Agents, Not Objects: Our Fights to Be

Ronald Bassman
Bureau of Recipient Affairs
New York State Office of Mental Health

People who have been diagnosed and treated for major mental illness have an insider expertise that can provide invaluable insight into the mysteries of people's often inexplicable movement in and out of madness. The author vividly describes his passages from identity-seeking young adult to mental hospital patient to psychologist and mental health system critic. The harmful, life-threatening treatments he experienced are examined as part of our society's propensity to treat people who are different as deviant and relegate them to ineffective and harmful medical interventions. Alternatives to psychiatric hospitalizations are promoted as more positive options for people going through confusing and frightening life-changing experiences. The article concludes with the author's ideas about what is necessary and helpful when working with someone who has been labeled with a major mental illness and what is counterproductive and harmful. © 2000 John Wiley & Sons, Inc. J Clin Psychol/In Session 56: 1395–1411, 2000.

Keywords: shock treatment; psychiatric hospitals; mental illness; therapeutic relationship

Not far from Manhattan, on the New Jersey side of the Hudson River, there's a clearing among the trees and rocks where Alexander Hamilton fought his fatal duel with Aaron Burr. Years earlier I went there with friends to innocently laugh, play, and enjoy the self-centered exuberance of our youth. On those rocks gazing across the river to the New York skyline, I first felt the charge of energy and power which would later tantalize and haunt me in my attempts to understand and control it. After my release from the hospital, I returned to that spot frequently. Sitting on those once familiar rocks and staring off in the distance, I searched and waited for a feeling or memory to infuse my apathetic body with that mystical power the hospital staff had shocked out of me. Both in daylight and at night the results were the same. There was no magic to be recaptured. No opening of the mind and senses, just the dull pain of longing for what once was. Along with so many

Correspondence concerning this article should be addressed to: Ronald Bassman, Ph.D., 13 Arden Craig Drive, Albany, NY 12203.

JCLP/In Session: Psychotherapy in Practice, Vol. 56(11), 1395–1411 (2000)

others praying and worshiping at their public and private shrines, I joined the community of the disappointed and resigned.

It is not philosophy, statistics, or brilliant logical arguments that convince me that the medical model of mental illness is dangerous. Those of us who were able to resist the brainwashing saw no salvation in accepting our illness, nor accepting the need for a lifetime regimen of noxious drugs. Those of us who were able to come out on the other side of our ordeal know that the medicalization of moral and spiritual questions has become a pathology-based model of mental illness that crushes the spirit and attacks our humanity. We are betrayed by a branch of medicine that blatantly violates its most important principle: *Do no harm.*

Ernest Becker in his Pulitzer Prize winning book *The Denial of Death* (1973) wrote, "The only secure truth men have is that which they themselves create and dramatize; to live is to play at the meaning of life" (p. 202). He asks us to consider what are the best illusions to use in guiding our lives, or, how do we legitimatize foolishness? How much freedom, dignity, and hope a given illusion produces remains dependent upon the smaller and larger communities' tolerance for difference. To live outside the agreed-upon illusions is to put yourself in harm's way.

The summer of 1966 marked the end to my years of half-hearted participation in an educational process that appeared to dead-end with a Master's degree in psychology. Graduation was not a commencement, but rather the premature termination of an unresolved developmental task. I had to face the present. No longer could I think or feel that my happiness and self-confidence would magically appear sometime in the future. I was ill-prepared to leave the school womb but I could not continue hiding in graduate sanctuaries.

Was it the angst I felt about my inability to match my construction of myself to what I believed was necessary that prevented me from following the safer, more well-traveled path? Or did it start when I elected myself hero, rescuer, savior of my family? Perhaps the seams and membranes of my psychic coat were sewn from ill-fitting hand-me-down intergenerational materials. Maybe I was too attentive to the wrong cues. Or maybe I was just being too attentive to cues that others ignored. When I denied my sensitivity, I could function, but I was holding back that which was most clearly me. It seemed like I was constantly hiding from others and myself. Once I was good at seeing and feeling, but the cost of unconfirmed intuitions was social awkwardness and distrust of self. I criticized myself for what came naturally, and the voice inside told me that I had better learn to see the way others did.

Gradually creeping into my conscious awareness and growing stronger was a simple but powerful solution to the disturbing identity issues that kept me wondering whether I would ever fit in and be comfortable with people. Too long I had been a prisoner tethered to an empty insubstantial identity constructed and dependent upon others' expressed and imagined expectations. Motivated by unhappiness, desperate for change, I made the fully conscious decision to not care what image I projected to people. I vaguely knew that coupled with the excitement of expansive possibility, there existed the confusion and fear of entering a realm of being that lacked the security of customary anchors. If to not care meant being considered crazy, I accepted it. Shedding the layers and layers of expectations from both within and without, dissolving the clutter, turning opaque lenses into transparent magnifiers was exhilarating. My psyche provided fertile ground for what seemed then to be an innocent insight. For a short while I was able to revel in the richness of an experience where all is new and adventurous possibilities are always present.

As a 22-year-old I had to interpret and attach meaning to a new set of experiences. I chose to see unlimited possibilities. I chose to be outrageous and as a consequence I

would be forced to find answers to questions I had never considered. My dreams and aspirations did not include proving my capability to live independent of the control and monitoring of paid caretakers. Would I struggle throughout my life to undo the decision to throw in the hand I was dealt, reshuffle the deck, and draw new cards? Did I transgress against inviolable rules? Had I crossed some Mason-Dixon line into the land of mental illness and triggered some biochemical process which transformed me into a schizophrenic? Would I ever be able to cross back? What I experienced was no more or less than my fully embracing the singularly human privilege of attempting to change and grow. My inability, my innocence, my lack of training and knowledge about alternative realities made me vulnerable to my own faulty explanations which sent me down false trails and into exaggerated notions of self-importance.

Change is a ghostly mistress: an apparition, tantalizing to the eyes, impossible to hold, frequently too elusive to be verified, but the glowing satisfaction it promises, how could I refuse to surrender to her charms? Vaguely, abstractly, I knew the danger of puncturing the societally determined membrane of acceptable reality and too boldly extolling the virtues of other ways of knowing, but the pursuit of possibility blinded me. I mistakenly thought I was ready for anything. I vowed to never return to the timid life of self-deceits. Freeing myself from the bondage to my fears and inhibitions released a source of energy that was going to lead me into believing I was capable of anything.

I pushed myself to experience all I could. Would sleeplessness help me accelerate the processes that were developing within me? How far could I expand my boundaries and control my bodily functions? I had read of yogis who could slow their heart rate and breathing to the point where they could remain buried for hours, but I overlooked their years of disciplined study and practice. I thought that if I accepted no limits, I would become limitless. I began to believe that I could do whatever I wished with my mind. Watching television became a creative enterprise. It was easy to change the theme or direction of a program. Once decided, the new creation had an unplanned spontaneous energy of its own, as vivid as an eidetic image. Stored memories and images were spontaneously combining into various themes and patterns, with only occasional conscious direction. Initially done just for fun, as I slept less, the images became stronger and I was certain that I had developed a special ability. I wanted to withdraw from the problems of the external world and spend my time enjoying the exciting imagery of my internal life. The adventure and thrill of my mind's creativity released a torrent of energy. The high I felt was self-sustaining. I moved deeper into my internal life, valuing its importance more than the external world. Little attention was paid to my appearance or to social amenities. I let my hair and beard grow long. We who cannot swallow the conventional interpretation of reality, who find the walls closing in and the pressure too painful can at times create tiny spaces of relief for ourselves. Those little cracks offer the opportunity to reconstruct oneself. At any age the ability to alter one's personal universe may be uncovered.

As with most families, mine had fixed pictures and expectations of its members. If one member of the family changes, the disquieting disturbance of the equilibrium reverberates throughout the system and activates the champions of the status quo. My behavior had gone beyond the family's tolerance for eccentricity. Someone had to evaluate how out of control I was and what could be done. My cousin George, a psychologist, arranged for me to see a psychiatrist and thus my introduction into a new world—the world of mental illness.

I looked at my visit to the psychiatrist as a test, an opportunity to vindicate myself and reassure my family. The door to the inner office opened and a woman walked out and hurried past us determined not to look at anyone and perhaps hoping in turn that no one would see her. Sitting there, I felt lonely and isolated; seeing her discomfort triggered

fear. Too late I realized the danger of this impending encounter with a stranger who was about to change the entire trajectory of my life. An overweight, middle-aged man in a poorly fitted, wrinkled suit came out. Quickly looking us over, he extended his hand to George and introduced himself. He nodded to me and motioned for me to enter his office.

I waited across from him and watched as he very slowly, almost ceremoniously lowered himself into the large leather chair behind a massive, fortresslike desk. Like the outer waiting room his inner sanctum was cold and impersonal. I began to sweat. I did not know what to do or say, but I was keenly aware of the need to be cautious. He looked me over; I looked him over. He did not speak; I did not speak. He sucked on a piece of candy; I had no candy and he didn't offer me any of his candy. I was thirsty and nervous. I waited for him to speak. It seemed to be a test of wills. It was not a fair fight or, for that matter, a fair assessment.

I became irritated, then annoyed, and only my anxious awareness of his importance to my future prevented me from giving in and letting out my anger. His bored air and mechanized rote manner of relating to me expressed an undisguised arrogant superiority towards a nonperson. I was an object to be acknowledged, but unworthy of respect. He did not need to attend to the civilities owed to a real person. There was not enough time nor the need for anything more than the face-to-face meeting required for a quick psychiatric evaluation in preparation for commitment. Later I learned that his recommendation was unequivocal: I should be taken to Newark City Hospital to be held until I could be transferred to Fair Oaks Psychiatric Hospital.

When I found out about the psychiatrist's evaluation of me, I was outraged by his audacity. "We never talked," I protested. "That psychiatrist knows nothing about me."

Being in a Psychiatric Hospital

The prodigious effort required to open my eyes made it seem as if my eyelids were glued together. The room was warm, the air heavy and stale. My skin felt clammy, especially my back, buttocks, and legs, which were sticking to what I discovered to be a black mattress covered with thick heavy-duty plastic. I had no idea where I was.

I very slowly became aware of myself and my surroundings. I noticed an aching tiredness when I tried to muster the strength needed to stand up. I stared at the strange room and tried to remember how I got there. My mind yielded nothing but empty spaces, a day or maybe even days were missing. I tried to concentrate, but I could not force back the memory. I was frightened, angry, and confused. I had lost time and events as if they had never occurred. My experience was stolen from me. The unfolding flow of my life story had been interrupted.

Each new discovery increased my alarm. My mouth and throat felt raw. I realized that I was naked and there were no clothes or anything else in the room. I pulled at a door that didn't budge. I looked out the tiny reinforced window in the door, but could see no one within the narrow view it offered. My shouts bounced off the door as if they, too, were unable to leave the room. I walked to the one window which overlooked an enclosed empty courtyard. I ran back to the door and yelled for someone, anyone, to let me out. I kicked and pounded on the door.

Waking stark naked in that tiny room with the black mattress on the floor is how I recall my hospital orientation. The heavy sedation that was forced into me for my transfer from Newark City Hospital to Fair Oaks Hospital left me without any understanding of what was taking place. The confused, frightened vacillation between anger and pleading would seem to be a normal gut reaction, but apparently not to the hospital treatment team. My panic and frantic reactions worsened my prospects of getting someone to listen to me.

The hospital staff did not approve of my behavior and responded quickly. More drug injections would sap my energy and begin my aversive training in passivity and dependency. I lost track of time. Somewhere, that week or the next, I passed the point of being willing and able to force myself to abide by the rules of rationality. I believe if someone had spoken with me before I reached that point, just listened to me and tried to understand without judging or commanding me to change, I could have responded. Compassion, warmth, and understanding are effective. Some respectful conversation, some regard as a worthwhile person, and I believe I would have been able to orient myself. After my initial treatment, I withdrew to a place inside where I was inaccessible. I had begun to be fitted for my new label, schizophrenia, paranoid type.

For the next few months I fought all attempts to get me to change. At my meetings with staff, they focused exclusively on changing my beliefs. They demanded that I acknowledge the irrationality of my beliefs. Each interview became an interrogation. It didn't matter to them what I believed, but rather the relinquishment of my beliefs and an overt demonstration of my submission to their authority were their prerequisites to progress. I persisted in trying to convince them that I was not harming myself or anyone else, that I had the right to explore altered states of consciousness. They called my experiences hallucinations and mocked my explanations and beliefs as delusions. I told them that if they would let me out of the hospital I would be fine, that my biggest and only problem was being held there. They insisted that I was sick and needed to admit it and realize that the drugs they were giving me were my only salvation. I knew that if I gave in, they would rob me of my spirit and I would lose all the power and self-confidence I had recently obtained. The more they challenged my beliefs and experiences with extrasensory perception, precognition, or other extraordinary phenomena, the more emotional and belligerent I became. They taunted me with challenges to demonstrate phenomena their minds were too closed to see. One psychiatrist, whenever he had an audience present, would point to his bald head, and declare what to him was unbeatable logic, "OK, if you have ESP, grow hair on my head." I responded by becoming even more committed to my version of reality and more protective of my power. In order not to give in, I became less available to their reason and logic, and grander in my assertions and beliefs. As the hospital staff increased the dosage of drugs and stepped up their attempts at coercion, I desperately countered by elevating my abilities and identity. What began for me as a simple belief in psychic powers was metamorphosized in the hospital crucible—I was touched by God.

Before too long, the drugs deadened the energy required to sustain anger. Boredom and restlessness were now my constant companions. My thinking and movements slowed down and required tremendous effort. My mind and body seemed to be separate from my will, and my shallow feelings were detached from events.

The drugs made me more compliant and easier to control, but I continued to hang onto my so-designated inappropriate beliefs. That ornery, stubborn refusal to say the right thing was what I could not give up. Looking back I see that self-defeating behavior which got me the most radical and potentially damaging treatments as necessary for me to maintain at least some tiny bit of autonomy and self-respect. Those of us who have managed to recover from our treatments, and whose lived lives have successfully refuted psychiatric predictions of dependent ineptitude, often find ourselves sharing our stories of impractical resistance, useless cries for fairness, and appeals for the return of our rights. Yet our unwillingness to give up the fight to be in charge of our own lives may have been central to the nurturing and survival of those much-needed tiny kernels of hope so essential to keeping our spirit alive.

My lack of positive response to medication and counseling convinced hospital personnel that I required a more powerful psychiatric intervention. The next stop on the patient tour was electroshock and insulin coma treatments. I remember nothing of the electroshock treatments, and only learned of them when I had the opportunity on a future job to look at my personnel file which contained a summary of my hospitalization. Until I looked at that record, I believed that my only shock treatment was insulin comas. Now I realize that I was given electroshocks while I was in the midst of insulin comas. Combined insulin and convulsive therapy had been used so extensively back then in insulin units that insulin coma treatment alone was hardly ever evaluated once electroshock became available.

I was chosen to become a member of the special elite group in the hospital, the insulin treatment group. Psychiatry's magical belief in the benefits, as compared to the potentially life-threatening risks of coma-induced random destruction of brain cells, was held in higher esteem than the magical beliefs of my altered state.

Every morning before breakfast we were marched into the grey, surreal basement of the hospital. Each of us, confined to our respective sterile beds, would receive injections of insulin to put us into comas. Not fully awake yet, it seemed as if we were just going back to sleep. Sometime during the treatment, after losing consciousness, our hands and feet were bound to prevent us from injuring ourselves. Their purposeful destruction of our brain cells was far more acceptable than an accidentally broken bone.

The full fear and terror did not begin until the end of the coma treatment when I was awakened to a semiconscious state. Starting to rouse, I would gradually become aware of the discomfort of laying in a sweat-soaked bed and feeling the initial anxiety turn into panic. Force-fed a sugar solution from what seemed to be a huge bottomless container, I felt like I was drowning in the liquid I was drinking. It was as if I were being pulled from my grave while I was gagging from the fluid that was being forced down my throat. Death seemed to be very near. I felt surrounded by and immersed in death, awake in a nightmare and not sure I was alive. I experienced sensations of falling into a dark hole and, at the same time, feeling someone pulling me back up and pouring and pouring and pouring liquid into me. With absolute certainty I knew that if I didn't do something, if I did not fight, I would die. I felt like I had to choose a side and fight, but which side? I did not know whether life was drinking and awakening, or life was letting myself continue to fall to the bottom of the hole. The choices had a frenzied urgency, but were fuzzily perceived through a thick haze of heavy fatigue.

As I became more awake and tried to move, I felt the straps around my ankles and wrists. Always, my first impulse was to pull and jerk my hands and feet against the restraints. The force of those automatic reactions left my wrists and ankles bruised and sore. I was fighting with all my strength. To my observers the battles were feeble attempts that could be easily managed. A lifetime of tortuous indecision between the poles of cooperation and rebellion, passivity and assertion, acceptance and challenge, were comically diminished in these insubstantial battles. The unalterable fact was that I would only be untied when the liquid in the container was completely drained. The war, the decisions were only waged in my mind. The outcome had already been determined and always mocked me in the same way.

After seven months, the day of my discharge finally arrived. My parents and I were to be interviewed and given instructions by the psychiatrist who was in charge of the 40 insulin coma treatments that were forced upon me. Ironically this same bald man, who found my beliefs so amusing, had appointed himself to be my outpatient therapist. I sank as deeply as I could into my chair knowing full well I had no right to object to anything. During the interview he imperiously outlined the conditions under which he would con-

sent to continue treating me. Along with weekly outpatient sessions to monitor my medication compliance and overall behavior, I was ordered to avoid my old friends because of their potential negative influence. He was emphatic in alerting all of us to the chronic life-long course of my disease and explained how I would have to learn to live with my limitations. If I did become able to work, future employment would have to be in a low-pressure, low-stress job.

My attention focused on making new friends. I was devastated. I was fearful I would not be able to keep my old friends. I was ashamed, embarrassed, stigmatized. My already damaged self-image had plummeted to an unrecognizable depth. The continuous heavy doses of Thorazine, Stelazine, and Artane made me feel like I was walking in slow motion under water with a parched dry mouth. Dull-witted and slow, I was easily fatigued and always tired and sluggish. My memory was shot. I had nothing to offer people. In the poorest physical condition of my life, my ballooning weight had made me appear the clown in too small clothes which no longer fit. To say that I was feeling insecure about re-entering the world was ridiculous understatement. How was I to face my friends? How was I to explain what had become of me? Give up my old friends! I was sure they already had given up on me. How could he expect me to make new friends? I needed all the support and acceptance I could get from my old social network.

Even more disturbing than the orders to give up my old friends was to hear him say that I would never be free of that oppressive hospital's control. To think of returning weekly to reveal any newly emerging hopes to my torturers was too much to swallow despite my quasicomatose intellectual and emotional state. I wondered how this doctor could know so little about me. Did he have no comprehension of the condition I was in when he discharged me?

The hospital staff had trained me well enough to know that I should not say anything there. Later at home, back in the role of dependent child, I asked my mother to let me see someone else for therapy. I was surprised how easily my mother agreed with me. She, too, did not share the hospital's sense of accomplishment when they returned to her the shell of a once-promising son.

I felt little the day I was released from the hospital, only a brief sigh of relief and a heavy awareness of the impending uphill struggle. Society could, at any time, again determine that I was incapable of taking care of myself. In fact, it was expected. I had a special name and label that could never be erased.

Alternatives: A Place to Start

Psychiatric hospitalization may be the most damaging and least effective service that can be provided to a person in crisis (transition). In addition to the iatrogenic, professionally induced effects of psychiatric treatment, the person must overcome despair, anger, learned helplessness, confusion, and shame, all framed against a forced dependency on drugs with severe and noticeable side effects. Attempts at re-entering former roles in school or community would be difficult even if one were fully recovered and simply dealing with the absence resulting from a nonstigmatizing illness.

I was hospitalized twice for a total of 13 month's inpatient treatment—six months in a private hospital and later, the second time, seven months in a public hospital. The first diagnosis was schizophrenia, paranoid type. After my second hospitalization, the diagnosis became schizophrenia, chronic type. More than one confinement in a psychiatric hospital makes it difficult to convince yourself and others that you are not fated to keep repeating this pattern. I have wondered if one or two more stays in the hospital along with another course of psychiatric drugs would have meant a future without my loving wife

and child, instead replaced with the specter of tardive dyskinesia haunting a lonely life of psychiatric dependency.

Admission to a psychiatric facility is a life-defining event that can never be undone. Preventing a person from ever going into the hospital should be the number-one priority when working with people in crisis. Once hospitalized, you are marked with a diagnosis and that label becomes an indelible tattoo burned into your sense of self. You may successfully hide your experiences from others, but you will always have to deal with that shadow.

I am certain I suffered harmful physiological effects from the series of insulin comas that served as the centerpiece of my psychiatric treatment. Some brain damage was inevitable, and along with my memory losses, perhaps some of my abilities were diminished, but the physical losses paled in comparison to the psychic destruction. It has been extremely difficult to regain the innocent optimism and dreams that were so much a part of me. I did not want to believe that unlimited possibilities and idealism were artifacts of youth, destined to disappear with advancing years. To the fortunate they remain vibrantly alive, blossoming rather than succumbing to the aging process. I like to think that it is still a possibility for me. For years I looked at my breaking down and giving into the psychiatric assault as proof of my weakness. In my heart I knew I was never again to be the comic book hero. My myth of invulnerability was punctured. I could be broken under torture. No more dreams of inviolable principles. Worse still was the knowledge that I could be stripped of everything: memory, identity, dreams, ideals, freedom to move or even to think. All this could be brought about with my tormenters feeling self-righteous, and those who cared for me thinking they were acting in my best interests. Never again to see an adventure movie and become that fantasized hero. Would the heroic acts which give dignity to human existence always remain outside my reach? Was my capacity for courageous acts lost forever? Would I regain values and convictions capable of inspiring me to fight for my beliefs?

I could accept the premise that I had been in a confused psychotic state, but I could not forgive the surrender of my will to fight. I envied the lucky people who go through life without ever having their most cherished principles truly tested. I let go of my envy when I realized that the battle I lost was not the final accounting of my courage. I now believe that each person's capacity for courage is measured against their own potential breaking point; each battle presents a new opportunity for heroic action. But until I could recover my dignity, pride, and sense of personal integrity, I could not shake free from the devastating effects of my hospital experiences.

Increasingly, people who have recovered and are recovering from their psychiatric struggles are being recognized for their unique expertise. Those of us who have been through cataclysmic, life-altering experiences are able to provide empathic understanding and serve as models to inspire hope. Consumer/survivors are highly critical of a mental health system that has forced damaging, unwanted treatments upon them. Many consumer/survivors are finding self-help and other forms of peer counseling more understanding, relevant, and helpful in their struggles.

Within the psychiatric survivor movement, people see their psychiatric treatments as direct attacks on their right to choose their own methods and styles for confronting their pain, developmental issues, life problems, self-definition of identity, and the examination of existential and/or spiritual dilemmas. Many believe that their altered states of consciousness were forcibly arrested to the detriment of a transformative process that contained the possibility of positive growth. The mental health professional's lack of tolerance and understanding of the individual's pursuit of the metaphysical, especially when it

occurs outside of established institutions, is a key element underlying distrust and suspicion. John Weir Perry (1974), a psychiatrist who trained with Carl Jung, established in the 1970s an eight-week treatment residence in San Francisco called Diabasis.[1] Perry designed a model of therapy in which persons undergoing a first-time acute psychotic episode could go for eight weeks to live in a supportive milieu where they could safely work through the spiritual, existential components of their transitional states. Staffed by nonprofessionals who were selected on the basis of temperament, he believed:

> The staff would be exposed to all the possibilities of relating to Individuals in altered states of consciousness, and of tolerant attending to nonrational streams of talk and other communication. They would not be indoctrinated in any particular psychological theories, but rather would be encouraged to adopt a general attitude of openness to anything that may come from the Individual's psyche (Perry, 1974, p.154).

Within Diabasis it was essential to assert the primacy of accepting the person's frame of reference and not violating that person's unique way of organizing perceptions of his environment.

The religious and spiritual traditions of diverse cultures provide prescribed rituals and paths for the novitiate in training. Guided by a priest, a rabbi, an elder, a shaman, a mother superior, roshi, or lama, one is supported in his search for self-development. Most traditions recognize the necessity for isolation and make it possible through a pilgrimage, retreat, or vision quest. Physical and/or emotional withdrawal from everyday life purposely heightened by some form of deprivation—silence, fasting, sleeplessness—is startlingly similar to the self-imposed wanderings of those designated as psychotic.

I would be foolishly presumptuous to assert that everyone who steps through the doorway into the unknown has made an active conscious decision to do so. Some emerge from that dark, seemingly endless tunnel bathed in clarity and immersed in a light that calls them into service to others. Others violently break out with shards of confusion, anger, and pain adhering to their being. However, most move in and out of their individually constructed tunnels with inconsistent fluidity and without either extreme being the sole motivating guide to their behavior. Regardless of the complex factors determining one's entrance, coercive drug-reliant psychiatric treatments that masquerade as help destroy hope and generally do not make the tunnels any more tolerable to inhabit, nor easier to exit.

Alternatives to treating people in psychiatric hospitals share the basic principle that a safe homelike, warm, protective setting with small numbers of people will facilitate the interpersonal processes that promote recovery. Listening and trying to understand, accepting a person's experience as valid, and expecting a person to take as much personal responsibility as he or she can are important foundations of programs that attempt to make available alternative services for people facing psychiatric hospitalization. A genuine alternative promotes choice, rejects the power of labels, and resists the inclination to take on the responsibility of fixing people.

After a person is hospitalized, it is easy and natural to spiral downward. The unfamiliar surroundings, the uncertainty as to what will happen next, the probing questions, the cold impersonal interactions with staff can only intensify fear and panic. Being brought to the hospital at night increases your confusion. After being processed through procedures with no explanation or hint of warmth or empathy, the new patient is expected to lay down in an unfamiliar bed and go to sleep. Suppose someone sat and talked with me, told me what to expect the next day, could she have enlisted my cooperation? Could I

[1] Greek for "crossing over."

have avoided the drugging and the disorientation? Would I have been able to avoid seclusion and restraint and the hostile adversarial reactions I felt toward staff?

A person who has passed through a doorway where the world is upside down and inside out, where sounds are smelled and sights are tasted, will be more trusting of those who have had similar experiences. I believe I could have responded to someone who had demonstrated an understanding of the process I was experiencing. I may even have been able to respond positively to someone who was merely interested and respectful of me and my subjective world.

Often, people who have been in a psychiatric hospital will recall one gentle person who reached out with warmth or kindness, who made a human connection. Those isolated, too infrequent acts are fondly remembered by some as small but necessary stepping stones to recovery. They can help reconnect with the self-respect that had been driven into deep underground hiding places. That human contact can penetrate the despair and hopelessness seeping from every crack, crevice, and interaction in psychiatric hospitals.

I believe that it would have taken a rare and very special therapist to connect with me during that exciting, turbulent emotional state. Although there are professionals who are able to work with people going through the disorganization and dissembling of the self, their professional ethics and legal obligations are prohibitive. Few can withstand the pressure to deal with behavior management issues that too often sabotage the trust required for meaningful work to occur. Yet when the key ingredient of trust is missing, people who have been diagnosed and treated for serious mental illness will be difficult to engage in a therapeutic relationship. An extensive study of 500 mental health clients, family members of clients, and mental health care providers in California reported that treatment was avoided due to fear of involuntary hospitalization. The research showed that 55% of the clients who had been at one time involuntarily committed avoided treatment because of their fears of again receiving forced treatment (Campbell & Schraiber, 1989).

Forced treatment is a highly charged issue among consumer/survivors, which often creates divisive splits and acrimony among groups. At a meeting of consumer/survivors and psychologists designed to encourage mutual understanding and lay some foundation for collaboration, to everyone's surprise, common ground was established in confronting the highly contentious issue of forced treatment. The ten consumer/survivor activists and ten psychologists who participated in the Center for Mental Health Services–sponsored meeting adopted the following resolution:

> Involuntary mental health interventions must be viewed as systems failures that indicate needed improvements. Alternative strategies, such as advance directives, mediation and peer supports must be developed and funded to prevent these interventions. Trauma resulting from involuntary interventions must be addressed, including the development of research, policy, planning, staff development and model procedures using the experiential knowledge of consumer/survivors (Consumers and Psychologists in Dialogue, 1998).[2]

For a psychotherapist to be effective during my crisis, he would have had to be able to establish a relationship with my family. First, he would have needed to build within my family enough confidence and trust in his knowledge and ability for them to be able to let go of their need to control me. By informing and educating the family or social context in which a person lives, that troubled person, instead of having to wage daily wars with parents, siblings, spouses, and friends, might find some support, respite, and mutually agreed upon therapy.

[2] The resolution represents the views of the individual consumer/survivors and psychologists who participated, not of any organization.

How different and freeing it would be to work with an individual without the absolute priorities of control and management trumping choice and restricting efforts at collaborative creativity. Working as a therapist you are bound by the context within which you work. As a professional you are held accountable for failure to perceive, reasonably judge, and report indications of dangerous possibilities that have been revealed to you. People who have been incarcerated in a psychiatric hospital have experientially learned about the limits of their real rights and the betrayal of trust. They have also learned not to let the people who have power over them become aware of how much they actually do know.

To effectively relate with someone engaged in working through the disintegration and reorganization of self, the therapist must confront key questions. Who does a psychotherapist work for—her client or society? Will the therapist allow a client to make choices that run counter to his own values? The therapist, forced to accommodate legal and societal demands, faces powerful disincentives to making the therapist-patient relationship the powerful collaboration it can and might be. The exercise of overly restrictive safety requirements prevents the development of real support, guidance, and help. Instead of the opportunity for success and failure, for growth and regression, for a wakeful life and dignified death, the system encourages an infantalized protected life of maintenance and stabilization. The genuine questions then become, how much risk can the therapist tolerate? Does the therapist risk professional and legal censure by engaging in an in-depth exploration of unknown territory?

John Stuart Mill's classic essay *On Liberty* (Mill, 1975), published in 1859, confronted a question that remains unresolved to this day: In a democratic state, how can the individual be protected from the tyranny of the majority? Mills based his essay on one simple principle which stated:

> That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not compelling him, or visiting him with any evil in case he do otherwise. . . . In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign (p. 10).

When combined, force and treatment are antagonistic to the recovery/transformation process. If people perceive a greater freedom to discuss their thoughts and feelings without the threat of incarceration, they are more likely to seek help. In fact, without the safety net of a pseudo-secure locked hospital room and mind-deadening drugs, family and friends may be more successful in their struggle to discover more humane, hope-inspiring ways of supporting people in crises. We can only help people extricate themselves from their encapsulated misery if they trust us enough to let us in.

Hope may soar to unreachable heights or be no more than a speck of light in black on black underground emptiness. The mind thrashes with hurricane force and then capriciously shifts to the detachment of painfully slowed motion. All of the senses are open and amplified. All is dull, colorless, without sound or taste. There is no meaning beyond the random pushes and pulls of unfathomable forces outside your own or anyone else's control. Everything is filled with meaning. Every act, every nuance is a clue. You become absolutely certain that the truth is only as far away as the next sound you hear. Meaning is forced onto chaos. Predictability is constructed to combat the terror of the unexpected.

And when we believe there is no hope, our last bit of identity is in the last act we can control. We might not exercise that last right, but having it keeps the spirit alive. Losing the choice to end one's life kills the spirit. The freedom to explore cannot be abandoned when a person is contemplating suicide.

The people who transform themselves are the very ones who have rejected the system's pronouncements and carved their own way into a new life. The people that I know who have transcended their psychiatric experience are easily recognized by their passion, vitality and appreciation of life. Victors in the fight to find meaning and identity, they are winners by virtue of having engaged in the process of peering deep inside and not being destroyed by what they encountered, but rather having grown.

Psychiatric survivors have come to know firsthand the inadequacy of currently dominant medical ideology and its derived myths:

- Psychiatric drugs are central to the treatment of major mental illness.
- Drug treatment noncompliance is a patient resistance that blocks successful outcome.
- Drug side effects are a small price to pay for symptom reduction.
- Diagnoses are critically important.
- Following practice guidelines developed by expert consensus is quality care.
- Clinicians know what is best for people who are mentally ill.
- The mentally ill need to accept the fact that they are mentally ill.
- Mentally ill people must accept their limitations.
- The mentally ill must down-size their expectations.
- The mentally ill should work at low-stress jobs.
- Thinking and behavior that deviate from societal standards are pathological.
- The mentally ill cannot make "correct" decisions for themselves.
- Symptoms of mental illness are unpleasant and interfere with life skills.
- Progress can begin only after symptoms are under control.
- Psychotherapy is ineffective for people with schizophrenia.
- Counseling must focus on maintenance and stabilization rather than growth.
- If the mentally ill refuse treatment, forced treatment is appropriate.
- Mental illness is life-long and irreversible.
- Complete recovery is rare or nonexistent.

Clinicians and policy-makers need to consider other possibilities. What they see and define as behavior stemming from poor functioning can be recast as arising from a social structure that deprives certain people of the opportunity and resources to allow their real competencies to manifest themselves. An episodic crisis can be reflective of developmental issues and may contain the potential for growth when evaluated within the whole and unique context of that individual's life. Can we be so sure that we know a person's limits?

Psychotherapy with a specially trained, experienced clinician with an advanced degree is generally unavailable to those diagnosed with serious mental illness. Ironically, people who are experiencing what is considered the most severe and debilitating forms of mental disturbance typically receive services from the lowest paid, least educated and trained of the mental health professions' pecking order. Supportive counseling directed at maintenance and stabilization is the most that can be expected unless there are unusual circumstances and substantial financial resources. Even within the confines of supportive therapy, many myths guide what should and should not be part of the process. Grossly overempha-

sized is the importance of accepting your illness before any progress can be made. Often unchallenged is the premise that a person must be stabilized on medication before any form of therapy will be effective. Uncritically accepted is the admonition against using hypnosis, guided imagery, or meditation with certain disorders. The particular and specific sensitivities (i.e., power imbalances, trust) may be poorly understood or overlooked altogether.

Psychotherapy is for many a favored path. But what of the person who is called mad? Is there no psychotherapy that will honor and work within his or her needs? I believe such work is possible, but therapists must first relinquish their reliance on diagnoses and their illusions of predictability. Each person lives a personal and special life story. The relationship is irretrievably diminished when the therapist lumps an individual's evolving narrative into a category. It is not possible to understand when we see through a prism that sorts and matches as if some sort of standard protocol can instruct us on what is right, possible, and best for Schizophrenics; wrong for Multiple Personality Disorders (MPD); and never appropriate when dealing with Borderlines.

A published interview (Borch-Jacobsen, 1997) with psychiatrist Herbert Spiegal illustrates how people are treated as dehumanized objects to be manipulated for their own good:

> If the MPD therapists knew more about hypnosis, their diagnoses would be more accurate. As it is now, they don't even know how they are molding their outcomes. They manipulate both the highly hypnotizable and the psychopath. The "grade fives" are highly gullible, and they just do what they're cued to do, quite innocently. They seem like pure multiples after they're coached. But most of the patients that the MPD experts have in the wards are not highly hypnotizable so what they are actually playing around with are borderlines and psychopaths who enter into the game for different reasons. (p. 61)

For an influential psychiatrist in 1997 to use words like play and games in the context of inpatient psychiatric treatment continues an appalling psychiatric history. Even more alarming is his obvious lack of awareness and sensitivity to an essential criticism (defining and seeing a person only as a function of their name-diagnosis) articulated by consumer/survivors over the last 25 years. Perhaps not surprisingly, in that same interview Spiegal is proud to compare what he does to the nineteenth-century work of Pierre Janet:

> When I have people with transient dissociations where they temporarily lose their sense of identity—which is consistent with a "grade five syndrome"—I put them together. I fuse them right away, just as Pierre Janet did. The point is to help restore a sense of control as soon as possible. (p. 61)

In contrast to Spiegal's approach, I prefer some of the later twentieth-century thinking. Brody (1987) notes that when "we shift our focus to recall the multiple examples of human resilience in reaction to sickness, this idea of fragility disappears to be replaced by a profound respect for the power of individuals to shape their own stories, to give meaning to their illnesses, and to ameliorate their own suffering" (p.188).

Medical ethicist Howard Brody points to important lessons to be learned from the report of an investigator doing research on the families of American soldiers missing in action in Viet Nam and believed to be dead. Attracting the attention of the investigator was a 12-year-old boy who tenaciously clung to the belief that his father was alive. The boy was generally angry, unhappy, and had behavioral and emotional problems in school and with his family.

During a retreat the investigator had the opportunity to go for a walk in the woods with this boy. Together they came to a large dead tree, at the base of which a sapling was growing.

> The boy stopped and stared at the tree for awhile, and the investigator was very surprised when this usually sullen and uncommunicative boy said, "That tree makes me think of my father. You know, I realize now that my father is dead. I think he's that big tree and I'm the sapling. As it dies, the big tree loses its leaves, and that lets the sunlight through so that the sapling can grow." (p.188)

Brody was impressed with the ingenuity of the parable the boy constructed. He had created a metaphor that allowed him to accept his father's death. The boy found meaning in his father's death by relating it back to his own continuing life and growth, and in so doing, he derived a therapeutic benefit for himself. Powerful lessons are demonstrated by this anecdote. A therapist would be unjustifiably self-confident to believe that he knows better than the boy does what is just the right moment for just the right intervention. If a therapist had given the boy the metaphor instead of the boy himself constructing it, the boy would have been deprived of the opportunity to feel the power of his own personal agency. If the investigator makes the metaphor and explains it, the message to the boy is that he is not powerful enough to divine meaning from the events in his life.

What Is a Good Therapist?

What are good therapists—do they take the place of wise uncles, grandfathers, village shamans, country doctors—those figures in the past who had taken on respect by virtue of the lives they led? What follows is what I believe to be essential components of meaningful psychotherapy for people experiencing the kinds of problems that will get them labeled mentally ill:

1. As a therapist not narrowing your view but expanding it so as *to see a whole person* who has a unique history, has many specific skills, and owns many roles. The label paranoid schizophrenic does not tell us that the person is a mother, sister, daughter who is athletic and enjoys playing tennis.
2. Be sensitive to the *uniqueness of the individual and her need to be special,* not just to be regarded like everyone else who comes into your consulting room. Do not mistake the need to fit in with the desire to live in the misty flatland of ordinariness. Does anyone really want to be just like the mythical everybody else? After being beaten down for being different, the first step up may be the wish to blend in, but the larger next steps require more ambitious individual goals.
3. Do all you can as a therapist to *decrease the power imbalance* in the therapeutic relationship. As articulated by an unknown aboriginal woman, "If you're coming to help me, you are wasting your time. But if you have come because your liberation is bound up with mine, let us work together."
4. So often people diagnosed with serious mental illness are treated as if they don't understand that information is being withheld or that they are being told half-truths or out and out lies "for their own good." Ironically, if anything, people have a heightened need and sensitivity to *genuine* interaction, not caretaking protection at the expense of truth.

5. Insights, techniques, and fidelity to favored therapeutic processes are not as important as *modeling* and its connection to *trust* (to be able to walk the talk—your own lifestyle). My most valuable and influential teacher (guide) was a traditional grandmaster in the martial arts. He could demonstrate and do everything that he taught.
6. Working in real *collaboration* means the abdication of the expert role in favor of a shared endeavor to explore and in which each person's unique expertise is utilized interchangeably.
7. The ability to see *possibilities*—to help rediscover the lost plans of discarded dreams.
8. The *expectation of success* is communicated and believed.
9. Enabling the natural development of *motivation* by expanding the possibilities and the practice of active genuine *choice*.
10. Looking at *skills*, *strengths* and *abilities*, not exclusively deficits and symptoms.
11. Clear understanding and communication of the limits of the clinician's personal *boundaries* and *responsibilities*.
12. Understanding the primary importance of *life circumstances*:
    - Health (food, exercise, physical contact, etc.)
    - Home
    - Meaningful work
    - Intimacy
    - Social relationships
    - Replacing mental health system supports with natural community supports
13. *Self-understanding* and *spirituality* as it relates to the person's struggles.
14. *Sociopolitical context* in which one's struggles occur.
15. An open examination of the *mental illness paradigm* and the limits of our current knowledge.
16. Recognition, acceptance, and ability to work with the positive as well as the negative aspects of *strong emotions* such as anger.
17. To explore possibilities for *transformation*, *new identity*, and *meaning*.
18. To be fully present and able to extend the warmth and richness of *real person-to-person contact*.

I would want my therapist to have a life-long hunger for understanding and an awareness of her or his own limitations. Such courage and integrity would enable me to trust him or her. A genuine humility would be evident in the therapist's sensitivity to the delicate process of exploring the psyche. My therapist would be capable of being guided as well as guiding—such role boundaries would be flexible and mutually respectful. She/he would be there to support, nurture, and expand my choices, not her/his own. My therapist would be able to show me through being-in-my-world that I am not isolated, alone, and unworthy. My therapist would be able to convey caring about me as an individual. I would know my therapist cared because I could feel him or her attentively present in our moments together sorting through our painful searching.

The personhood of the psychotherapist and its manifestation in the interpersonal relationship builds the opportunity for positive outcome. The model psychotherapy relationship would aspire to maximize: integrity, equality, warmth, rapport, courage to risk,

trust, respect, openness, genuineness, positive regard, empathy, unconditional love, authenticity, and an abiding belief that the mystery of life contains the seeds of the miraculous.

When you allow yourself to descend into the depths of an altered state, the need for safety becomes less important. The passage through and return from death's threshold as described in near-death experiences cannot help but radically modify one's requirements for safety in the future. I believe that we actively make a decision to let go when we enter a different realm of consciousness. In the time-tested mystical traditions, one's decision is guided and reinforced by a commitment to rigorous preparation. Most of us do not have the determination, clarity of vision, or access to the right guide. Instead we accommodate to our fears and life demands. But for those who must deal with too much fear; who cannot fit into the limited number of paths presented to them; who lack the skills, self-esteem, societally approved competencies; who have been hurt repeatedly; who feel the constant pain of extreme sensitivity; who have not learned how to trust or love, or have never been loved in a way that matched their needs; who see no future and abhor themselves and hate their life story; when critical mass is reached, there is a choice—to forgo safety and risk all. The mental health system is not a facilitator of growth and change if it cannot permit a person to risk his life in an attempt to create a future that is not a continuation of his predictable and horrific past.

Conclusion

Throughout our history people have been fascinated by altered states of consciousness. What is it like to live in a world stripped of others' reality rules? Have people who work in the mental health field learned to intellectualize, rationalize, and train away simple, unaffected natural curiosity about what it is like to be crazy? The wonder of who we are and what we become when the self is no longer anchored to the usual and comprehensible retains its fascination for the lay public. Within all of us are memories of the capacities we possessed as children. Fantasies, imaginary playmates, and all-consuming intensity are learning and emotional coping tools for the developing little person. We who have lived in, out, through, and beyond the experience named psychosis have developed an empathic bond born of having confronted dangers and fears from within and without. It is too easy to ignore the similarities shared by all regardless of where one falls on the societally defined continuum of normal-madness. We all have varying levels of ability to construct inner and outer worlds and we are also capable of being willfully instrumental in determining where the two meet.

In the not-acceptable world models of reality drop-outs, there is little outside reinforcement or approval for an undefined mission which lacks a predictable learning plan or reasonably attainable objective. If you intuitively or subconsciously understand that the very act of living is a transitional change process rather than a stable state, then it becomes more evident that some of us may perceive the electric energy of too many possibilities, while some perceive themselves frozen in exhaustive despair, and yet others concede to living in the currently defined range of normal. As observers we are always outside and therefore can only see, measure, and evaluate a particular person through the lens of the most recent snapshot photo that we now encounter. You are not able to see the unique personal history that an individual construes for herself, nor predict her future. However, the mental health professional's influence on a person's vision of his past and future can open possibilities in the present.

Any form of illness or violation of what we have come to expect our minds and bodies to be has the potential to alter the way we construe our experiences and attempt to integrate them into meaningful narratives. We are all changing, possible, and potential

life stories. Most of us can use and would be grateful for genuine help. The one who helps must support active choice in which the participant actively takes full responsibility for the changes he or she chooses to make. "To do so, however, he must stop ranking either people or talents and accept the fact that there are many roads to truth and no culture has a corner on the path or is better equipped than others to search for it. What is more, no man can tell another how to conduct that search." (Hall, 1976, p. 6) Too many people have been deprived of their rights. Too many people have been prevented from making the false starts and stops so necessary to develop their unique potential talents.

> At every moment you choose yourself. But do you choose *your* self? Body and soul contain a thousand possibilities out of which you can build many *I*'s. But in only one of them is there a congruence of the elector and the elected. Only one—which you will never find until you have excluded all those superficial and fleeting possibilities of being and doing with which you toy, out of curiosity or wonder or greed, and which hinder you from casting anchor in the experience of the mystery of life, and the consciousness of the talent entrusted to you which is your *I*. (Hammarskjold, 1964, p. 19)

Hope, safe niches, natural supports, reconciliation with family, the absence of irreversible damage from treatment, self-discipline (development of will), belief in oneself, successful experiences, a friend's provision of reasonable accommodations before it became an ADA mandate, meaningful work, psychotherapy, intimate relationships, and, perhaps most of all, the successful passage of time not needing services from mental health professionals (remaining out of the hospital) were all significant in my movement out of the mental illness role into becoming a valued member of society. The varied combinations and relative importance of each of the above elements were unique to me, yet I believe that the above identified concepts are common to others' transformations. But each of us defies set formulas. For all of us, the timing and options are different. Underlying all of the above is the question of whether a person has the freedom to choose. Without risk, without choice, the whole process is perverted into, at best, stabilization and maintenance, and, at its worst, incarceration.

I do not demand that my journey become the preferred path for everyone. But I do demand that people have the opportunity to discover what they can be and do. As long as I can search for meaning and occasionally get parts of answers, I can live and die without clinging to some false certainty that makes me think and act as if I know the absolute truth.

Select References/Recommended Readings

Becker, E. (1973). Denial of death. New York: Free Press.

Borch-Jacobsen, M. (1997). Sybil—The making of a disease: An interview with psychiatrist Herbert Speigal. New York Review of Books, April 24, 1997, 60–65.

Brody, H. (1987). Stories of illness. New Haven and London: Yale University Press.

Campbell, J., & Schraiber, R. (1989). The well-being project: Mental health clients speak for themselves. (Available from The California Network of Mental Health Clients, 1722 J Street, Suite 324, Sacramento, CA 95814)

Hall, E.T. (1976). Beyond culture. New York: Anchor Press Doubleday.

Hammarskjold, D. (1971). Markings. New York: Alfred A. Knopf.

Mill, J.S. (1975). On liberty. In D. Spitz (Ed.), On liberty: Annotated text sources and background criticism (pp. 1–106). New York and London: W.W. Norton.

Perry, J.W. (1974). The Far Side of Madness. Dallas, TX: Spring Publications.