On Our Own

Patient-Controlled Alternatives to the Mental Health System

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Real Alternatives and False Alternatives

Once the decision to start an alternative service is made (whether it is to be a crisis center, residence, drop-in center, or whatever), the founding group must make a number of decisions. What will the alternative be like? Whom will it serve? Who will participate in planning? How will decisions be made? The ways in which a group solves these problems will have significant effects on the shape of the service or organization that develops. Since, presumably, the group is reacting to deficiencies and flaws in existing services, it will want to ensure that the alternative provides fundamental (and not merely cosmetic) differences.

The question of participation is perhaps the most basic. If the founding group consists entirely of ex-mental patients, it must decide what its relations will be with nonpatients and with mental health professionals. If the founding group, on the other hand, consists of a mix of patients, nonpatients, and professionals, it must face the inevitable strains and tensions and evolve ways of dealing with them. Groups that consist solely of ex-mental patients will set up very different kinds of alternatives from groups dominated by liberal mental health professionals. I have identified three distinct models within what are usually recognized as alternative services.

In the *partnership model,* professionals and nonprofessionals work together to provide services. The recipients of services are told that they, too, are partners in the service.

However, the distinction between those who give help and those who receive it remains clearly defined. I consider services based on this model to be alternatives in name only. The overwhelming majority of alternative services (most halfway houses, for example) fit into the partnership model.

In the *supportive model,* membership is open to all people who want to use the service for mutual support. Nonpatients and ex-patients are seen as equals, since everyone has problems at some time or another, and all are capable of helping one another. Professionals are excluded from this model (except in external roles, such as writing letters of support) because they use a different model of helping, which separates those who give from those who receive help.

In the *separatist model,* ex-patients provide support for one another and run the service. All nonpatients and professionals are excluded because they interfere with consciousness raising and because they usually have mentalist attitudes.

Alternative services based on the supportive or separatist models are few in number, but they present a real alternative to the dehumanizing effects of mental health "care" in the United States today. "Alternatives" based on the partnership model continue many of the same abuses.

Mental health professionals are used to taking a controlling role, and they continue to do so even within "alternatives" based on the partnership model. An excellent example of the workings of the partnership model is provided by Fountain House, a well-known psychiatric rehabilitation service in New York City. The history of Fountain House clearly shows the limitations of this model.

What is now Fountain House began as WANA—We Are Not Alone—a self-help group formed by several patients in Rockland State Hospital in the late 1940s. The group continued to meet in New York City after the patients were discharged, and attracted the attention of some volunteer workers, who found them a place to meet but who also transformed the group from a self-help project to a new kind of psychiatric facility. A professional staff was hired and, in the early 1950s, most of the original founding group of ex-patients quit in disgust. Some idea of the contempt these volunteers felt for the ex-patients

may be seen in the words of Auguste Richard, one of the original board members, who quotes an Episcopal hymn to describe the volunteers as "Angels of Mercy, Angels of Light, working to rescue the afflicted from their plight."[1] The "afflicted," obviously, can play no part in the service except as recipients.

Jordan Hess, who was a member of WANA, remembers how things changed when the group became professionally controlled:

> There was a feeling of solidarity and companionship in WANA that deteriorated when the professionals got involved. For awhile, the ex-patients continued to run the club. We raised our own money (by holding bazaars, for example), and we voted in new members. But eventually the administrators decided to take that power away from us. Instead of the members deciding who could join, when new people came in they were interviewed by the staff, who decided if they were "suitable cases." WANA was unique because patients ran it—that was abolished when it became Fountain House.[2]

Today, Fountain House occupies a five-story building, which was built for it at a cost of two million dollars in 1965, on West 47th Street in a poor residential neighborhood. A staff of more than sixty (including psychologists, social workers, and consulting psychiatrists) provide services to nearly two thousand "members." The main emphasis at Fountain House is on work, and although some members use the clubhouse as simply a place to sit and socialize, most are involved in some sort of work program, either at Fountain House (where members work in the kitchen, on maintenance crews, as clerical workers and switchboard operators, producing the daily "Fountain House News" on the club's closed circuit TV, or in one of the other work areas), at the Fountain House Thrift Shop around the corner, or on a work placement in private industry. Fountain House also has an apartment program, in which several members share the rent on an apartment that is leased to Fountain House. Fountain House is a large agency—

there are about 120 work-placement positions and more than fifty apartments.

Fountain House doesn't look like a hospital, but it does look like the large and successful institution it is. Although the hierarchy is not rigidly structured, it exists, and the role performed by the director is quite different from that performed by members. Administration and direction of the program are clearly and unequivocally in the hands of the staff. The staff and members involved in each unit (the kitchen or the clerical office, for example) meet daily to review progress and difficulties, but there is no provision for overall membership meetings. (As we have seen, this makes consciousness raising impossible.)

During my visit to Fountain House, staff member Sheila Sherman told me that Fountain House is run by its members.[3] This is the official ideology of Fountain House, but what it appears to mean in practice is that members do most of the work while professionals make most of the decisions. By this standard, most mental hospitals could be said to be "run" by patients.

Director John Beard told me that one of Fountain House's main strengths is its flexibility.[4] Members aren't expected to move through the program at a predetermined speed but can take as long as they like. They can drop out of the program and come back at any time. But the flexibility goes only so far. It does not allow members to question their need to be "rehabilitated" or to determine the suitability and qualifications of the staff.

The Fountain House work program is better than that offered by sheltered workshops, where the pay is often below the minimum wage, but it is still stigmatizing. The Fountain House member is known to be an ex-mental patient, both by the employer and by co-workers, and the tendency in such situations is to blame any deficiencies in the work on the "fact" of the member's "illness." The advantage to Fountain House jobs is that members don't have to go through job interviews (which often automatically eliminate ex-patients, anyway) but can make arrangements through Fountain House. Salaries are paid directly and in full by the employer to the Fountain

House member. The jobs are entry-level—messengers, clerks, food service workers.

Fountain House (and similar programs) separate out those ex-patients who are more needy and less competent and make the assumption that they are representative of all ex-patients and their needs. A paper coauthored by its executive director states that "typically, the members of Fountain House are those ex-patients who find it difficult to make the transition from hospital back into the community."[5] Members don't get to see competent ex-patients; their role models are staff members—only they have responsible, interesting, well-paid jobs. This reinforces the assumption (held by both members and staff) that ex-patients should not aspire very high. A "successful" Fountain House member is one who satisfactorily performs a simple, low-paying job, even if he or she is capable of more. Or, occasionally, a member may become part of the staff, but only if he or she is willing to think of himself or herself as someone who has been "ill" and is now "rehabilitated."

Another example of the partnership model is provided by Center Club, a social club for ex-patients in Boston. The club is located in a rather drab suite of rooms in the YMC Union Building in downtown Boston. Several large rooms are simply furnished with tables and chairs; there are shelves of books and a bulletin board. Several more rooms are set aside as offices.

Center Club, like Fountain House, clearly defines some people as staff, others as members. Staff people are mostly professionally trained, primarily in the field of social work. The club was started by Dr. Samuel Grob, a clinical psychologist. Membership is open to ex-patients from certain hospitals and geographical areas, since funding for the club is channeled through contracts from several mental health service providers. Ex-patients not covered by these contracts can join at a monthly fee of fifty dollars, which is prohibitive since the club is geared primarily toward people unable to hold jobs.

Activities at the club are primarily social, both informal (card playing, conversation) and structured (trips, activity groups). All groups are led by either staff members or

volunteers. Bernard Alderman, the director of Center Club, told me that groups led by members invariably fall apart quickly.[6]

A reliance on staff and volunteers (and an unspoken lack of trust in members) is clear from Center Club literature. Members are seen as "seriously handicapped," and although the club is described as "self-governing," this is qualified by the requirement of "professional guidance and consultation."[7]

Self-government is exercised through weekly council meetings, open to all members. The functions of the staff and of the board of directors (consisting of charitably minded citizens) limit the degree of control exercised by the membership. A club member is an *ex officio* member of the board. ("This avoids any ideas of self-reference or paranoia," Bernard Alderman told me.) Since day-to-day administration is in the hands of the staff and long-range planning is done by the board of directors, there is little left over for the members' council to decide.

While Center Club states that members and staff are equal, a number of practices make clear that staff is in charge. The initial decision about membership is made by staff, who can decide that a prospective member is "too sick" or "unable to benefit from the program." Files are kept on each member, and while members are allowed to see their folders on request, the mere keeping of such records reinforces the staff/member dichotomy. Although Center Club is said to be valued by members because it is not a hospital, this record-keeping subtly reminds members that they are looked upon as mental patients. Center Club staff also take repsonsibility for notifying a member's therapist (usually with, but sometimes without, the member's knowledge and consent) that the member appears to be in difficulty. No rhetoric about members being responsible people can disguise this infantilizing practice. Staff can suspend the membership of anyone they deem to be "too sick."[8]

Center Club strongly upholds mental health ideology and terminology. Ex-patients are viewed as handicapped people needing services with a mental health orientation. When I asked Bernard Alderman how he saw the club fitting into the

mental health system, he replied that the club was a part of a member's overall treatment, filling a member's need for social rehabilitation while the member's therapist takes care of the member's emotional problems. The image of the member as a sick, needy person who depends on other people to provide services indicates the distance staff feel from members. Members, of course, experienced this same distrust from hospital staff when they were patients. Obviously, self-government under such conditions is extremely limited.

This is not to deny that alternatives based on the partnership model have a number of satisfied members. Situations that encourage passivity acquire satisfied, passive participants. But by (subtly) encouraging passivity, professionally run "alternatives" can never evolve toward true membership control.

Consciousness raising is impossible in professionally run ex-patient services. Because the orientation is totally within the mental health framework, members are seen as people with individual, personal problems or defects. Expressions of dissatisfaction with psychiatric treatment, even if they occurred in alternatives based on the partnership model, would be seen as part of a member's illness. Without consciousness raising, as we have seen, ex-patients are as likely as professionals to view such anger as "paranoia," and to view themselves and one another as "sick."

From this description of "alternative" services based on the partnership model, it is clear that true partnership is impossible because the partners are not equal. The staffs of these "alternatives" keep records on members, consult with others about members, and make decisions members have to abide by. Members, on the other hand, can participate in only the most limited kinds of decision making. They can vote to schedule a bowling night instead of a swimming night, but they cannot vote to fire the director or to point out to a staff member that his or her behavior is "abnormal." A member dissatisfied with the basic structure of these "alternatives" has little recourse. The kinds of changes that are within membership control cannot achieve fundamental changes in the way the service is run. Calling such "alternatives" membership controlled is just one more form of psychiatric mystification.

"Alternative" services based on the partnership model are

typically set up with no (or limited) input from potential users of the service. We have seen that Fountain House, for example, quickly replaced membership control with volunteer control, and ultimately with professional control. A guidebook for starting ex-patient social clubs, published by the National Association for Mental Health, suggests that in order to assess the need in the community for a social club a study committee be set up, with members drawn from "lay and professional groups directly involved with the care of psychiatric patients."[9] Clearly, client input is not an essential element in the model.

When mental health professionals are involved in setting up "alternative" services, those services will clearly mirror psychiatric ideology. Even when ex-patients are involved in the creation of the service, the involvement of professionals prevents the ex-patients from developing beyond this ideology. So long as patients are willing to view themselves as the professionals view them, they can continue their involvement, but any attempt to make the alternative truly membership run is impossible, since psychiatric ideology defines the patient as weak, helpless, and in need of outside support. The members of WANA, who initially remained when the group became Fountain House, finally walked out, not in a fit of pique, but because they had seen their dream of helping one another transformed into a nightmare. They had become "members," instead of "patients," but they were still under the direction and control of professionals who viewed them as sick.

Most so-called alternative services for former mental patients follow the "partnership" model. *They are alternatives in name only.*

Alternatives that follow the supportive model and the separatist model are fundamentally different. Although some professionals may be involved in setting up services under the supportive model, their participation is deliberately limited by the membership. In Vancouver, for example, the Mental Patients' Association has received help from a number of professionals, particularly in the area of support letters for funding purposes, but the professionals do *not* come to meetings or take part in day-to-day operations.

The supportive model relies on the abilities of the mem-

bership. The role of professionals is simply to ensure the organization's credibility with funding agencies and other bureaucracies that are impressed by professional credentials. Most mental health professionals, conditioned by their belief that patients are incapable of self-directed activity, cannot go along with the limited role allotted to them under the supportive model. Sometimes, professionals in this situation attempt more direction of the group than is needed or desired by the membership. For this reason, it is essential that when a group attempts to get some help from professionals without being dominated, the members hold frequent and regular meetings without the professionals.

Many professionals deeply resent being excluded from meetings and activities of the group. In fact, this is one of the organizational problems with which any group attempting to set up an alternative service will probably have to deal early in its existence. Public meetings called to discuss deficiencies in mental health programs and the setting up of alternatives will frequently attract a number of well-meaning professionals, as well as a larger number of ex-patients and an intermediate number of relatives and friends of patients. As we have seen, ex-patient consciousness raising cannot take place in such mixed groups, and without consciousness raising, the group will probably incorporate psychiatric ideology, which stigmatizes and discredits ex-patients as it claims to help them. It must be up to the ex-patient members of the group to determine the degree that nonpatients may participate. This requires that some meetings (consciousness-raising meetings) exclude nonpatients. Those professionals and other nonpatients who fight attempts by ex-patients to exclude them from some meetings are precisely the same people who will probably attempt to control and direct the group. Those nonpatients who recognize the need for consciousness-raising meetings and don't object to being excluded from them are the only nonpatients who can participate successfully in what is basically a patient-run service.

The Mental Patients' Association, while it limits the role of psychiatric professionals to serving as outside supporters, has a number of members who have never been mental patients.

Since MPA has never developed an ongoing consciousness-raising process, and many members (both nonpatients and ex-patients) continue to accept psychiatric ideology, this has resulted in *some* members viewing nonpatients as superior and ex-patients as inferior.

Dissatisfaction with even limited amounts of nonpatient involvement has led to the establishment of alternatives that exclude nonpatients entirely. I have termed this the separatist model. In New York City, Project Release operates a seven-day-a-week community center that is entirely patient run. They see themselves not as a service but as a supportive community. It is an important distinction, because the concept of a service implies the existence of two roles, the server and the served. No matter how much a group may attempt to break down such roles, some residue of them always remains when a group is delivering "services." The concept of community, on the other hand, implies interaction. (I am deliberately ignoring here such tortured constructions as *community psychiatry*.) The separatist model is by far the most radical model of alternative services, but it is also the model that promotes the greatest degree of ex-patient confidence and competence.

Project Release was formed around the issue of SRO (single-room occupancy) hotels on Manhattan's Upper West Side, which house many welfare recipients (including large numbers of recently released mental patients) in totally inadequate and unsafe conditions. Project Release secured office space from a tenants' organizing committee and, as it grew and needed an office of its own, was given the use of a room in a neighborhood Universalist church. From a concern with housing, the group moved into other areas, including publishing an informational handbook on psychiatric medication,[10] and working on a patients' rights manual. But providing an alternative had always been a major long-range goal, and in late 1976 Project Release obtained a ten-thousand-dollar foundation grant, with which they rented an apartment and opened their community center.

The Project Release community center consists of a two-bedroom apartment in a large, older apartment building on the Upper West Side, comfortably furnished with donations

and creative scavenging. The community center is a gathering place for members and prospective members and is busy from late in the morning until late in the evening, seven days a week. A highlight of each day is a community meal in the evening. No one is designated "staff." Members are there not because they are running the center but because it is clearly a place where they enjoy spending their time. In order to discourage anyone from becoming a passive recipient, all members are required to serve on one or more of the committees (fund raising, community center, newsletter, and so on) that oversee the various areas of responsibility. As the group states:

> Professional supervision creates a dependency pattern which is a cause of recidivism. In the informal programs of Project Release, members seek to extend acceptance and cooperation, letting each individual set her/his own pace in tasks and responsibilities. Project Release feels that this form of self-help is a strong antidote to the anxiety of isolation and helplessness induced by society and psychiatry.[11]

In a moving tribute to the impact of Project Release on her life, a member has compared the effects of being in a conventional aftercare facility to those of becoming a member of Project Release:

> Everything at the aftercare facility perpetuates your feelings of helplessness, dependency, and role-playing. You move from phase to phase of a program: from working at the work area to working at a volunteer job; from a beginning to an advanced group.
>
> Criteria are purposely kept nebulous; one moves in a track virtually set up and operated totally without any personal exercise of will; you are never asked, nor, under the circumstances, could you ever say, what changes should be made. . . . You are, in actuality, willy-nilly, learning that the one person who is not able to help you in your relationship to other people is *yourself*. . . .
>
> Project Release exists in opposition to the whole self-perpetuating bureaucracy of "Mental Health" care in this society. . . . Here, you can learn a whole different way of *being*; you begin to trust yourself and your reactions. Instead of feeling coldness at your core, you feel *warmth* and *strength*. . . . Here, we are *with* each other to an extent never possible at an aftercare facility. We experience the entire range of emotions as being positive, as all being us; no feelings are ever invalidated. . . . Most of us feel that a true alternative has to be different *ENTIRELY* from what it is objecting to.[12]

Project Release has also maintained its original interest in housing for ex-patients. The housing program helps members to get their own apartments, either by themselves or communally with other group members. The apartments are not part of Project Release—they are rented and run by their residents—but they form part of the wider Project Release community. They compare their apartment program to other kinds of housing programs for ex-patients:

> SRO's and adult homes, halfway houses and residences are horrible and self-perpetuating institutions. We are always being shunted from one form of institution to another or just put back into the same living situation that caused many problems in the first place. Why can't we just live in our own apartments, like other people? Contrary to most "experts" opinions we can and we are.[13]

Project Release has completely broken down the concepts of staff and clients. They have avoided setting up any more structure than is absolutely necessary, preferring occasional confusion to impersonal efficiency. They are adamant that no one receive a salary for working at Project Release, since they believe that members could not be equal if some were paid for being there. (They are currently trying to get a grant to start a nonprofit printing business, which would provide employment for interested members. And they have recently opened a thrift shop in which members work.) The concept of community, of people helping one another because they care about one another, is dramatically different from conventional concep-

tions of therapy. The example of Project Release shows clearly how a group of former mental patients working together follow a completely different model from that used by mental health professionals. The separatist model doesn't divide people into fixed categories of sick and well, since everyone experiences stress and reacts in different ways. Rather than setting up one group of people as "experts," people are seen as equals who can help one another.

This look at three different models for alternative services shows that the role played by ex-patients is the crucial variable. When they are excluded from any meaningful role in planning the service, it becomes an alternative in name only. The same attitudes of condescension and distancing that are found in mental hospitals are also found in many of the halfway houses, rehabilitation services, and social clubs that are the supposed alternative.

On the other hand, the alternatives built on the supportive and separatist models—the true alternatives—have been designed by ex-patients who are not merely passive recipients of a service but who are actively involved in running it. Role distinctions between service providers and service recipients blur and disappear. Mental health professionals tend to be skeptical of true alternatives because they cannot see patients as competent people. In the professional versions of alternatives, based on the partnership model, the professional is always the senior partner. True alternatives are threatening because they do away with the need for professionals.

Mental health professionals and the facilities they control frequently display contempt for the recipients of their services. And the people they think of as incompetent and untrustworthy feel and react to these unspoken attitudes, which exist in supposedly modern, progressive community mental health centers as well as in old-style state hospitals. A few examples:

A small group of staff members come into a room that is sometimes used by patients and sometimes by staff. They tell several patients that they are planning to use the room now, and the patients leave. The staff members then take out a cake and have a small party for one of the staff. When a patient comes into the room for a glass of water, they offer her a piece of cake, but although there are several other patients sitting in the next room, and more than half the cake is left over, they do not invite the patients to join them. (I observed this in the Chelsea Mental Health Center in Massachusetts.)

I try to explain to a therapist why I am feeling so depressed. "For one thing, I miss my daughter, who lives 3,000 miles away with my ex-husband. Sometimes I just can't help thinking about it, and I feel so lonely." "You shouldn't let that bother you," the therapist says glibly. "I hardly ever see my kids, and it doesn't bother me." I looked at him in horror, wondering if he wanted me to be as cold and unfeeling a person as he seemed to be. (This happened to me at the Whatcom Counseling and Psychiatric Clinic, in Washington State.)

Several attendants enter the dayroom, where a group of patients are gathered in front of the TV, watching a program. Without a word to the patients, one of the attendants changes the channel, and then the group of attendants pull up their own chairs in front of the patients so that they can watch their chosen program. (This happened to me at Rockland State Hospital in New York.)

These attitudes occur in many so-called alternatives, as well as in traditional psychiatric facilities. "Clients," "residents," and "members" are still looked on by staff members as patients, as essentially different from themselves. In halfway houses, residents seldom get to decide whom to room with, let alone who the director should be. Ex-patient social clubs have rules against staff members and club members socializing—yet the rhetoric claims they are equal. At Fountain House, which presents itself as a model rehabilitation service, all job placements are deliberately in entry-level jobs, ignoring the differing educational and aspirational levels of members. Once you've been a mental patient, the staff thinks you're suitable only for a job as a waitress or a file clerk, and you're expected to go along meekly with their judgment.

Journalist Anthony Brandt, who feigned hearing voices and was admitted to a state hospital, was amazed how easily he and the other patients submitted to becoming "creatures of no significance to be herded through the day, to be managed and controlled."[14] Drugs were used extensively to numb patients and slow them down.

> But drugs were not the whole story. What subdued us even more effectively was this mindless routine and our mindless participation in it. By treating us routinely as if we lacked the ability to make any choices for ourselves at all, little by little they persuaded us it was true. Subjected to a routinized disrespect and indifference, we began to believe something must indeed be wrong with us, something fundamental must be missing. We began to behave like the empty beings we were supposed to be.[15]

After only two days as a mental patient, Brandt had already become dehumanized in the eyes of the psychiatrist assigned to him. Without making any inquiries as to his interests, education, or abilities, she mapped out her life plan for him. As he recalls:

> I was to stay in the hospital three months or so to stabilize my life, she said. When I seemed up to it I would go to work in the hospital's "sheltered workshop" where I would make boxes for IBM and be paid on a piecework basis. When I had made enough boxes I would then be moved to the halfway house in Kingston, across the Hudson, where they would arrange a job for me in a special place called Gateway Industries established for the rehabilitation of mental patients. There I would presumably make more boxes. Eventually I might move out of the halfway house into my own apartment.[16]

Brandt, of course, was horrified by this limited vision of his future. When he told the doctor that, instead, he might try to go back to his wife (from whom he had claimed to be separated in his admission interview), she ridiculed him, asking him if perhaps his wife wouldn't rather have a "real man."[17] Mental hospital, halfway house, rehabilitation service, psychiatrist—some are considered alternatives, yet all have the same limited view of the mental patient and demand that the patient believe in it as well.

Staff are so conditioned to viewing anyone who comes before them in the role of a patient as sick that they have a hard time picking out impostors. Both journalists and scientific investigators have posed as mental patients and are seldom, if ever, found out by staff, although several of the Rosenhan investigators, for example, were challenged by patients.[18] People who have been hospitalized for mental illness are simply presumed by staff to be mentally ill.

Even people who are not mental patients and who are behaving quite "normally" (whatever that may be) may be perceived by psychiatrists as mentally ill. Maurice K. Temerlin reports a study in which an actor was coached so as to portray "a mentally healthy man." Many psychiatrists who viewed the tape, in which the actor provided "normal" answers to mental-status questions, diagnosed various mental illnesses. One psychiatrist who found the man on the tape to be "psychotic," is quoted as saying, "Of course he looked healthy, but hell, most people are a little neurotic, and who can accept appearances at face value anyway?"[19] On the basis of such casually made decisions, people can be, and are, committed to mental hospitals to be made into mental patients.

The casual disregard for individuals that is commonly displayed by mental health professionals, in all kinds of mental health facilities, communicates an unspoken message. "Good patients" are patients who know their place, who go along with these subtle put-downs. And since the penalty for failure to cooperate is so great, since any protests can be dismissed as merely pathological symptoms, since the power professionals hold over patients is so enormous, is it any surprise that most of the patients go along?

Even outpatients at community mental health centers can be subjected to enormous penalties. (Community mental health centers, introduced with great fanfare in the early 1960s as a replacement for state hospitals, have become simply another

layer of the psychiatric bureaucracy.) During 1976, along with other members of the Mental Patients' Liberation Front, I participated in a weekly patients' rights meeting held with patients at a community mental health center near Boston. Despite the fact that these patients were officially voluntary day patients, we witnessed a great deal of coercion. One patient "voluntarily" entered a mental hospital after the head of the center threatened her with commitment. Another patient was unable to get his medication changed or to get any information about side effects.

We also saw patients demeaned and degraded. One woman had to wait in the hall if she arrived late for the day activities program, which caused her to feel like a small child. The one room in the entire center where people could smoke and drink coffee had to be vacated by patients whenever staff wanted to use it. A poster designed by a patient to publicize the patients' rights group was torn down under circumstances indicating that it had been done by a staff member.

Becoming a client of *any* mental health service may result in being subtly degraded. Whether the service is a "traditional" mental hospital or an "alternative," such as a halfway house, it is likely to view its clients as incompetent people who constantly need looking after. These attitudes prevent professionals from helping their patients to move toward independence and self-sufficiency, even when that is precisely what they claim to be doing.

Alternative services must be designed so that this psychiatric elitism is eliminated. People who are having difficulties in living and who seek help with their problems are *not* served by a system that maximizes their inadequacies and ignores their strengths, nor by one that implies that only incompetent people have problems. "Professionalism" demands that mental health practitioners project a neutral, impersonal manner. Sometimes this may be concealed by a bland friendliness, such as an insistence on first names, but it is, more likely than not, only a pretense of friendliness. Real friendliness would break down the role structures of "professional" and "patient" and lead to the acknowledgment that everyone may experience difficulties. Some therapists may genuinely want to

be friendly with their clients; but the structure of therapy interferes. Friends don't stop talking when the hour is up, nor does their relationship involve payment. One therapist I had insisted on first names, wore jeans and boots, and sat on the floor during sessions. This did not negate the fact that he had power over my life; his game that we were friends did not change this fact.

In alternative services, the entire question of role structure is confronted openly. Distinctions between staff and clients are kept fluid, if not eliminated, not only in the area of service delivery but also in terms of administration. When ex-mental patients run an alternative, they have opportunities to prove their competence as well as to get help with their problems. If someone makes a mistake (and not only ex-patients make mistakes), people work together to straighten things out. Alternative organizations tend to work in some form of collective structure, which encourages the sharing of responsibility. Rather than delegating authority to a director or administrator, which implies that only a few special people are capable of exercising authority, collective structures allow people of varying abilities to work together. Many people's lives have been transformed by their participation in alternative services. Group support, for many, has been far more helpful than various psychiatric services they may have used in the past.

Although some participants have had to return to mental hospitals, this has usually been for short periods and can usually be attributed, at least in part, to limitations imposed on the group by the lack of money to provide some of the services the group has defined as necessary. Project Release, for example, is currently trying to get funding to open "sanctuaries," where members can receive short periods of intensive support from other members.

All this is not to deny that some people occasionally become dramatically disturbed. They may hear voices, for example, or see things that other people do not, or take actions that appear irrational and impulsive. But most people who do become disturbed in these ways are reacting to extremely difficult circumstances that have been a part of their lives for long periods

of time. If people could find nonjudgmental, supportive services that can provide help with their ongoing life problems, it is likely that there would be fewer incidences of dramatic "breakdowns."

Most people maintain stereotypes of the "mentally ill" that are far different from the reality that leads to some people being labeled mental patients. Most mental patients (excluding those who have suffered damage from having been kept institutionalized for long periods of time) are not strikingly different in their problems and their concerns from so-called normal people. Although the public stereotype of the mentally ill would indicate that most mental patients have hallucinations and delusions or that they speak in incomprehensible gibberish, such behavior is comparatively uncommon.

Many studies have shown that the incidence of "mental illness" among people who have never been hospitalized or received psychiatric treatment is quite high. In other words, according to psychiatrists, there are a lot of "mentally ill" people walking the streets. Perhaps the best known of these studies, the Midtown Manhattan Study, found that less than a fifth of the residents they interviewed could be rated psychiatrically well and that between a fifth and a quarter of the population they studied were psychiatrically impaired.[20] The authors of the study interpreted these figures to mean that there is a great unmet need for more psychiatric services. There is, however, another way to look at the results of the Midtown Manhattan Study. The huge numbers of people that the authors of the study felt needed mental health services but weren't receiving them *were managing and functioning in the community*. They weren't screaming in the streets or disrupting their neighborhood. They were making do, as best they could, like most people, and they did not define their problems and difficulties as psychiatric in nature. What makes mental patients different is not the nature and severity of their problems but that their difficulties have been redefined as psychiatric "symptoms," requiring professional help. Since more and more kinds of behavior are being redefined as psychiatric in nature, psychiatry is creating an ever greater "need" for its services.

The creation of patient-controlled alternatives stands in sharp contrast to the psychiatric system. Instead of creating clear and stigmatizing distinctions between those who are competent to give help and those who are weak enough to need it, these alternatives are creating new communities of equals, counteracting the alienation and powerlessness most people rightly sense to be a prime cause of their unhappiness.

NOTES FOR CHAPTER 4

1. Auguste Richard, *The Early Days of Fountain House* (New York: Fountain House, n.d.), p. 4.
2. Personal interview with Jordan Hess, July 14, 1977.
3. Personal interview with Sheila Sherman, December 28, 1976.
4. Personal interview with John Beard, December 28, 1976.
5. Bonnie R. Bean and John H. Beard, "Placement for Persons with Psychiatric Disability," *Rehabilitation Counseling Bulletin* 18, no. 4 (June 1975): 253.
6. Personal interview with Bernard Alderman, October 27, 1976.
7. Samuel Grob, "Psychiatric Social Clubs Come of Age," *Mental Hygiene* 54, no. 1 (January 1970): 133, 135, 136.
8. Information and quotations in this paragraph are taken from an untitled, undated, unsigned ten-page mimeographed paper describing Center Club and given to me during my visit.
9. Mabel Palmer, *The Social Club* (New York: National Association for Mental Health, 1966), p. 8.
10. David H. Briggs, *Consumer's Guide to Psychiatric Medication* (New York: Project Release, 1975).
11. "Project Release: A Statement of Purpose," n.d.
12. Joyce Kasinsky, "Why Am I in Project Release?" *Silent No Longer! The Newsletter of Project Release* 1, no. 4 (n.d.): 6–7.
13. "What's Happening," *Silent No Longer! The Newsletter of Project Release* 1, no. 5 (n.d.): 1.
14. Anthony Brandt, *Reality Police* (New York: William Morrow & Company, 1975), p. 168.
15. Ibid.
16. Ibid., p. 170.
17. Ibid., p. 171.
18. D. L. Rosenhan, "On Being Sane in Insane Places," *Science* 179 (January 19, 1973): 252.
19. Maurice K. Temerlin, "Suggestion Effects in Psychiatric Diagnosis," in *The Making of a Mental Patient*, ed. Richard H. Price and Bruce Denner (New York: Holt, Rinehart and Winston, 1973), p. 235.

20. Leo Srole et al., *Mental Health in the Metropolis: The Midtown Manhattan Study* (New York: McGraw-Hill Book Company, 1962), pp. 143–144.

5
When People Go Crazy

There are no commonly accepted definitions, among either physicians or the general public, of *mental health* and *mental illness*. The kinds of behavior that get labeled mental illness are deviant acts that don't fit into neat categories, such as "crime" or "immorality." Sociologist David Mechanic has concluded that "mental illness is regarded usually as a residual category for deviant behavior having no clearly specified label."[1] Calling certain kinds of deviance "illness" is a widely accepted convention in this society, but rather than conceding that it is just a theoretical construct, most people accept it as a scientifically verifiable fact. Most of the scientific literature about mental illness is biased in just this way; the possibility that the behavior being described might be explained in other ways than by calling it mental illness is not even considered.

Psychiatrists can have expertise in "diagnosing" and "treating" mental illness only if it truly is an illness; otherwise psychiatrists are merely making moral pronouncements about behavior disguised as objective medical opinions. By calling some kinds of behavior mental illness, psychiatrists invalidate any meaning that behavior might have, since the behavior is merely a "symptom." It is, of course, possible that by calling some behavior mental illness, psychiatrists are obscuring the causes even as they attempt to explain them. As psychiatrist Thomas Szasz has observed: