

THE PARALLEL UNIVERSES OF
MENTAL HEALTH CARE PROFESSIONALS AND PATIENTS

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You must make the unjust visible.

—Gandhi

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One Introduction

For years, mental health patients¹ have endured abuse by various methods. There were the obvious, clear abuses that today most people consider as such, like lobotomies, and there are the more subtle abuses that patients still face, like being routinely stereotyped. There was a time when psychiatrists sincerely believed that lobotomies were effective for treating mental illness. Similarly, most people today clearly recognize slavery in the United States as abuse. However, like in psychiatry, there was once a time when slave-owners sincerely believed that slaves were inferior to the rest of the population and that slavery benefited the slaves. Abraham Lincoln's "Emancipation Proclamation" legally freed slaves from the abuse of slavery. Mental health patients were legally freed from the abuse of lobotomies through anti-psychosurgery laws.

As a racial minority, many former slaves and their descendents still faced abuse in the form of legalized racism. As a less obvious and clear type of abuse, racism was a trickier issue to illuminate; having to drink from a "separate but equal" water fountain was not nearly as extreme as being whipped during forced labor. The civil rights movement was successful in removing most legalized forms of racism in the United States, criminalizing many activities of racial discrimination, and making racial oppression visible to the public. Mental health patients, on the other hand, are still fighting in obscurity against the subtle, less obvious abuses they face in mental health care.²

The progression of mistreatment that both mental health patients and slaves and their descendents have had to fight illustrates psychiatrist Seymour Halleck's³ concept of direct and

¹ "Mental health patients" are patients under mental health care; all patients discussed here are mental health patients.

² "Mental Health care" includes inpatient and outpatient, psychological and psychiatric care.

³ Expanded notes on the credentials of cited authors are included as annotations in the list of references at the end.

indirect oppression (1971, 22-23). In his description of direct oppression, Halleck states that direct oppression comes from identifiable sources (1971, 22-23). In the case of slavery, the abuse perpetrated by slave-owners was a direct source of oppression. In the case of mental health patients, lobotomies ordered by psychiatrists were a direct source of oppression. In his discussion of indirect oppression, which he describes as a form of oppression that does not have an easily identifiable perpetrator, Halleck briefly mentions the difficulty that African Americans have as a result of institutionalized racism (1971, 22-23). This difficulty arises because indirect oppression is more nebulous than direct oppression, raising questions of who to blame, how to stop the oppression, and where the feelings of being oppressed come from. An African American indirectly oppressed by racism might be frustrated by not having the same opportunities as Caucasian peers, yet have difficulty justifying this frustration because it is so nebulous and less visible, especially to those not actively being oppressed.

Currently, both direct oppression against slaves and indirect oppression against racial minorities are widely recognized as oppression, but the oppression of patients in mental health care is not so widely recognized. Many people express horror at stories of lobotomies, an example of direct oppression, but the indirect oppression of mental health patients goes unnoticed by most of society and unaddressed by most mental health care professionals.⁴ This happens because today most of society does not actually experience mental health care as it is experienced by patients and the professionals who do experience mental health care may not believe they act oppressively toward patients.

⁴ "Mental health care professionals" is a generic term for all professionals who are actively involved in providing mental health care for patients.

Ann E. Cudd, PhD, a professor of philosophy, carefully defines oppression and the way it operates. According to Cudd, four conditions must be met for a set of social circumstances to qualify as oppression: harm, the presence of two social groups, one social group having a privileged position over the other, and unjustified coercion (2006, 25). Cudd defines “oppression” as “a harm through which groups of persons are systematically and unfairly or unjustly constrained, burdened, or reduced by any of several forces. Oppression ... names a social injustice” (2006, 23). Here, social injustice is injustice that is “perpetrated through social institutions, practices, and norms on social groups by social groups,” however, “it is individuals who suffer the injustices of oppression, though they can do so only as members of social groups” (Cudd 2006, 23). Thus, in oppression, harm is experienced by members of a social group at the hands of members of a privileged social group by unjustified coercion. The psychological forces of coercion can be direct or indirect; direct psychological forces are those that “cause inequality through the intentional actions of members of a dominant group on members of a subordinate one” (Cudd 2006, 156).

In order to demonstrate that mental health care professionals oppress mental health patients as Cudd defines oppression, I give examples of individuals suffering the injustices of oppression by being stereotyped. By showing the mistreatment patients experience, the distinction of the group of professionals from the group of patients, the privilege of professionals, and the unjustified coercion of patients, I show that mental health care qualifies as oppression according to Cudd’s requirements.

Many of those who do know the situation of mental health patients are bewildered by the distress they see caused by professionals. Mike Pritchard, a hospital chaplain who works with

mental health care professionals, says, “A question I’ve asked myself time and again is: ‘Why might it be that so many members of staff, who to me seem to be able and caring, manage to make patients who already, because of the circumstances associated with their illness, feel of little or no value, feel even worse?’” (2007, 189) Like Pritchard and others, I believe that most professionals genuinely desire to help patients. Again, like Pritchard, I see that mental illnesses do not cause all of the distress patients experience while in mental health care, but that the professionals who are employed to heal patients’ distress often cause patients additional distress. According to Cudd, explicit intentions to oppress are not necessary for people to act as oppressors (2006, 156). To demonstrate how well-intentioned professionals can act as oppressors, I posit scenarios where good intentions transition into actions of mistreatment over time.

Finally, because I believe both that mental health care is oppressive and that professionals do not always intend to oppress patients, I suggest how mental health care can change. My suggestion for change includes two parts. The first part can be employed in mental health care as it is presently structured. The second change, however, requires patients and professionals to work together to develop effective new policies and reform strategies.

Two The Present Situation

As an individual mental health patient, without looking into the experiences of others in mental health care, I have felt oppressed. Over time I became able to articulate the mistreatment I experienced, but I wasn't certain how common this mistreatment was. Without knowing the experiences of others, I could speak only for myself. Now, having read from the experiences of others and having noticed where their experiences parallel mine, I can speak more generally: not only as an individual, but also as one of many. Additionally, speaking as one of many, I can potentially give voice to those patients who have experienced mistreatment but who perhaps weren't able to identify its source acutely enough to express it. From reading about the experiences of other mental health patients, I now see that the mistreatment that I experienced was not isolated, but was a set of injustices resulting from a larger system of oppression.

In a metaphor for what Halleck calls indirect oppression, Cudd says,

When the sources of pollution are small, they are not harmful in themselves, but only become harmful when they become part of the larger set of sources which together make up a polluting mess that cannot be effectively dissipated in the environment. Likewise, some psychological forces of oppression can only be seen when they are taken together as a whole set of small slights or insults against a group. (2006, 157)

In indirect oppression, each single act of mistreatment doesn't have the same impact as a single act of oppression would in direct oppression; being stereotyped once doesn't have the same impact as being lobotomized once. However, the accumulation of small acts of mistreatment in an indirectly oppressive situation gives the situation the oppressive quality that the small acts, individually, do not. Quantitative studies of the mistreatment of patients testify to the accumulation of mistreatment in mental health care.

One such quantitative study surveyed patients for their experiences of potentially harmful and traumatic events while in mental health care (Grubaugh et al. 2007). Many of the events included on the survey might not be huge incidents of mistreatment by themselves, but when taken in conjunction with the variety and prevalence of these incidents, they constitute an oppressive force. Some of the events, and the percentage of respondents who reported having experienced these events, include

being placed in seclusion (59.6%), ...being put in restraints (34.0%), receiving a “take down” (i.e., subdued by physical force; 29.1%), being forced to take medications against wishes (27%), being strip searched (24.1%), having medications used as a threat or punishment (19.9%), and staff name calling (14.3%). (Grubaugh et al. 2007, 194)

In this study, some of the types of harm surveyed for are legal methods for handling situations in mental health care, such as seclusion and restraint, but the authors note that patients still experience harm from these events and that there is room for improving on present policies (Grubaugh et al. 2007, 199). Although not all patients experience all types of harm, the variety and frequency of harm in mental health care indicates the presence of an oppressive force in the form of “a whole set of small slights or insults,” as described by Cudd above (2006, 157).

The specifics of the mistreatment that patients receive from professionals are visible in accounts of individual incidences from individual patients. These accounts also show that this mistreatment is often based on the individual patient’s membership in the group of patients, that coercive treatment is not always justified because the stereotypes are often incorrect, and specific ways professionals gain from their privileged position in this relationship. Additionally, by creating different standards for themselves than for patients, the professionals emphasize the separation of the two social groups and their position of privilege.

In addition to showing that patient experiences meet the requirements of Cudd’s definition of oppression, I must show that these reports are reliable. Paralleling the experiences

of other patients with my own shows that some of the ways in which I have felt mistreated are not unique to me. However, showing that mental health patients share the experience of being mistreated by mental health care professionals still isn't enough to show that they are actually being mistreated. The thing that unites these patients—mental illness—also tends to invalidate their reports of their experiences in the minds of professionals and the greater population. Because of this invalidation of patients as reliable sources of information, I must demonstrate that, in this area, patients as a group are reasonably reliable sources.

To validate the experiences of mental health patients I turn to the experiences of the “pseudopatients”⁵ in D. L. Rosenhan’s study, “On Being Sane in Insane Places” (1973). Rosenhan designed his study to answer the question “do the salient characteristics that lead to diagnoses reside in the patients themselves or in the environments and contexts in which observers find them?” (1973, 251). Rosenhan’s method in this study was to send pseudopatients of various backgrounds to various psychiatric hospitals to find out if, once given a diagnosis based on one feigned symptom, they would be detected as normal in the day-to-day milieu of the hospital ward (1973, 251).

While designed to answer a question about the nature of psychiatric diagnoses, the experiences of Rosenhan’s pseudopatients also confirms actual patients’⁶ experiences of being mistreated. For my purpose, if the pseudopatients experienced a relatively normal relationship with the mental health care professionals charged with their care, this would indicate that professionals tend to treat patients appropriately. In this case, Rosenhan’s study would invalidate the perceptions of mistreatment in mental health care that actual patients have in common.

⁵ “Pseudopatients” are mentally healthy people who feign symptoms of mental illness in order to experience mental health care as patients.

⁶ “Actual patients” are patients who are mentally ill. I refer to them as “actual patients” only to distinguish them from pseudopatients.

However, Rosenhan's study includes summaries and examples of the experiences of the pseudopatients that parallel reports of mistreatment from actual patients. Comparing experiences from pseudopatients with those of actual patients shows this resemblance between them in support of the accuracy of actual patients' reports of their experiences.

While using pseudopatients as a control group against which to compare the experiences of actual patients, I realize they are not a perfect control group.⁷ As far as the mental health care professionals knew, the pseudopatients actually were mentally ill and did experience one symptom, auditory hallucinations (Rosenhan 173, 251). In considering the interactions between pseudopatients and professionals, I treat this symptom as real and isolated, causing no other symptoms, just as the pseudopatients presented it (1973, 251). The hallucinations as described by the pseudopatients to the professionals had no impact on the areas of experience in which Rosenhan reported pseudopatients' experiences of mistreatment because they stopped feigning hallucinations immediately upon admission to the hospital (1973, 251). This indicates that professionals treated the pseudopatients inappropriately regarding the information they had from the pseudopatients; any additional symptoms noted or socially responded to by the professionals were as imaginary as the originally feigned symptom.

Because there are so many kinds of mistreatment mental health patients experience at the hands of mental health care professionals, I must focus on a select few. I have experienced each of these types of mistreatment and my experiences parallel those of other patients. Rosenhan addressed some of these kinds of mistreatment because his pseudopatients also experienced them. My examples are of three kinds of stereotypes that professionals make: that mental health

⁷ It is ethically dubious to employ the use of pseudopatients, which is why there are so few studies using pseudopatients in today's mental health care system.

patients are mentally retarded or unintelligent, that patients are dishonest, and that patients are pervasively affected by their mental illnesses.

Even though Rosenhan's report on the experiences of pseudopatients in mental health care does validate the experiences of actual patients in these types of mistreatment, I do not deny that mental illnesses can affect patients' perceptions of their mental health care. The general assumption that the lens of mental illness will cause patients to exaggerate and fabricate oppression against them is true in some cases. However, this is not true for all patients. Some patients have differently distorted experiences of their relationships with professionals, passively accepting everything mental health care professionals do. Many patients do not fit into either category; they do not exaggerate or minimize the mistreatment they experience. However, when accused by a patient of mistreatment, mental health care professionals can and do, intentionally or not, use both distortions to their benefit.

Some patients exaggerate and fabricate oppression against them as a result of their particular form of mental illness. A diagnosis of Delusional Disorder—Persecutory subtype requires that the patient's delusions "involve situations that can conceivably happen in real life" (American Psychiatric Association 2000, 324). The specific content of these delusions involves patients' beliefs that others intend to malign them and "small slights may be exaggerated [by the patients] and become the focus of a delusional system" (American Psychiatric Association 2000, 325). Because this and other diagnoses can involve delusions of oppression, mental health care professionals can easily delegitimize accusations of mistreatment or oppression from patients by calling them delusions, even when the accusing patient is not affected by such delusions. Because the professional is an expert on mental illness and the patient is mentally ill, the public is more likely to trust the professional. Because the professional has the power in mental health

care settings, even if the accusation is true, the patient may suffer the consequences of making a false accusation and the professional may suffer no consequences.

Dependent Personality Disorder is a diagnosis that is especially conducive to passive acceptance by patients of the treatment they receive. These patients “often have difficulty expressing disagreement with other people, especially those on whom they are dependent, ... feel so unable to function alone that they will agree with things that they feel are wrong, ... [and] do not get appropriately angry at others whose support and nurturance they need” (American Psychiatric Association 2000, 722). Patients with these symptoms are highly unlikely to voice their concerns if they feel mistreated by professionals in any way. I have seen mental health care professionals refer patients who voice complaints of mistreatment to patients with diagnoses like Dependent Personality Disorder, saying, “Patient A [with Dependent Personality Disorder] doesn’t complain about being mistreated, so why do you?” or “Patient A is doing very well in treatment; you should look to Patient A as a role model.” This sort of response by professionals delegitimizes patients’ complaints by suggesting that if the complaints were valid, Patient A would also be complaining.

Professionals exert direct psychological force, force by intentional actions (Cudd 2006, 156), by using stereotypes that can humiliate and degrade patients. While some assumptions are necessary in day-to-day work in mental health care, such as the assumption that patients are mentally ill, stereotypes are unnecessary and unwarranted. When coercive treatment of a patient is based on the content of a stereotype rather than on the individual patient, this coercive treatment is unjustified.

By its nature, being stereotyped is a kind of harm that happens only when an individual is assumed, rightly or wrongly, to be a part of a particular social group. In these examples the assumption that patients are part of the social group of mentally ill people is warranted, but the stereotypes are not warranted because stereotypes are not true of all people to whom they are applied. The harm that patients experience through being stereotyped happens by virtue of their membership in the social group of mentally ill people because without that social group, these stereotypes would not exist. Thus, stereotypes as an oppressive force satisfy the part of Cudd's definition of oppression where she says that individuals can suffer the injustices of oppression "only as members of social groups" (2006, 23). Regardless of the long-term effect of the stereotypes made by professionals of patients, being stereotyped by those charged with their care is a negative aspect of life as a mental health patient. The ubiquity of such stereotypes points to a greater problem than the occasional insensitivity of a handful of mental health care professionals.

In addition to the negative impact stereotypes exert directly on patients, professionals set up separate standards for themselves and patients by using stereotypes. Nearly every time I have been in inpatient mental health care, I have received a list of "cognitive distortions" copied from Feeling Good: The New Mood Therapy by psychiatrist David Burns (2000, 42-43). Professionals have told me to avoid using cognitive distortions because they perpetuate negative thinking about oneself. For example, the cognitive distortion Burns calls "disqualifying the positive" means maintaining negative self-image in light of positive attributes or accomplishments by saying that those positive things are too few or resulted from luck (2000, 42). While I have only heard cognitive distortions used in mental health care and in the context of maintaining negative self-image, they apply equally well to justifying negative stereotypes of others. In this context, disqualifying the positive would be justifying a negative stereotype of someone else by saying

that person's positive attributes and accomplishments are too few or resulted from luck. By telling patients to avoid using cognitive distortions while using these distortions themselves, professionals set up a different standard for themselves than for patients. These separate standards emphasize the separation of the patient group from the professionals group and afford the professionals benefits of convenience.

One of the common stereotypes mental health care professionals make is that patients are mentally retarded or unintelligent. While this may not be intentional, this is an assumption I have seen expressed through the actions of many professionals. In some situations, I have been mixed with patients who actually are mentally retarded, but instead of treating patients on an individual basis, professionals treated everyone as equally mentally retarded in both group and individual interaction. When I have not been mixed with mentally retarded patients, professionals have often treated me as generally unintelligent despite what they knew of me as an individual. In addition to involving the use of cognitive distortions, this specific stereotype violates professionals' own emphasis on providing developmentally appropriate care.

In one situation, I was lied to by professionals who insisted they were not lying, as though I were not intelligent enough to notice. One day, the two therapy groups in the eating disorder program I was in were separated neatly by age; the adult group had patients eighteen years of age and older while the adolescent group had patients under age eighteen. The next day, the groups were the same except that I, twenty years old at the time, had been moved from the adult group to the adolescent group. When I asked why I had been moved, the professionals told me that the new groups had been randomly chosen. When I challenged their claim, the professionals were unwilling to discuss the situation with me, so I calculated the probability that

the random group assignment would differ from the age divided group assignment by only one patient. When I offered to explain my calculation and my very low final probability, a professional tried to redirect me to think about my own therapy.

The professionals insulted my intelligence by assuming I would not notice that the change in group assignments was not random. When I challenged their claim of randomness with my probability calculation, they could have admitted their lie. If they had actually chosen the groups randomly or if they wanted to maintain their lie without insulting me, they could have acknowledged the striking and unlikely similarity between the random group assignment and the age divided group assignment. Instead, they chose to respond to me in such a way that insulted my intelligence by refusing to discuss the situation.

In this situation, professionals harmed me by stereotyping me as unintelligent based on my status as a mental health patient. The coercion I experienced, in being forced into a different therapy group without being allowed to discuss this, was based upon my supposed lack of intelligence, as per the stereotype. Because that stereotype was false, the coercive treatment was unjustified because it relied on that stereotype as its justification. Maintaining this stereotype gave professionals an extra benefit of convenience because they did not have to spend the time to discuss the situation with me. A cognitive distortion allowed the professionals to maintain their negative stereotype of my lack of intelligence by disqualifying the positive, my intelligence, that contradicted their stereotype.

Former patient Pat Risser also experienced being stereotyped as unintelligent in a mental health care setting:

I went through a severe depression, was in a lot of pain. I said I wanted to do something with my life. Instead of sending me to school as a paralegal, they sent me to a sheltered workshop. I was standing next to someone who was severely retarded and we were

counting fish hooks. I was class president in college, I was a law school drop out. (Reidy 1993)

While he tells this story to make a point about professionals seeing no potential in their patients, the professionals evidently saw no intelligence in Risser either. Otherwise, they could have helped Risser find a job that used his intelligence to a fuller extent and would have been more interesting and rewarding.

The harm Risser experienced was in being stereotyped as unintelligent and sent to a job that was inappropriate to his ability level. It was coercive for professionals to decide to send Risser to the sheltered workshop without his input. This would have been justified if Risser was not intelligent enough to make or help make this decision, but because that stereotype of Risser was false, this coercion was unjustified. By acting based on this stereotype, the professionals did not have to exert the extra effort required to help Risser find more appropriate employment. The professionals used cognitive distortions in this situation by discounting Risser's intelligence in favor of emphasizing their belief that he had no potential in life beyond counting fish hooks.

Rosenhan reports an instance when a pseudopatient had his intelligence insulted. This pseudopatient "asked his physician what kind of medication he was receiving and began to write down the response. 'You needn't write it,' he was told gently [by his physician]. 'If you have trouble remembering, just ask me again'" (Rosenhan 1973, 253). In this situation, the professional, though kind, condescended to the pseudopatient by suggesting that he would have trouble remembering, treating the patient as though he had the intelligence of a child. This physician may have been trying to reduce the patient's stress but, by giving a different tactic to reduce stress, asking the question again, suggested that the patient's tactic, writing down the answer, was not adequate. This pseudopatient experienced harm in being stereotyped by his physician. The physician maintained this stereotype despite the pseudopatient's display of

intelligence and problem solving by writing down the answer to his question, using the cognitive distortion of disqualifying the positive (Burns 2000, 42).

Mental health care professionals also commonly stereotype their patients as being dishonest. While professionals and others already discredit patients on account of their mental illnesses, this assumption of dishonesty goes beyond that by assuming that patients are maliciously and intentionally dishonest. Some mental illnesses are partly defined by dishonesty; pathological lying is a symptom of both Factitious Disorder and Factitious Disorder by Proxy (American Psychiatric Association 2000, 513-514, 781-782). However, since not all patients are dishonest, when professionals apply a stereotype of dishonesty to patients regardless of their histories and diagnoses, they are using cognitive distortions.

One of my experiences with being stereotyped as dishonest involved my possession of contraband: a razorblade. While in the hospital, I opened my journal and was surprised to find a razorblade between the pages. It may not have been the right thing to do, but I kept the razorblade as a security device, being that self-injury was one of my current ways of coping. When I mentioned to a visiting friend that I had this razorblade, she asked if I would let her tell one of the professionals, to which I agreed. The professional she told immediately removed the razorblade and all books from my room. While searching my person, a nurse angrily said, “this is not a place for playing games.” When I asked what she meant by “playing games,” she told me that she could not keep me safe if I insisted on smuggling razorblades into the hospital.

I asked my parents how the razorblade got in my journal. After we figured it out, my mother explained the chain of events to the professionals in order to clear me from suspicions of malicious dishonesty and smuggling. I was later told by a professional that my mother’s

explanation was unnecessary because they did not think I was a liar. When I asked to have my books returned to me, the professionals refused, which told me that they still viewed me with suspicion and contradicted the statement that they did not believe I was a liar. In this case, their actions spoke their true beliefs much more loudly than their words.

The harm I suffered in this situation was from being stereotyped as dishonest and, as a result of that stereotype, not being allowed to read books. Keeping my books from me was unjustified coercion unless I had a history of intentionally smuggling razorblades into psychiatric hospital wards, which I didn't. Here, the mental health care professionals maintained their stereotype of me as a liar despite my general honesty, including the honesty that allowed them to know that I had a razorblade. They magnified my dishonesty in keeping the razorblade and considered that act more representative of my overall behavior than my acts of honesty, which they minimized. Both magnification and minimization are types of cognitive distortions (Burns 2000, 42). By maintaining this stereotype of me as a liar, the professionals did not have to risk trusting me with books; by keeping my books away from me, they didn't have to entertain concerns that I had razorblades hidden in other books.

Beate Braun, a former patient, was directly called a liar when she brought a concern about medication to her doctor: "The drugs were so strong that I would bite my lips and fall to the ground. The forced drugs caused me to have these awful convulsions. When I would complain, the doctor told me that I was lying, I didn't have convulsions, and wouldn't do anything to help me. I felt so helpless" (Braun 2002). When accusing her of lying, it seems that Braun's doctor completely denies the reality of Braun's situation. Braun suffered being called a liar by her doctor and the unaddressed side effects of her medication. By calling her a liar and refusing to address her concerns, Braun's doctor neglected to properly care for her and gave her

no choice but to continue suffering the side effects of her medication. Although denying reality is not a cognitive distortion, it is something that professionals regularly tell patients to avoid and it did allow Braun's doctor to maintain a stereotype of her as a liar. Additionally, by denying Braun's situation, her doctor did not have to spend the extra time it would have taken to address her side effects.

A third common stereotype made by mental health care professionals is that patients' mental illnesses pervasively determine every aspect of their lives. In order to be diagnosed with many mental illnesses, there is a requirement that the symptoms interfere significantly with the patient's life. For example, in order to be diagnosed as experiencing a Major Depressive Episode, "The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal but requires markedly increased effort" (American Psychiatric Association 2000, 349). Similar requirements are typical for diagnoses of other mental illnesses. However, even while their mental illnesses do interfere significantly with their lives, there still may be many unaffected aspects of patients' lives. Indiscriminately attributing symptoms to actions carried out by patients is an activity of stereotyping.

In one situation when my actions were falsely attributed to my mental illness, I was in a hospital-based treatment program targeted toward stopping self-injury. Because the professionals who founded the program noticed a trend of secrecy in self-injury (Conterio and Lader 1998, 161), one focus of the therapy in this program was to avoid letting patients socially isolate themselves from others. Since I was a college student at this time, I tried to keep up with my schoolwork while I was in the hospital. Whenever professionals noticed me working on my

schoolwork, they asked me why I was socially isolating myself. The professionals ignored my explanation that I did not want to fall too far behind in my schoolwork because of how highly I value my education. Instead, they attributed my voluntary social isolation to my mental illness and told me to rejoin the social milieu of the hospital unit. The professionals could have interpreted my voluntary social isolation to do schoolwork in many different ways: perhaps that I enjoy school, that I didn't like the other patients, or that I had an impending due date. However, they specifically interpreted my action as a symptom.

I experienced harm in this situation by being stereotyped and by not being allowed to spend time alone on the basis of that stereotype. Coercing me to remain in the social milieu was unjustified because this was based on the assumption that my voluntary social isolation was a symptom of my mental illness, which it wasn't. The professionals jumped to the conclusion that my voluntary isolation was motivated by my mental illness, as though they could read my mind, as per the cognitive distortion Burns calls "mindreading" (2000, 42). Because they maintained this stereotype, these professionals made a rule forbidding patients from being alone for more than fifteen minutes at a time between about nine o'clock in the morning and eight o'clock at night. By instituting this rule, the professionals did not have to bother considering alternative motivations for why patients might voluntarily isolate themselves from others.

Caty Simon is a former patient who called the process of being diagnosed, being "pathologized," emphasizing the idea that when a patient is diagnosed with a mental illness, suddenly everything they do is interpreted as an expression of that illness (Simon 2007). Simon said that patients'

earlier idiosyncrasies, what were once just oddities of their behavior, become part of their sickness... I remember I had a medical student [ask] if there was any particular reason I was painting my nails different colors. Because what was once just a tiny little oddity of youth subculture, was now one of my array of symptoms. (Simon 2007)

According to Simon, this medical student assumed her multi-colored nails were a symptom of her mental illness. To consider fifteen-year-old Simon's multi-colored nails (Simon 2007) a symptom of mental illness seems preposterous to, knowing how common multi-colored nails are among fifteen-year-old girls. This medical student harmed Simon by stereotyping her. Knowing that she had a mental illness, this medical student over-generalized, by assuming that Simon's mental illness motivated her to paint her nails various colors in addition to motivating her other symptoms.

Rosenhan's pseudopatients also experienced professionals mistakenly attributing their actions to symptoms of mental illness. For Rosenhan's study, the pseudopatients took copious notes of ward activity. Outside of the context of a psychiatric ward, note taking would be an unremarkable activity. However, in the context of a psychiatric ward, the motivation for such behavior was misinterpreted:

Nursing records for three patients indicate that the writing was seen as an aspect of their pathological behavior. "Patient engages in writing behavior" was the daily nursing comment on one of the pseudopatients who was never questioned about his writing. Given that the patient is in the hospital, he must be psychologically disturbed. And given that he is disturbed, continuous writing must be a behavioral manifestation of that disturbance. (Rosenhan 1973, 253)

Rosenhan clearly believes that this nursing note was intended to be indicative of a symptom.⁸ I also interpret this nursing note as documentation of a symptom. Referring to someone as "engaging in writing behavior" is very unusual diction. However, as a description of a symptom, this is not unusual diction because mental health care professionals frequently refer to symptoms as "behaviors." This is so frequent that it even changes the diction of some patients. Once, while

⁸ Of this nursing note, Robert Spitzer, a psychiatrist, writes, "Because nursing notes frequently and intentionally comment on nonpathological activities that patients engage in so that other staff members have some knowledge of how the patient spends his time, this particular nursing note in no way supports Rosenhan's thesis" (1975, 445). According to Rosenhan as presented in his study, this nursing note was intended to record a symptom; according to Spitzer, it was not. Rosenhan and Spitzer have comparable credentials. I agree with Rosenhan for reasons expanded below and because he had more access to the context of this nursing note than Spitzer.

in a hospital cafeteria, because I was making anagrams to avoid the social anxiety of the situation, another patient yelled across several tables, “Jessica’s using behaviors!”

This pseudopatient was harmed by mental health care professionals by being stereotyped and having his actions misinterpreted. This interpretation of note taking as a symptom involves the stereotype that all patient actions are symptoms of mental illness. Applying this stereotype to individual patients, as Rosenhan posits, involves the cognitive distortion called “mindreading,” because the professionals assumed that they knew what motivated the actions of this pseudopatient (Burns 2000, 42). By assuming that they know what patients are thinking, professionals do not have to spend time talking with patients to learn what they are thinking.

The four requirements of oppression that Cudd lists are harm, the presence of two social groups, one group having special privilege over the other, and unjustified coercion (2006, 25). In the examples of how professionals use stereotypes, each example includes some element of harm. Although my language clearly separates the professionals and patients into two separate groups, the professionals exaggerate this distinction by telling patients not to use cognitive distortions while using these themselves. Using stereotypes of patients often makes work easier for the professionals because they do not have to make exceptions in order to treat patients appropriately as individuals since, according to stereotypes, there are no individual differences among patients. This gives professionals extra benefits of convenience. Finally, coercion based on false assumptions from stereotypes is unjustified because the element that would justify the coercion is not actually present. Thus, all four requirements of Cudd’s definition of oppression are present in mental health care. Patients are oppressed by professionals in mental health care.

Three How Good Intentions Go Astray

Although the mistreatment patients experience at the hands of mental health care professionals constitutes oppression, I believe that most professionals have good intentions in their work. As Oryx Cohen, a former patient, put it, “In fairness, most of the staff was incredibly well meaning, but I felt that they were victims of an oppressive system as well. I always felt distanced from my supposed caretakers, like an impenetrable wall divided the patients from the staff, the ‘weirdos’ from the ‘humans’” (Cohen 2003). If I believe my oppressors, mental health care professionals, to be well-intentioned, they can be nothing other than more victims of an oppressive system that has somehow swept them up into the role of oppressor. Here I present two possibilities of how I believe good intentions can, within an oppressive system, turn into acts of mistreatment of patients.

According to Cudd, it is not necessary for members of privileged social groups to have explicit intentions to oppress in order to do so. She says, “members of privileged groups are often quite unaware of their privilege—their prerogative to ignore these group relations is part of what constitutes their privileged status” (Cudd 2006, 156). Having power in a relationship and being unaware of having that privilege of power can turn neutral or good intentions into mistreatment because that power goes unchecked.

Anthony Brandt describes a phenomenon he called “goal displacement” (1975, 180). In this phenomenon, an abstract goal is made and then a concrete method is developed to ensure that the goal is accomplished. When people who use the method have forgotten the original goal it was made for accomplishing, that method, which was only meant as a means to an end, becomes the new goal. In proposing possible ways good intentions from professionals can have

consequences of mistreatment for patients, the abstract primary goal of mental health care professionals is to provide effective therapy for patients and an abstract secondary goal is to avoid imposing their values on patients. This secondary goal could be accomplished through various methods, such as framing situations in terms of healthy versus unhealthy or suspending blame when relating to a patient. The phenomenon of goal displacement is an example of how well-intentioned mental health care professionals can maintain good intentions while mistreating patients in small ways that, taken together, constitute oppression.

In the first scenario of goal displacement in mental health care, the primary abstract goal is for professionals to provide patients with effective therapy. An abstract goal secondary to this is for professionals to avoid imposing their values on patients. A concrete method for accomplishing these goals is for professionals to frame situations in terms of “healthy” versus “unhealthy”. Because this method was developed with an aim toward accomplishing the goal of not imposing values on patients, toward the goal of providing effective therapy, professionals may feel secure that by using this method they will always accomplish these goals. However, if these goals are displaced, using the method for accomplishing them will no longer be as effective.

I encountered the method of framing situations in terms of “healthy” versus “unhealthy” when mental health care professionals tried to use this framework to replace my existent and functional framework of “good” versus “bad”. The professionals who espoused this health-based framework to me said that my value-based framework was what caused me guilt. For example, when I expressed feeling guilty for feeling anger, which I labeled “bad”, a professional told me

that feeling anger is “healthy”, but it would be “unhealthy” if I chose to express that anger by throwing chairs at people.

I believe that the health-based framework is a flimsy disguise for professionals to promote their own values subtly. Eventually, when the professionals began calling my values-based framework “unhealthy” on account of all the guilt it caused me, I felt this was equivalent to morally judging my values-based framework as “bad”, since I believe their framework is as values-based as my own. At this point, when I felt moral pressure from professionals to give up my own values in favor of theirs, the professionals had crossed into goal displacement.

When they called my values-based framework “unhealthy”, the professionals imposed their values on me. Since the second abstract goal of the professionals was to avoid imposing their values on me, it is apparent that their policy for using a health-based framework did not accomplish this goal, but rather prevented its accomplishment. Their therapy became ineffective when I became suspicious of their other therapeutic techniques on account of their imposing values on me. If the professionals who were following the policy of using a health-based framework had kept the goals of providing effective therapy and not imposing their values on patients in mind, they could have altered or abandoned the method of using a health-based framework when it began to interfere with the accomplishment of their goals.

A second scenario of how well-intentioned professionals might end up mistreating patients has the same abstract primary and secondary goals as the scenario above, but a different concrete method is used for accomplishing these goals. In this scenario, the primary goal for the mental health care professionals is to provide patients with effective therapy, the secondary goal

is for professionals to avoid imposing their own values on patients, and the method for accomplishing these goals is to suspend blame in their interactions with patients.

I incorporated this as a method based on a statement by Mike Martin on the intersection of therapy and values, “Therapists often know their clients have engaged in wrongdoing, but they are trained not to blame them and instead to adopt a supportive and future-oriented stance,” and his assertion that the reason for the suspension of blame is partly to respect the values of patients (2006, 57). I have seen professionals who take this method of suspending blame too far.

In one therapeutic program, I found the suspension of blame particularly troubling. In trying to rid patients of guilt, because guilt was a frequent focus of therapy in this program, patients regularly confessed various actions over which they felt guilt. Rather than considering each deed and its context on an individual basis, it seemed like the professionals cleared all patients of guilt no matter the deed or context. It is possible that no one ever did anything the professionals believed was blame-worthy. However, I wanted to know whether a patient’s deed could ever be blame-worthy in the eyes of those professionals, so I asked. When I could not imagine any scenario extreme enough that they admitted it would be blame-worthy, my frustration level flared. Because the professionals told me that they would not consider a patient who had committed homicide blame-worthy, I felt they had taken the method of suspending blame to a farcical extent.

Because I refused to participate in this absolute suspension of blame, the professionals regarded me with suspicion as intolerant of alternative value systems. In this position, I felt pressured by professionals to abandon my adherence to moral standards in favor of the tolerant and accepting perspective where blame and guilt do not exist. This suspension of blame, originally a method for avoiding imposing values on patients, was now a value in itself, to which

I did not adhere. The abstract primary and secondary goals for which this method was intended had been displaced by this method, which became the new goal. This method could have ended at professionals suspending blame so that any blame that came up in therapy would be entirely from the patient's own value-system without influence from professionals. However, this method had become a value in itself, one that professionals did impose on their patients beyond just using it as a device for therapy.

Although this section deals with examples of how situations in mental health care might be happening, it illustrates that well-intentioned professionals can participate in a system of oppression against patients. Although the intentions and goals of professionals may be entirely altruistic, if the goals are displaced in favor of the methods for accomplishing these goals, professionals may unwittingly mistreat patients. This happens when they forget the goal the method they employ was meant to accomplish, but believe they are helping patients because they trust the method that was made to accomplish a therapeutic goal. However, even though the method may have such intentions, if it displaces its goal, the method may no longer be able to successfully accomplish its goal.

Four Conclusion: Moving Forward

Mental health care includes all of Cudd's requirements of an oppressive situation (2006, 25). Mental health care is indirect oppression (Halleck 1971, 22-23) from a direct psychological force (Cudd 2006, 156) through a large number of small incidents of mistreatment (Cudd 2006, 157). Examples of mistreatment from my experiences, experiences of other patients, and experiences of pseudopatients demonstrate that these reports of mistreatment are reasonably reliable. However, although mental health care is an oppressive system, this does not mean that all professionals intend to mistreat patients. Even well-intentioned professionals can mistreat patients through the process of goal displacement.

It is clear to me, having experienced mental health care as a patient, that changes need to be made; it is clear to scores of former patients everywhere that changes need to be made. It is true that being stereotyped is a common experience in the world outside of mental health care and is an experience everyone faces. However, this is so routinely experienced in mental health care that it is part of the indirect oppression against patients. Additionally, by stereotyping patients, mental health care professionals model behavior contradictory to some of the practices they encourage in their patients.

As I see it, two things can be done to change the mental health care system. The first is for mental health care professionals to engage in the two-way open communication they recommend to their patients, modeling this behavior for their patients instead of contradicting it. This change of increasing open communication between patients and professionals can begin in the mental health care system as it is presently structured. The second thing I think would change

the mental health care system is for professionals to collaborate with patients in forums with a goal toward reform. While the first change is a specific change in mental health care that I am requesting primarily of mental health professionals, the second is a process for patients and professionals to determine together what other specific changes need to be made in mental health care.

Unlike the oppression faced in slavery and racism, mental health care is uniquely equipped to eradicate the oppression within it. This is because the changes that I believe can eradicate the oppression within the mental health care system—increases in communication between patients and professionals—are already touted by professionals as a way for maintaining good mental health. Professionals often encourage patients to engage in open, honest, respectful, two-way communication with others as a way to prevent and resolve conflict and the resultant stress. If professionals engage in this communication style with patients, patients will be more able to apply this communication style to their relationships outside of mental health care. Additionally, if professionals communicate with patients like this, many conflicts between professionals and patients will be prevented and others will be resolved more quickly and fully.

Open and honest two-way communication is something I have often wished for in mental health care. My frustration with the lack of such communication has been illustrated in some of the examples above, such as when the professionals lied to me about the “random” group therapy assignments. In this and other situations, while I still may have been frustrated with my situation once it had been explained to me, when professionals eschew open communication, they leave me frustrated with both the situation and their refusal to talk about the situation. Even if the professionals told me that they couldn’t talk with me because they didn’t have the time, as long as they demonstrated openness communication, I would have been satisfied. These situations

show the need for open communication directed from professional to patients. Because communication is a two way process, there is also a need, yet unfilled, for professionals to be open to communication with them from their patients. The examples above have also illustrated my frustration when mental health care professionals have refused to engage in my attempts at communicating with them, such as when I offered to explain why I did not believe that the therapy groups had been randomly assigned. In this situation, by refusing to listen to what I had to say, the professionals heaped frustration with their refusal to engage with me on top of my frustration at not having the situation explained to me and my frustration with the situation itself. Open, honest, respectful, two-way communication is something I propose for mental health care because its absence exacerbates other problems and currently it is not consistently present.

I am not the only patient who has noticed a conspicuous lack of communication and thought that communication could solve many problems in mental health care. Clare Ockwell, operations coordinator for the CAPITAL project, a patient led training and research group, relates several stories of restraint from CAPITAL members. Ockwell writes, “In each case [of restraint] the key problem appears to be lack of communication when people are feeling at their most vulnerable and desperate for compassionate human contact” (2007, 50). In describing how communication could help, another CAPITAL member said, “If someone had sat down and talked to me and explained what was going to happen it would probably have been different. I’d rather know it [being restrained] was a possibility so I could explain to myself how it was going to make me feel” (Ockwell and CAPITAL members 2007, 49).

While adding real communication between patients and professionals is a change that can be made within the present mental health care system and can have enormously positive benefits, I imagine that there are more benefits to be had by structurally reforming the present system. I

believe that specific reforms can be decided on by holding forums with mental health care professionals and patients working collaboratively. In order for such forums to be most effective, both the patients and the professionals participating will have to engage in respectful, open, two-way communication with each other. Without this respectful communication, the forum will have the “us versus them” tension that pervades current mental health care and at least one side will leave unsatisfied with the results. In this case, the forum will have failed to produce meaningful reform.

One way of approaching the forum and entering into fruitful discussion would be for each side to lay their complaints on the table, for each group to then address the other group’s complaints, and then for the groups to work together to come to compromises. This way, every participant will be able to see each situation that causes complaints from the perspective of both groups. After everyone is aware of both sides of each issue, the participants will be more able to come to compromises on these issues. While sacrifices will be necessary for the sake of compromise, when all the participants are aware of the perspectives of the other participants, empathy will allow greater willingness for compromise.

Other than addressing complaints about the current mental health care system, there are several issues that need to be addressed in a forum with patients and professionals. One such issue is the goals each group has for mental health care. Each group needs to be clear on their goals and priorities in mental health care so that, together, they can create an integrated set of goals and priorities. Another issue that would be useful to address in this type of forum would be the methods and policies that need to be set up in order accomplish the shared goals of mental health care and how to monitor these methods and policies in order to prevent them from displacing the goals.

I examined the current situation of patients under mental health care in regard to their experiences of indirect, subtle oppression. I illustrated how this oppression is experienced in individual incidents of mistreatment. In examining one issue professionals face, avoiding imposing their values on their patients, I showed that, despite good intentions, the methods that are used by professionals to accomplish this have sometimes gone astray and can perpetuate experiences of oppression among patients. I suggested changes that can be made to reform mental health care in order to eradicate oppression from it. One change, a pervasive willingness among professionals to communicate openly with patients, can be made within the current structure of the mental health care system. The other change, reform brought about through respectful forums of patients and professionals, is a tool for restructuring the mental health care system in a way that will bring about meaningful change. I am incredibly grateful for the eradication of direct oppression of patients through changes, such as anti-psychosurgery laws. However, I believe that open, honest, respectful, two-way communication is one key to successfully eradicating oppression from mental health care.

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