. Only the appearance of the mental ward is clichéd; the experience of occupying one is as human, earthy and ambiguous as anything. And in all three places, solitude is strangely present and acutely lacking. People often imagine a greater aloneness than truly exists.

In all three places, what others think of the occupants can create both their situation and the outcome of it. Lovers in an illicit tryst, a convict, and a mental patient may find themselves confined not by their own perceptions, but by the judgments of others.

There is another similarity between prisons and mental wards: they can be considered places of punishment, not help. When I entered a locked ward in mid-2008, punishment loomed large in my mind.

To be clear, the confused anxiety that provoked my hospitalization made it difficult for me to distinguish if I was safe. Memories of terrific danger ricocheted through my mind, overwhelming other thoughts—and indeed, this was my mental illness. So when I saw the mental ward as unsafe, this distinguished it little from the rest of the world. But if I feared psychiatric personnel more than others, it was with good cause.

My problem was Post-Traumatic Stress Disorder. When I was 13, the son of one of my pill-popping relatives, choked me until I lost consciousness—attempting, he said, to kill me. (Another relative saved my life, I guess, by wandering past and punching the boy in the head.) Although it stands out for lethal intent, the incident wasn’t the sole act of abuse in my childhood. Family trouble, including physical aggression, was quite common.

When I left my family in my late teens, preferring near-homeless instability, my boyfriend—the first person I ever let love me—forced me into nonconsensual sex. His raping me figuratively replicated extensive, bizarre, sexually degrading verbal abuse from my childhood. Failing to realize that other ways were possible, I regarded life itself as innately excruciating and blamed myself for my own panic and depression. Violence made me mentally ill.

But the immediate antecedent to my hospital admission mostly involved mental health clinicians. Six months before the locked ward, I attended my university’s outpatient psychiatric clinic during final exams. My long-standing anxiety had been worsened by stressful pre-med studies and a verbally abusive boyfriend (“I’m glad you were raped. That’s what you deserve.”) Oddly, the doctor blamed my anxiety on intelligence, saying “All smart people are obsessive!” He prescribed antidepressants.

1,000 miles away during winter break, I found the side effects intolerable. Dizzy and vomiting, I quit the pills—without reaching the doctor, who hadn’t informed me about his own vacation. At a second appointment, the doctor attributed my physical reaction solely to depression itself. His recommendation was to continue trying antidepressants, six weeks per prescription. “You may have

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to try five or six drugs before you find one that works," he advised.

My anxiety grew. Rape and attempted murder meant others wrested control over my body from me, then blamed my discomfort on my "misperception" of events. This doctor, who disregarded my trauma history, replicated this. Just as my family had demanded I accept violence in order to receive ordinary support, this treatment plan mandated that I subject myself to physical misery to find relief from intolerable emotional pain. Thirty more weeks of side effects seemed like the antithesis of relief, but refusing meant I was "noncompliant"—and therefore *I* was the problem, not my illness. I refused further care. I felt safer that way. But this left my anxiety unchecked. Suffering intense panic, I soon landed in the university counseling center.

The counselor was a man I had never met, whose bland friendliness seemed an odd response to my shakiness. In his office, he put his chair between me and the door, cornering me like some abusers had. He pushed me to describe my anxiety's source, ignoring that his intrusive questioning increased my panic. Concluding I'd been victimized, he demanded, "Were you mugged? Were you beaten? Is someone harassing you?" "Just you," I wanted to say between sobs. I remembered how my ex blamed rape on my saying no: "If you don't want me to force you, just go along with it." Although I wanted to stop this interrogation, I feared insisting would somehow make me responsible for the counselor's abuse.

When he asked about rape, I froze, dizzy with fear. He saw it was true and demanded details: how long I stayed with my boyfriend, how many times he raped me, why I didn't leave sooner, if I got pregnant, if I had an abortion. He questioned if, "you're upset because being raped turns you on." He wanted to know why I was gasping "no, no," with fists clenched and eyes overflowing.

He suggested that I should be hospitalized. I refused, seeing this as another punishment—indicating, as his victim-blaming questions did, that my personal response was the only real problem. He called in his supervisor. She cancelled the unjustifiable hospitalization. Abruptly, I found myself on the sidewalk outside, free.

After I walked home, I began planning my suicide. I was too afraid to remain alive. I had no way to seek desperately needed help without receiving the exact opposite. Abuse didn't scare me as much as dead-eyed non-empathy. The doctor and counselor had both made light of my pain. They echoed my family and boyfriend, whose abuse couldn't have been sustained unless trauma was regarded as somehow unreal.

Violence shook me. But what made me suicidal was seeing myself reflected in the funhouse mirrors of others' insane reactions to violence. I felt the need to stay safe by endlessly juggling competing theories of mind, playing to others' prejudices and implicit threats, even while the endless cognitive dissonance made my own mind fall and shatter at my feet. I couldn't possibly grieve honestly while calling my pain a joke, a lie, a nonissue.

I could not trust my mind without obeying its ceaseless announcements of desperate pain. If I couldn't trust my own mind, whom could I trust? If I couldn't say no to abuse without being blamed for it, what could I do to avoid abuse? If harm led to insanity and this led to more harm and more insanity, my life was a downward spiral. Suicide was logical.

I wanted to live. I planned my suicide over long weeks that winter and wept bitterly about dying. Eventually, I phoned a friend who was a therapist—who understood how sick I was and arranged for my hospitalization.

Huddled under a blanket in my bed on the mental ward, I felt terrified and thrilled. I knew I needed help; the hospital represented a possibility to finally get it. But a mental patient is also disenfranchised and isolated by definition—away from the world, I was totally vulnerable. My thoughts ran at high speed: would the doctors blame me, drug me, shock me, kill me? If they did, who would stop them? This place existed only to heal people, and yet I knew people were abused in psychiatric facilities. The stakes felt terrifyingly high.

I was so scared I could say and do little. The doctors struggled to diagnose me from what little I would disclose. The chart read "Psychosis NOS," question mark implied. Perhaps I was schizophrenic. Each morning, the medical team called me into

the ward's shabby conference room. The attending asked questions and then dismissed me with a smooth, cold "thank you." Residents and medical students watched him and I talk, passive, analytical.

The attending was patient but beleaguered. I had the impression that, for him, scientific rationality took great precedence over believing what I said about my own life. But he took my staunch refusal of antidepressants in stride. Later, he handed me the medication package insert for my atypical antipsychotic prescription, calling me "highly intelligent" in front of the medical team. He remained stiff, as though struggling to withhold negative judgments of me. He freely admitted confusion about my diagnosis. I was too wary of his judgment to explain anything.

The weekdays passed, and on Saturday I met the weekend-shift doctor. In the break room, there was just one short, friendly man in a rumpled dress shirt—no medical team. The day was sunny and the ward quiet. Even though I was still scared, I found myself telling the doctor about the abuse.

To my surprise, the doctor said I didn't deserve to be hurt, and I was right to dislike victimization. Then he said I'd get better. I realized this was what I wanted: permission to believe in my own experience, to feel reasonable feelings, to heal. Like a prisoner or a lover in a hotel room, I had imagined a greater aloneness than truly existed. Trapped by others' negative perceptions, I felt liberated by his clarity.

By then, I realized the violence I had anticipated would never come—that the ward was a place of help and security, not harm. I felt much better and had begun asking to go home. By Monday, the seventh day, the doctors agreed, and I walked home through an overwhelmingly vibrant spring.

Getting better took time. The attending treated me for a year. We agreed I would stay on the antipsychotic he had prescribed. I decreased the dose, which he accepted without debate. I was grateful.

At the same time, I was incensed. Because I was an undergraduate, my university created a "mental health contract" for me. I found it painful: the counseling center where the counselor had abused me influenced my care for a full year. Although I

did not attend their services, they could access my confidential records—and expel me if I didn't comply with treatment. I remained terrified and furious about their counselor's behavior. I was afraid of the abuse recurring and my degree being withheld if I resisted it. I believed if I disclosed sensitive information in outpatient counseling at the hospital, the university counseling might find out and humiliate or punish me again.

But I had no choice. For months, I maintained stony silence in therapy. I was simply too angry and afraid to speak—even if counseling itself was the only way to resolve my fear of counseling. I wanted to be left alone. Often, I stood up and left my sessions abruptly.

Hospital records label my belligerence "borderline personality disorder." I thought of it as "bad patient disorder." To me, it meant being required to submit myself to conditions violating my own best interests, and being blamed for my unhappiness about this. I had heard my abusers blame their misdeeds on my faults. The official diagnosis of a rotten personality seemed to confirm this: yes, you disgusting ruined thing, you deserved being raped and nearly killed.

My disorder was that I lacked the courage to believe any longer that I deserved to have my human rights upheld, that violence is unacceptable. The diagnosis was a medicalized way of invalidating my authority over my own life—this time with scientific evidence, not physical threats. The stigma of diagnosis deepened my sickness.

To the doctor, I said little. He provided only prescriptions. Still dry and businesslike, he gave me no trouble, but offered no hope. Realizing his role was to maintain a holding pattern—that the misery underlying my PTSD could be healed only after graduation, when I was free of university counseling altogether—I didn't ask for much. But I took note that it was hope that mattered for my healing.

When I met the Saturday doctor on the ward, I realized that compassion didn't mean indulgence of my disorganization, but rather the space for it to settle into coherency. I needed mental healthcare not to allow me to cope with present symptoms, nor to control me, but to allow me to envision transcending my problems.

I discovered how simple this compassion was. What I lacked were simple, nearly axiomatic truths—things that circumstances, not identity, had made opaque to me. The revelations were banal and profound: nobody deserves rape and abuse is unacceptable. Human rights are for everyone. Being sick doesn't mean you can't get well. Nothing takes away your right to say "no." If the doctor had said as much, I might not have responded. I imagine I would have been confused. But when I was ready to heal, I would have remembered his words. I wish he had said them. I wished for a doctor who had spent more time diagnosing my potential, not my present. I wanted him to use the DSM-IV, but also Goethe, "If we treat people as they are, we make them worse. If we treat people as they ought to be, we help them become what they are capable of becoming."

Eventually, I graduated, dispensed with mental health contracts forever, moved home, and found a psychotherapist and friends who did what the doctor might have done. With time, luck, and intense effort, I healed from the trauma that nearly ended my life.

Trauma is never entirely a thing of the past. But I have few symptoms now, and borderline personality disorder has proven irrelevant. My sense of being controlled by everyone else has inverted itself; I own this life, and no matter what hard luck I've had, the future is mine to make. My only lingering resemblance to a psychiatric inpatient is my knowledge that most circumstances are earthy, ambiguous, and beyond all stereotypes; and that it is often empathy, not identity, that determines how healthy we are.

Not a mental patient, not a prisoner, not an anonymous hotel occupant: these days I'm a graduate student in public health, an aspiring doctor and a deeply lucky woman.

The Power Of Human-To-Human Contact

Viesia Novosielski

When I was twelve, I appreciated my need to be locked up. I was aware of the threat I posed to myself. I accepted that a certain amount of my autonomy needed to be sacrificed in the interest of my own safety. I felt safe in the hospital but that safety came with a price. In 1990–1991 I was hospitalized for a year and a half, first on the children's unit of a private hospital and then the adolescent ward of a state hospital for children. In this article I address those who work to help people with psychological conditions and try to show what helps, and doesn't help.

The cost of safety was that the hospital dehumanized both staff and patients. This ran counter to their efforts to help children because help cannot be dehumanizing. You are trying to help human beings, not pathologies. One way that the hospital dehumanized children was that clinical attitudes, protocols and language facilitated an us-versus-them divide between hospitalized children and the staff. This made the staff who worked with us on a day-to-day basis seem amorphous and interchangeable. They had power and authority, we didn't. Their point of view had validity, ours didn't. Usually we interacted with them and reacted towards them as if their individuality had been submerged into their role as staff. Reflecting back on my hospitalization I realized that you can't dehumanize someone else without dehumanizing yourself. And mutual dehumanization was the unfortunate *modus operandi* in the hospital.

Some staff persons tempered their professional roles with human warmth that was more compassionate for the both of us. I was always happy when a staff person didn't treat me as a walking pathology seething with weird symptoms and bizarre behavioral patterns. It was a pleasure when they treated me as a human and I got to treat them like they were human in return. I treasured those occasions when our encounters and communications transcended our roles and we related to each other as people aware of our shared humanity.