

Identifying and Overcoming Mentalism

Coni Kalinowski, M.D.

and Pat Risser

InforMed Health Publishing & Training

Mentalism is a term coined by author and activist Judi Chamberlain to describe discrimination against people who have received psychiatric treatment (1). Like other "isms," such as racism and sexism, mentalism is characterized by complex social inequities of power that result in the pervasive mistreatment of people who have been labeled "mentally ill." Some of this mistreatment is blatant, such as being stripped and locked in a cold room or being beaten during physical restraint. However, like all discrimination, mentalism is even more commonly expressed in the multiple, small insults and indignities that the labeled person suffers every day. Dr. Chester Pierce, an African-American psychiatrist and author writing about racism, termed these small attacks "micro-aggressions" (2).

Individual micro-aggressions tend not to be powerful in themselves. To understand their impact upon people, one must consider that the person is subjected to hundreds or even thousands of these denigrating, disrespectful communications each day over years. These micro-aggressions have a cumulative effect. In the US, we are constantly surrounded by derogatory language regarding psychiatric problems ("He's a basket case." "You're nuts." "What a loony tune."), negative stereotypes about anyone who seeks mental health services, hostility ("They need to be locked up."), and sensationalistic media stories depicting people as crazed killers and "dangerous mental patients".

Over time most people cannot help but be affected by this barrage of abuse. Many people who have experienced psychiatric treatment internalize these negative attitudes and begin to feel badly about themselves (3,4,5). People may feel ashamed or blame themselves

for their difficulties, feel worthless and hopeless about their futures, or lose confidence in their abilities. Often, people find that they must hide their histories, and live in fear of losing their job, their friends, or their credibility. These reactions to discrimination can become devastating to people as they begin to direct more and more of their anger and helplessness back at themselves.

Unfortunately, in the field of mental health, we rarely recognize or acknowledge the power of mentalism. Instead, the person who is demoralized by his or her treatment as a "mental patient" is more likely to be re-diagnosed, labeled "treatment resistant," or offered more medication. A mental health professional will rarely address the issue of discrimination as a focus of services, and often, we are more likely to contribute to the problem than to help.

Those of us who provide mental health services are certainly not free from the influence of mentalism. Offensive and injurious practices are integrated into everyday clinical procedures to the point where we no longer recognize them as discrimination and find it strange that anyone should question our approach. Yet these unintentional micro- and macro-aggressions are no less damaging to the people we serve. We are also subject to the influences of mentalism in the sense that if we try to change our mentalist attitudes or those of our fellow practitioners we may find that we are questioned, challenged, spurned and even disdained.

It is always unpleasant to discover that we have been acting to oppress others. It is equally uncomfortable to consider relinquishing power to others. However, if we truly want to help people to recover and heal, we must address the impact of mentalism upon their health and well-being. We need to do everything possible to eliminate mentalist practices from our services. To truly combat mentalism we must move beyond superfluous changes that make us sound politically correct. We need to earnestly challenge our own assumptions and attitudes in order to personally recover from the prejudices we have learned.

Us vs. Them

Mentalism, like all the "isms," separates people into a power-up group and a power-down group. In the case of mentalism, the power-up group is assumed to be "normal," healthy, reliable, and capable. The power-down group, composed of people who have received psychiatric treatment, is assumed to be sick, disabled, crazy, unpredictable, and violent. This black-and-white style of thinking is referred to in psychodynamic literature as "splitting."

Splitting paves the way to establish a lower standard of service to the power-down group. An apartment that is too run down for "us" is good enough for "them." Side effects that "we" would never tolerate should not interfere with "their" compliance. Medication risks that "we" find unacceptable are reasonable for "them." "We" need credit cards to extend our salaries, but "they" need to budget their social security income to the penny. The assumptions of mentalism are further recruited to justify these inequities, as for example, "forcing 'them' to take medications that cause tardive dyskinesia is necessary because 'they' are sick and 'we' are not." Mentalism, like racism, is also used to justify violence. If "we" were jumped upon by a group of people, taken down and forcibly injected with powerful medications, then locked up and tied down in isolation, it would be considered assault and battery, kidnapping, or torture. If we do this to "them" in a hospital, it is "treatment" for their own good.

Mentalist splitting also allows the power-up group to judge and reframe human behaviors in accord with the power dynamic. The behaviors of the power-down group are framed in pathological terms while the same behaviors are excused or even valued in members of the power-up group. For example, a psychiatrist colleague who threw abusive tantrums at nursing staff was seen as "authoritarian" and "running a tight ship" while people receiving care on the same unit were forcibly medicated and secluded for the same "inappropriate" behavior.

Of course, we all know from personal experience that most people don't fit into either of the artificial extremes created by splitting. Most of us have good and bad periods in our lives, times of good and bad judgment, strengths and weaknesses, and periods of distress and of health. Rather than acknowledging that splitting is a distortion of reality, mentalist thinking has led people to establish a category that we would call "almost us": *"high-functioning."*

The "high-functioning patient" is generally a person who is just like "us" in every way except one - his or her psychiatric label. The power-up group can feel gratified that they have recognized the person's contributions by acknowledging that the person isn't "just one of them," yet the person retains his/her cautionary label and all the negative stereotypes that go with it. Other individuals are given the designation *"low-functioning"* which clearly conveys the perception that the person does not make valuable contributions and is considered to be of lower worth to the community (6). At times the "low functioning" label can be used punitively to describe a consumer who challenges the power of the staff.

"About twenty years ago, I'd been hospitalized several times for suicide attempts. My initial diagnosis was schizophrenia but, that changed each time I saw a different doc or therapist. The diagnosis also changed depending upon what the insurance companies were likely to pay for at any given time. I'd taken and tried most of the psychiatric drugs available at the time. I'd been in and out of day treatment several times.

The day treatment I was in at the time was changing. They were going to create two new levels. One level would be for the "high functioning" and the other would be a longer term, more elementary program for the more hopeless cases who were designated "low functioning." I fell into the latter group because I had the audacity to challenge one of the therapists.

Of course, in every hospital and in every treatment program in which I'd participated, there was the same old worn out standard fare. They would have groups which included stress management, assertiveness, recreational therapy (RT) also known as play time and of course, occupational therapy (OT) which is another name for ceramics and other useless arts and crafts sorts of activities.

One day, I'd grown bored with hearing the same thing repeated in eight week cycles and so, as assertiveness group was beginning, I challenged the therapist. I claimed that I could run the group as well or better than they could. Naturally, this upset the poor fellow and in his flabbergasted state, he accepted my challenge. He haughtily assumed that I'd fail miserably and thereby be set in my proper place.

I approached the front of the room with confidence and calmly proceeded to articulate a method of understand assertiveness which was far in advance of that which he was going to teach. Flustered, he got up in a huff and left the room to the cheers of the dozen or so of my fellow compatriots who were present.

From that day forth, I was known as "treatment resistant" and "low functioning" among the treatment staff but, I was elevated to a sort of informal "senior client" status amongst my friends." -P.R.

Labeling someone as either high-functioning or low-functioning has no healing impact upon the person in distress and in fact, can have quite the opposite effect. It can cause them to feel more hopeless and helpless and thus iatrogenically more distressed than before being labeled in this pejorative way. The cumulative effects of this sort of micro-aggression can even cost lives.

"Unbeknown to the staff, we clients talk a lot. We talked before groups, we talked after groups, we talked before day treatment, we talked after day treatment, we talked during lunch. One friend named Mark had a drinking problem. He was also on some very heavy duty neuroleptic drugs. Using all the "senior client" influence I could muster I warned Mark of the dangers of doing both the drugs and alcohol. With the added influence of the others in the program, Mark stopped drinking.

Staff had their own impression of Mark. Mark was bored with day treatment. He'd sit in the back of the room with his arms folded across his chest and never say a word. He was labeled "low functioning" also.

After he stopped drinking, Mark was very alive and animated among us mental patients. He'd come in every day and boast that he had gone another day without a beer. Mark was especially eager to let us know on Monday's that he'd managed to go a whole weekend without a drink. We were very proud of Mark. We saw his great sense of humor and his enthusiasm for life. Staff on the other hand saw none of this. All they saw was the same old Mark, sitting in the back of the room with his arms folded across his chest.

At my weekly appointment with my therapist, I was told of a brand new program to train consumers to work as case manager aides. She asked if I was interested. I could barely contain my exuberance. Of course I was interested. I'd be interested in anything to get me out of the drudgery of day treatment. The next day, I applied and was accepted to this revolutionary program. It was the first of it's kind in the country. I leapt into the program with all the enthusiasm I could muster. I'd never look back at the day treatment program. HARUMPH! Call me "low functioning" would they? I'd show them!

Toward the end of the eight week training program, I got a call from a friend in the day treatment program. They informed me that Mark was dead. I asked what happened.

It seemed that Mark got despondent about being placed in the "low functioning" group and started to drink again. He grew more and more desperate. He went to the staff and asked for help. He begged them to intervene. They just sort of chuckled at him. They hadn't seen him get better without the booze and they hadn't seen his deterioration when he returned to drinking. All they saw and knew of Mark was that he sat in the groups, in the back of the room, with his arms folded across his chest, in silence.

Mark had tried desperately to get ahold of me in his final week of life. He felt that because I'd once stood up to the staff, I could make them listen to his pleas for help. Finally, in one last act of desperation, he went home, downed a twelve pack and pulled the trigger, blowing his brains out.

I was devastated. I felt consumed with anger at the staff. I wanted to grab them all by the throat and shake some sense into them. But, with time, my anger changed. I also grew angry with the other clients. Why hadn't they spoken up for Mark? For that matter, why couldn't Mark speak up loudly enough for himself? Mark's parents just wanted more drugs for Mark. They didn't understand either.

Finally, it became clearer to me. I was disgusted with what I witnessed in day treatment. I saw folks who'd been there for many years and the system called them a "success" because they had learned to comply with taking the drugs and hadn't been in the hospital recently. What I saw were soul-dead folks who did nothing but smoke cigarettes and drink coffee all day. I figured I could do better so I built drop-in centers. Folks came to the drop-in centers and guess what? They did nothing but smoke cigarettes and drink coffee. The problem was that they had been brainwashed into a dependent state of helplessness. I knew that the problems ran deeper than just getting folks away from the professionals. I knew that I must work to help clients have their own voice. Not just some weak squeaky whimper but a strong and loud and clear voice. This was my first tentative awareness of micro-oppressors and the life and death consequences of those oppressions and that the true struggle lay in helping my fellow mental patients to overcome this brainwashing." -P.R.

A simple rule of thumb that can be used to identify and combat splitting in ourselves is to evaluate clinical practice as if we are the recipient. For example, we might ask ourselves if we would live in a certain place, take a medication, put up with a risk or side effect, go to a group, or want to be talked about in a given manner. If the answer is "No, but..." followed by any sort of justification, you have identified mentalism in practice.

It is difficult to generate genuine empathy for another person in the presence of splitting, as the splitting dynamic itself causes us to view the other person as entirely apart from and unlike ourselves. Seemingly empathic statements such as "If I were in his shoes..." often obfuscate the underlying mentalist assumption that results from splitting: "but of course, I never will be." Such statements give the appearance that the provider is actively trying to understand the perspective of the other person but, in reality, they often function to reinforce perceptions that the other person is different, defective, or deviant. Often it is subtly implied that the person has brought her difficulties on herself, or that the person has chosen to affect disability and could choose to "snap out of it." It further implies that the competent provider would exert better judgment in the recipient's situation and would therefore escape the difficulties facing the recipient.

The overall effect is that the seemingly empathic statement becomes a validation of the superiority of the provider and can then be used to justify inequities of power and the oppressive practices that result. Because "being in the recipient's shoes" is seen as a purely hypothetical situation, the provider can justify giving it little serious introspective

consideration and draw broad conclusions with little attention to logic. A clear example of this is the provider who asserts, "If I were homeless and mentally ill, I would want to be medicated involuntarily" as a justification for outpatient commitment for others. Rarely do these individuals have advance directives for themselves stating this preference, as they would if their comment was made in earnest. They clearly see homelessness and psychiatric disability as unlikely to occur in their lives and have, therefore, not seriously considered the complex social and personal barriers that they might face in that situation. Their pseudo-empathy becomes a platform for promoting social control rather than any true understanding of people's difficulties and needs. It also reinforces the power differential between provider and consumer; the provider's *imagined* experience of homelessness and psychiatric disability is given more credibility than the consumer's actual experience with these challenges.

Ideally, we should treat people as we would want to be treated, with respect, dignity, and concern. We should listen to people and provide services based upon their expressed interests instead of judging them and acting in what we (perhaps falsely) believe to be their best interests. We should never refer people to any service or resource that we would not use ourselves, or subject anyone to treatment that we would not welcome for ourselves. This is a lofty goal in a society that continues to provide inadequate public supports and resources for people's basic needs. Undoubtedly most clinicians will find themselves in the position of making less-than-optimal referrals. Even in the face of these difficulties, we can communicate concern for the comfort and preferences of the person we are serving, and affirm the person's deservedness of a better life. It is very important that we not convey the impression that people must accept substandard treatment, or should be grateful for whatever they are given. We need to express hope that the person will achieve the quality of life that s/he desires and offer assistance to help the person to improve his or her circumstances. We also need to encourage people to hope and dream. Too often, we tell people what they can't do and thus, we rob them of the ability to hope. Instead, we need to help people to find within themselves both the ability to dream and the belief that those dreams can become

possible. We can communicate caring and respect by retaining a vision of people's strengths and value even during the bad times, and encouraging them always to draw upon their better qualities and abilities.

Distinguishing What We Think From What We Know

For the most part, humans tend to believe they know a lot more than they actually do. Most of what we think we know is actually belief in a model or an approximation, and very often these models prove to be false. Consider, for example, the people who reviled Semmelweis and Pasteur because they *knew* that microbes could not exist, or the Inquisitors who punished Galileo for believing in anti-scriptural Copernicanism that stated that the sun was the center of the solar system and that the planets revolved around the sun. Like them, we can expect that most of what we have learned in professional training will similarly be replaced by different models and new information.

New learning is further complicated by the length of time that transpires between research and implementation. Unfortunately, in the human services realm, that length of time is very long, on the order of ten or more years. So, while research has confirmed the benefits of consumer choice in the healing process, professionals generally continue to provide services that focus on conformity and compliance. Due to this lag between research and practice, people using services will not have the benefit of contemporary approaches that address the effects of mentalism for many years and practitioners will continue to implement services that are already outmoded and are frequently injurious.

For these reasons, we must develop a deep appreciation for how much we don't know, and approach our work with commensurate humility. If we are honest, we must admit that we don't know why people have the experiences that are labeled "psychiatric" or whether these are actually illnesses. We don't know how medications affect people. We don't know

how neurochemistry relates to human feeling and behavior. We don't know how people recover and heal.

This is not to say that mental health professionals have nothing to offer people. We have useful information, resources, and various treatment approaches. We can also offer the one thing that consumers identify as an essential factor in recovery: a supportive, respectful, genuine helping relationship.

"In all the times I was hospitalized, both voluntarily and involuntarily, I never received any help through the drugs, the seclusion, the restraints, the impersonal structure of the day, the "milieu," the worn out tired old "same 'ole, same 'ole" groups or any of the other staff imposed routine. The ONLY thing that ever helped me was face-to-face, person-to-person contact with caring individuals. Only rarely did any staff person ever even attempt to make that sort of connection. More often than not, those caring individuals were my fellow patients. Those caring connections were literally what kept me sane in insane places and were the only thing that produced any healing effect. It's why I went on to form effective self-help groups outside of the hospital. I realized that the healing benefits come from other people and not within the structure of the institutions." -P.R.

Mentalist thinking often causes us to lose sight of the gaping holes in our knowledge and to underestimate our limitations. We begin to believe that we have sound scientific answers for people's problems and that the treatment we recommend is "right." Failure to recognize the limits of our knowledge can lead us to act prematurely and restrictively. We tend to interpret behavior when we should inquire about its meaning, and prescribe interventions when we should listen and learn.

"I used to sit under a bridge and bang the back of my head on the concrete until the back of my head was a bloody mess. The typical mental health worker would, upon observing this, panic and forcibly intervene. This intervention would be predicated upon the belief that I was too "out of it" to know what I was doing. However, both my personal experience and that of most mental health consumers I've talked with cause me to believe that even though we may appear to be "out of it," we are still connected on some level. I KNEW I was banging my head and could have even talked with someone about that fact if anyone had taken the time to attempt to communicate with me. A good friend, sums this up by saying, "just because I'm banging my head on a table doesn't mean I don't know that I'm banging my head on a table." Most professionals won't listen to us and learn that even in our worst "psychotic state" they could still connect with that part of us which still has a level of awareness if they'd only try. It seems easier for them to just assume we're totally "out of it" and to impose their will forcibly upon us in the name of help." -P.R.

Typically, when treatments are ineffective or unacceptable, the recipient is blamed. He or she is "treatment-resistant," "uncooperative," "non-compliant," or "characterologic" and has therefore failed the provider rather than the other way around. S/he may even be pressured, threatened, or coerced to accept the treatment, despite the fact that it has already proven to be inadequate. This is particularly common in the case of the person who refuses a psychotropic medication due to side effects; clinicians often insist upon "compliance" despite the person's experience of physical discomfort, neurological impairment, or other evidence that the treatment is not effective.

To combat this mentalist prejudice, we need to modify our assumptions and approach people in a manner that acknowledges the imperfections of our tools. The recipient's lack of response or objections to the treatment must be assumed to be reasonable and credible. When treatment fails, *it is **always** due to the shortcomings of the treatment.* These short-comings may include inadequate understanding of the person or his/her problems, medication side effects, poor match between the treatment and the person's lifestyle, stigma associated with the treatment, difficulty with access, cultural unacceptability or many other issues. It is the clinician's responsibility to initiate the response to treatment failure in a collaborative manner by talking with the person receiving the service. These discussions should examine the difficulties with the treatment and explore ways that it can be modified to better fit with the person's needs.

Mentalism in Language

Mentalism is eloquently expressed in the jargon of mental health, which directly reflects the power difference that exists between the "power-up" and the "power-down" groups. Changing our language alone will certainly make us less offensive to others and give the appearance of being politically correct. However, to truly address the issue of prejudice

and have an impact on our participation in discrimination, it becomes necessary to look at the attitudes and assumptions underlying the words.

The language that has become politically charged in mental health includes terms that communicate condescension, blame, and the perception of labeled people as defective. Many offensive terms are obvious - basket case, loony tune, etc. The offensive aspects of seemingly professional terminology are often more subtle. How these terms are used from an interpersonal or systemic standpoint is generally more important than their overt meaning. Interestingly, mental health professionals often object that they "need" these words to communicate psychiatric concepts. Yet most of the offensive terminology is non-medical and non-specific, and could easily be expressed in a more accurate, less offensive manner.

A good example is the term *decompensate* which is used colloquially to indicate that a person is having more distress. It does not refer to a specific clinical finding, spectrum of symptoms, or event, so that the clinician who is referred a person who "decompensated" knows nothing about the person's needs or history. Interpersonally, the term is generally used to designate someone who is defective and fragile, who cannot take care of him- or herself, and who cannot tolerate stress and therefore falls apart. "Decompensating" is an us-them term; under stress "we" may not do well; "we" may cocoon, take to bed, get bummed out, get burned out, get a short fuse, throw plates, scream, call in sick, or need a leave of absence. "They" *decompensate*. Occasionally, the term is used with an overtone of superiority that is clearly intended to convey the power difference between the "competent professional" and the "sick client." Both activists and clinicians have suggested that people abandon this term in favor of describing, briefly but accurately, what the person is experiencing. For example, "After the break-up with her girlfriend, Mary couldn't sleep. She started pacing at night and complained of hearing voices." This brief statement factually describes Mary's experience and gives meaningful information that begins to suggest interventions that may be helpful.

Many activists have noted that part of the demotion from "us" to "them" is a loss of one's designation as a person. One is suddenly no longer a person with a diagnosis, but "a schizophrenic" or "a bipolar." People who have internalized this dehumanizing labeling process will even at times introduce themselves as "a mental patient" or "a CMI" ("chronically mentally ill") rather than introducing themselves by name. Professionals who are entrenched in this terminology will often counter that this is no different than referring to a person as "a diabetic." However, it is important to factor in the reality that medical illnesses are not associated with the negative assumptions and prejudices that are inferred from a psychiatric label. A "diabetic" is not assumed to be violent, unpredictable, or incompetent.

The dehumanizing aspects of psychiatric diagnosis combined with the traumatic experiences that many people have had under psychiatric treatment have caused people to associate the term "patient" with discrimination, coercion, and oppression (7, 8). Unlike the patients of a dentist, optometrist, or gynecologist, the psychiatric "patient" is often forced to have treatment, incarcerated against his or her will, and stigmatized for life. In activist circles, the term applied to a person who has received psychiatric treatment has become a very personal choice that reflects the individual's experiences, feelings, and identity. Individuals may choose to refer to themselves as ex-patients, survivors, consumers, or clients, or they may refuse a designation altogether. Civil rights-oriented groups often refer to "consumers/survivors/ex-patients," while the designation "client" remains the most common and generally accepted term in public mental health systems.

Many people in the medical community have been overtly resistant to changing their terminology, and equally resistant to considering the trauma that underlies the movement for change. Psychiatrists and nurses seem particularly unwilling to examine the cruelty and betrayal experienced by the people who have been mandated to psychiatric care. Most individuals who have had a long-standing psychiatric disability can recall forced ECT without anesthesia, physical or sexual abuse by staff, being taunted or humiliated, being

shackled to a bed, involuntary lobotomy, or being subjected to painful "behavior therapy." A colleague of the authors even reported that he remembered being herded into a mass shower with a cattle prod while he was a patient at the state hospital. Efforts to protect the rights of individuals have eliminated some, but certainly not all, of these injurious practices. It is the pain and the fear generated by these experiences that underlies the movement to find new terms and concepts. It is hoped that a change in language will contribute to a change in assumptions and attitudes that will in turn deter such abuses and underscore the need to preserve a person's safety, liberty, and dignity.

Yet, much like the person who justifies the use of ethnic slurs because s/he intends no harm, medical personnel have continued to justify the use of the term "patient" because they see it as simply technical. Others defend its use because it represents a sacred trust between doctor and patient. These seemingly reasonable and noble explanations are a smoke screen for the mentalist power dynamic: professionals are generally accustomed to being in charge and, as a colleague once said, they're "not about to be dictated to by a bunch of patients." Consistent with the power dynamic, the power-up group is comfortable with the existing terminology and that comfort takes precedence over the feelings, well-being, and dignity of those who are power-down.

Most of the time, professionals cause these offenses unintentionally, but this makes them no less wounding. In order to escape from mentalist attitudes and language we need to examine the underlying meanings and functions of our communications. For example, if I describe someone as "a borderline with intense dependency," "a non-compliant schizophrenic," "an oppositional patient," "a typical drug-seeking antisocial personality disorder," "a manipulative, gamey manic," am I seeking to understand, respect, and help, or merely pass judgment, feel superior, and assert my professional dominance? It can be illuminating to ask oneself why one continues to use a term that offends and stigmatizes the people one aspires to help. If we lack the empathy that would motivate us to change our

language to avoid hurting the people we serve, what does that say about our integrity as healers?

Respectful clinical language should focus both the clinician and the recipient on the search for the most successful tools for health and recovery. If a diagnosis helps a person to understand her/his experiences and gain control over her/his life, it is a useful tool. If it stigmatizes, communicates contempt, and excludes the person from services, it is a weapon. Respectful clinical language is not a misrepresentation or under-estimation of a person's difficulties and experiences. It should be precise, factual, and complete. It should also communicate the perspective of the person receiving services, including his/her values, interests, and priorities.

Many individuals who have received mental health services feel that the vernacular of clinicians misrepresents reality.

"I hate that word "treatment." It's been twisted by the system and perverted beyond recognition. If they lock you up against your will, strip you literally and figuratively (of your rights) and force you into bondage and solitary confinement and then inject you with powerful and painful drugs, they call it "treatment." In every other possible realm on earth, this is torture and not "treatment." If they set a fifteen-minute appointment for you to renew your drugs every two weeks or month, they call that "treatment" and they can bill your insurance for payment. I consider it fraud." -P.R.

"To be a mental patient is to participate in stupid groups that call themselves therapy -- music isn't music, it's therapy; volleyball isn't a sport, it's therapy; sewing is therapy; washing dishes is therapy. Even the air that we breathe is therapy -- called milieu. " -Rae Unzicker (9)

"Normal behaviors are NOT symptoms. Normal people can have a bad day, an "off" week and even a "down" month. However, if we exhibit those normal behaviors on the job, we get labeled and we are asked if we took our medications or if someone needs to call our shrink." -P.R.

"There is no such thing as a 'side-effect.' There are only 'effects' from taking drugs. Some effects are desired and others are undesirable. Calling something a "side-effect" obscures and minimizes the resultant pain, suffering and misery that can be caused by psychoactive drugs and in doing so, it discounts our experiences and perceptions and thus sets us up as less than we are. It denies our reality." -P.R.

A good rule of thumb to address mentalism in language is to ask oneself if you would use the same language when speaking directly to the person or if you would feel comfortable having the person read what has been written in the chart. Other useful questions include:

Would I want to be talked about in this manner? Would I talk about my friends and colleagues in this manner? Does this language help the person and the clinician to find solutions to problems and create positive change? Any "No" answers, no matter how seemingly justifiable, indicate mentalism is operating within the communications.

Mentalism in Prognostication

Mental health professionals are commonly called upon to predict what people will do in life and whether they will recover. We have become accustomed to conveying rather dire predictions about chronicity, and often in charts under "Prognosis" one will see such terms as "poor" or "guarded." In general, my experience has been that mentalist assumptions have caused clinicians to have a rather pessimistic view of the capacity for their clients to recover. Many clinicians overtly dismiss the idea that people overcome their difficulties and leave mental health services to have full lives. When one points out the large number of people, including many mental health activists, who have overcome their disabilities, clinicians commonly respond that these individuals must have been "misdiagnosed" or "do not really have schizophrenia."

In fact, many longer-term research studies have shown that a significant number of people having serious psychiatric concerns recover completely, irrespective of their presentation or diagnosis. Dr. Courtney Harding's studies, for example, showed that approximately 50% of people having psychiatric disabilities recovered fully over a 25 year time period (10, 11, 12). Many of these people received no further treatment, including psychiatric medications. These observations are in marked contradistinction to the assumptions of most mental health professionals, and many clinicians are quick to try to discount or discredit this research.

While one can endlessly dispute research methodology, the human impact of mentalism in prognostication is undeniable. People receiving the pronouncements "You will

have this disability for life," "You will always have to take medications," or "You will not become a lawyer/doctor/economist/teacher" are almost invariably devastated. Some experience helplessness and despair. Others resist, refuse further treatment, or seek other alternative ways to heal. In fact, the accuracy of such predictions is abysmal, and repeatedly, studies have confirmed that the criteria that clinicians employ to make such predictions are not related to recovery. For example, clinicians have traditionally discouraged people from seeking employment on the basis of the severity or frequency of their symptoms or the length of time they have been disabled. None of these factors has proven to correlate positively or negatively with successful employment; the best predictors are intuitively obvious - motivation to work and capacity to learn (13, 14).

Overcoming mentalism in prognostication requires that we critically examine our assumptions about recovery from psychiatric disabilities. In many instances, clinicians' views have been skewed by the fact that they are most likely to see people only during the times when they are experiencing distress. Those who recover rarely come back to the clinic or the hospital. We must disclose to people that we don't know who will recover, when, or how. In many ways this allows us to impart a very hopeful message to everyone we serve. No matter how painful a person's disability, no matter how incapacitated s/he may have been, no matter how long s/he has struggled, there is always a significant chance that s/he will improve considerably or even recover completely. A message of hope also opens the door for clinicians to inform people about the things they can do to restore their health and what pitfalls to avoid. In our experience, people are often more motivated to work on their health if they are aware that there is a reasonable likelihood of success.

Mentalism and Psychotropic Medications

The attitudes and practices that surround the use of psychotropic medications are unfortunately full of manifestations of mentalism. In its most obvious form, the person

receiving treatment is presumed to be "crazy" and therefore unable to make medical decisions, so that medical personnel fail to observe the usual procedures with respect to informed choice. Often a person's objections to medications are dismissed on the grounds that "mental patients cannot appreciate the gravity of their illnesses" and therefore the person's experience of the treatment is deemed invalid. It is also both unfortunate and common in busy office practices for clinicians to gloss over the problematic side effects described by their clients without fully considering the impact upon people's lives.

The myth of compliance is a particularly destructive manifestation of mentalism in psychiatry. Nowhere in medicine are physicians more preoccupied with enforcing "compliance." Most non-psychiatric physicians have come to accept that compliance itself is a myth. Certainly, studies of "compliance" with everything from diabetic diets to anti-hypertensive agents show that humans don't comply with anything. At least one third of people in these studies fail to follow their doctors' instructions and many studies have shown rates of "non-compliance" of over 50% (15). Studies of people who are contending with psychiatric disability have shown that the best results are obtained when people are well-informed and in control of their treatment and when health care providers build flexibility into treatment regimens (16, 17, 18).

Yet psychiatry has continued to support measures that focus on forcing people to comply with treatments that they feel are unhelpful. To a large degree this reflects a key element in the discrimination and mistreatment of people having psychiatric concerns: because mentalist prejudices portray people having psychiatric concerns as violent and unpredictable, treatment has largely become synonymous with social control. As a result, mental health clinicians tend to equate subduing the person with treatment; a quiet client who causes no community disturbance is deemed "improved" no matter how miserable or incapacitated that person may feel as a result of the treatment. As in other forms of social control, incarceration is used to contain the person who will not comply, though, because the incarceration occurs in a hospital, it is deemed to be "treatment."

When applied to other forms of medical treatment this model sounds absurd. Imagine jailing a diabetic for having dessert or incarcerating a person having chronic bronchitis for lighting up a cigarette or forgetting his/her inhaler. If stringent monitoring of compliance with general medical treatment were enforced through social control, it is fair to say that we would all be incarcerated over time. No one would find such a solution to public health problems acceptable because it violates people's right to choose their lifestyles and medical treatment. In virtually all other medical concerns, we have upheld individuals' rights in this regard irrespective of the possible risks to self or others. The only exception has been in the reporting and treatment of highly communicable diseases. Yet numerous legislative initiatives throughout the US are presently proposing that people having psychiatric conditions be locked up in psychiatric facilities if they fail to comply with treatment and are deemed to be *at risk* of becoming ill. This clearly compromises the rights of people having a psychiatric diagnosis in ways that we would never consider for people having medical diagnoses.

Mentalism in psychiatric practice is also apparent in the lack of thoroughness in informed consent and in the monitoring of medication side effects. In California, informed consent is presently obtained by having people sign a paper on which possible medication side effects are listed. No distinction is made between dangerous side effects and uncomfortable ones; no suggestions are given for identification and management. Once signed, the information is placed in the chart so that the individual has no access to it. Often, medically serious side effects are "dumbed down" so that people do not get an accurate view of the risks involved. For example, tardive dyskinesia, a potentially permanent neurological condition caused by antipsychotic medications, is often described as "having muscle tics." Many people are approached for consent only during crises or acute bouts of their conditions, and the information is never revisited when the person is more able to concentrate and process information. This approach to informed consent is of minimal benefit to the person receiving treatment. The perfunctory quality of this approach to informed consent is clearly

driven by the mentalist power dynamic, which acts to protect the clinician from allegations of negligence without truly informing the person getting treatment.

Monitoring of side effects is also conspicuously affected by mentalist prejudices. A particularly worrisome example of this is the failure of many psychiatrists to examine people for tardive dyskinesia (TD). As noted above, TD is a neurological condition caused by antipsychotic medications. It is characterized by the gradual onset of involuntary muscle movements that may include grimacing, rapid blinking and squinting, tongue protrusion, movements of the arms and legs, and twisting and writhing motions of the trunk. When TD is detected early, it is often completely reversible. If it is not detected early, TD is often progressive and permanent, so that even if the medication is stopped, the person may continue to have odd movements that s/he cannot control. When these movements are severe, they can interfere with sight, eating, speech, walking, and other basic activities. The movements are extremely stigmatizing, and can have serious health consequences. For example, when TD causes involuntary movements of the muscles of the throat, liquids may leak into the windpipe when people swallow, causing repeated bouts of pneumonia. While the person is taking the antipsychotic medication, the movements of TD are often masked. They also may not be apparent until the person is distracted or excited.

For all these reasons, the American Psychiatric Association recommended in 1980 that psychiatrists reduce the dose of antipsychotics on a regular basis and examine people taking these medications for TD annually using a standardized assessment such as the AIMS or the DISCUS (19). However, this is not what typically happens in mental health clinics. Generally, individuals taking neuroleptics are encouraged to stay on a maintenance dose of medications. Regular dose reductions are rare, as clinicians fear the person will "decompensate." Psychiatrists typically observe the person informally for obvious involuntary movements and indicate in the chart "no TD." Rarely is an AIMS or DISCUS performed or documented. Generally the discussion of TD is limited to the warning of possible "muscle tics" given in the informed consent. Hopefully it is obvious that these

measures are inadequate to detect TD or address the medical risks associated with it. The net result is that year after year, thousands of people receive antipsychotic medications without ever being thoroughly evaluated for a potentially disabling medication side effect.

One can only wonder why psychiatrists are failing to perform this routine monitoring of medication risks. Certainly, it is not due to time constraints, as the modified AIMS (Abnormal Involuntary Movement Scale) or DISCUS (The Dyskinesia Identification System Condensed User Scale) takes only 10 minutes to perform and rate (20). It cannot be due to fears that people will abandon treatment, as research suggests that well-informed recipients tend to be more involved in their care and less likely to be "non-compliant." One can only conclude that mentalism is operating here as elsewhere, causing psychiatrists to feel that unidentified TD is somehow an acceptable risk for people having psychiatric disabilities. The comparison with medical maltreatment based upon racism, such as the Tuskegee experiment in which African-American men were allowed to be exposed to the risks associated with untreated syphilis, is inescapable.

It has been virtually impossible to penetrate psychiatric denial regarding the issue of TD, despite APA recommendations and multi-million dollar malpractice suits. Its most recent incarnation is the prevalent belief that newer antipsychotic medications do not cause TD. Many clinicians appear oblivious to the fact that all antipsychotic medications have been found to be associated with the development of TD, and that the studies showing reduced risk with newer agents have been conducted for relatively brief periods of time. Even clozapine, the "gold standard" among antipsychotics, and the serotonin reuptake inhibitor antidepressants have been associated in rare instances with this condition (21, 22, 23). Inexplicably, the same physicians that insist upon other early detection measures such as blood tests, PAP smears, mammograms, and prostate exams continue to refuse to perform the AIMS for people taking neuroleptics.

Elimination of mentalist discrimination in medication practices requires that we reflect on our attitudes and make significant departures from the present state of psychiatric procedure. Some suggestions follow:

1. We must separate, conceptually and in practice, the use of psychotropic medications to enforce social control from true treatment. Psychiatrists are presently burdened with the unrealistic societal expectation that they can ensure public safety through the use of psychotropic drugs to control people who are labeled as potentially deviant. Until we are relieved of this oppressive myth, clinical practice will continue to reflect the public's mentalist prejudices rather than the needs of the people we serve.

2. Informed consent must be refined so that people receive comprehensive and easily understandable information about their choices that neither catastrophizes nor downplays the health risks of the treatment. This information should be reviewed with the person periodically and needs to go with the person rather than sitting in the chart.

3. When making treatment decisions, we must give highest priority to the individual's assessment of the treatment, especially his or her subjective report of side effects and the impact of the medications on his/her life. We need to be aware of the biases of others who may report that a person is "improved" when in fact the person is simply too sedated or too neurologically impaired by the medication to "cause trouble."

4. We must abandon the myth of compliance and focus instead on understanding the decision-making processes that people go through as they choose their treatment.

5. We must diligently apply ourselves to the task of early identification of the medical consequences of psychotropic medications. This should include regular examination for TD, appropriate blood tests for liver or kidney damage, annual ophthalmology exams for people taking phenothiazine antipsychotics, audiology screening for people taking valproic acid preparations, and so forth.

Mentalism and the Physical Environment

In clinics, residences, and in the community, mentalism can be found in the design and maintenance of the physical environment. The indicators of power expressed in environmental terms include space, privacy, safety, cleanliness, comfort, choice, access, and aesthetics. We all know how this works from personal experience. For example, the person at the top of an organization has a large private office with comfortable, or even lavish, furnishings and usually her/his own computer and printer. The people at the bottom work in small "cubes," have utilitarian furnishings, and share facilities such as refrigerator, printer, computer, and restroom.

Mentalism makes these differences even more pronounced. Individuals living in supported environments often share rooms with roommates not of their choosing, rarely have privacy, and use furniture that is chosen by others for easy maintenance and durability rather than comfort or aesthetics. Many have insufficient space to display or store personal possessions. Many residences provide no way for people to lock their possessions, their rooms, or the bathroom to insure safety and privacy and deter theft. Often, housing options are run-down or located remotely, and labeled people are left to use public transportation that is inconvenient, uncomfortable, or even unsafe.

In many ways, these conditions are shared by anyone who has little money. However, mentalism does contribute to many specific environmental micro-aggressions as well. A common one, occurring in many clinics, is simply the separation of staff and client restrooms. The separation of the facilities for "staff" and "clients" mirrors the conditions in the Southeastern US prior to the civil rights movement of African-Americans, where racist beliefs led to the separation of all public facilities for "whites" and "non-whites". In public mental health clinics, the separation of facilities is often combined with a lack of maintenance and privacy in the restrooms used by clients. In one place that I am aware of, stalls in the "client" restroom had no doors. This was justified as a "safety measure." As with other discriminatory practices, clinicians often justify the separation of facilities: "clients

have a different standard of hygiene than we have." Hopefully, the condescension contained in this response is obvious. It also obfuscates the responsibility of a public service to provide a respectful physical environment for public use. If public use causes the facility to need more cleaning, it is simply the responsibility of the organization to see that it is cleaned frequently enough to make it acceptable to anyone, rather than setting aside a "clean space" for staff and allowing public space to deteriorate.

In inpatient settings, the space around the nurses' station is often a site where environmental mentalism is evident. Frequently, staff congregates here and observes the behaviors of people on the unit from a distance. It is also a place where staff converse informally. Individuals receiving treatment who approach are shooed away from this staff territory. The rationalization is that staff must "monitor the milieu" and ensure safety on the unit. Yet in reality this function would be better served if staff were mixing with people on the unit, influencing the milieu by engaging people and supporting various activities. The real function of the nursing station is to convey a sense of superiority and control. Often this impression is emphasized by the use of plexi-glass dividers or even chain-link caging. In one very sad place familiar to the authors, staff worked within a centrally located plexi-glass enclosure. This enclosure was surrounded in turn by a high counter and clients were only permitted at the perimeter beyond the counter, usually seated in a line of recliners facing inward toward the nursing station.

Environmental offensiveness is often combined with procedural micro-aggressions to produce particularly disparaging messages toward people using services. For example, from the patients' point of view, the "call for medication" on an inpatient unit more resembles a cattle call than a caring distribution of helpful medications. In a regular hospital setting, the staff individually distributes medications to patients. On many psychiatric units, staff have the patients all line up at certain times of day to receive their daily doses. This impersonal process further reinforces the depersonalization of the individual and contributes to the sense

of the person being more a chart number, a diagnosis or an object rather than a unique individual human being.

Innumerable examples of mentalism in design exist in clinical settings. By themselves, they often seem like small concerns, and the person who seeks to address them is frequently accused of being petty. Yet taken together, these small, belittling messages in the physical environment have a major impact on people. Again, a good general guideline in evaluating the environment is to reflect upon how we would feel coming into the setting seeking services.

Trauma and Re-traumatization

Mentalism can cause further difficulties for those who have a past history of trauma. There is great negligence in obtaining trauma histories from people receiving mental health services even though available studies indicate that a huge number of people, between 50% - 80%, in the public mental health system are affected (24, 25, 26). Selective inattention to a past history of abuse often causes clinicians to fail to diagnose the root cause of psychiatric disability.

"I was horribly abused as a child. My mother physically and emotionally abused me even prenatally by trying to jump off of tables at work (for which she was fired). My father was seeking divorce and custody when he died in a car accident just before I turned two years old. From the court investigators report, my mother would have been found to be an abusive and unfit mother and my father would have been granted custody. He would have been the first male parent to have been awarded sole custody of minor children in the state of Ohio had he lived.

My mother remarried when I was seven years old. My stepfather was sexually abusive from the time I was age seven until I moved out of the house at age seventeen. To cope with this abusive environment, I learned to dissociate in a couple of ways. I blanked out the memories of the abuse, I could both numb my body to feel no pain or I could actually leave my body and experience a sort of floating out-of-body experience. I did this to minimize the fear and the pain I felt.

Years later, when these memories, that I'd successfully repressed, started to intrude, the way I coped with the painful flood, lead me to become a mental patient. A typical experience would have me searching for some way to cut myself to try and quell the overwhelming feelings of pain and fear that welled up in huge flashbacks. For me, cutting was a way to

overcome the pain. It created another focus. It was like stubbing your toe in the dead of night when you get up to get something for a headache. The pain in your toe makes the headache become forgotten and thus go away." -P.R.

Clearly, there is a need for more research on psychiatric disability among people who have a history of trauma. In addition, there is a need for training to increase sensitivity and understanding of staff regarding how to gather data on abuse histories and how to help people who have experienced abuse. It is important to understand that, due to the power differential between staff and recipients, many psychiatric interventions trigger or retraumatize the survivor (27, 28, 29).

"A typical response on the part of staff to these episodes [of cutting] was to strip me, place me in restraints and seclusion and to inject powerful drugs. I reacted very badly to these "interventions." I kicked and screamed and carried on something fierce. The reason for my reaction was simple. As a child, the overwhelming, all encompassing feeling while being raped by my stepfather or beaten to a pulp by my mother was a feeling of powerlessness. Painful powerlessness. And, as I was trying to cope with those feelings as an adult in a mental hospital, the very things they did to me just pushed those buttons again and again. I was overwhelmed with feelings of powerlessness to which the staff responded by abusing their power and making me feel more powerless.

A more appropriate interaction would have been verbal support, which offered some understanding of the pain and an alternative way of coping with the pain. At the very least, some compassionate understanding of the trauma I'd suffered and even perhaps a hug would have been far more soothing and healing. However, that's probably not possible. After all, psychiatric settings have a paranoid feeling about touch. Even though psychiatry claims to be medical and in any medical setting touch is okay and even considered healing, psychiatry reacts with a paranoiac phobia about it. Instead, they'd rather abuse those who have been abused and are trying to heal from that abuse." -P.R.

Triggers and retraumatization can occur in both the physical and interpersonal environments. Examples include spread-eagle restraint of a rape victim or disbelieving the history given by a survivor of incest. Because powerlessness is a core element of trauma, any treatment that does not support choice and self-determination will tend to trigger individuals having a history of abuse. People may re-experience the helplessness, pain, despair, and rage that accompanied the trauma. They also may experience intense self-loathing, shame, hopelessness, or guilt. Mentalist thought tends to label these negative effects of treatment in pejorative terms that blame the survivor: "He's just acting out," "She's manipulating," "He's

attention-seeking." These labels are often communicated through the attitudes and language of staff, and become re-traumatizing in themselves. It is essential that we recognize the individual's behaviors as post-traumatic manifestations so that effective services can be provided to the survivor of trauma and so that re-traumatization can be avoided.

Addressing Mentalism in Service Organizations

Most clinicians enter the mental health field in response to an inner conviction that people matter and that helping each other is important. Yet upon graduation, most of us are thrust into service organizations that have been built upon bureaucratic or financial imperatives and the expectation that mental health services will enforce social control. Often, clinicians find that the goal of providing quality service to individuals has been superceded in these organizations by the goals of generating paperwork or revenue. In these settings, clinicians are at risk of becoming estranged from the core values that give their work meaning and life. Alienation from values and disappointment in "the system" cause many clinicians to burn out and to become hardened in the cynical, mentalist beliefs that pervade these organizations.

Often, clinicians will feel pulled by organizational or group dynamics to use pejorative terms, express pessimism and contempt for our clients, or act in a restrictive or punitive manner. Each clinician must take personal responsibility to resist these very real forces in our work. Despite organizational pressures, we can establish the clear expectation for ourselves that we will treat the people we serve with dignity and respect, and that caving in to discrimination and scapegoating of clients is never "OK." This does not necessarily mean that we can personally make up for systemic deficits such as gaps in the continuum of services or inadequate resources; in most instances we cannot. However, no matter what the circumstance, we can endeavor to approach people with empathy and genuine concern, and treat our clients, as we would like to be treated.

We must also find the courage to openly confront discrimination when we find it.

Mentalism, like racism or sexism, is abuse. We cannot underestimate the damage that is done to individuals when mentalist attitudes dominate service delivery.

"At one time, I worked with a team in which two team members were clearly invested in a mentalist view of the people we served. Whenever I made suggestions about client-directed ways to address our clients' needs, these team members typically responded "We've already tried that," "That won't work," "You're just being manipulated," "He's just a sociopath," "She can't do that," "He's not ready," "People never really change," "Don't be so naïve." Other team members allowed these responses to go unchallenged. As a result, we consistently left these meetings feeling embittered and discouraged about our work, and our team process was constantly overshadowed by this judgmental, angry, and punitive attitude. Not uncommonly, I was approached after the meeting by other team members who offered support for my suggestions, but because this support never occurred within the group, I continued to be alienated and abused by the team, much as our clients often said they felt. Needless to say, we were not effective in helping many people, and the prevailing mean-spirited attitude detracted from all our work as a team. Despite the fact that I had been hired into a position of leadership as team psychiatrist, I found that I was powerless to change the long-standing tradition of cynicism and mentalism in this group. My refusal to share in that negative attitude made me a traitor to the group and a new target for attack in a parallel process that I likened to that observed in psychotherapy supervision." -C.K.

To change this situation the group needed two things: support from leadership and support from within the team. Management needed to provide supervision to the team members who had adopted a cynical, mentalist attitude to clearly communicate that discrimination of this sort would not be tolerated. They needed clear feedback about the deleterious effect that their negativity had on their performance as professionals and guidance to establish and implement a plan for amelioration. Clear policies were also needed that included "zero-tolerance" for mentalist discrimination. Just as employees would hopefully be dismissed for disparaging sexual or ethnic remarks, staff who are entrenched in negative stereotypes, attitudes, and beliefs about the people we serve need to be removed from service organizations to keep them from harming clients and destroying organizational morale.

The team also needed input from the team members who continued to have hope and respect for our clients. Their silence was taken within the group to be tacit agreement, and the unspoken message was that mentalist prejudices were the accepted standard of the group.

Simply to affirm hope and positive values, to question the position of the cynical members, or to express agreement with an alternative approach would have greatly diffused the power of the highly vocal, angry, and vindictive team members.

This example illustrates the important role of the bystander in the perpetuation of mentalism. Bystanders wield great power both when they speak up and when they are silent. Silence in the face of injustice or abuse is a subtle but very real form of discrimination. It allows the abuse to continue and gives the impression of support. Often people keep silent because they correctly perceive that they will become the next object of attack if they intervene on behalf of a person receiving services. These attacks can admittedly be vicious and can include slander, libel, verbal and physical abuse. However, we need to consider the impact of our silence. Supporting discrimination through silence is really no different than perpetrating the injustice. Ultimately, it commits us all to living under the tyranny of people who have chosen to relinquish their values and ideals.

Combating discrimination requires courageous and decisive interventions that frighten most administrators. Discrimination cannot be corrected through "compromise" and "gradual philosophical change." When we find discrimination, it needs to be incisively eradicated. Partial solutions to discrimination do only one thing - they perpetuate the injustice. One cannot address the objectionable message of separate restrooms by moving "separate but equal" facilities closer together. The U.S. could not address the injustice of denying African-Americans their right to vote by offering individuals "2/3 of a vote." One cannot "ease" people into using respectful language by tolerating mentalist or racial slurs. Equality means equality, respect means respect, and anything less is discrimination and oppression.

Moving from "Power-Over" to "Power-Sharing"

Eradicating "isms" like mentalism requires that we change our view of power relationships. We must be able to envision an interaction between people that is based on

mutual personal empowerment and respect rather than one person being "on top" and the other "on the bottom." Such a relationship has been termed "power-sharing." These relationships acknowledge the strengths and limitations of both parties, and build upon common goals, values, and concerns through a process of collaboration and negotiation (30, 31, 32).

In power-sharing clinical relationships, the clinician no longer decides what is best for the recipient of the service. Instead, the individual receiving the service defines the goals and plans for recovery. The clinician's role is to assist the person to develop the plan and to facilitate its implementation. The power-sharing relationship acknowledges that the clinician *cannot* make real decisions for the person in treatment, since that person will by necessity leave the clinic at the end of the appointment and make innumerable independent personal decisions every day that determine the outcome of her/his life. The clinician acts much like a consultant to the recipient, providing information, treatment options, access to community resources, support, insights, and feedback that the person can draw upon in his/her own search for recovery.

A common misconception about the process of reducing discrimination based on mentalism is that amelioration means role reversal. It is often assumed that those who were power-down, once empowered, will assume an oppressive stance towards people who formerly were power-up. This misconception causes many people to retreat from addressing the issue of discrimination. Power-sharing does not mean that clinicians must obey the dictates of the person served, and does not obligate the clinician to do anything unethical or illegal. A part of the clinical relationship is open, respectful feedback and communication; this includes honest disclosure about why a clinician may feel unable to support a particular course of action.

When confronted with a request that s/he cannot support, the clinician needs to be constantly vigilant for encroaching mentalist attitudes. The clinician may feel irritated or offended by the request. In these circumstances, it is only human to react in a judgmental or

punitive manner. For example, when a client requests a prescription for Valium, it is common for clinicians to flatly refuse and label the person as "drug-seeking." In a power-sharing mode, the clinician would earnestly explore the reasons for this request. S/he would use this opportunity to discuss the underlying reasons for the refusal, including concerns about the person's health and the risk of addiction, the potential for creating more medical problems for the person, legal concerns, alternative means of managing anxiety or insomnia and so forth. Ultimately, the clinician might express genuine regret that s/he feels unable to fulfill the person's request. Though the person's wishes are not fulfilled, such discussions generally communicate the clinician's genuine concern and conscientiousness regarding the person's care. In my experience, this virtually always deepens the trust and respect within the clinical relationship, and sets the tone for a collaborative search for treatment alternatives. Within the context of this sort of trusting relationship, people even sometimes withdraw their request in response to the provider's concerns.

At times, clinicians claim that a recipient is unwilling to work on treatment goals or "acts out" in response to the clinician's refusal to support the person's plan. In the majority of these cases, the authors have found that the clinician has set up the conflict by treating the person in a disrespectful, judgmental, or dismissive manner. For example, one community psychiatrist in our acquaintance complained bitterly about the "abusive behavior" of "borderlines" admitted to the inpatient unit. It was later learned that this man denied people's requests for Tylenol for pain, refused them any medications for sleep, and told people that they were "manipulative" for coming to the hospital.

It is unfortunately common for clinicians to justify mentalist behavior by stating that the person coming for services was demanding, angry, or "needed limits." It is important to keep in mind that it is always the *clinician's* responsibility to initiate the respectful tone of the clinical relationship and to cultivate power-sharing in that relationship. When respectful communication breaks down, the first thing the clinician should ask her/himself is whether s/he has inadvertently expressed mentalist prejudices that may have disrupted the therapeutic

process. If this does not seem to be the case, then one can consider whether the individual receiving the service is having difficulties with interpersonal communication. Cultivating respectful communications with people in the presence of conflict may entail listening respectfully to the person's anger and frustration, despite its unpleasantness, and helping the person to express these feelings assertively and effectively.

The Benefits of Power-sharing

There are many benefits for the clinician who chooses to confront mentalism in his/her thinking. Most importantly, striving for equality and respect in our clinical relationships brings us closer to the values that attracted most of us to clinical practice in the first place. It refocuses us on relationships as the vehicle to healing and on service to others as our most important goal. By doing this, power-sharing relationships restore our core values and express our integrity. Part of the power-sharing relationship involves sincere efforts to understand, rather than label or judge, the perspective of the person served. From that understanding, the clinician and the person seeking services then collaborate to devise solutions that are uniquely suited to the person's needs. This creative process can refresh us and help us to learn and grow professionally.

Power-sharing also increases the efficacy of clinicians. Very often our energy as clinicians is frittered away in efforts to get people to conform to our expectations or fit into our idea of a helpful program. We lose sight of the fact that each individual has unique needs and priorities, and that, unless the person feels that these are being addressed, s/he is unlikely to be motivated to participate in the service. For example, the staff of one program spent an inordinate amount of energy persuading and pressuring people to attend all the groups at day treatment. They found that voluntary participation was much better when they changed the program to offer a wider variety of options that reflected consumer preferences and

included opportunities for work. Staff found they had much more time to work creatively and individually with people when they no longer felt they had to be "traffic cops."

In relationships based on power-sharing, dilemmas and responsibility are also shared. Clinicians can relinquish the role of having to prescribe the right solutions for people, and can instead discuss pros, cons, options, and recommendations with the empowered consumer. The person receiving the service is involved directly in developing the service plan. Essentially, this approach takes informed consent one step further into the realm of informed decision-making. In the former, the clinician arrives at a conclusion about the best treatment, and seeks the person's permission to proceed. In the latter, the clinician prepares the recipient to make his or her own decisions regarding treatment. The clinician is free to share his/her concerns and misgivings about the services with the person, and to receive as well as give support.

Informed, collaborative decision-making protects both the recipient and the clinician. By fully addressing the possible outcomes of treatment decisions, power-sharing reduces the risk to the person receiving services. The well-informed consumer can actively reduce serious consequences of medication side effects through vigilance and early intervention. Likewise, one can plan proactively for possible crises, reducing risk by paving the way for prompt intervention in an emergency. The clinician is protected from some of the most common allegations of psychiatric malpractice. Such allegations often stem from poor communication between clinician and client and inadequate discussion of possible side effects of medications. Contrary to popular belief, perfunctory informed consent forms do not always stand up to legal scrutiny. Collaborative service planning, respectful relationships with people, and thoughtful documentation remain the most effective protections against liability claims.

A focus on equality, dignity, and respect in mental health services will help people to heal. Andrew Phelps, an activist and originator of the Accountability movement, has called this process the restoring of "equities" (33). He believes that the traumas that caused

people's emotional distress, compounded by the traumas and disenfranchisement they experience as a result of mentalism, are the real source of psychiatric disability. As noted earlier, post-traumatic effects of trauma can include hopelessness, feelings of worthlessness, apathy, anger, nihilistic beliefs, withdrawal, and loss of trust. To begin to heal, the individual must begin a process of overcoming these injuries. However, the nature of post-traumatic effects makes it difficult to embark on this process. For example, it is hard to invest effort in one's life if one feels worthless or to connect with other people if one cannot trust.

Dr. Phelps' model suggests that services and organizations need, above all, to help people to overcome the effects of trauma. To do this, they must express hope and affirm the inherent value and dignity of the person, irrespective of his/her current difficulties. They need to convey respect and support the person's ability to direct the course of her/his own life. They need to model acceptance and empathic understanding of differences between individuals. They also must preserve accountability for the quality and impact of interpersonal interactions within the organization. Dr. Phelps believes that this approach is most likely to overcome individual, systemic, and societal barriers to recovery. When organizations or services fail in these goals, they tend to reinforce post-traumatic effects. For example, pejorative labels support feelings of worthlessness, mentalist prognostication erodes hope, and unilateral treatment planning undermines trust. Such experiences tend to be re-traumatizing for people who are attempting to address recovery and only worsen their distress.

Summary

Clinicians are not immune from the pervasive effects of prejudice against people who have received psychiatric labels. Unfortunately, negative stereotypes and assumptions are often interwoven with clinical practice, language, procedure, and even the physical environment. Generally, we are unaware of our prejudices and of the injury we cause the

people we serve through our mentalist beliefs, and clinicians often give various justifications for the way things are traditionally done. A good rule of thumb to evaluate for the presence of discrimination is to reflect on what our own response would be if we were to receive the same treatment.

It is important that we confront discrimination when we find it, in ourselves and in others. As painful as it may be to consider our role as perpetrators of mentalism, clinicians must come to grips with both our personal mistakes and our participation in a profession that historically has done much to abuse the people who came for care. In truth, we need to undergo our own process of healing and recovery in order to unlearn judgmental behaviors, controlling attitudes, and negativistic belief systems.

In an ideal world, clinicians would be able to offer unlimited resources to their clients in organizations in which service was the first priority. In reality, resources are generally insufficient to people's needs and service takes a back seat to fiscal and administrative concerns. Despite these real and serious barriers, each clinician has a professional responsibility to be accountable for the quality of her/his interactions with people seeking services. Each of us can choose to communicate hope, concern, and respect. We can be dependable and trustworthy. We can take responsibility for questioning our assumptions, admitting the limits of our knowledge, and broadening our skills. A client-directed, egalitarian approach to services will have many benefits including improved efficacy, reduced risks, greater creativity, and greater satisfaction for both clinician and consumer. In doing all these things, we will improve the quality of our lives as well as those of the people we serve.

1. Chamberlin J *On Our Own: Patient-Controlled Alternatives to the Mental Health System* New York: McGraw-Hill, 1978.
2. Pierce C "Offensive Mechanisms" in *The Black Seventies*, F.Barbour, ed., (Boston:Porter Sargent, 1970), 265-282.
3. Deegan P *Spirit Breaking: When the Helping Professions Hurt* The Humanistic Psychologist 1990b, 18(3):301-313.
4. Ridgeway P *The Voice of Consumer in Mental Health Systems: A Call For Change* Burlington: Center for Community Change Through Housing and Support, Trinity College of Vermont, 1988.

5. Blaska B "First Person Account: What It Is Like to Be Treated Like a CMI" *Schizophrenia Bulletin* 1991, 17(1):173-6.
6. Lovejoy M "Expectations and the Recovery Process" *Schizophrenia Bulletin* 1982, 8(4):605-609.
7. Deegan P "Recovering Our Sense of Value After Being Labeled" *Journal of Psychosocial Nursing* 1993, 31(4):7-11.
8. Deegan P *Spirit Breaking: When the Helping Professions Hurt* The Humanistic Psychologist 1990b, 18(3):301-313.
9. Unziker R "*To be a mental patient*" 1984
10. Harding CM, Zahniser J "Empirical Correction of Seven Myths about Schizophrenia with Implications for Treatment" *Acta Psychiatr Scand* 1994, 90(suppl 384):140-146.
11. Harding CM, Zubin J, Strauss JS "Chronicity in Schizophrenia: Fact, partial fact, or artifact?" *Hospital and Community Psychiatry* 1987, 38(5):477-486.
12. Harding CM, Zubin J, Strauss JS "Chronicity in Schizophrenia Revisited" *British Journal of Psychiatry* 1992, 161 (suppl. 18):27-37.
13. Anthony WA, Rogers E, Cohen M, Davies R "Relationships Between Psychiatric Symptomatology, Work Skills, and Future Vocational Performance" *Psychiatric Services* April 1995, 46(4):353-358.
14. Anthony WA, Jansen MA "Predicting the vocational capacity of the chronically mentally ill: Research and implications" *American Psychologist* 1984, 39:537-544.
15. Cramer, JA "Compliance With Medication Regimens for Mental and Physical Disorders" *Psychiatric Services* February 1998, 49(2): 196-201.
16. Paykel ES "Psychotherapy, Medication Combinations, and Compliance" *Journal of Clinical Psychiatry* 1995, 56(suppl 1):24-30.
17. Aquila R, Weiden PJ, Emanuel M "Compliance and the Rehabilitation Alliance" *Journal of Clinical Psychiatry* 1999, 60(suppl 19):23-29.
18. Frank E, Kupfer D, Siegel L "Alliance Not Compliance: A Philosophy of Outpatient Care" *Journal of Clinical Psychiatry* 1995, 56 (suppl 1):11-16.
19. "Tardive Dyskinesia: Summary of a Task Force of the American Psychiatric Association" *American Journal of Psychiatry* October 1980, 137(10):1163-1172.
20. Munetz MR, Benjamin S "How To Examine Patients Using the Abnormal Involuntary Movement Scale" *Hospital and Community Psychiatry* November 1988, 39(11):1172-1177.
21. Leo RJ "Movement Disorders Associated with the Serotonin Selective Reuptake Inhibitors" *Journal of Clinical Psychiatry* October 1996, 57(10):449-454.
22. Dubovsky SL, Thomas M "Tardive Dyskinesia Associated with Fluoxetine" *Psychiatric Services* September 1996, 47(9):991-993.

23. Ahmed S, Chengappa KNR, Naidu VR, Baker RW, Parepally H, Schooler NR "Clozapine Withdrawal-Emergent Dystonias and Dyskinesias: A Case Series" *Journal of Clinical Psychiatry* September 1998, 59(9):472-477.
24. Craine LS, Henson CE, Colliver JA, et al "Prevalence of a history of sexual abuse among female psychiatric patients in a state hospital system" *Hospital and Community Psychiatry* 1988,39:300-304.
25. Bryer JB, Nelson BA, Miller JB, et al "Childhood sexual and physical abuse as factors in adult psychiatric illness" *American Journal of Psychiatry* 1987, 144:1426-1430.
26. Jacobson A, Richardson B "Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry" *American Journal of Psychiatry* 1987, 144:908-913.
27. Doob D "Female sexual abuse survivors as patients: avoiding retraumatization" *Archives of Psychiatric Nursing*, August 1992, 6(4):245-251.
28. Harris M "Modifications in service delivery and clinical treatment for women diagnosed with severe mental illness who are also the survivors of sexual abuse trauma" *Journal of Mental Health Administration*, Fall 1994, 21(4):397-406.
29. Jennings A "On being invisible in the mental health system" *Journal of Mental Health Administration*, Fall 1994, 21(4):374-387.
30. Deegan P *Spirit Breaking: When the Helping Professions Hurt* The Humanistic Psychologist 1990b, 18(3):301-313.
31. Kisthardt WE, "A strengths model of case management: the principles and functions of a helping partnership with persons with persistent mental illness" in *The Strengths Perspective in Social Work Practice*, Dennis Saleebey, ed., (New York: Longman Publishing Group, 1992), 59-83.
32. Lazare A, Eisenthal S, Wasserman L "The Customer Approach to Patienthood" *Archives of General Psychiatry* May 1975, 32:553-558.
33. Personal communication.