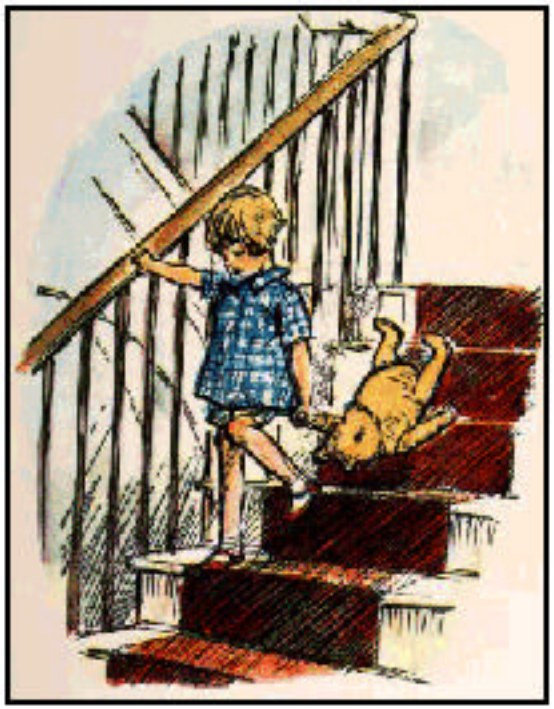
Overcoming Mentalism

The trip from mental patient to psychiatric survivor



"Here's Edward Bear coming down stairs now, thump, thump, thump, on the back of his head behind Christopher Robin. It is, as far as he knows, the only way of coming down stairs but, sometimes he feels that there really is another way; if only he could stop thumping for a moment and think of it."

From "Winnie the Pooh" by A. A. Milne

Mentalism

Discrimination against people who are receiving or who have received psychiatric treatment.

Other common "isms"

Racism

Sexism

Ageism

Common Mentalism

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"

Micro-aggressions

1. **Not powerful individually**
2. **hundreds, even thousands daily**
3. **cumulates over years**

Examples of micro-aggressions (mentalism)

Derogatory Language:

He's a basket case
You're nuts
What a loony tune
She's crazy

Stereotypes of people who receive mental health services range from hostility ("They need to be locked up.") to sensationalistic media stories depicting people as crazed killers and "dangerous mental patients".

Effects of Mentalist

Micro-aggressions

- **Negative attitudes become internalized**
- **People feel ashamed**
- **People blame themselves for their difficulties**
- **People feel worthless**
- **People feel hopeless about their future**
- **People lose confidence about their abilities**
- **People feel they must hide their histories**
- **People fear losing their job, their friends, their credibility**
- **People become demoralized**
- **People direct their anger and helplessness back upon themselves creating a worsening spiral downward**

Mental health professionals rarely, if ever, acknowledge the power of mentalism.

More often, the person who is demoralized by his or her treatment as a "mental patient" is more likely to be rediagnosed, labeled "treatment resistant," or offered more medication.

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.

Different Standards

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.

'We' "force" 'them' to take medications that cause tardive dyskinesia because 'they' are sick and 'we' are not.

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, and torture. If "we" do this to "them" in a hospital, it is "treatment" for "their" own good.

If a psychiatrist threw abusive tantrums at nursing staff, s/he would be seen as "authoritarian" and "running a tight ship" while people receiving care on the same unit would be forcibly medicated and secluded for the same "inappropriate" behavior.

Rather than acknowledge that splitting is a distortion of reality, mentalist thinking leads clinicians to establish a category that is "almost us":

"high-functioning."

High-functioning vs Low-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.

At times the "low functioning" label can be used punitively to describe a consumer who challenges the power of the staff

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.

A Simple rule of thumb to identify mentalist splitting

"No, **but…**

Examples of Mentalist Splitting

Would I live in a certain place?

No, **but…**

Would I take a certain medication?

No, **but…**

Would I put up with a risk or side effect?

No, **but…**

Would I go to a certain group?

No, **but…**

Would I want to be talked about in a given manner?

No, **but…**

Mentalist splitting precludes genuine empathy

Seemingly empathic statements such as "If I were in his shoes…" often cover up the underlying mentalist assumption that results from splitting: "But of course, I never will be."

Pseudo-empathy as mentalist splitting

The implication is that the competent provider would exert better judgment in the recipient's situation and would therefore escape the difficulties facing the recipient.

The provider's ***imagined*** experiences are given more credibility than the consumer's ***actual*** experiences.

Seemingly empathic statements become a validation of the superiority of the provider and can then be used to justify inequities of power and the oppressive practices that result.

An 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.

This provider clearly sees homelessness and psychiatric disability as unlikely to occur in his life and s/he has, therefore, not seriously considered the complex social and personal barriers that s/he might face in that situation.

WE SHOULD TREAT PEOPLE AS WE WOULD WANT TO BE TREATED, WITH RESPECT, DIGNITY, AND CONCERN.

Providers should listen to people and provide services based upon people's expressed interests instead of judging them and acting in what providers (perhaps falsely) believe to be people's best interests.

Providers should never refer people to any service or resource that they would not use themselves, or subject anyone to treatment that they would not welcome for themselves.

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 sometimes find themselves in the position of making less-than-optimal referrals.

Even in the face of these difficulties, providers can communicate concern for the comfort and preferences of the person they are serving, and *affirm the person's deservedness of a better life.*

It is very important that providers not convey the impression that people must accept substandard treatment, or should be grateful for whatever they are given.

Providers 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.

Providers (and everyone else) need to encourage people to hope and dream.

**Too often,
people are told
what they can't
do and thus,
they are robbed
of the ability to
hope.**

A primary task of providers is to help people to find within themselves both the ability to dream and the belief that those dreams can become possible.

It is important to 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

Clinicians tend to believe they know a lot more than they actually do.

Most of what clinicians think they know is actually belief in a model or an approximation, and very often these models prove to be false.

To overcome mentalism, providers must develop a deep appreciation for how much they don't know.

If providers are honest, they must admit…

They don't know why people have experiences that are labeled "psychiatric"

They don't know whether these experiences are actually illnesses

They don't know how medications affect people

They don't know how neurochemistry relates to human feeling and behavior

They don't know how people recover and heal

Mentalist thinking can cause providers to lose sight of how much they don't know.

Mentalist thinking can cause providers to believe that they have sound scientific answers for people's problems and that the treatment they recommend is ***"right."***

Failure of providers to recognize the limits of their knowledge can lead them to act prematurely and restrictively. They tend to interpret behavior when they should inquire about its meaning, and prescribe interventions when they should listen and learn.

Mentalism in treatment

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, providers need to modify their assumptions and approach people in a manner that acknowledges the imperfections of the provider's 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 short-comings of the treatment.*

short-comings of treatment 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

• many other issues

It is the **clinician's** responsibility to initiate the response to treatment failure

Mentalism in Language

(mental health jargon)

Obvious terms:

basket case

loony tune

nuts

fruit cake

etc.

The offensive aspects of seemingly professional terminology are often more subtle. How these terms are used 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.

Example:

Decompensate 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. The clinician who is referred a person who has ***"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*.

An example of a better way to describe a situation than using the term *decompensate*:

"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.

The demotion from "us" to "them" is a loss of one's designation as a person.

A person with a diagnosis can become, "a schizophrenic" or "a bipolar" or "a borderline," etc.

People who have internalized the 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 mentalist 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.

In psychiatric treatment, the term "patient" has come to be associated with discrimination, coercion, and oppression. 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.

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 one professional once said, he's "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, wellbeing, and dignity of those who are power-down.

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 "C/S/X" ("consumers/survivors/ex-patients,") while the designation "client" remains the most common and generally accepted term in public mental health systems.

Most of the time, professionals use offensive language unintentionally, but this makes it no less wounding.

To escape from mentalist attitudes and language clinicians need to examine the underlying meanings and functions of their communications.

For example, if they describe someone as "a borderline with intense dependency," "a non-compliant schizophrenic," "an oppositional patient," "a typical drug-seeking antisocial personality disorder," or "a manipulative, gamey manic," are they seeking to understand, respect, and help, or merely pass judgment, feel superior, and assert their professional dominance?

It could be illuminating to ask clinicians why they continue to use terms that offend and stigmatize the people they aspire to help.

If they lack the empathy that would motivate them to change their language to avoid hurting the people they serve, what does that say about their 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 of discrimination.

More on language

A few quotes from psychiatric survivors

"I hate the 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."

"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. "

"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."

"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."

To combat mentalism in language, clinicians should ask themselves…

• Would they use the same language if they were speaking directly to the person?

• Would they feel comfortable having the person read what they have written in the person's chart?

• Would they want to be talked about in this manner?

• Would they talk about their friends and colleagues in this manner?

• Does this language help the person and me to find solutions to problems and create positive change?

Any "**No**" answers, no matter how seemingly justifiable, indicate that mentalism is operating.

Mentalism in Prognosis

Mentalist assumptions have caused many clinicians to have a rather pessimistic view of the capacity for their clients to recover.

When one points out the large number of people, including many mental health activists, who have overcome their disabilities, many clinicians commonly respond that these individuals must have been "misdiagnosed" or "do not really have schizophrenia."

FACT

Many long-term research studies have shown that a significant number of people having serious psychiatric concerns recover completely, irrespective of their diagnosis.

No matter the debate on the research, the human impact of mentalism in prognosis is undeniable.

People receiving the pronouncements,

"You will have this disability for life," or

"You will always have to take medications," or

"You will not become a lawyer/doctor/economist/teacher," etc.

are almost invariably devastated

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.

FACT

The APA (American Psychiatric Association) has repeatedly stated that psychiatrists are unable to predict dangerousness with any degree of certainty.

Overcoming mentalism in prognosis requires that professionals critically examine their 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.

Clinicians must disclose to people that they don't know who will recover, when, or how. In many ways this allows clinicians to impart a very hopeful message to everyone they 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.

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.

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.

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%.

Yet psychiatry has continued to support measures that focus on forcing people to comply with treatments that they feel are unhelpful.

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.

Mental health clinicians tend to equate subduing a 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 but, 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.

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, individuals' rights in this regard have been upheld, irrespective of the possible risks to self or others. The only exception has been in the reporting and treatment of highly communicable diseases.

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.

Informed consent is often obtained by merely 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 of these effects.

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.

The indifferent 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 conspicuously affected by mentalist prejudices.

Many psychiatrists fail to examine people for tardive dyskinesia (TD).

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.

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.**

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 (Abnormal Involuntary Movement Scale) or DISCUS (Dyskinesia Identification System Condensed User Scale).

What typically happens in mental health clinics:

1. **Generally, individuals taking neuroleptics are encouraged to stay on a maintenance dose of medications.**
2. **Regular dose reductions are rare, as clinicians fear the person will "decompensate."**
3. **Psychiatrists typically observe the person informally for obvious involuntary movements and indicate in the chart "no TD."**
4. **Rarely is an AIMS or DISCUS performed or documented.**
5. **Generally the discussion of TD is limited to the warning of possible "muscle tics" given in the informed consent.**

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.

Why are psychiatrists failing to perform routine monitoring of medication risks?

- **not due to time constraints, since the modified AIMS or the DISCUS takes only 10 minutes to perform and rate.**

- **not due to fears that people will abandon treatment, since research suggests that well-informed recipients tend to be more involved in their care and less likely to be "non-compliant."**

It is likely 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.

Mentalism has lead to a 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.

Studies showing reduced risk with newer psycho-pharmacologic agents have been conducted for relatively brief periods of time.

Even clozapine, the "gold standard" among antipsychotics, and the serotonin reuptake inhibitor antidepressants (SSRI's) have been associated in rare instances with TD.

Suggestions
for elimination
of mentalist
discrimination
in medication
practices:

1. The use of psychotropic medications to enforce social control must be separated, conceptually and in practice, 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 they are relieved of this oppressive myth, clinical practice will continue to reflect the public's mentalist prejudices rather than the needs of the people they 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, clinicians 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. Clinicians 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. Clinicians 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. Clinicians must diligently apply themselves to the task of early identification of the medical consequences of psychotropic medications. This should include regular examinations 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

Power expressed in environmental terms includes:

- **space**
- **privacy**
- **safety**
- **cleanliness**
- **comfort**
- **choice**
- **access**
- **aesthetics**

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 power differences even more pronounced.

Individuals living in supported environments often:

- share rooms with roommates not of their choosing
- rarely have privacy
- use furniture that is chosen by others for easy maintenance and durability rather than comfort or aesthetics
- have insufficient space to display or store personal possessions
- have no way to lock their possessions, their rooms, or the bathroom to insure safety and privacy and deter theft
- are given only housing options that are run-down or located remotely
- are left to use public transportation that is inconvenient, uncomfortable, or even unsafe

Many of these conditions are shared by anyone who has little money. However, mentalism does contribute to many specific environmental micro-aggressions as well.

A common mentalist micro-aggression, occurring in many clinics, is simply the separation of staff and client restrooms.

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".

The separation of facilities is often combined with a lack of maintenance and privacy in the restrooms used by clients. There are places where the stalls in the "client" restroom have no doors. This is justified as a "safety measure."

The mentalist justification for this discriminatory practice by clinicians is, "clients have a different standard of hygiene than we have."

Such mentalist attitudes are not only condescending but they also obfuscate 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 congregate here and observe 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.

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 the impression of superiority and control is emphasized by the use of plexi-glass dividers or even chain-link caging.

Environmental offensiveness is often combined with procedural micro-aggressions to produce particularly disparaging messages toward people using services.

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 distribute 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.

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.

Selective inattention to a past history of abuse often causes clinicians to fail to diagnose the root cause of psychiatric disability.

There is a need for additional 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.

One psychiatric survivor reports, as a child, the overwhelming, all encompassing feeling while being raped by my step-father or beaten to a pulp by my mother was a feeling of powerlessness. The controlling nature of psychiatric hospitalization retriggered those feelings of powerlessness. Being secluded or restrained or forcibly drugged not only did NOT heal, they recreated the same sense of abuse and trauma and exacerbated my condition and lengthened my stay.

Triggers and retraumatization can occur in both the physical and interpersonal environments.

For example, the spread-eagle restraint of a rape victim and, disbelieving the history given by a survivor of incest, can both be retraumatizing.

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.

People may also 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 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 by the goal of generating paperwork or revenue.

Alienation from values and disappointment in "the system" causes many clinicians to burn out and to become hardened in the cynical, mentalist beliefs that pervade these organizations.

Clinicians often feel pulled by organizational or group dynamics to use pejorative terms, express pessimism and contempt for their clients, or act in a restrictive or punitive manner.

Every clinician must take personal responsibility to resist very real mentalist pressures in the workplace. Despite organizational pressures, clinicians can and must establish the clear expectation for themselves that they will treat the people they serve with dignity and respect, and that caving in to discrimination and scape-goating of clients is never "OK."

Clinicians must find the courage to openly confront discrimination when they 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.

I have a friend who is a clinician who reported:

"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, 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."

To change this situation the group needed two things:

- **support from leadership**

- **support from within the team.**

• Management needs to provide supervision to team members who have adopted a cynical, mentalist attitude to clearly communicate that discrimination of this sort will not be tolerated.

• The team needs clear feedback about the deleterious effect that their negativity has on their performance as professionals and guidance to establish and implement a plan for amelioration.

• Clear policies are needed that include "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 they serve need to be removed from service organizations to keep them from harming clients and destroying organizational morale.

• The team also needs input from team members who continue to have hope and respect for their clients.

• Silence within the group is taken to be tacit agreement, and the unspoken message is that mentalist prejudices are an acceptable standard for the group.

• Simply to affirm hope and positive values, to question the position of cynical members, or to express agreement with an alternative approach would greatly diffuse the power of 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.

Consider the impact of 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.

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.

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.

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**
- **the risk of addiction**
- **the potential for creating more medical problems for the person**
- **legal concerns**
- **alternative means of managing anxiety**
- **alternative means of managing insomnia**

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. 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 clinician has set up the conflict by treating the person in a disrespectful, judgmental, or dismissive manner.

Example:

The community psychiatrist who complains bitterly about the "abusive behavior" of "borderlines" admitted to the inpatient unit. However, this psychiatrist denies people's requests for Tylenol for pain, refuses them any medications for sleep, and tells people that they are "manipulative" for coming to the hospital.

Unfortunately, it is common for clinicians to justify mentalist behavior by stating that the person coming for services was demanding, angry, or "needed limits."

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.

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.

Striving for equality and respect in clinical relationships brings clinicians closer to the values that attracted most clinicians to clinical practice in the first place.

Power-sharing refocuses clinicians on relationships as the vehicle to healing and on service to others as clinicians' most important goal.

The focus on power-sharing in therapeutic relationships restores clinicians core values and expresses their integrity.

Part of the power-sharing relationship involves sincere efforts to understand the perspective of the person served rather than to label or judge.

The clinician and the person seeking services can then collaborate to devise solutions that are uniquely suited to the person's needs. This creative process can refresh clinicians and help them to learn and grow professionally.

Power-sharing also increases the efficacy of clinicians.

Very often clinicians' energy is frittered away in efforts to get people to conform to their expectations or fit into their idea of a helpful program. They 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.*

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.

This approach takes informed consent one step further into the realm of informed decision-making.

In the existing style of informed consent, the clinician arrives at a conclusion about the best treatment, and seeks the person's permission to proceed. In power-sharing informed consent, 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.

With power-sharing, 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.

Some in the psychiatric survivor movement believe 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.

This 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

• 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 must preserve accountability for the quality and impact of interpersonal interactions within the organization

When organizations or services fail in these goals, they tend to reinforce post-traumatic effects.

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.

Negative stereotypes and assumptions are often interwoven with clinical practice, language, procedure, and even the physical environment.

Generally, practitioners are unaware of their prejudices and of the injury they cause the people they serve through their mentalist beliefs, and clinicians often give various justifications for the way things are traditionally done.

A good rule of thumb for clinicians to evaluate for the presence of discrimination is to reflect on what their own response would be if they were to receive the same treatment.

It is important that clinicians (and everyone else) confront discrimination when they find it, in themselves and in others.

Clinicians must come to grips with both their personal mistakes and their participation in a profession that historically has done much to abuse the people who came for care. They need to undergo their 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.

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.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