

# YOU THINK YOU KNOW ME

You think you know me  
but you don't  
You think you know how to help me  
but you don't.

*Does he hit you?* You wonder  
I don't want to sound  
like our former president  
but I have to ask  
*What do you mean by "hit"?*  
Because it's true he can be rough  
but it's not like  
he's beaten me to a pulp.

*You have to leave,* you insist  
as if I'm the problem,  
a trespasser  
in my own house.  
Where am I supposed to go?  
To a shelter,  
like some homeless person?

*Plan an escape route,* you urge  
which is ridiculous  
Whoever heard of anybody  
trying to escape from  
the place she's lived her  
entire adult life  
the place her children were born?  
It's not like I'm  
a prisoner, you know.

*It's not your fault,* you say  
But how do you know?  
Have you ever seen me  
when I'm mean-mad,  
when I provoke him  
beyond reason, beyond control?  
You've never seen me  
like that  
and you better hope  
you never will.

*He has no right,* you argue  
and that's true  
It's not like it's in the Constitution  
or anything  
But then *he* says abortion  
isn't really in the Constitution either  
and women still do it  
whenever they want  
for their own selfish reasons  
So who's to say really  
what's a right and what's not?

*Does he hurt the children?* you worry  
and I have to laugh  
As a matter of fact,  
he adores those kids  
He'd do just about anything for them  
as long as they behave themselves  
And he's a very good provider  
he really is.

And when I try to explain  
how that man comes on his  
bended knees to me and is  
*sincerely repentant* and you say  
It's just part of the pattern  
Then I know you'll never understand me  
because when he holds me  
and kisses me  
and tells me he is sorry  
truly sorry

Then at that moment  
I am the most cherished  
woman in the world  
and I am loved  
as I never have been before  
and never will be again  
in all my  
miserable, pathetic life.

Johanna Shapiro

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## COMMENTARY

It was late on a Wednesday afternoon, and I was tired. As a psychologist on the faculty of a department of family medicine, I spend a portion of my time observing residents interviewing patients at a federally qualified community clinic. I sit in a small, windowless room, stuffed with video equipment, and watch and listen. After the encounter, the resident and I talk. Occasionally the resident invites me in to participate in an especially complicated psychosocial interview. My role is to help residents focus on the doctor-patient relationship, hone their communication skills, and remind them of the whole life context that the patient brings to the exam room. Simple.

Mostly it is a privilege to be part of other people's lives, patients and doctors both, at such a raw and intimate level, and I am grateful for the opportunity to do what I do. But it can be frustrating as well. Sometimes—usually—the resident is tired, even exhausted. Always the resident has too many patients and not enough time. Most of our clientele fall 200% or more below the official government poverty line. Many are recent immigrants to this country, usually from Mexico, who do not share a language with their health care providers. Others struggle with alcohol and drug abuse, personality disorders, and homelessness. Many of them are very sick, with multiple medical problems, complicated by factors of poverty and neglect. Often it seems everyone at the clinic—residents, staff, and patients—is operating in survival mode. Under these circumstances, talking about the doctor-patient relationship can seem like a luxury. We know it is not, but it sure can seem that way.

At the end of a long clinic day, it is easy just to want to go home. That day, the resident I was observing had already seen a slew of patients—a woman with diabetes and astonishingly high blood sugars, who could not change her diet because her husband liked the way she cooked; a lady with pain "*en todo el cuerpo*" (all over her body); a snotty-nosed kid in for a well-child check who pulled the blood pressure cuff off the wall; a follow-up with a former heroin user hospitalized for a flare-up of hepatitis C; and a

young man with a laceration he had acquired in the factory where he worked. Finally the last patient for the day arrived, complaining of being tired.

Doctors hate this complaint. Fatigue is not like fever of 101.2 degrees or a broken bone. It is a vague, ambiguous, uncertain symptom, hard to pin down, indicative of nothing at all or of potentially serious, even life-threatening disease. My resident had been on call the night before, and his patient thought *she* was tired! Still, he tried hard with her, as the clock ticked irrevocably toward 5:00 p.m., then 5:30. He probed for symptoms and history of anemia and thyroid disease and scheduled lab-work. He did a conscientious depression screen; and it sounded like the patient was depressed, but it also sounded like there might be something more. At 5:25, the resident knocked on my door and asked me to come into the exam room.

Mrs. Henderson was probably in her mid-30s. She looked a little dirty and rundown, but tough. You could see she had had a hard life. What struck me most when I entered the room was how hostile she seemed. That had not come through the one-way mirror as strongly. While we talked, she kept tapping her wedding band against the edge of the exam table, which produced a little pinging sound. Mrs. Henderson had been married 12 years, and had three kids, the oldest by another man than her current husband. Sometimes she worked as a waitress, but right now she was out of work. Her husband was in construction.

Because of the way she had answered some of the questions during the depression screening, we began to ask about the possibility of domestic violence. All of a sudden it became a very bizarre interview. It was like playing a game of cat-and-mouse, or fencing with a very smart lawyer. We, the resident and I, soon were convinced Mrs. Henderson was being abused by her husband. She, on the other hand, seemed determined to deny it, to justify her husband, and to blame herself. Actually, not an atypical response. But somehow, in the 30 minutes we spent in that room, we could not get through to her. Each question we asked, each suggestion we made met with more animosity, more resentment, more unfriendliness. From the compas-

sionate helpers, we had become the enemy. When she told us a little about her husband, he sounded like a jerk.

Afterward, when Mrs. Henderson had left without giving an inch and a pretty clear intention of not returning to our clinic, I could not stop thinking about her. What had gone so wrong in an interview where ostensibly we did everything right? We nailed the patient's problem, assessed the safety of her children, cautioned her about an exit plan, provided shelter numbers, and even educated the patient about the dysfunctional patterns that characterize many abusive situations. Still, in retrospect, we did not do a good job of understanding this woman, really seeing her as a particular human being with desire and longings. It was late, we were tired, the clinic needed to close, and we were quick to find a category—victim of domestic violence—for her that did not begin to scratch the surface of who this woman was.

Thinking back, we did not listen to Mrs. Henderson nearly carefully or respectfully enough. We did not hear how much security she found in the ramshackle little house she had lived in for 10 years. We did not hear how demeaning she found the whole idea of a shelter to be. We did not appreciate how important it was for her not to see herself as an abused woman. Most of all, we did not begin to understand about the love. And that is probably why Mrs. Henderson left that day in a huff.

When Mrs. Henderson talked about her relationship with her husband, and how much he loved her, we were quick to dismiss her descriptions as “denial” or “the dv cycle.” Of course we were not wrong, just irrelevant. Like I said, Mrs. Henderson had had a hard life. We only caught

glimpses, because we were racing so fast to our tidy conclusion, but in passing, we learned about an emotionally abusive childhood, a time on the streets, her own history of cocaine addiction. If we had stopped to listen, we would have heard a woman who had never had much love in her hardscrabble life, had never been valued or told how precious she was by parents, boyfriends, or lovers. To bask in that feeling of being cherished, no matter how illusory, she was willing to put up with a lot, including a few shoves and bruises. Until we understood that, we would never be able to understand anything about her.

We never saw Mrs. Henderson again. There was not much we could do—patients are lost to follow-up all the time—but I felt I owed her something. All I could give her is this poem. I knew deep down I had wanted to get away from Mrs. Henderson, so the poem is a way of moving closer, rather than farther from, her. Writing the poem in the voice of the patient is a way to say that although too late this time, I am finally listening. It is a way of acknowledging that when all is said and done, Mrs. Henderson was simply a woman as I am a woman; with three children as I have; a woman sometimes afraid of men, as I have been; and a woman who yearned for love, as do we all.

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