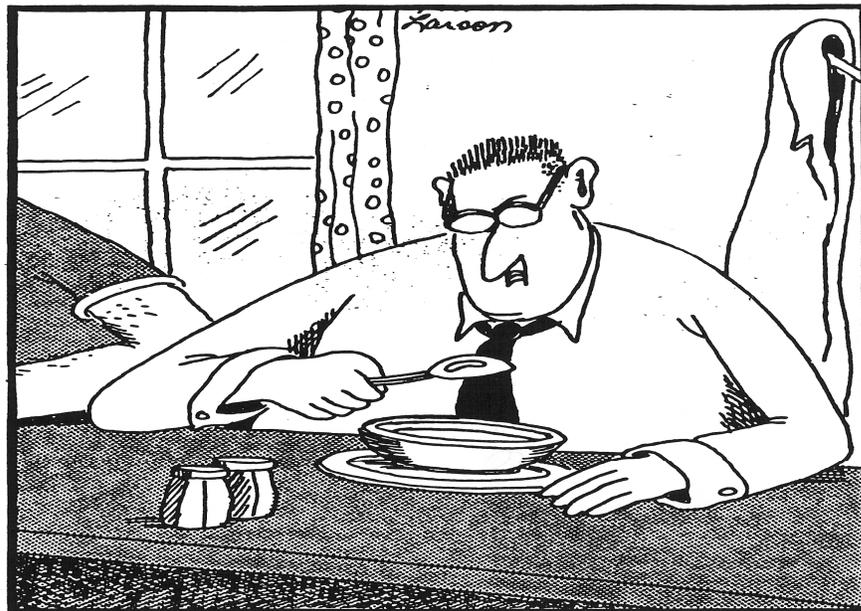


# SEARCHING FOR COHERENCE

## Volume I

*Jerome R. Gardner*



Darrell suspected someone had once again slipped him a spoon with the concave side reversed.

**It's not the event which  
causes the feeling . . .  
It's how you think about it!**

# Seeking Coherence

An exploration of the development of systematic and interrelated governmental social policy regarding the delivery of human services to people with problems in living which is based on a consistent pattern of values and a congruous set of ideological principles which enable the advent of a learning system based on feedback regarding outcome.

Prologue: **Mundus Vult Decipi:** The world wants to be deceived

Volume I: **Perspective & Philosophy:** An exploration of the individual will and preference as a motivation

Volume II: **Governance:** An exploration of the development and implementation of social policy within local government as it is and might be.

Volume III: **Theory, Technology & Methodology:** An exploration into the efficacy of present performance and the technologies which may enable positive social outcome from a new social policy.

Epilogue: **Paradise Lost**

Birds fly because they believe they can; one moment of doubt and they would plummet to the earth.

Author unknown

# Seeking Coherence

*Prologue: Mundus Vult Decipi*



**It may look good, but there is deception  
here.**

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Coherence: Systematic or methodical connectedness or interrelatedness especially when governed by principles; integration of social or cultural elements base on a consistent pattern of values and a congruous set of ideological principles.

# SEEKING COHERENCE

Mundus vult decipi: the world wants to be deceived. The truth is too complex and frightening; the taste for the truth is an acquired taste that few people acquire.

Not all deceptions are palatable. Untruths are too easy to come by, too quickly exploded, too cheap and ephemeral to give lasting comfort. Mundus vult decipi; but there is a hierarchy of deceptions.

On a higher level we find fictions that men eagerly believe, regardless of the evidence, because they gratify some wish.

Near the top of the ladder we encounter curious mixtures of untruth and truth that exert a lasting fascination on the intellectual community.

What cannot, on the face of it, be wholly true, although it is plain that there is some truth in it, evokes more discussion and dispute, divergent exegesis and attempts at emendations than what has been stated very carefully, without exaggeration or onesidedness.

Mundus vult decipi: The world winks at dishonesty. The world does not call it dishonesty.

Once a few respected men have fortified a brazen claim with their prestige, it becomes a cliché that gets repeated endlessly as if it were self-evident. Any protest is regarded as a heresy that shows how those who utter it do not belong; arguments are not met on their merits; instead one rehearses a few illustrious names and possible deigns to contrast them with some horrible examples.

**I And You: A Prologue**  
Walter Kaufman

**That people with problem in living are defective is a brazen claim.**

## PROLOGUE

*The psychologically distressed among us are not the symbol of failure that some would have us believe. If they are a symbol at all, they are a symbol of humanity's everlasting endurance against all odds. Human beings are capable of inordinate endurance. We have lived through blizzard, drought, famine and holocaust. Time and time again, we have turned seeming disaster into victory. Few, if any, simply "give up", and those that do are generally lost to our history. The psychologically distressed have not given up. When their great sensitivity conflicts with an insensitive world, they find new and creative ways to endure. They are not "heroes" nor "artists", for those have found acceptance for their creative efforts. These are everyday people striving to overcome the prejudices and welfare offered by those around them who are too uncomfortable to see their strength and see instead only their strife. We mistakenly see their fight as flight and their flight as failure, instead of noticing that they do battle with us for their very survival. If only we could see, perhaps we could lay down our arms and channel their enormous endurance into a struggle to grow, instead of just survive.*

J.R. Gardner - 1987

Generic Principles of Psychosocial Rehabilitation

## Coherence<sup>2</sup>

*"Judaism, Christianity and Islam found their way through the Word. 'In the beginning was the Word and the Word was with God, and the Word was God.'*

"For you and I belong to a species with a remarkable ability: we can shape events in each other's brains with exquisite precision. Simply by making noises with our mouths, we can reliably cause precise new combinations of ideas to arise in each other's minds" [Pinker - 1994]

The *word* is a symbol used to convey an *idea* - a notion, thought or impression. This 'word' is remarkably potent. Since we as a species find use of words so easy, we often fail to realize the impact that the use of words has on those around us. This power to shape ideas, to create awareness, to enlighten as it were through *ideas*. We use the symbol of a light bulb to represent a person with an idea; the implications being that "they have seen the light" or have become enlightened. It should not be unusual that the most powerful religions in the world use the word and the light as representation of the spirit of the deity. For it is through words and ideas that mankind has developed culture and through culture that mankind has shaped his own evolution.

This book, in some ways, attempts to help us reconsider how powerful words and ideas are and to understand how we have come to use them unwisely. When looking at societies it is sometimes helpful to understand how they treat those of marginal abilities, the young, the old, the feeble and the disabled in order to understand what they believe about life, liberty and the pursuit of happiness. The critical issue of our exploration is the impact of our society's approach to those with *problems in living* and the potential for change.

Ideas are potent. Some become established as conceptions or standards of perfection and are called ideals. Such ideals become valued by enlightened individuals and populations and become *beliefs* [or commitments] which predispose those individuals and populations to certain ways of behaving. The strength of these beliefs make the believers *prophets*, in that they believe so strongly that their expectation will happen, that they behave in ways as to enhance the potential for them happening. In this way, we

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**Definitions: Coherence** - Systematic or methodological connectedness or interrelatedness especially when governed by principles; integration of social or cultural elements based on a consistent pattern of values and a congruous set of ideological principles. [The congruence between what one believes and what the evidence demonstrates - The congruence between one person's beliefs and behaviors and that of the sociocultural entities they inhabit.] Idea - presentation of sense, concept or representation. Belief - a state or habit of mind. [A predisposition to behavior] [Non bracketed - Webster].

create the future. Self fulfilling prophecies reinforced by beliefs in valued ideas. Enlightened people are aware of the power of these ideas and the impact they have on the creation of the future.

But belief is a nebulous thing. One moment of doubt, and we plummet to the earth. Naysayers whisper in our ear that the ideal is impossible. Doubt becomes the ideal: things will never be the same. *Mundus vult decipi*: the world wants to be deceived. Coherence is lost. The individual strays from the population. And the population reacts with alacrity to control their incoherence.

A few respected men have fortified with their prestige and influence the brazen claim that people with severe and persistent problems in living have a *pathology* that makes them not responsible for their own behavior. These men have altered the laws of the nation on the notion that they know best, taking away the liberties guaranteed by the Constitution on the presumption that they can *predict* the future. Yet, there is no scientific or experiential evidence to support their claim. They support their arguments with horrible examples of violence and atrocities which, if the evidence of common experience is to be observed, are the same kinds of abhorrent events that take place when people who are sane, 'lose control'. Charles Manson is the horrible example of sanity that comes to mind. Yet, the world winks at dishonesty. The world wants to be deceived.

But it is the author's belief that this brazen proposition is not coherent. It is destructive. It allows a dichotomy between what we believe we are doing and what we actually do. It shapes the way we perceive people with problems<sup>3</sup> in living and affects the manner in which we develop and implement social policy for *all* people with problems.

We seek to develop principles and values that are consistent with sociocultural enhancement and interrelatedness. We seek to increase the reader's *awareness* and cause them to rigorously analyze this brazen proposition in light their own belief system. Truisms concerning freedom, violence, anger, help, power and the like will need to be reviewed if one is to consider a new reality.

The reader is to be provided with evidence with which to do analytical work. Whether you choose to expend the energy to do so or not, we cannot control. We hope that you will and we expect that if you do, you will arrive at a conclusion that the proposition made by these respected men is not coherent despite the complex and frightening deceptions. We would hope that you would apply your will to insist on change in our social policy, so that people with problems in living can use their considerable strength to grow and develop into what they were meant to be. Your voice is powerful in the creation of a different future.

## Fitness

The field of human services perceives and describes the functions and circumstances of helping in the negative<sup>4</sup>. A great deal of time and energy is spent trying to identify the etiology of the *social problem* that client's bring with them. Additionally there is focus on those disordered qualities of thought or behavior that seem to create for these clients, problems in living. But rarely, if ever, do we discuss what would be

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<sup>3</sup> The phrase "**people with problems in living**", coined originally by Thomas Szasz in *The Myth of Mental Illness* will be used throughout as the generalization for people with atypical behaviors, who may use the public human service system. This generalization, while quite functional, does not, however, denote whether the individual is in the system or not. For purposes of such delineation, the term "client" is used. Although this term is often challenged as pejorative, and replaced by customer, end user and the like, the term client is the only term for which a fiduciary relationship exists. While the customer is open to a "buyer beware" attribution, there is a requirement and responsibility for a beneficial outcome for a client. Since this is a factor presently missing in human service delivery systems, but one that is to be addressed, the term client remains preferable.

<sup>4</sup> The author is not concerned here with either religion or politics. It is significant, however, that congregate activities are also most often proposed in the negative. In politics, people are expected to fail, need sustenance from a powerful government, which then inhibits their ability to believe in themselves, which supports the negative proposition. In religion, it is increasingly proposed that people need to be controlled for their own good for religious ideals. Both Islam and Christianity appear to believe that they must fight for ideals that cannot be sustained without control.

an *ideal* way of life. The definition of quality eludes us. We ask the question "what is mental illness?" and endlessly debate theories of causality without asking the question "What is mental health [or more appropriately *psychological fitness*]?" or carry on similar debates. One goal of this paper, therefore, is to change the debate.

Many question whether there is some abstract ideal or absolute of psychological fitness that one can define. The human mind is probably much too complex and interactive for that potential. "The everyday way of defining mental health is more subjective. If I do it, it's healthy; if I don't do it, it's sick." "...this common sense way of defining mental health sets ourselves up as the standard against which to make comparisons. There's nothing wrong with this except that it's just possible that some of us - not me, you understand - are a bit odd ourselves. And you can't measure accurately with a bent ruler." [Chance - 1988]

"Imagine a group of people who are always together. Their work totals about 30 hours each week. It is cooperative, proceeds at an easy pace, includes everyone and is accomplished by pleasant chatter. There is no distinction between labor, politics, homemaking and play. Children are free to go anywhere because everywhere they are watched, fed and taught as if every adult were their parent. There is much touching. Conflict is discussed until consensus is reached on what is best for everyone. There is no violence. When children fight, they are distracted by amusement or affection from an adult. People take only what they need, and what each needs is what they all need. They worship their environment." [Drummond, 1980]

Are these well adjusted, psychologically fit human beings? What are the characteristics of these people [the Ik] that make them so? Is the lack of aggression a sign of psychological fitness and what happens to people who appear to be psychologically fit when the circumstances of their lives change?

"Now imagine a group of people who have lost their humanity. There is no kindness, compassion or caring. Love does not exist. Sex, when it occurs, is as perfunctory and joyless as defecation. The only source of satisfaction is someone else's misery. Children are abandoned at age three. The sick are beaten: the dead left unburied. There is no religion, no music, no art, no hope, no rage, no sadness. There is only boredom, bitterness, envy and suspicion." [Drummond, 1980]

The *Mountain People*, by Colin Turnbull describes what happened to the Ik, a group of hunter-gatherers, whose life style was forced to change by 'progress'. If the group as first described was psychologically fit, why were they so devastated when the circumstance changed? What are the characteristics that go into creating this *ideal* psychological fitness and why do we continue to measure the psychological fitness of others with a 'bent ruler' which does not even take into account the context [environment, relationships and circumstances] in which people live? Can we truly believe that we are more psychologically fit than the tribal Ik; could we survive their trauma?

While psychiatrists are labeling more and more human behavior as abnormal, we find these behaviors more and more prevalent. Could this simply mean that society is under more stress and acting appropriately to that stress? Or are we perhaps seeing the *pygmalion* impact of the very negative thoughts of a brazen proposition? And what of the unusual [bizarre] behaviors such as hallucinations and delusions? Are we to continue to *demonize* such occurrences. If so, how do we account for the fact that it seems that delusions are much more commonplace than most people would assume. "A belief is considered a delusion if a person holds to it no matter how bizarre it is and despite all evidence to the contrary." [I will leave it to the reader to determine what this definition means in regard to religion.] "...researchers say the delusions of those with psychiatric disorientation are fundamentally no different from, say, a private belief that a color is unlucky or popular beliefs in the existence of flying saucers." [Goleman, 1989]

Dr. Brendan Maher, a psychologist at Harvard has said that: "Many or most people privately hold strange beliefs that could be diagnosed as delusional if brought to the attention of a clinician." [Goleman, 1989] If this is so, should we believe that such people are psychologically unfit, and if so, what does this say about the ability of humankind to survive? "In 1917...the classification system used by the American Psychiatric Association included only 59 forms of mental complaint. By 1952 ... there were 106. By 1989... 292." The 1994 version of the manual, which is employed by mental-health professionals lists 396 possible diagnostic codes. This proliferation of labels is causing some dismay. Indeed, some critics wonder if the

multiplication of mental disorders has gone too far, with the realm of the abnormal encroaching on areas that were once the province of individual choice, habit, eccentricity or lifestyle." "As one psychologist says, 'It's a very political process.'" [Goode, 1992]

Part of this process seems to be a labeling of unhappiness, yet there may be reason for such unhappiness and it may even be an appropriate response. Unhappiness, fear, aggression and the like are not only uncomfortable feelings, they are potentially motivators of positive human behavior. In fact each of these emotions offers a distinctive readiness to act that has enhanced our survival value over evolutionary time. Goleman [1995] suggests that a view of human nature that ignores the power of emotions would be sadly shortsighted. One must find ways to use the power of these emotions, rather than to simply allow them impulsive abandon or repressive control. The labeling of unhappy people as *victims* has a great deal to do with both the ability to attach pathology to the feelings and to disempower and take responsibility away from the individual. In that way, the 'helping' process creates or supports a 'pathological' response to everyday life. It also has a corollary of enhancing the power [and status] of the helping professionals.

Webster defines hallucinations as false illusions. But illusions are false perceptions. This sounds like double talk. Hallucinations are false perceptions that are false. And since truth is in the eye of the beholder, is the perception false or simply not verified? "Those who hear voices are usually considered psychotic or saintly" [McCarthy, 1993] Would Jesus be suffering from *delusions of grandeur* or perhaps hallucinating the presence of God? How do we separate the common psychotic from the saint, and who is justified in making that decision?

In the course of her research, psychotherapist Myrtle Heery indicates that otherwise ordinary people may sometimes hear voices, too. Heery found three types of inner voices. The first, she says, is a fragmented part of the self. One man reported that whenever he lacked courage, for instance, a voice told him what to say or do. The second type of voice provides guidance for growth through individual dialogue. Heery gives the example of a painter 'who checks things out' with her inner voice before she does them. The third type of voice is a doorway to a higher self...and has a spiritual dimension. This type of voice, generally heard by people who practice prayer or meditation, 'are typically engaged in service for the larger good of humanity, without any monetary gain or ego manifestation.' Heery emphasizes that her subjects 'are *functioning* members of the community' [emphasis ours] [McCarthy, 1993].

So the question of psychological fitness or 'mental health' seems to have little to do with the presence or absence of thoughts, feelings and/or behaviors, but perhaps more to do with functioning. People may have extremely bizarre thoughts and actions, but if they are seen as functioning well in the valued places of their society, they are much more likely to be considered psychologically fit. It doesn't matter if the perception is false, if it is accepted. The prevalence of UFO sightings may or may not be real, but they are increasingly accepted. It is a statement of our sociocultural norms that such sightings are as prevalent and acceptable as visits from God or his/her designees, angels.

But the Goleman article [1989] might suggest another clue - "Explanatory beliefs tend to be self-confirming in that contradictory data are ignored, while anything that might support the theory is given prominence. That, Dr. Maher says, has been shown to be the case with ordinary beliefs as well as with people who develop delusions." Thus, *coherence* to a basic belief system is a significant factor in the holding of personal truisms regardless of apparent discrepancies. The ability or willingness of the individual to *rigorously analyze the evidence* is one that this paper will intensively explore. People develop, over time and through significant people and events, personal truisms, which in combination are valued and used to determine the truth or falsity of events and propositions in the future. The *validity* of those personal truisms [belief systems] in relationship to the personal truisms of others individually and collectively [sociocultural beliefs] and their utility in helping the individual function in living become significant standards of psychological fitness.

Each person develops standards by which to judge the world. These standards may be labeled thoughts, fears, fantasies, attributions, expectancies, values, truisms, beliefs and the like. The standards are developed in regard to *self*, *others* and *prospects*. In regard to self, the individual evolves a self concept. In regard to others they evolve prejudices, stereotypes and/or world views. In regard to prospects, the standard set of truisms are used to predict or prophesize the future. Often such prophecies are self fulfilling since the person behaves in ways that make their expectation come true. These personal

standards are held either powerfully or weakly depending on their impact upon the individual's overall way of functioning, and they are not necessarily coherent, meaning that often contradictory standards are held. The failure of rigorous analysis on the part of most people allows such dichotomies to persist. Thus people with prejudices make excuses for people who belong in the stereotype, but somehow don't fit. While I don't like [women, Catholics, Irish, etc.] this person who happens to be a [woman, Catholic, Irish, etc.] is not like those others. Clearly rigorous analysis of this evidence should begin to erode the prejudice, but it often doesn't.

Within this set of propositions, some become the standards by which the individual makes judgements about themselves and the world around them. Since the standards may cover both the general and specific [a baseball player is confident that s/he can hit well and that is supported by the evidence [batting average], but s/he believes that s/he cannot hit one pitcher or in one ball park and that is also supported by the evidence], these standards do not present a unilateral profile of the person, but a complex compilation of fact and fiction in regard to relationships and experiences. This *personal standards profile* is used to make sense of the world and to create one's personal reality.

Such fitness then seems to resolve around at least three elements: **reality** [as defined by the sociocultural belief system norms], **self evaluation** [as defined by the degree to which the personal belief systems coincide with the sociocultural belief systems and the extent to which the personal belief systems are *rigorously analyzed in regard to the evidence* and modified in regard to that analysis] and **competence** [as defined by the utility of the personal belief system in allowing the person to *function* in ways that are considered appropriate and the personal behavioral repertoire which allows the actual functioning to take place].

A person might be considered to be psychologically fit if s/he were able to perform appropriate behaviors in a productive manner in a given sociocultural reality. Change the reality as happened to the hunting-gathering tribe, the Ik, and this *fitness* is threatened. Such threat requires a modification [in this case quite dramatic] in both personal belief systems and repertoire of behaviors. The Ik were apparently unable to accommodate the changes in their circumstance and therefore became *unfit*. To say that the circumstance were unfit is quite arbitrary as many people obviously perceived the circumstances as *normal*. But the match between the Ik and their environment was traumatic enough to make their coping and achievement skills inadequate. This probably led to a re-evaluation of themselves and, instead of taking the most positive evidence [that they were okay, but the environment was skewed], doubt set in. One can imagine them beginning to evaluate themselves as inadequate to the task. Once this decision was made, supportive evidence continued to accumulate and *helplessness* resulted. One could imagine a member of the Ik visiting a psychiatrist who would diagnose clinical depression [perhaps indicating a chemical imbalance] and suggest medication. Such practices would, of course, provide continuing evidence of personal unworthiness and failure. The Ik became *victims*. Their personal powers were reduced. Their worthiness as verified by self and others was reduced. And they no longer tried. They had learned helplessness.

And yet, while we cannot always be responsible for the circumstances in which we find ourselves, we are always responsible for how we respond to those circumstances [Frankel]. Each of the elements is interactive with the others and each has its own complexities. Reality, for example, is 'observer created'. This term, borrowed from the theoretical physicists pertains to quantum mechanics, and is best demonstrated in the macro world by the story of the three blind men of India who come across an elephant. Each describes the animal in the context of his own perception: i.e., one describes a tall pole as he feels the leg; another a huge round animal as he feels the body, and one finally as a long snake like animal, as he feels the trunk. Such perception problems are common as any accident victim can tell you. Most of us see what we expect to see and therefore our very reality is formed by what we bring to the subject matter [our personal truisms].

Which one of the blind men had a *false perception* or illusion. Why is it that some people are less likely to accept illusions than others? Such people are constantly scanning for clues and facts that will give the necessary information required to effectively evaluate a situation. They 'reality-test' by paying attention, rather than making up emotional answers to fill in the gaps. These people have the ability to see the same things over and over with a fresh focus each time. Zen masters are the same way. They, too, have been tested for signs of enhanced perception. It was found that their ability to accurately perceive the day-to-

day events was directly related to their desire to see the world clearly and not to take things for granted. People who do not readily fall for emotional illusions are able to see old things through new eyes, day after day. It's a type of internal 'illusion-busting' [Buffington, 1985].

It seems that certain personalities can 'see' reality more vividly than others. But it also seems that people can train themselves to see more clearly. The Zen concept of a 'beginner's mind', meaning the conscious opening of one's self to seeing things anew each time is a method of overcoming seeing only what you expect to see. This is a *learned* skill. Learned expectations are called schema or coding. We have a certain set of paradigms built from experience regarding most of what we expect to see in the world, and we code everything within those parameters. People with psychological difficulties often have a very negative triad of beliefs about themselves, their circumstances [including luck] and their future potential. Since this lack of self esteem colors their perceptions of reality, they see many things as negative that were never intended that way. In interactive relationships between people, the players often create a reality by their coding of the message given. If someone threatens me and I code it as a joke [in real life it is more likely to happen the other way around], a completely different scenario is likely to occur than if I code it as a threat. The ability to contain the intensity of our emotions, certainly impacts upon our ability to place events and experiences into a context that allows for considerations of reality. Salesmen are adept at *reframing* rejection and attempting, therefore, to alter reality. "How much will this cost?" "Your investment will be ....." cost and investment are two different concepts.

One can, within certain limitations create the future through coding. A confidence code is likely to result in achievement. But confidence is not the only factor in regard to achievement. Psychologists have worked hard to penetrate the fact that most people in the world do not really care all that much about improvement, while there is a "minority which is challenged by opportunity and willing to work hard to achieve something. This is not a question of motivation since many people have desires for something to happen, but not the desire to make it happen. McClelland - [1966] reports that these achievement motivated people only behave this way if *they* can influence the outcome and would not be interested in attainment by chance even if the odds were the same and the effort easier. "The evidence suggests that this is not because they are born that way, but because of special training that they get..." So not only is the perception of self, situation and prospects learned, but the desire to excel is also learned.

Finally, there is the dimension of competence. This is generally defined as the ability to function effectively within social and productive environments. Capacity equal to the task. Competence concerns both cognitive and behavioral skills. These skills are all teachable, and most are learned developmentally, often from peers. When one has usable skills and functions well, there is a tendency to feel good about oneself and to get positive reinforcement from others. When one does not have competence, there is a tendency to feel inadequate or 'bad'. Such feelings are reflective like the circles in a pond and can, without containment, grow and feed upon each other.

The psychologically fit person, therefore, is one who feels competent and acts competently thereby creating a reality that is positively reinforcing. This aura of fitness can break down at many points, but usually occurs around self affirmation issues. Feelings of depression and paranoia, aggression and frustration are often generated because we feel somehow we are not good enough [or that others think we are not good enough]. Trauma producing crisis is a point where the coping skills [or competencies] break down. What worked before is no longer effective and this alters our feelings about ourselves and our competencies [and we begin to project these negative thoughts on others. Our inadequate coping behaviors change the positive reinforcing environment, often into a sympathetic, but patronizing one or one that is rejecting and coercive. Either of these becomes a self-fulfilling prophecy to our depression and/or worthlessness.

But psychological fitness is not just seeing reality as it is. "Supporting evidence shows that depressed people are accurate judges of how much skill they have, whereas nondepressed people think they are much more skilled than others judge them to be.... nondepressed people remember more good events than actually happened, and they forget bad events. Depressed people are accurate about both [Seligman - 1994]. This paradoxical finding seems to be supported by Meichenbaum and Fong [1993], who write that this issue has been highlighted by Taylor and Brown [1988], "who have challenged the traditional assumption that mental health is defined at least in part, by having an accurate perception of reality. [They] suggest instead that the tendency to engage in positive illusions [that is, distortions of reality in

which the individual sees his or her world in a more favorable light than is actually the case] is actually associated with psychological well-being and positive affect. Furthermore, it is the *accurate* perception of reality that may be psychologically problematic, being that it is associated with negative affect and depression." They conclude that positive illusions may be adaptive.

Part of the response that we would make to such a paradox is that in observer created reality as in Zen philosophy, the future is *created* by the experience [cognitions, emotions & actions] about the present. Thus, the person who sees things as being positive creates a positive reality. When these researchers identify that depressives see an accurate perception of reality, one must ask the question "an accurate perception of whose reality?". The researcher is caught in the position of using his or her reality as the baseline upon which to judge the judgements of others. This is the same 'craziness' that physicists have in trying to determine whether light is a wave or a particle: it depends on which reality they choose to use to detect light. There is no reality - until someone decides upon it.

To simply accept this premise, however, is probably not useful from the standpoint of trying to develop new and unique ways in which to help people with problems in living deal with life differently. It is not easy to simply suggest that they *think* differently about reality and therefore change it. Of more importance to the helper is the understanding of how explanatory patterns of reality develop and help and/or hinder our ability to live effectively. The difference in interpretations is not simply that individuals without depression see things in a better light, they *take responsibility* for how things are. As Seligman [1994] noted "All successful therapy has two things in common: It is forward-looking and it requires assumption of responsibility". He goes on to suggest that depressed people ... have four kinds of problems: *behavioral* - they are passive, indecisive and helpless; *emotional* - they are sad; *bodily* - their sleeping, eating and sex are disrupted; *cognitive* - they think life is hopeless and that they are worthless.

While they may judge measurable qualities like skill more accurately than nondepressives, they believe that they are incapable of doing anything about self, situation and future prospects; and they are right. They have created a reality in which the glass is not only half empty, that which fills it is toxic. On the other hand, people who choose to see life as less problematic than it may appear to a researcher are saying something about their own perceptions of themselves and their potential power to achieve *despite* what life offers. If one needs to choose between being a *victim* of circumstance or being *responsible*, the latter is more likely to help you live with fewer problems.

Part of the difficulty goes back to the Goleman [1995] perspective on the power of the emotions. As he suggests there are two fundamentally different ways of *knowing* the world and these interact to construct our mental life. "The emotional/rational dichotomy approximates the folk distinction between 'heart' and 'head'; knowing something is right 'in your heart' is a different order of conviction - somehow a deeper kind of certainty - than thinking so with your rational mind." But *knowing* is not simply a matter of accepting your "gut" feelings. It is a matter of understanding the essential message that such emotions are sending you; seeking to "grasp" these emotions by labeling them with mental representations that contain them; and then using this combined information in better functioning in life. Restoring the balance between the emotional and rational mind is a significant part of psychological fitness.

Maintaining psychological fitness is not contingent upon simply avoiding potential problems that may overwhelm you and cause a breakdown of coping skills; but is contingent as well upon quickness of recovery if such should occur. Any person, at any moment may be placed in circumstance where their coping skills are overwhelmed. Our ability to recover is to some extent contingent upon our ability to attribute that collapse to *controllable* factors. If the response to that collapse is authoritative people confirming that you are, in fact, inadequate, the downward cycle continues. Crisis intervention, therefore, needs to be oriented towards restoring confidence in the ability to be responsible for themselves through helping the person think through and decide on new coping strategies. "Optimism, the conviction that you *can* change, is a necessary first step in the process of all change" [Seligman - 1994].

Mentally tough individuals are able to recognize that all psychological stress is internal and to set that aside. Test pilots are renowned for their ability to continue testing the plane until it hits the ground. Their attention is not oriented towards the problems, but rather the solution. The development of such mental toughness is a learned process. And it must be noted that mental toughness is supported by physiological states. "The last source of self-efficacy information that Bandura defined is the individual's sensations of

his own physiological reactions. People respond physiologically as they experience events in their daily lives, and they sometimes interpret their bodily reactions as evidence of high or low self-efficacy" [Eden - 1990]. People codify aches and pains and tiredness after strenuous activity and may see themselves as having a high or low capacity. Such interpretations can affect their expectations for successful performance and their sense of themselves in the world around them.

People experience stress when they perceive the threat of being overwhelmed by a situation whose demands seem to outstrip their capacity. The more we are able to increase our sense of capacity through realistic evaluation of ourselves and others, increasing skill repertoire and developing physical energy, the greater our ability to avoid feelings of stress. But another factor needs to be accepted and that is that most people will occasionally face situations that demand more than they have to give. The ability to *realistically* determine and accept this experience as an opportunity to learn about ourselves and our circumstances on the one hand or to cope through appropriate avoidance on the other protects and maintains our psychological fitness. If overwhelmed, it is important to regain control quickly. Separation and understanding of *wants* and *needs* helps to avoid overly emotional responses to being thwarted.

Psychological fitness is thus, a learned and sometimes transitional thing. We are more or less fit, if we are able to perceive the world around us as supportive, we have positive thoughts about our selves, our activities and our options for the future, and we have functionally competent skills. Rarely does one achieve perfection of this triad. Each variable is constantly readjusted as the job, family, friends, hobbies, age, health, etc., change in status. The most frightening variable is that we can almost decide whether to be fit or not. Like the child who fantasizes about fearful situations and then ends up actually being afraid of their own fantasies; we all can readjust the world by thinking positively about it and ourselves in it.

One of the major failures of human services as we practice them today is that we approach the person in stress from the perspective of experts. The clear attribution of such expertise is that the person will never be able to do what the expert is able to do. Just as we marvel at savants and feel inadequate in light of their virtuosity, so the very expertise of the human service practitioner can reinforce the person's own downward spiraling feelings that they are not up to the task. Such a delicate balance between self and other, perception, codification and behavior suggests itself to a reorientation to the restoration process where the major architect of successful recovery is the person himself.

Psychological fitness is comprised of:

- feeling good about your self, your circumstances and your prospects. The greater the confidence of self, the greater the mental toughness to recognize and suppress the internal aspects of stress. The person who feels good enough about him/herself to fit into various sociocultural environments and at the same time is willing to be different is demonstrating fitness. Those who only narrowly cope with life may show fitness in present circumstances, but not be flexible enough in times of crisis. Prejudices are signs of a lack of fitness; an inflexibility to deal with each person as an individual experience and the stress [fear] of difference.
- having control over your emotional responses, being able to identify both the validity and intensity of the feelings and using such information to contain impulsive behavioral responses. Lacking emotional weight, experiences and events lose their hold and become potentially manageable occurrences. Research has shown that in the first few milliseconds of our perceiving something we not only unconsciously comprehend what it is, but feel positive or negative emotions towards it [Goleman - 1995]. Such processes are the evolutionary residue of the need for instantaneous flight, fight or accept responses which were important for survival. However, the next behavioral steps required a *queuing* of actions, which gave rise to *thinking* [Vallacher - 1993]. Such thinking has the ability to modify the *instinctive* or reflective action through *reflection*. It is not the abandonment of emotion that is necessary, but the balance between reflexive/reflective behavior which marshals the forces of both.
- having the competencies necessary to function in the valued arenas of your sociocultural entity or any in which you may find yourself. The broader the repertoire of competencies, the greater the ability to respond to sociocultural and event changes.

- having a personal support group of significant persons who are able to positively support your efforts at regaining control. While significant training on mental control and behavioral repertoires can enhance the ability to withstand trauma, the relationship to significant people who will provide the positive reinforcement at time of collapse if and when it happens, is critical to successfully rebound from traumatic setbacks.

Like physical fitness, psychological fitness requires that one exercise<sup>5</sup> the mind [as well as the body], eat nutritiously and avoid overstress. Knowing the body and mind and their limits provides the added advantage of being able to withdraw to more relaxed environments when necessary.

### Pygmalion

To have continued psychological fitness, it would certainly be helpful to be surrounded by people who believed in the same things as you do, and who were willing and able to provide consistent positive expectations. Such positive expectations tend to indicate to the individual that they *are* capable of achievement. Such interrelatedness of human beings is significant and profound. Each person shapes, and is shaped by the people and events around him. The influence of significant others [either through relationship or acknowledged authority] is particularly powerful upon the developing self, or the underdeveloped self.

Two logical outcomes result from such incoherence: a) the individual rejects the propositions offered by the environment and holds steadfastly to their coherent beliefs, or b) the individual begins to *believe* the propositions offered by the environment and reorganizes their personal coherency. The effects of such options are obviously developmentally helpful or harmful depending upon the nature of the environmental input. For example, if the individual persons feel themselves as competent and the environment is suggesting that they are incompetent; we would hope that they would fend off the environmental input and maintain their present personal beliefs. On the other hand, if the individual felt generally incompetent, and the environment was suggesting that they are much more able than they believe; we would like to see this new proposition accepted and the personal coherency changed.

Such an effect has been demonstrated by researchers of self-fulfilling prophecies [SFP]. "An SFP is said to occur when one's belief concerning the occurrence of some future event...makes one behave in a manner...that increases the likelihood that the expected event *will* occur...." [Eden<sup>6</sup>, 1990]. Identified as *interpersonal expectancy effects* these phenomenon demonstrate how much individual human beings are interrelated.

"Webster's New Universal Unabridged Dictionary [1983] defines expect as 'to look for as likely to occur or appear.' It is this likelihood-of-occurrence sense that triggers SFP. Webster's also defines *expect* as 'to look for as due, proper, or necessary; as your bill is due and immediate payment is expected. This is a normative definition of expectancy. This object of normative expectancy is what *ought* to occur in the future. This is not the type of expectancy that produces SFP; it is the stuff of which role expectations and other normative concepts are made." While it is important that individuals understand how they ought to perform in the roles that they inhabit, it is more important that they feel from others that they *can* perform those roles.

"These two meanings of expectancy - likelihood of occurrence and normative - are sufficiently different that they can be contradictory. If the boss tells a subordinate that he *is expected* [in the normative sense] to report in on time, but in his heart he actually *expects* [in the probability sense] the subordinate to be late, it is the latter expectation, not the normative one, that will be unwittingly communicated and initiate an

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<sup>5</sup> We should not underestimate the exercise of the body as a means of supporting psychological fitness as well. While some people are comfortable with their body image regardless of sociocultural ideals, the maintenance of the body will provide both an *acceptable* [and reinforced] image and a body less prone to health problems that often cause the trauma of psychological deterioration. A sound mind and a sound body.

<sup>6</sup> Much of the discussion in this section is developed from Dov Eden's *Pygmalion in Management*, a highly recommended book for managers to which I am indebted for it brought together much of my thinking.

SFP that may result in tardy behavior on the part of the subordinate. Thus it is expectancy in the sense of that which the expecter *believes is likely to occur*, rather than that which a person believes *ought* to occur, that leads to the behavior that fulfills the prophecy. In particular the use of “performance expectation” refers to the level at which the manager believes the subordinate is likely to perform” [Eden - 1990].

While Eden talks about the boss, we will see throughout, that the effect not only has impact between superior and subordinate roles, but between peers as well. “It is important to understand that [self fulfilling prophecy] is somewhat of a misnomer. The prophecy does not fulfill *itself*; it is a mental abstraction that cannot ‘do’ anything. It is the *prophet* who, acting under the influence of the prophecy, behaves in a manner that molds events to conform to his expectations.” The prophet, or expecter, is able, within limitations which we will explore later, to manipulate the behavior of the other person through a) believing strongly in his or her expectation, and b) consciously or subconsciously behaving in ways that make the expectation happen. This manipulation is a substantial part of the maintenance of the *pathology* perspective of people with problems in living. If the human service professional *believes* that the root cause of the problems in living is pathological, s/he will tend to behave in ways that are not helpful in influencing the person to change such behaviors. The best that could be hoped for would be the *limitation of the problem behaviors*.

“To illustrate, Rosenthal and Fode [1963] had psychology students serve as ‘experimenters’ in what was introduced to them as a study of maze learning among laboratory rats described as having been bred to be either maze-bright or maze-dull. The students were told that rats designated maze-bright could be expected to perform well in the maze-running task, whereas those labeled maze-dull should perform poorly. However, the only difference between the rats designated bright and dull was the designation itself; in reality there was no systematic difference in innate maze-running ability as the rats were distributed to the experimenters at random.”

“The rats designated as bright outperformed their controls beginning with the first day and continued through the fifth and last day of the experiment. Furthermore, when asked to rate their own attitudes and behavior toward their subjects, experimenters who had been told that their animals were bright rated them as brighter, more pleasant, and more likable, felt more relaxed with them, reported behaving toward them in a more pleasant, friendly, enthusiastic, and less talkative manner, and reported handling them more and in a gentler manner.” [Eden - 1990]

As prophets who fulfill their own prophecies, the experimenters got their animal subjects to fulfill their expectations. While human beings are more complex, the same experiences occur with them. “The existence of interpersonal expectancies has been supported by seven metaanalyses that cover 388 studies. Metaanalysis combines the results of a large number of studies and estimates the magnitude and significance of the overall effect. There remains no reasonable doubt that the experimenter effect is a real phenomenon.” [Eden - 1990]

The *reality* of our existence is based upon our ideas about ourselves, our circumstances, and our prospects for the future. Other people play an important role in the development of our internal and external reality. The Pygmalion effect is a major explanation of one way this important role is played out.

“Rosenthal and Jacobson coined the term “Pygmalion effect” to refer to these phenomenon. They borrowed the label from George Bernard Shaw’s [1957] play in which Professor Henry Higgins trained a simple, uneducated flower girl from the streets of London to exquisite mastery of the English language. Shaw was inspired by the Pygmalion of Greek Mythology, a celibate prince of Cyprus who sculpted a maiden of ivory and then fell in love with his inanimate masterpiece. Aphrodite brought the statue, named Galetea, to life, and they lived happily ever after. The common theme in all these phenomena, mythology, literary, and scientific, is that one person inspired by a vision, desire, prophecy, or expectation, persists in his relationship with another person, ultimately transforming that person in accord with his vision. Rosenthal’s [1973] four mediating factors are:

*Socioemotional climate*, which is defined as ...behaviors that are nonverbal, and mostly subconscious, that convey positive or negative feelings toward pupils.

*Feedback*, is an indispensable ingredient to any learning process. [Teachers] give more feedback and more varied feedback to [pupils] of whom they expect more.

*Input*, in the form of teaching more material and harder material, is provided more to those expected to do well. This mediating factor may serve to challenge these pupils and spur them on to greater achievement. It may also be a means of communicating high expectation to pupils.

*Output* is defined as producing a learning result as in answering a question in class. Teachers give pupils opportunities for producing output by assigning them challenging projects or by calling upon them to do something extra, beyond the minimal requirements.

The combination of all four factors points to a straightforward explanation of the Pygmalion effect: high expectations work their 'magic' by making teachers more effective instructors for those they expect to do well. " [Eden - 1990] Whether or not they know it, teachers, managers, human service workers and others are *prophets*. They expect certain things to happen, and then act in ways that fulfill their own expectations. And yet, to a large extent, these experiences have been neglected by the very people who are responsible for the care and development of people with problems in living.

"This relative neglect may be caused in part by a tendency not to attend to SFP *because* it is so ubiquitous and so deeply embedded in the social fabric .... We often fail to notice phenomena that pervade our everyday lives. To the extent that SFP...is part of the organization's culture, to become cognizant of it we must 'uncover the mundane as well as the more vivid aspect of the reality-construction process. And sometimes these are so subtle and all-pervasive that they are very difficult to identify' [Morgan, 1986]"[Eden - 1990]. But we cannot allow such neglect to continue to happen. While lay people may not be responsible for the rigorous analysis of themselves in relation to others, professional and paraprofessional human services workers are. These workers and their organizations are designed to provide *service* to people with problems in living and, as we shall see, have consistently and comprehensively failed. This failure can be clearly connected to a *belief system* that cannot be supported by evidence, but contributes heavily to the very problems which are supposed to be positively addressed.

Thus if we seek psychological fitness for the people we serve, we must take into account not only the individual, but also the individual *in context*. "No man is an island." Each of us inhabits a space with others, significant, authoritarian and minor, who support or erode our personal beliefs about self, others and prospects. The potential held by modification of both the internal and external space is profound.

This brings to mind Hofstadter's [1979] discussion of *figure* and *ground*. In artistic distinction, the figure is the "positive space" [e.g., a human form, or a letter, or a still life] which, when drawn inside a frame, causes an unavoidable consequence of a complementary shape - called the "ground", or "background", or "negative space". While in most drawings this figure-ground relationship plays little role, since the artists is much more interested in the figure than the ground, some artists [e.g., M. C. Escher] have made a career of making the ground as important as the figure. In fact, Escher has made the ground figure, and vice versus. Hofstadter calls these *recursive* drawings because the ground can be seen as a figure in its own right. "The 're' in 'recursive' represents the fact that both foreground *and* background are cursorily drawable - the figure is 'twice-cursive'."

Human space is "twice-cursive". The figure shapes the ground and the ground shapes the figure. An alteration in one human has the impact of re-drawing the other people around him. The strength of one human being to resist the influence of another impacts on the strength of the other human being to be influenced. Thus each of us influences and is influenced by others. This influence goes further. Since human beings are capable of giving sense to insensible objects; we are equally capable of taking sense from the insensible. Thus, messages subliminal and sublime are attached to the environment in which we abide. A dark and foreboding environment is likely to detract from a effervescent mood. The degree to which an individual is influenced by the environment, including the human inhabitants of that environment, gives us some quality of that person's psychological fitness.

A person is an *interactive* entity whose properties are the *product of that interaction*. It is not valuable to suggest that an individual is “aggressive” or “psychotic” without an understanding of the relationship to the totality which impacts upon him/her. The human organism is intrinsically an active system with or without stimuli. “Man is an *active* personality system capable of self-initiated behavior. He has some measure of autonomy in his action and is not necessarily subject or reactive to his environment in a probabilistic sense. Seeing him only in terms of the molecular units - reflexes, sensations, drives, traits, and the like - permits us to understand only the discrete functions, a view which minimizes and dehumanizes” [Goldstein - 1973].

Individuals who are able to maintain their thoughts and emotions within changing and stressful environments demonstrate mental “toughness” and psychological fitness. The personal hold on “reality” is the anchor upon which they stand. People easily swayed by superstition and suggestions are less likely to be able to maintain a level of “fitness” which is compatible with optimal growth and development. The boundaries of the person may be thin and vulnerable to external demands or they may be rigid and impermeable and therefore isolate the individual from others. Psychological fitness demands a permeable boundary and a self regulating process. The individual must maintain some method of regulation that maintains itself as a system, but sufficiently changes to adapt to stimuli from the outside. The inability to change cause fragmentation of a personality and trauma. Thus, a *steady state* concept that expresses both *structure-maintaining* as well as *structure-elaborating* features is needed. [Goldstein - 1970]

However, there are two dimensions to psychological fitness. One is the strength of personality; the ability to maintain one’s *self* in the midst of change, but the second is more pragmatic; it entails the *effectiveness* of the personality in helping the individual to predict and control future events. Some of the people who have problems in living are so rigid in their personality protection that they go to extreme hallucinations or delusions to avoid dealing with the stimuli which seems to “attack” them. Thus, the product of the personality becomes less “useful” in meeting the purposes of the personality [i.e., success, power, happiness, etc.]

Thus it is not the structure of the individual’s personality that remains steady, for in order to maintain the wholeness and continuity [psychological fitness] some alteration of that structure [belief system] may constitute growth and development. How much the “figure” [individual] modifies the “ground” [people around him], or the ground modifies the figure is a highly complex relationship. However, as helpers, we must recognize this ability to modify and use it effectively for purposes that are coherent to our goals. A wholeistic view impels us to understand the entirety of the social, psychological and physiological organization and enlarges our appreciation of the *creative* and *adaptive* potential.

## Paradigm

There is an inherently different way of thinking about the world that is implicit in the shift from the traditional model of human services delivery and the new model. In the traditional model that was exploited and enhanced, though certainly not created by Freud, the helper’s focus was upon identifying the **problem**. What was the difficulty that limited the person’s ability to function in satisfying ways. Once the problem could be identified, then strategies and tactics could be developed to **reduce or eliminate** the problem, therefore freeing up the individual to a higher quality of life.

Such traditions have certain implicit difficulties. First, it has a **negative** focus. The consistent focus on the problem allows both the helper and the client to fall into feelings of apathy and distress when the problem is complex and not easily resolvable. When we talk about **needs** assessment, we are talking about **deficits** in the person. The very description of the concern lowers the self esteem of the individual and places the helper in a superior status despite the fact that the helper may have problems of even greater proportions. Since the process does not focus on the problems of the helper, the distinct impression can be gained that the helper is superior to the client. To his credit, Freud identified the *helper’s* own problems as significant and required that each helper undergo *treatment* for his or her own problems before offering help. Even assuming effectiveness in the first sense, this does not alleviate the negative impact in the second sense. In fact, it may enhance it, since the helper can now claim that s/he has *resolved* her issues whereas the client clearly has not.

When problems are complex as human difficulties frequently are, there is often a frustration with the inability to reduce or eliminate it. Being human, we usually then identify someone who is responsible. Clients often place this burden on the therapist. If the therapist had been better at his or her job, perhaps the client would be better off. On the other hand, the therapist is clearly the superior person in this relationship as established as a part of the **context** of the relationship and therefore, clients often look elsewhere. Two immediate options become apparent; either it is someone else's fault or it is mine. Both of these responses have critical deficits. Placing the blame on someone else [mother, for example] limits the ability of either the client or the therapist to effectively reduce or eliminate the problem. Unless mother is willing to enter into therapy as well, the therapist is reduced to suggesting ways in which the client might change his or her relationship with the mother by either doing things differently or removing him/herself from the relationship. Since the latter is considered a non-resolution, the former strategy is often the most articulated.

Continued failure of the client to be able to implement a new relationship with the mother, focuses the issue back to them: they must be responsible. The problem is that we have delegated responsibility without authority. It is acknowledged at the beginning that the client cannot solve the problem, which is why they have come for help. In this fashion, the client **becomes the problem**. Since as professional helpers we find it difficult to blame our clients for their own problems and we have taken the responsibility for resolving these complex problems for them in the first place, many professionals find it easier to find a more mystical answer. It is not **really** the client, it is a **pathology**, in the face of which the client is helpless, which causes the difficulty. The pathology might be a germ, chemistry or genetic defect, or conversely a neglected and/or abusive past, but it is not something over which the client has control.

The fact that such solutions free the therapist from **failure** while establishing them as **experts** in an exotic field; and at the same time push the client further into helplessness is often obscure. What is less obscure is the fact that such a pathology that interferes with the client's ability to control their own behavior, sanctions the therapist to **control** the client's behavior. This sets in motion a coercive process of "doing for one's own good" quality of helping, which this book rejects.

The traditional or classic model is seemingly grounded in **scientific** theory because of its similarity to general physiology and medicine. However, it only emulates that scientific base since the **mental** or **behavioral** illness does not really exist. While it is true that in the last twenty-five hundred years, we have identified **one** brain disease that we will discuss later, and over the next twenty years genetic study is likely to **document** genetic *propensities*, it is the author's opinion that this type of reductionism will ultimately prove futile. As an example, we would cite the studies of twins. While often used as **proof** of the generic base for schizophrenia, they in fact, prove just the opposite with rigorous analysis. The studies have show to date that of identical twins who are raised separately when one is diagnosed as schizophrenic, as many as 50% of the siblings are also so diagnosed. Now this is significant. Fifty percent is much more than chance would allow. The problem, of course, is that it is not 100%. If the **disease** of schizophrenia were in fact genetic, then all of the identical twins must be consistent. While one can argue that there is a **propensity** for the **disease**; and equal counter argument can be made that appropriate nurture can reduce the propensity to zero. In fact, the success record is 50%.

When discussing genetics, we are required to address the issues of natural selection. The endowing of the genes with emotional and psychological predispositions is a very unsettling construct. Obviously, the first question is whether such constructs can be biologically set. An initial response would be no. That is the emotion, itself, cannot be so selected. However, natural selection is a process that approximates learning. Natural selection increases behaviors that satisfy evolutionary needs for a given environment. If the behaviors enhance the species potential for reproduction, whatever chemical or electrical design that allows for that behavior to take place, is selected. Genetic propensities that promote natural selection increase; while genetic propensities which defeat natural selection decrease through the competition of "mating" and production.

Thus the organism *learns* how to achieve in a given environment, improving capacity and performance over time, by passing the "tests" 1) mastery of the environment; that is, avoiding getting killed off before reproduction, 2) mating, 3) production of offspring, 4) survival of offspring. Mastery of the environment is the most demanding of these "tests", since sudden or dramatic change can cause these "improvements" to become "deficits", if the "learning" has become too specific. In this regard,

generalized, flexible “skills” become highly valued since the potential for sudden or dramatic change in the environment is the most likely test of these learned skills.

The emotional basis of behavior is developed around the one critical decision of all animal organisms, which is to **fight** or **flee**. The emotions are either the “trigger”<sup>7</sup> [or the result] of the biopsychological changes which are required to increase the entity’s capacity to carry out these behaviors effectively. Thus, anger and fear [aggressiveness and anxiety], are evolutionary “improvements” which enhance mastery. Since these emotions have supplied positive outcomes for substantial periods of time, they are, therefore, deeply embedded in the genetic code of the species. This does not mean that the emotions and resultant behaviors were “placed” in the genetic code, rather that these traits were selected for because of their effectiveness in helping the entities pass the evolutionary tests [they weren’t eaten by lions and tigers and bears and lived long enough to procreate] and therefore members of the species who had them in sufficient supply to be effective, survived and passed these traits on through their genes.

But while the fight/flee emotions are innate and instinctive; this does not eliminate the ability to learn how to use these emotions effectively. There is still a decision to be made and those animals that make the decision to fight or flee unwisely suffer the consequences. Thus a hyena may be aggressive and fight leopards at will with a high degree of success; but ought to be much more anxious at the sight of a lion. The *decision* as to when to fight or when to flee is often learned. The more sophisticated the organism, the more learning is involved. The fact of genetic involvement means that there is a genetic structure that limits or enhances learning, but does not negate it. In his book, *The Language Instinct*, Steven Pinker builds the case for innate psychological mechanisms, including learning mechanisms that predispose human children to learn language. He points out, however, that while the *grammatical instinct* is powerful in children, it fades as we grow older; hence it is more difficult for adults to learn a new language and the so called “wild” children have never been able to learn to use language efficiently.

Similar limitations may be made on the instincts of anxiety and anger. Human beings are able to remember the past and predict the future with much more precision than most other animals. Our awareness of ourselves makes the decision making in regard to fight/flee, much more complex. Even the meaning of fight and flee may be modified extensively, so that fighting may take on the aspect of avoiding violence through manipulative behaviors which enables the individual to get their own needs satisfied. In addition, we have created an environment [culture] that is artificially organized to affect and control [particularly through technology] the environment in which we live and face these decisions. The pattern making of the human mind becomes a telling element in the development of decision-making and behavior. How the mind organizes the cues from the environment regarding self, others and circumstances is critical to predisposing behavior. The person who emphasizes the [fear] anxiety side of the equation is likely to be pessimistic about the environment; seeing himself as a “victim”, unable to control the circumstances and incapable of mastery. The person who emphasizes the [fight] aggression side is likely to be optimistic about the environment, seeing themselves as masters of their fate, responsible, powerful and capable of mastery. Pessimists see causes of failure and rejection as permanent, pervasive and personal. Optimists see them as temporary, narrow and circumstantial.

Most members of the species will be ambivalent about their mastery, changing with circumstances, affirming in some areas and becoming unsure in others. The ability to realistically affirm both the mastery and the incompetence and to seek “improvement” in the areas of deficit would most approximate psychological fitness. This would be so regardless of the actual balance of mastery versus incompetence. Persons with virtually no competence, who accept this fact of themselves realistically and affirm themselves as human beings with value, potentially capable of learning competencies, must be said to have attained psychological [although perhaps, not evolutionary] fitness.

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One of the interesting questions regarding the so-called “chemical imbalance” constructs is to consider the chemical/electrical connection between fear and adrenaline. Does the fear [which is a codification of a stimulus] cause the adrenaline rush, or does the adrenaline rush cause the fear. Which triggers which? This chicken/egg type conundrum leads to the question: does the chemical imbalance cause the emotions of psychosis, or does the psychosis cause the chemical imbalance? If the adrenaline causes the fear; what about anger? And how can we be fearful or angry without some mental codification of the stimulus?

Problems can occur on both sides of the fight/flee emotional standard, when the personal pessimistic/optimistic explanations are irrational. Irrational fear causes suffering and maladaptation. Irrational anger causes suffering and maladaptation. The maladaptation of fear is depression; the maladaptation of anger is paranoia. The explanatory style of fear is pessimism and hopelessness. The explanatory style of anger is hostile attribution and violence. The optimism of society is that these explanatory styles can be redirected through new technologies that involve both individuals and cultures in positive expectations. While the technology of culture itself has seemed to become self-defeating for the individual members, the technology of cognitive/behavioral skill building combined with the philosophy of self determination, community membership and competence/empowerment seems to have arrived just in time to help restructure both individual and cultural structures towards more positive goals.

By looking at the other side of this genetic equation, we create **hope** and **rational optimism**, which are the ingredients of the new way of thinking about a transformational model. The basic paradigm shift is to recognize the client as the **master of his fate**. This is frightening to many who recognize the frailty of the human psyche; but we contend that it is so. Being the master of your fate has the downside scariness, but also has with it some dignity and respect. It means that you have **power** and in the final analysis problems in living almost always deal with power. It is when our power fails us, that we feel trauma and seek help. To be then told that the power is inadequate or will never return is the worst of all worlds. It creates in the mind an idea of futility and hopelessness. It is interesting that this is **not** what general physicians do with people who really have an illness. In the case of AIDS, for example, we are told over and over how important it is to keep the persons hope and rational optimism up as a means of keeping them alive. In fact, the immune system is affected by this hope and optimism.

The new paradigm starts therefore from a **vision of a perfect future**. The client who is expressing dissatisfaction with his or her life is asked to define the elements of a more perfect future and in the process, define **quality**. What would need to happen to make the future 'rosy'. This is not an easy task for those who have always focused on the problem. We look for the **magic bullet**; the million dollars which will make everything okay or the pill that will make it go away. But we have not defined for ourselves the task: *what would be different?* It is only through this arduous task that we can begin to build the **positive** actions that can be taken to make this dream a reality. It is only through a precise **analysis** of what *might be* that we can create the future. If your child wants to become an astronaut, there are certain prerequisite steps that must be taken so that when the opportunity arises, they are prepared. In the process of precisely identifying the vision and the steps, we may find that the goal of astronaut is **not** the precise nature of the **vision of a perfect world**. In fact, that goal may cost too much in time and energy to make its pursuit worthwhile.

We shall see, also that the vision of a perfect world will change over time. Achievement brings a different perspective and often generates as much dissatisfaction as satisfaction, leading to a new vision of a perfect world. This is **not** a problem. Human service people often forget that it is dissatisfaction that motivates many important movements. People who are satisfied with their life rarely contribute something new and different into the world. It is the discomfort of an idea or a situation that motivates us to seek solution. It is this dissatisfaction that is the **strength** of the client before us.

So this new perspective is one of hope and optimism based on the vision of a perfect world and the strength of the client in being able to take the steps to achieve that perfect vision. The client becomes the **change agent**, the helper merely a hired employee who has expertise in building steps. The role of the helper is quite different and includes several things:

- a critical analyst who helps the client determine how s/he really wants the future to look. This is a *rigorous* process and must be looked at in detail. It does not take a great deal of skill, but requires an almost brutal honesty in order to help the client be honest to themselves about this future. The criticism is **not** towards the vision, but is focused on the requirement that the client rigorously analyses the motivation for the vision.
- a provider of creative alternatives who is willing to offer an exhaustive supply of alternative ways in which the vision might be approached and provides opportunities for supports where

needed. This is the psychological equivalent to the builder who repeatedly offers different ways to build a house on a hill overlooking a lake. Each has its advantages and disadvantages, but all will ultimately reach the goal. The client may decide that the house is too expensive to build on that lot, but should not be faced with the **impossibility** that it can be built. This takes *serious* skill and places the expertise of the helper in an *enabler* role.

- a provider who establishes **baseline** performance. The client must be aware of where they stand in relation to the vision of a perfect life. If the vision is to *walk on two legs* and the client has no legs, this must be identified as a baseline performance factor. The establishment of baseline performance set the basis for identifying targets for improvement. During the first time period, this will happen, and during the second time period, that will happen. This establishes a **continuous improvement** focus. The vision for a perfect future will not happen instantaneously, but over a period of time. It is important that the client **feel** and identify movement toward the vision and commit the time and energy necessary to raise the baseline performance each time period.

The baseline also establishes the parameter of partialization and prioritization. We will work on this **aspect** of the overall expectation **first**. This establishes a clear context for client decision making on a daily basis and offers the helper the opportunity to *teach* decision making skills.

Finally, the establishment of a baseline provides the context for collection of data and measurement. Data must be **informative** in regard to the movement toward the vision. If the building of a stairway is important to the final completion of the house or a *deep understanding* of math is important to the final completion of becoming an astronaut, these factors must be identified, collected and complied. Collecting data about math *grades* is not good enough. Good grades may get you in the door, but without a deep understanding of the material, you cannot perform. Counting the number of times you see your therapist is **not** a factor in your reaching your vision of a perfect world. While the therapist may want to collect such data for *his or her own purposes* [for example, billing] this must not be confused with pertinent data regarding outcome expectations.

- collects, compiles and analyzes data. The client is often unable to examine data critically and appropriately. First, the client must overcome the confirmation bias – the desire to ignore all data that disputes his or her beliefs. This is a **learned** skill and requires both teaching and help. In fact, a major premise of this book is that people in general do not rigorously collect and analyze the evidence. The helper must help the client evaluate and re-evaluate the direction, movement and time/energy resources that are being used in regard to the vision, which may cause a re-evaluation of the vision itself.

To state that all of this cannot happen without the helper being **significant** to the client in terms of trust, respect and affection is to miss the point. A rigorous analysis of your own activities is a tiring and frustrating job. It would be so much easier just to blame someone else and just “grin and bear it”. The helper must be sanctioned to help.

This process of change is not different for people and organizations. Organizational change has the same requirements. The organization defines the vision for a perfect world through its mission or social policy statement. Without this vision for a perfect world, its articulation and debate, what do staff strive for?

Once this perfect future is described, management must do several things:

- develop measuring tools.
- use the measurement indicators to indicate the *baseline*: where are we now in each of the dimensions?
- describe the strategies we intend to use to create change. [These have already been described although based only on an illusion of what might be a perfect world.
- indicate the degree of improvement that we might expect over a given period of time.
- measure the change over time.
- adjust/incorporate the strategies and/or tactics based on the degree of improvement.

- revisit and refine the future.
- set new goals based on newly established baseline [new data].

This process requires critical thinking in terms of defining the perfect world, creating the measurement tools, strategies and tactics as well as sophisticated data collection. The data collected must be related to the factors that indicate the perfect world. Collecting data on how many children were placed in approved private schools in a timely fashion has no bearing on the principle that **all** children should achieve both educationally and developmentally in a regular class. Management has generally operated in the classic tradition of seeking to identify problems and developing solutions. This has led to credentialing, program funding, crisis management, and the like.

In the helping professions, as in the rest of the world; creation of the future is no longer a Zen conundrum, but rather a professional reality. The goal is to create a *community vision*. As described by John McKnight [1987] this is a goal of “recommunalization” of exiled and labeled individuals. It understands the community as the basic context for enabling people to contribute their gifts. It sees community associations as contexts to create and locate jobs, provide opportunities for recreation and multiple friendships, and to become the political defender of the right of labeled people to be free from exile.

This vision seeks to reject the *sociology of exclusion* that concentrates on stigma and the labeling and rejection of people with negatively valued physical, mental, and behavioral differences [deviant, different, or atypical] and to replace it with a sociology of acceptance. No attribute of a person, no matter how atypical, precludes accepting relations [Bogdan & Taylor] providing there are people who can come to know them. People form accepting relations with convicted mass murderers and child abusers, AIDS victims, chronic alcoholics, as well as the severely disabled.

It was the desire for a community vision which led to the legal position of “least restrictive environment”, which has been unfortunately operationalized in terms that led to serious conceptual flaws which result in the acceptance of restrictiveness as a construct which applies to people with problems in living [Taylor - 1981]. It is the recognition that people with problems in living, whether they are the result of disabilities or social issues play valuable social roles within communities which if acknowledged and enhanced can begin to bring the strength and vitality of the neighborhoods to the forefront.

The very process of striving for a community vision empowers those with valued roles to greater levels of responsibility and “seeds” the sociocultural environment with prosocial values and good choices. The process of enabling the community to salve the uncertainty and fear of the professionals changes the power relations and frees both the community member and the professional to provide according to their capacity, rather than their credentials.

The design of new systems for health, education and welfare are the expected products of such transformational activities. It is hoped that exploration of these concepts in some detail will help the reader participate in and actively pursue this transformation.

The exploration will generally develop in three different contexts:

- Volume I: Perspective, Philosophy & Principles
- Volume II: Governance
- Volume III: Theory, Technology & Methodology

These books must be considered a **work in progress**, since the search for coherence [truth] is, by nature never ending. Segments have been written and rewritten in a process of thinking and rethinking about the issues for over twenty years. Each installment has brought to the author new insight into just how insufficient our human service principles and technologies really are. The paper cannot in any way be considered either a full or partial answers to the debacle we call human services; merely reflections on the important questions.

At this point, it is fair to conclude that individual human beings, groups of human beings [sociocultural entities] and human social systems [management systems, human service systems, etc.] all have similar

characteristics. Each must develop an optimistic outlook on goal development and outcome expectations. Each must develop high positive expectations. And each must develop an extensive repertoire of competencies to flexibly deal with change. When each of these entities is highly optimistic in its goals and expectations, has positive and high expectancy values, and has a capacity to many expectations, it is capable of progress. If just the opposite occurs, it is likely to deteriorate.

Any approach to human existence is embodied in an **attitude** based upon a **belief system**. Those with a strong biomedical, psychotherapeutic, "illness" and "defect" paradigm belief system have either stopped reading by this time or find the concepts **incoherent**. This perspective does not fit the mental constructs [truisms] that make up their belief system about themselves and others, and therefore they cannot even contemplate them very easily. Such dramatic changes in perspective demand **rigorous analysis**, and the seeking of hard evidence to support the new proposition. Most people do not rigorously analyze new propositions. In fact, often such analysis takes place almost unconsciously. We accept or reject propositions without thought.

For those who are still "doing analytical work", the following attempts to develop the data necessary for rigorous analysis of Perspective, Policy and Principle.

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# *Seeking Coherence*<sup>8</sup>

## Volume I: Perspective, Philosophy & Principles

An exploration of individual will and preference as a motivation.

**VOLUME ONE: PERSPECTIVE, PHILOSOPHY & PRINCIPLES** *An exploration of the individual will and preference as a motivation.*

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## PREFACE

“All the world is a stage and all the men and women merely players.”

William Shakespeare

The essential difference between humankind and the animal world is our conscious awareness of self: our differentiation from all other human beings, our “specialness”. It is upon this specialness and the critical ambivalence between the drive to enhance our difference and the desire at the same time to be like [and liked by] our species that the plot for our drama of *becoming* is built.

Other actors, by encouraging or discouraging our personal specialness, vie for specialness of their own. There is often an evident desire to bring down the star, while at the same time enhancing one’s own role in the process. Admiration and envy are the handmaidens of special recognition. The actor, thwarted in his/her ability to obtain specialness through normal means, often seeks unorthodox, even primitive means of elevating himself above the crowd. But, like most human endeavors, achievement mitigates this desire and the underlying ambivalence to unite counterbalances our success.

Thus, the oscillation between our desire to separate and our desire to unite with others; the dismal anonymity of being “a face in the crowd”; the hostility towards a desire for the other, remains the prevailing human condition.

Certainly, some actors are given better roles than others in the bard’s drama. But each ultimately decides how his own should be played. This *creative* interpretation constitutes that part of the individual that we call the **will**. To be “willful is to assert one’s difference; a new personal interpretation of the part.

When people interpret their part so differently from others, they are identified as atypical. Sometimes, their difference causes difficulties to themselves or to others to the extent that they have problems in living. When that happens, society often assumes a responsibility to help them learn how to better play their role. But present efforts seem much more oriented towards stopping them from playing their role at all. They are removed from full community membership and helped to *stop* doing what they are doing.

Perhaps we would do better to teach them how to act.

## Values

Values are ideas that have become a part of the individual’s belief system and are therefore considered by the individual to be coherent and *true*. Values are the important beliefs upon which the individual builds the future. If the values and principles are of a nature that is different from the “common knowledge”, the future that is created will be different. As *ideals* or *goals*, values “seed” the environment with

influences which reasonable men debate and analyze to seek coherence. As *commitments* [beliefs], these values change reality and the future.

The earliest documented conception of psychopathology viewed behavioral anomalies as external manifestations of evil spirits that entered the victim's body and adversely affected their behavior. Treatment was thus directed toward exorcising demons by various methods, such as cutting a hole in the victim's skull, performing various magical and religious rituals, or brutally assaulting - physically and socially - the bearer of the pernicious spirit. As early as the fourth century B.C., Hippocrates was influential in changing demonological conceptions of deviant behavior by relabeling it disease rather than demonic manifestation. Wholesome diet, hydrotherapy, bloodletting and other forms of physical interventions, some benign, others less humane, were increasingly employed as corrective treatments.

Although the use of psychological approaches have gradually intruded upon physical procedures in society's attempts to modify deviant behavior, the analogy of physical health and disease continues to dominate theories of psychopathology. In this conceptualization, behavioral patterns that depart from the accepted social and ethical norms are considered to be derivatives or symptoms of an underlying disease. Modification of the social deviance has thus become a *medical* specialty, with the result that persons exhibiting atypical behavior are most frequently labeled "patients" suffering from "mental illness" and are generally treated in medically oriented facilities. These disease concepts have been further extended to quite indiscriminately apply to social phenomena, as evidenced by the frequent designation of cultural response patterns as "healthy" or "sick".

While the *disease* model has been widely employed, it has, until recently, held the underlying pathology to be psychic rather than neurophysiological in nature. According to this approach, the conditions supposedly controlling the behavior continue to function in a manner analogous to toxic substances in producing undesirable or deviant responses; however, the disturbing agents actually comprise a host of inimical psychodynamic forces [for example, repressed impulses, energized traits, psychic complexes, and other types of energy systems] somewhat akin to the pernicious spirits of earlier times. Most contemporary theories of psychopathology thus employ a quasi-medical model fashioned from an amalgam of the disease and demonology conceptions, which have in common the belief that deviant behavior is a function of inimical inner forces. Consequently, attention *is focused, not on the problem behavior itself, but on the presumably influential agents* that must be exorcised by "catharsis" and acquisition of insight or subdued and controlled by drugs or incarceration.

The designation of behavior as pathology involves *social* judgements that are influenced by, among other factors, the normative standards of persons making the judgements, the social context in which the behavior is exhibited, certain attributes of the behavior, and numerous characteristics of the deviator himself. Consequently, the appropriateness of symbolic, affective or social responses to given situations constitutes one major criterion in labeling "symptomatic" behavior. Departures from normative

standards that do not inconvenience or interfere with the well being of others are usually tolerated; deviations that produce rewarding consequences, such as “creativity”, may be actively promoted; and deviance that generates aversive consequences for others elicits strong societal disapproval, is promptly labeled abnormal, and generally is met by coercive pressures to eliminate it.

*“Volumes of research have been done to demonstrate the absolute unreliability of psychiatric diagnosis. The only consistent pattern is that the more the doctor likes the patient, which by and large means the closer they are in social class, the more likely he is to diagnose the patient as neurotic rather than psychotic. Poor people, blacks and Hispanics are quickly labeled psychotic or character-disordered for the same behavior that earns white, middle-class patients the label neurotic [i.e., relatively healthy]. To be called neurotic by a psychiatrist is a compliment”*  
[Drummond, 1979].

Preoccupation with internal response producing agents has resulted in a disregard of external variables that have nevertheless been shown to influence behavior. An organism that is impelled from within but is relatively insensitive to environmental stimuli or to the immediate consequences of its actions would not survive for long. Human functioning, in fact, involves *interrelated control systems* in which behavior is directed by external stimulus events, by internal information processing and regulatory codes, and reinforcing response feedback process. Human beings are *learning systems*; they learn from the feedback of experience and alter their behavior in order to find new behaviors that prove more effective. Unfortunately, people with problems in living often accept satisfactory compromise, rather than seek full membership and coherence.

But the recent movement to neuropsychology is even more disturbing. Recent technological events in the biomedical field have led to even greater speculation about a gene or chemical that causes behavior. Recently, the newly appointed director of the National Institute of Mental Health made some truly frightening statements about how these findings merely had to be connected to behaviors for helpers to be able to know how to manipulate the biology sufficiently to alter behavior. When one truly thinks of the ramifications of such a statement, one ought to be afraid. Extreme behaviors are in the eye of the beholder. If we merely must alter the biogenic structure to achieve **compliance** with our point of view, can Orwell’s 1984 be far behind?

Nor are our present technologies without flaw. Arnold Mandell, a San Diego psychiatrist has stated that: “By any objective measure, the modern business of ‘psychopharmacology’ - the use of drugs to treat everything from anxiety and insomnia to schizophrenia itself - has to be judged a failure” [as reported by James Gleick, 1987]. As he saw it, the problem was conceptual. Traditional methods were linear and reductionist. “More than 50 transmitters, thousands of cell types, complex electromagnetic phenomenology, and continuous instability based on autonomous activity at all levels, from proteins to

the electroencephalogram - and still the brain is thought of as a chemical point-to-point switchboard. ...how naive."

## Heretics

The biomedical/psychodynamic approach to people with problems in living has been challenged on many fronts. When we discuss the theoretical models, such disagreements will become quite apparent. However, by and large the public system of managing the behavior of people with problems in living has stood firmly in the grasp of the biomedical/psychodynamic community for some time. There have always been people who have openly challenged the professional dogma through actions. The idea that people with problems in living may have an *autonomous* spirit and be the legitimate change agent, has rallied support over the ages. While there have been many naysayers, including Drummand and Mandell, there are some major heretics who took stances which either started specific movements or for which they were persecuted in significant ways who should be identified.

The close of the eighteenth century heralded a new [although not inherently different] era of social values. Demonological causation was giving way to disease causation and treatment included elaborate formulations with exotic ingredients and such remedies as bloodletting, purging, the use of emetics, blistering, warm and cold baths, and pouring cold water down the sleeves of the afflicted. Dr. Benjamin Rush invented several ingenious machines known as "the tranquilizer" and "the gyrator" which reduced the activity of the violent patient by making him dizzy. The management of the mentally ill was often inhumane and callous, since it was generally believed that they had no sensibilities. Consequently, they were kept in cold and in dirt, inadequately fed and clothed.

It took the quiet steadfastness of Quaker **William Tuke** in England to bring the mentally ill a new form of treatment, called significantly *Moral Treatment*.

Moral treatment was based "...on the conception that mentally ill persons were by no means deprived entirely of susceptibility to the same influences that determine the behavior of well persons..." As a method of management, this conception became the basis upon which new mental hospitals were organized. It sought, by providing a hospital atmosphere that combined kindness, firmness, and individual attention, to help the patient to *minister to himself*. The inherent conception of self-help as opposed to a vector that controls behavior was the creation of a critical difference of ideology between Moral Treatment and the biomedical or psychodynamic models.

While *Moral Treatment* reached its zenith in private mental hospitals, the state institutions had also introduced these methods in varying degrees. About this time [1828] the "Gentle Warrior", Dorethea Lynde Dix, was starting her indomitable campaign to improve the care of the mentally ill. Her efforts led to the establishment of at least thirty asylums [a name which indicated places of retreat and refuge]. It

must be recalled that the first state institutions were small. Residents remained only for limited periods of time. These state institutions enjoyed admirable reputations. So great was the renown of moral treatment that a period of residence in the atmosphere was considered sufficient to produce recovery. Gradually, the asylums which had started out so brightly, with moral treatment as their foundation of hope, became places of “inhumanity and neglect”; “...hundreds of naked mental patients herded into huge barnlike, filth-infested wards, in all degrees of deterioration, untended, and untreated, stripped of every vestige of human decency” [Orzarin - 1954].

What happened to Moral Treatment? It may be only coincidence that in 1831, the Asylum Committee of New York Hospital determined:

The physician alone is responsible for the cure of patients and the grand means of effecting this object is moral treatment; it therefore of right belongs to him.

As other asylums quickly followed suit, physicians rushed to take control of this “new treatment”. The perspective of disease was not coherent with moral treatment and therefore the treatment had to change to be connected with the ideological principles of the illness model. The concept that the patient was able to help himself and was influenced by the same things as other people were abandoned in the zeal to find and “cure” the illness. Such “improvements” remained until the *snake pits* [portrayed vividly by the movie of the same name<sup>9</sup>] of the late nineteen fifties.

**Otto Rank** was a member of Freud’s early coterie and a powerful figure in the young psychoanalytic movement. He was not a doctor of medicine and this may account for his failure to make his activities analogous to the medical experience. His background and training were in the areas of engineering, philosophy, psychology, history and art. Rank’s major impact on American psychological thinking has been through the field of social work, where his work became the basis for the *functional*, as opposed to the psychodynamic or *diagnostic* approach.

Rank’s definition of the person is rooted in his perception of the experience of birth. Within the womb, the embryo functions as a unit of symbiosis with its surroundings. Birth means the death of this union. It is the archetypal problem of the struggle of relinquishing the old integration in adopting the new; i.e., dying in order to be born again. On the one hand the individual strives to reinstate a unity between himself and his environment; that same individual experiences every advance towards independence as a threat. The fear of independence, of giving up the safety of symbiotic relationships analogous to the prenatal state, Rank calls “life fear”.

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If one thinks that the movie “Snake Pit” was just a Hollywood version of the problem, you are right. For a real view of real atrocities, “Tittycut Follies”, a documentary, is much more horrible and does not “smooth over” as does the Hollywood version. Fiction can never compete with truth.

On the other hand the emergent **will** is assertive and potentially creative. It strives toward separation and individualization. Thus from this perspective, the symbiotic union is seen as a sort of death, a regression, a return to the womb, a loss of individuality and "life". Thus, union also becomes a threat, something to be feared, called by Rank the "death fear". It is the death fear that drives the person to vital effort; the life fear which inhibits effort. The essential point in all this is the polarity between life and death, between separation [individuation -> life fear] and union [loss of individuality -> death fear]. This *necessary* and inherent human conflict leads to three further concepts.

- Fear becomes, at least *potentially*, a constructive force rather than the crippling anxiety emphasized by the human services professional.
- Resistance becomes, at least *potentially*, the constructive power of the **will** - even though it may be misdirected.
- The major ideal for individual growth and development should be the constructive, creative integration of the conflicting trends towards union and separation.

These are far different constructs than those which imply that the person with problems in living is out of control and unable to take responsibility for their own actions. To Rank, growth requires the breaking down of the wholeness that the individual has established in order to achieve new integration. Partialization is the necessary means of adaptation to reality. After birth, the person must in a very real sense *create* a new unity for his or her own being and for the relationship to new and changed surroundings.

The name Rank gives to the integrative thrust of the personality as a whole is the **will**. The will is ambivalent from the outset. The child at and before birth is completely at one with the mother; they are one entity. Separation, through which individuality [the self] develops, begins as the infant comes to discover through experience that s/he and the mother are two different beings. This life experience of separation is the process of differentiation. The child, especially the adolescent, feels it necessary to assert him/herself in a forceful or negative way against his parent, in order to define the boundaries of his/her own self. Since the child is bound to the parent by still existing dependence, the negative assertion or counter-will stirs guilt in the child. This guilt is the demonstrable ambivalence between the need to willfully separate and the need to be acceptable [remain in unity] with his/her parents. Since the problem is that his/her 'difference' has been unacceptable to him/herself and to potentially to others, a relationship that accepts this *willfulness* is a new and fortifying experience, one that has engaged the positive **will** and affirmed his/her right to be different from others. Having had this difference accepted by others, the client can now accept him/her self. Self-acceptance becomes possible through the *love experience* of being accepted by another person. This progressive reintegration is accomplished mainly by

love [affirmation, acceptance]. The valid love experience requires acceptance of the *self-willing* in another. Awareness of difference, of partialization, enriches the new sense of union. The **will** with its conflict towards separation and union is ambivalent and cannot become truly constructive until it is accepted by another person. Until the person can feel that his/her own willing is right [i.e., not guilty], until the individual can feel accepted by *others*, s/he cannot resolve the problem of separation along with its counterpart union.

The concept of some force, demon or disease, implicitly negates the acceptance of the client's self willing and defeats the purpose of the helper's services. It is only through the acknowledgement of the **will** [i.e., responsibility for behavior, choice, direction] that the helper explicitly accepts the individual with love. The helper must separate out the acceptance of the individual and his or her inherent right to *choose*, from acceptance of the *choice* [behavior]. In doing this it becomes acceptable to not accept and in fact, limits behaviors without denying the chooser. Rank emphasizes the bringing together of opposing forces in the constructive effort, in contrast to theories which consider a person as essentially *good* or essentially *bad*, or in the grip of *instincts* or *diseases* which independently determine his or her actions. The constructive attitude, by its very nature, involves realistic partialization and reintegration. The **will** creates the personality through resolution of the opposing principles of its being.

Essentially, Rank saw the individual as an *assertive* force that makes decisions, often creative, about who they will be and how they will behave. The adolescent is particularly vulnerable to this choice and the implementation of the will [willfulness] is often in rebellion against parents and/or society as a means of establishing him or herself as a person. The fact that adolescence is the time of onset of many of the most severe "mental illnesses" cannot be ignored.

Another heretic, **Maxwell Jones**, developed what he called the *therapeutic community*, - the words themselves suggest a group of people assembled for the purpose of healing. Jones developed a social structure that used each *individual as a component in helping others* improve their functioning. The therapeutic community was distinctive among other comparable treatment centers in the way both staff and clients were self-consciously pooled to further treatment. This carries with it, above all, a change in the usual status of the people being served. They now became *active participants* in the therapy of themselves and others.

In the life of the community the tendency was for the client's role to become progressively closer to the roles of staff, with whom they shared decision making. The responsibility allowed new values to come into being. It is clear that the change in social order is in the direction of a more democratic state, which resulted in many cultural changes. The very body of knowledge, beliefs and values that are held by staff and client become therapeutic. The field of mental health paid little attention to the design of a whole culture which will foster healthy personalities, although numerous experiments have shown that changes in social structure lead to changed functional roles and subsequently to changed individual attitudes.

Treatment in a therapeutic community presented normal interactions of a healthy community life. Staff learned to resist demands and to develop roles more like that of a *teacher* who assists the entire class.

In essence the entire experience could be viewed as a learning situation in which all of the players are actively involved and consciously involved in making decisions about the social interrelationships and their part in them.

**Dr. Thomas Szasz** has pointed out the ambiguities of psychiatry, characterized by its insistence on discovering a disease entity which would put mental illness in the jurisdiction of the neurologist, while continuing to use behavioral means for treatment of what is, nevertheless, defined as a medical problem. Is this confusion or conspiracy? In 1960, he committed the ultimate heresy as he courageously published a book that debunked the idea that “problems in living” were caused by a medical illness. Cogently challenging the basic tenets of modern psychiatry, he brought to the attention of the general public and the profession the incongruities of the mental illness metaphor.

What made this heresy particularly hard to accept was the fact that Dr. Szasz is a psychiatrist. Thus, this scathing attack came not from the outside, but from an elite member of the profession. It is perhaps not surprising therefore that within a year of publication, the Commissioner of the New York Department of Mental Hygiene demanded, in a letter citing specifically “The Myth of Mental Illness”, that Dr. Szasz be dismissed from his University position because he did not “believe” in mental illness.

What makes this so interesting is that the very words indicate that “mental illness” is a belief, not a fact. “It is no exaggeration to state that Szasz’s work raises major social issues which deserve the attention of policy makers and indeed of all informed socially conscious Americans”, said Edwin M. Schur of the *Atlantic*. But the policy makers haven’t seemed to hear. Szasz raised simple questions that cause powerful cultural and economic pressure that define “correct” answers. The *Myth of Mental Illness* is powerfully coherent to all but the most ardent believers of the myth, and we will not reiterate those arguments here. It is perhaps because of the inability of the profession to coherently address issues that personal attack became the defense of choice.

**Dr. Peter Breggin**, another psychiatrist adds a potent argument against the use of so called modern treatments in his book *Psychotropic Drugs: Hazards to Your Health?* Using the research done by the drug manufacturers and true believers themselves, he indicates the toxic affects of these cures. Like Szasz before him, personal attack was made in an attempt to take away his professional credentials. The fact that both attacks failed might be indicative of the failure of modern medical science to make its case in a court of law.

While Dr. Breggin is not alone in his attack on the hazards of the toxins used to treat “mental illness”, he is clearly the most profound of those willing to take on the psychiatric and pharmaceutical establishment at the risk of his own reputation and livelihood.

The author himself is quite proud to have been publicly attacked partially because of his open contact and admiration for Szasz and Breggin, but also for his own positions. The attack was rather interestingly precipitated in a publication of some suspicious origin. It was an author who has no apparent connection to mental health issues, although as an independent “reporter” of sorts could have been doing an “in-depth” investigation. Nonetheless, the publication took a position that seemed to indicate that psychiatry was abandoning the “mentally ill” by moving towards more effective and humane means and ignoring the “medical” needs.

I can’t speak about the attacks on Szasz and Breggin, both of whom are quite capable of defending themselves; but I can state that the specifics about my positions were at the least inaccurate; although substantively quite correct.

The author states “Gardner brooks no interference with the “choices” of those called mentally ill, including suicide.” and then presumably quotes from an unpublished article [thereby keeping others from reviewing the source] of mine in which I presumably stated

“We must stop being ‘parents’ and let our ‘children’ go. The dignity of risk [of suicide] far outweighs the humanity of treatment for one’s own good.”

The actual quote, in context is:

“The paradigm of service must change. We cannot act for someone’s own good; only the individual himself can do that. We must ‘influence’, not command, and this demands the ultimate in human concern and caring. *We must stop being ‘parents’, and let our ‘children’ go. The dignity of risk far outweighs the inhumanity of treatment for one’s own good.*”

It is interesting to note the interjection of *suicide*, and the absence of the *in* regarding inhumanity. This is quite a different statement even ignoring the reference to suicide. Did the author simply misread - or was there some other intent? I will leave it to the reader to decide whether the author of this error prone document is correct when s/he states:

“For Gardner, both ETC and psychoactive drugs are ‘adverse strategies’; he believes the chief problems of mental illness, used to justify hospitalization, are in fact ‘caused by the treatment’. Gardner’s view that rehabilitation is ‘in conflict’ with the medical model of mental illness may explain Breggin’s presence [at a sponsored conference]. But it does

not account for the latter's enthusiastic reception, the standing-room-only audience and the absence of challenges in question periods."

Mundus vult decipi: Any protest is regarded as heresy that shows how those who utter it do not belong; arguments are not met on their merits; instead one *designs* [my change] horrible examples. The world does not call it dishonesty.

Perhaps the heresy, represented by the packed house and enthusiasm indicates heretics too numerous to mention. This was a psychosocial rehabilitation conference that attracted 1800 people many of whom were present or former clients of the system. It was, the peak, and death knoll of a true client driven psychosocial movement. The following conference, held in Florida, re-instituted the medical approaches and was predominated by psychiatrists who were not supporters of Szasz and Breggin. The people represented by the Philadelphia conference, have different basic *values* than do the biomedical or psychodynamic leaders who start with a basic assumption of pathology. And because they have different values, they create quite a different future for people with problems in living. Of great concern, of course, is why, even with the demonstrable success of these perspectives versus those of the present regime, no change is ever permanent. Moral Treatment was highly successful, but failed. Functional Social work has disappeared. More recently, psychosocial rehabilitation proved quite successful but was finally eroded by the biomedical and psychodynamic approaches. These erosions cannot be based simply on the respectability of a few brazen physicians - they don't even represent the "common knowledge" of the public, which substantially rejects the medical excuse. Perhaps they are backed by pharmaceutical funds and paid propagandists.

*"I know that most men, including those at ease with problems of the greatest complexity, can seldom accept even the simplest and most obvious truth if it be such as would oblige them to admit the falsity of conclusions which they have delighted in explaining to colleagues, which they have proudly taught to others, and which they have woven, thread by thread, into the fabric of their lives.*

*Lie Tolstoy* [As Reported by James Gleick, 1987]

## **Social Policy**

Social policy is developed through the political process that grew out of common law.

"The common man has acquired many habits under the rule of common law, since time immemorial. By the spontaneous reflex of the vendetta, refined and rationalized in the penal codes; by the quarrels over possession of land and tools formalized in the property codes; by the shrewd habits of making, keeping, and breaking promises and agreements formalized in the law of contracts; and by the ways and means of compensating for

wrongs, injuries, and negligence, measured and judged in the law of torts, common man, newly introduced into the public world under democratic governments, gets his first understanding of politics as the negotiation and resolution of conflicts: conflicts of freedoms, of rights, and of interests. The so-called political arena is the place where private matters are made public. Power politics takes the place of the duel, the marketplace, and the joust" [Buchanan - 1964]

In the ideal, social policy is developed through reason and persuasion. However, there is a basic division of perspective in these debates and that is the question of importance of the "common good" versus "individual rights". This basic division is one around which our political parties have generally developed [although neither party seems to quite understand the terms liberal and conservative in this context, and seem to operate more through "deals" than through reason<sup>10</sup>]. This question regarding a balance of common good and individual rights is one that concerns us a great deal. For nowhere other than human services have we seen the abrogation of the Constitution of the United States<sup>11</sup>. While done with *good intent*, such activities seem to us to be quite destructive to the explicit purposes of present social policy.

The reason that such *good intent* is able to persist despite its obvious failure and continued punitive impact is because the "common man" has failed to rigorously analyze the proposition of *mental illness* and therefore have allowed social policy makers to continue the perspective of coercion and power. Thus social policy while *explicitly* avowing to *help* people with problems in living; *implicitly* is concerned with the "common good" of protecting society from these same people. This dichotomy is carried over into the penal system where the traditional *explicit* intention is to punish law breakers has become one of *rehabilitation* and then vacillated whenever a horrible example was found.

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<sup>10</sup> It is interesting to note that social planners also get confused. Levine and Levine [1970] suggest that "When the social ethos is essentially conservative...the causes of problems will be located in the individual's personal weaknesses and deficiencies [and]...a mental health facility is primarily an agent of deviance control." Just the contrary is, of course, true. Conservatives believe in individual rights and therefore would support the person's right to be different; it is the liberal's concern for the common good; the protection of society, which leads to coercion. Of course, those who label themselves conservative often are punitive and liberals always have good intentions, so....

<sup>11</sup> This happens with involuntary commitment. This is the only **predictive** incarceration that is accepted in the courts. Thus, by *social judgement*, mental health professionals take away a person's civil liberties.

The fact that the penal system and the 'mental health' system show such similarities and interrelatedness is not surprising since any criminal act can be seen as being incoherent with the reality of society and any incoherent act can be seen as potentially dangerous [i.e., criminal]. In fact, as our example of insanity [Charles Manson] clearly demonstrates, the line between craziness and atrocity is very *fuzzy* in the public mind. To the public, Manson is clearly sick or crazy. Therefore, when the professionals talk about the *potential violence* of people with severe problems in living; it is hard for the public not to imagine Charles Manson. But according to these same experts, almost all of the best known violent killers are sane. This probably says something about our decision criteria for sanity, but that is beyond our intent in this paper.

Our intent is to help the process of rigorous analysis by tracing the issues of individual rights [helping clients function better] and common good [the need for protection] and indicate how only through the former [individual development] can the latter [social protection] be met. Thus we believe emphasis on helping people with problems in living must become both the explicit and implicit intention of our social policy and through that emphasis and evaluation both needs will be enhanced.

There is also a desire to indicate that the technology is now available to actually and demonstrably help people with problems in living. But there is some recognition that the technology is contained within a belief system that supports *individual preference* and therefore some people may choose to remain "crazy". That being the case, the sorting out of the penal issues are also probably necessary, although they will not be addressed.

## **Technology**

*But to accept the future, one must renounce much of the past.*

*James Gleick*

The new technology has been developing over the last fifty years and as stated above starts with a principle of self preference and self-directiveness. In many ways it can be compared to jujitsu, in that it uses the *wilfulness* of the individual, through slight redirection. In fact, it acknowledges that all people, including those with problems in living, have the same desire to grow towards the norm as anyone else, but that they need some help in perceiving how to best achieve those goals.

The technology is available in *preventative, developmental, and remedial* form, but with a focus on helping people rather than protecting the public, the social policy can emphasize prevention as the most efficacious means of meeting these goals.

The technology can be defined essentially as cognitive behavior management that is couched within the organismic perspective of human growth and development and the humanistic and existential

psychologies. Thus, the individual is seen as an assertive, not merely reactive entity and there is concern with the positive aspects of living and self-actualization. The use of the individual *will* as the force for change is overriding.

The technology is rooted in experimental research and has many documented results. This contrasts with the biomedical and psychodynamic interventions that at best, have been shown to reduce symptoms [often at the loss of major cognitive and behavioral functioning] without resultant improvement in ability to live a quality life. Thus, the emphasis for such interventions has been on taking away symptoms that have proved to be a problem to society while having little or no impact on concerns that are a problem to the individual. The so-called *dead man test* is the present applicable evaluation. Therefore, the more the clientele act like “dead men”, i.e., no behavior at all, the better.

Over the course of history, several ways of defining and approaching abnormality have been developed<sup>12</sup>. Presently, there are five major models, sometime complimentary, often competing in their attempt to understand and deal with abnormality.

#### *The Biomedical Model*

Those who advocate the biomedical model typically approach abnormality as a medical researcher approached illness, with the following sequences of definition: identify a syndrome [diverse symptoms that tend to occur together], search for the etiology [cause] of the syndrome, and decide on the treatment for the illness. Having observed the symptoms of a syndrome, biomedical researchers will consider three possible causes for the illness: germs, genes and biochemistry.

The idea that psychological disorders have physical etiologies is both ancient and venerable. But it was not until the latter half of the nineteenth century that anyone convincingly demonstrated that any form of psychological disorder was caused by organic illness. At that time, it was found that syphilis caused general paresis, the symptoms of which seemed to be mainly delusions of grandeur [false notion that one is rather more important than the objective facts indicate].

Despite continued efforts, schizophrenia continues to puzzle the medical researchers. Although some genetic correlation has been found, it is sufficient only to demonstrate that propensity *might* be inherited, and not necessarily the “disease” itself. Additionally, the “dopamine hypothesis”, as it is called, states that schizophrenic behavior is caused by too much dopamine in the brain. Dopamine is a chemical in the brain that allows “messages” to be relayed from one neuron to another. There is a considerable amount of evidence in favor of this hypothesis. But all of it is rather indirect. The most important evidence comes

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The following is generously excerpted from Roseman & Seligman, *Abnormal Psychology*. Any changes which misinterpret are the responsibility of the author.

from the fact that drugs usually relieve the symptoms of schizophrenia also lower the amount of usable dopamine in the brain. This is called dopamine "blocking".

The major weakness in this approach is that it has sometimes been observed that psychological events sometimes cause psychopathology, and changing these events - without directly changing anything about the body - can indeed cure. Secondly, biomedical treatments often produce unpleasant and harmful side effects. Finally, some disorders may indeed be illnesses of the body, but others are problems in adjustment to living. General paresis is a disease, the consequence of syphilitic spirochetes. But it still remains to be seen if and what other illnesses will be able to be placed in that distinct category<sup>13</sup>.

### *The Psychodynamic Model*

There is a specific influential set of theories that, taken together, are called psychodynamic. They are so named because they are concerned with the unconscious psychological forces that influence the mind and subsequent behavior. These inner forces - desires and motives - often conflict. When they do, people may experience anxiety and unhappiness, against which they may try to defend themselves.

Psychodynamic approaches to personality and abnormality begin with the work of the Viennese physician, Sigmund Freud. His own methods of studying and changing personalities are called psychoanalysis. Throughout his life, his consuming intellectual and clinical passion was with psychic energy. He assumed that people are endowed with a fixed amount of psychic energy and how they used it would lead to either a vigorous or listless life.

Freud was able to attract a number of original thinkers who elaborated on his views. In the case of three well-known individuals [Jung, Adler and Rank] these disciplines disagreed and broke with him. Others have built upon, modified and altered his original notions. The most consistent conflict has been between Freud's emphasis on biological urges [defined as the id impulse] as the determinants of behavior and the feeling of others who felt that the determinants were more *social*. Rank and Adler, in particular, saw the self, or "*will*", as a *creative* force enabling people to become more than their genetic heritage. Others, notably Erickson and Horney, viewed people as fundamentally social. Therefore, psychosocial, rather than psychosexual, development became their focus.

Psychodynamic treatment focuses on *conflict*, *anxiety*, and *defense*. It seeks to alter thought and behavior by examining early conflicts and especially by making conscious that which is repressed, through free association and discussing dreams and resistances. In doing so, psychic energy is freed for more constructive purposes, and the individual is able to find more constructive resolutions for conflict.

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I have recently been advised that Lyme Disease, like syphilis, is a disease of the Central Nervous System caused by the presence of an organism(s) which result in the rapid onset of personality disorders, as well as physical disorders.

Anxiety is reduced because impulses now find “safe” methods of expression. Coping strategies, where they are required, thereby become more mature. Psychodynamic theory is nothing less than a comprehensive description of human personality. Perhaps the greatest of Freud’s contributions is his view that the *psychological processes that underlie normal and abnormal behavior are fundamentally the same*. Neither conflict, nor anxiety, nor defense, nor unconscious processes are the sole possession of abnormal people. Rather, the outcome of conflict and the nature of defense will determine whether behavior will be normal or abnormal.

These theories, unfortunately, rely too heavily on observations of individual cases and are difficult to prove or disprove. Studies have too often failed to provide support for them. Moreover, in emphasizing and focusing on the role of the person, they often neglect to take into account the situation or context of the aberrant behavior. In addition, the process is couched in a biomedical metaphor which tends to make the person with problems in living dependent upon the expertise of the therapist through attribution, if not fact. Finally, psychodynamic therapies have not proven notably effective in dealing with the more intransigent and challenging cases.

#### *The Behavioral Model*

Behaviorism is not only a model for the study of abnormal behavior, it is a world view. Its first assumption is *environmentalism*, that is, that all organisms, including humans, are shaped by their environment. Individuals learn about the future through association with the past. That is why, for example, our behavior is reactive to rewards and punishment. The second assumption of this model is *experimentalism*, which states that, through an experiment [a simulated trial], one can discover and identify what aspects of the environment has caused particular behavior and how this behavior can be changed. The third assumption is *optimism concerning change*. The thinking here is that if an individual is a product of the environment and if those parts of the environment that have molded him can be identified by experimentation, the individual can be changed when the environment is changed.

For the behaviorist, two basic learning processes exist. It is from these two that all behavior, both normal and abnormal, derive. In this view, individuals learn what goes with what through Pavlovian or classical conditioning. In addition, they learn what to do to obtain what they want and rid themselves of what they do not want through instrumental or operant conditioning.

#### Pavlovian or Classical Conditioning

Just after the turn of the century, the Russian physiologist, Ivan Pavlov, accidentally made a discovery which would form the basis of the behavioral school of psychology. Pavlov was studying the digestive systems of dogs, specifically the salivary reflex. In the course of his work, he notices that the dogs began to salivate merely when he walked into the room. This could not be reflex, since he had not observed it to

happen at the beginning of the experiments. It only occurred once the dogs had learned that his appearance signaled food. Pavlov's appearance had become associated with a future event; food. This came to be called a conditioned response.

Thus, an unconditioned stimulus [I.e., an agent which arouses activity] food, became tied to a conditioned stimulus, Pavlov's appearance, to produce the conditioned response. There are two processes in Pavlovian conditioning that occur time and time again, regardless of the species, the kind of conditioned stimuli or unconditioned stimuli, or the kind of response being tested: acquisition and extinction. Acquisition is the *learning of a response*<sup>14</sup> based on the pairings of a conditioned stimulus and unconditioned stimulus. Extinction is the *loss* of the conditioned response's power to produce the formerly acquired response.

There are situations in the world that arouse strong emotions in us. Some of these arouse emotions unconditionally, that is, from our very first encounter with them; for example, a loud clap of thunder startles us the first time we hear it. Other objects acquire emotional significance: the face of a person we love produces a sense of well-being; seeing a stranger in a dark alleyway arouses dread. Pavlovian conditioning provides a powerful account of how objects take on emotional significance; it is this account that makes conditioning of interest to the student of abnormality. According to the behavioral account, the basic mechanism for all acquired emotional states is the pairing of a neutral object [conditioned stimulus] with an unconditioned emotional state [unconditioned stimulus]. With enough pairings, the neutral object will lose its neutrality, become a conditioned stimulus and, all by itself, produce the emotional state.

The therapeutic optimism of this behavioral view follows directly from this view of the disorder. If the disorders are, in fact, the symptoms and do not necessarily reflect pathology, elimination of the symptoms will cure the disorder. This sharply contrasts with the biomedical and psychodynamic stance on therapy: for these modes, getting rid of the symptom is only *cosmetic*; the cure consists of removing the underlying disorder<sup>15</sup>.

### Instrumental or Operant Conditioning

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14 This is not quite the same thing as *learning a behavior* and *using it appropriately*.

15 *Mundus vult decipi*: the world wants to be deceived. While the biomedical model suggest that it wants to deal with the underlying disorder, it has not identified it in any meaningful way and therefore is only *cosmetic* in its "dead man" features. The psychodynamic model, without empirical evidence to suggest any effectiveness whatever in dealing with the underlying disorder or the symptoms, being equally as effective as time. *Mundus vult decipi*. The behavioral model, on the other hand, sees the symptoms as the *fundamental issue* and therefore is dealing with underlying disorders [as they define them] effectively.

B.F. Skinner built on Pavlov's findings and the work of Edward L. Thorndike, specifically, his "law of effect". This proposed that, in a given stimulus situation, when a response is made and followed by *positive consequences*, the response will tend to be repeated; but when a response is followed by negative consequences, it will tend not to be repeated.

Skinner defined the elements of the law of effect rigorously. His three basic concepts consist of the reinforcer [both positive and negative], the operant, and the discriminative stimulus. The positive reinforcer is an event which increases the probability that a response will occur again. A negative reinforcer decreases the probability of recurrence of a response that precedes it. An *operant* is a response whose probability can be either increased by positive reinforcement or decreased by negative reinforcement. The *discriminative stimulus* is a signal that means that reinforcement is available if the operant is made.

The operant therapist used these principles in asking three essential questions:

- what undesirable or maladaptive operantes does the individual engage in?
- what reinforcers maintain these maladaptive responses?
- what environmental changes, usually reinforcement or discriminative stimulus changes can be made to change the maladaptive behavior into adaptive behavior?

The model and the therapies that follow from it are specifically scientific in nature and can be tested for effectiveness.

A major drawback to this approach is the belief held by some that the original theories did not take into account the intelligent and complex decision making processes of the human species, hardly likely to be documentable. The major issue is in selection of the target behavior, or that behavior that is to be increased or decreased in activity; and the selection of the reinforcement. These issues raise ethical questions about control and intuitive questions about the human *will*.

### *The Cognitive Model*

The cognitive school is a modern outgrowth from and reaction to the behavioral school. The basic premise of behavioral therapy is that behavior is determined by events in the environment. Moreover, abnormal behavior is a learned response to the environment. When the therapist changes the environment, the client's behavior will change.

Implicit in the behavioral view is the assumption that the connection between the environment and behavior is direct. However, others, among these, cognitive psychologists, hold that behavior is influenced by more than just this direct relations between environment and response. They contend that what a person thinks, believes, expects, attends to - in short, his or her mental life - influences how s/he behaves. Behaviorists, when pressed, frequently admit that mental life exists. But they deny that such cognitions play a causal role in behavior.

The cognitive psychologists contends that disordered cognitive processes cause some psychological disorders and that, by changing these cognitions, the disorder can be alleviated and perhaps even cured. Underlying the cognitive model is the view that mental events -that is, expectations, beliefs, memories, etc. - can cause behavior. Believing this, the cognitive therapist looks for the cause, or etiology, of psychological disorders in disordered mental events. The therapist's job is to draw out all of the distorted negative thoughts, to have the client confront the contrary evidence, and then to have the client change these thoughts.

For the purposes of therapy, cognitive processes can be divided into short-term and long-term processes. The short-term processes are conscious. People are aware of them or can become aware of them with practice. These include expectations, appraisals and attributions.

Expectations are cognitions that explicitly anticipate future events. In his early work, Albert Bandura showed that people learned not only by direct reinforcement, but also by observing others being reinforced. He concluded that the behavioral principles of reinforcement were insufficient and that such "vicarious learning" must involve the learning of expectations. He proposed two kinds of expectancies: an outcome expectation, that is a person's estimate that a given behavior will lead to a desired outcome; and an efficacy expectation, the belief that the individual can successfully carry out the behavior that produces desired outcomes.

Appraisals are evaluations of both what happens to us and what we do. Sometimes they are very obvious, but at other times we are unaware of them. Such automatic thoughts often precede and cause emotion. The individual is not only expecting future consequences, he is also appraising his actions. He judges them to be failures, and this appraisal causes negative emotions. This appraisal process is automatic. After a lifetime of practice, it occurs habitually and rapidly. The individual must, thus, be trained to slow down the thought process to become aware of such thoughts. Automatic thoughts are not vague and ill-formed, rather, they are specific and discrete. While they may seem implausible to the objective observer, they seem highly reasonable to the person who has them. The goal of the therapist is to enable the client to catch hold of his self-defeating thoughts as they come about, criticize them, control them, and thereby avoid the occurrence of anxiety.

Attributions are in individual's conceptions of why an event has happened. Depending on the causal analysis made, different consequences ensue. An individual might make an external [an impersonal force, like bad luck or a difficult situation] or an internal [a personal force such as one's own ability or effort] attribution. In addition, s/he may make a stable [one that persists in time] or an unstable [transient] attribution. Finally, an attribution for failure can be global or specific. An attribution to global factors means that failure must occur generally, that is, on many different tasks, while an attribution to specific factors means that failure occurs only on this one task.

Long-term cognitive processes are seen as different. They are hypothetical constructs, inferred dispositions that govern mental events now in consciousness. One of these long-term cognitive processes is beliefs. Albert Ellis, the founder of rational-emotive therapy, argues that psychological disorder stems largely from irrational beliefs. These irrational and illogical beliefs shape the short-term distorted expectations, appraisals, and attributions that produce psychological disorder. Therapy here is an aggressive one. It makes a concerted attack on the client's beliefs in two: 1) the therapist is a frank counter-propagandist who contradicts superstitions and self-defeating propaganda embodied in the irrational beliefs of the client, and 2) the therapist encourages, persuades, cajoles, and occasionally insists that the client engage in behavior that will itself be forceful counter-propaganda against the irrational beliefs.

Cognitive therapists, then, believe that distorted thinking causes disordered behavior and that correcting distorted thinking will alleviate and even cure the disordered behavior. Behavior therapists, in contrast, view disordered behavior as learned from past experience and they attempt to alleviate the disorder by training new, more adaptive behaviors. These two positions are not incompatible and many therapists try both to correct distorted cognitions and to train new habits.

The cognitive and behavioral models have been seriously criticized on the stance that human beings are more than their behaviors and cognitions, and that it is superficial to treat only the symptoms rather than the whole person.

### *The Existential/Humanistic Model*

The humanistic and existential psychologies constitute a major third approach in psychology, focused on the distinctly human elements, in which there are powerful roles for will, responsibility and reciprocal determinism. Humanistic psychologies are concerned with the positive aspects of living, and most specifically with self-actualization.

These approaches are centrally concerned with conscious human experiences and are united in revolting against the narrow deterministic view that often characterizes other theories. They hold that people can exercise much greater freedom in taking action than was acknowledged previously, and see people as

what they choose to make of themselves. Some aspects of human experience are taken to be determined - by genetics or constitution, by age and gender, and by the very times in which people live. But this is not the whole of it, for those determinants lie outside of individual control. Human beings can imagine, dream, engage in reflective thoughts, use symbols, and create and manipulate meanings. These abilities allow people to plan and choose among alternative courses of action, rather than simply performing rigidly proscribed actions. Human experience is, thus, characterized by reciprocal determinism; that is, we interpret our environment and therefore control our responses to it. We affect the environment as much as it affects us.

When people believe that they have no freedom, person crises may ensue. This may first lead to psychological reactance; the tendency to react against these constraints rather than to make free choice. When people believe that they cannot control their own future, they may become severely depressed. When they feel that all of their thoughts and behaviors are predetermined, they may become paranoid. One's feeling free to choose and control and one's own use of that freedom are significant elements in the humanistic and existential approaches to abnormality.

Humanistic psychologists are generally opposed to formal personality diagnosis [such as labeling of depression, schizophrenia]; instead they hold that each person lives in a "continually changing world of experience in which s/he is the center". Diagnostic categories do not summarize private experience, they are created from without, on the basis of observed behavior and verbalization, as well as diagnostic assumptions regarding how a mature person should function. Those perceptions and assumptions do not conform with the humanist notions.

The notion of the self is central to understanding the private world of experience. The self is that aspect of personality that embodies a person's perceptions and values. There are two kinds of values: those acquired from experience and those that are introjected or acquired from others. Values that arise from experience are easily labeled and therefore easily accessible to the individual. Values that are introjected, however, may be a source of confusion, for they often require a person to deny his or her own feelings in order to conform to the desires of another. This cause tension and conflict.

Humanistic psychologists place great emphasis on three features of self: feelings, experience and perceptions. When the self is integrated and not threatened, experience and feelings are deep and alive, and perceptions are accurate. When the self is threatened or divided, experiences become blunted and perceptions distorted.

Humanistic psychologists stress that people are naturally good. They propose that, given the kinds of psychological conditions that are necessary for psychological development, people will grow and fulfill themselves, they will self actualize. In fact, they see that the natural destiny of people is to actualize their potentials. They will do precisely that, providing they are given adequate nourishment and are not

thwarted by others. Conditions for such proper psychological growth includes the need for self regard and for positive regard for others. These needs are gratified to the extent that the person experiences unconditional love. The principal causes of psychological disorder arise from the application of conditional love; love that is withdrawn when the individual does not behave as the other wishes. Under such conditions, children become what their parents want them to be, not what they want themselves to become. Their own self actualizing drives have been thwarted. In this way, over time, many people lose track of who they are and live out their lives in unwilling accommodation to the desires of others.

Humanistic theories are concerned with defining the needs that are central to human functioning [see, for example, Maslow's hierarchy of needs]. As each of the lower needs becomes gratified, more and higher needs emerge and require fulfillment. If at any level, the needs are not gratified, conflict ensues. Until the conflict is resolved, the individual does not proceed to the next level. Moreover, if lower needs cease to be satisfied, regression to lower levels is likely. Those who have all levels of needs fulfilled, self actualizing people, tend to accept themselves and others. They tend to be relatively autonomous of their environment. They are not, however, without problems and conflict. But these experiences do not arise from deficiency motivated sources. Rather, life itself is, in fact, often difficult and sad, and is the source of problems in their lives.

Existential psychologists assert that the central human fear from which most psychopathy develops is the fear of dying, Death means being forgotten, being left out. Death means helplessness, aloneness, finiteness. They posit two strategies to overcome the fear of nonbeing; by coming to believe oneself special, and by fusion.

The notion of specialness holds that the laws of nature apply to all mortals except oneself. It underlines many valued character traits, such as physical courage, ambition and striving. But, at the extreme, the unconscious belief in one's specialness may also lead to a spectrum of behavior disorders.

Protection against fear of death or nonbeing can also be achieved by fusion with others. Fusion is a strategy especially used by those whose death fears take the form of loneliness, by allowing them to attach themselves to, and make themselves indistinguishable from others. This fear of "standing apart" has valuable social features, leading to marriage and children, clubs, communities and organizations. At the extreme, however, fusion is responsible for much unhappiness. Among such individuals, abuse is accepted, not because there is nowhere else to go, but because of a connection with the abuser which they are afraid to destroy.

A desire for either specialness or fusion can lead to unauthentic or false modes of behavior in that they are designed to achieve unattainable goals. Bending to others in order to belong can cause the gradual loss of focus on what the goal was.

The assumption of responsibility is central to existential thinking for responsibility means authorship. We are, thus, responsible for the way we perceive the world and for the way we react to those perceptions. To be responsible is "to be aware that one has created one's own self, destiny, life, predicament, feelings and if such be the case, one's own suffering."

Existential psychologists generally pay careful attention to language; they are particularly sensitive to the use of such words as *can't* and *it*, which imply behavior removed from individual control. Responsibility avoidance is, therefore, occasionally achieved by losing control. More accurately, it is achieved by the appearance of losing control, by seeming to go out of one's mind, by making it appear that forbidden actions were taken, because one was drunk or "crazy". But behavior that is "out of control" is never really so. Otherwise, it could hardly be purposive.

Will is used by existentialist in at least two senses. First, there is will, as in will power. This is exhortative will. A second and more significant will is associated with future goals, called goal-directed will. Much as memory is the organ of the past, the goal-directed will has been called "the organ of the future". It develops out of hope, expectation and competence. It is not urged upon us, but is a rather freely chosen arousal. It cannot be created; only unleashed or uninhibited. Goal-directed will arises from the capacity to wish. Willing is nourished by wishing, and in turn, will provides the power that may ultimately gratify the wish. Disorders are, thus, found among people who have no notion of what they want to do. They may simply fear wanting; they may fear rejection; or they may want others, magically, to discover their silent wishes and fulfill them.

Existential/humanistic therapist seek to explore inner experiences, with emphasis on the here and now. They emphasize personal responsibility, freedom and will; and finally, they participate actively in the therapy.

The best know humanistic therapy is client-centered therapy, which rests on two fundamental assumptions. The first of these is that therapy proceeds best when the client experiences the therapist's unconditional positive regard. This arises from the belief that people are fundamentally good even when they are doing "bad" things. Second, the therapist attempts to achieve empathy with the client, to see the world as the individual does.

Gestalt, another type of existential therapy, has little interest in the past, except as it impacts on the immediate present. When it does, it is seized and made extraordinarily vivid. The therapist will ask the client to act out the conflict and re-experience the emotions, teaching people to know, control, and be responsible for their feelings. In this view, confronting feelings is the first step in taking responsibility for them.

Logotherapy, yet another existential therapy, uses a variety of techniques to communicate that individuals are free to control their lives and to endow them with meaning. The first is dereflection, which involves turning away the client's attention from symptoms and pointing out how much the individual could be doing, becoming and enjoying if not so preoccupied with self. The second is paradoxical intention, which encourages clients to indulge and even exaggerate their symptoms.

These existential/humanistic approaches to personality are very difficult to evaluate, in large measure, because the approaches are really a group of philosophical positions rather than a scientific theory. Much about them cannot be evaluated, such as matters of belief and values. Other aspects of these approaches require careful evaluation. With the exception of client-centered therapy, these treatments have not undergone careful evaluation. Client-centered therapy has been able to establish that the therapist's empathy and warmth have positive impact on client outcomes.

### Summary

As we go through the material, we will see that the technology is based more on the *cognitive* than behavioral aspects, although the construct of reinforcement is still a strong one, and that the humanistic/existential philosophies are critical to the milieu of the helping process, adding cognitive attributions and expectations to the environment.

If for no other reason than its optimism, the new technologies are able to generate the volition of the person with problems in living. The biomedical and psychotherapeutic models are **defect** models, while the others are **competence** models. "'Social Competence' means possession of and ability to use appropriate social skills" [Sarason - 1985]. While the behavioral model on its own tended to linger in the defect mode, the advent of cognitive theory brought with it a sense of competence building and the behavioral techniques have proved to be helpful in skill building.

As we examine the specific perspectives, philosophy, governance and implementation as they apply to a public system of human services, the threads of these five models will show a marked separation of the biomedical model and its analogous relationships. The new technologies are not only more coherent they are demonstrably more productive. But while the five models exist in present society, it must be clear that the existential/humanistic and cognitive models are not readily apparent in public systems. They lack the ability [and motivation] to control the individual and therefore are found wanting by a self protective social policy. But like the technology of paradoxical intention, coercive methods have the paradoxical impact of producing what they choose to control.

"...madness is a function of power in our society and to declare that madness resides solely within the individual is the power elite's lie." "Being a patient means being powerless. A 'good' patient accepts his powerlessness. A 'sick' patient rebels against it. The fact that follow-up studies of patients who leave

mental hospitals 'against medical advice' find those people generally doing better than those who await discharge is one of many embarrassing facts." [Drummand - 1979]

"Power corrupts and absolute power corrupts absolutely." The power that the human services expert exerts over the person with problems in living is appalling. The age of demonology has not passed. The recognition of people with problems in living as assertive, autonomous people is a basic requirement to improving their ability to live productively in a free society. The confusion of the human services system and the penal system is not surprising from a power perspective. "The road to hell is paved with good intentions" and we have seen its demonstration over the last forty years. In the name of "goodness" we have done things for a person's own good in the same fashion as the leaders of the Soviet Union and yet have failed to see the comparison.

In the course of human history, many social changes have occurred which constitute a trend toward increasing self-sufficiency, self-determination and personal freedom for the human individual. With each age, greater and greater numbers of individuals have been liberated from devalued social roles to gain full suffrage through social integration and participation. While this process has often been exceedingly slow, it is expected that progress in this direction will be inevitable.

One of the greatest barriers yet to be broken in the quest for a fully integrated society is that which exists in regard to persons who are labeled "mentally ill". They are, as a group, the last social entity to achieve recognition as valued members of society. Although women, minority races, and other social groups have made progress in recent years in their search for full and equal participation in society, those labeled "mentally ill" have yet to make a significant impact upon the attitudes and beliefs of the general public so as to measurably improve their status in society.

Fear and misunderstanding, generated by the stereotype of a "psycho", have placed a stigma of heroic proportions on anyone with a history of mental disorder that goes well beyond that applied to other handicapped groups. This stigma keeps individuals from seeking help; keeps families from being supportive and caring [often distorting their own behavior with guilt]; keeps society wanting such individuals to be "put away"; and keeps potential employers, landlords, teachers, etc. from offering their services. This fear is further escalated by the "mystical treatment" focus and practices of those who are supposed to serve. The professionals with *good intentions* have created this stigma and in the process have considerably elevated their own status.

"The only purpose for which power can be rightfully exercised over any member of a civilized community against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the option of others, to do so would be wise, or even right.

We seem to have lost our ability to think critically. Are we no longer willing to create a future where all are created equally free and independent and have inherent rights? The power of these ideas of “common good” are eroding the common good. The holding power of these negative ideas is so great that the Declaration of Helsinki references the International Code of Medical Ethics that declares that, “Any act or advice which could weaken physical or mental resistance of a human being may be used *only in his interest*” [emphasis ours]. Not at his/her own direction, but in his interest. This is the ethical declaration that was developed as “Recommendations guiding medical doctors in biomedical research involving human subjects”. Obviously, it offers little protection against the opinions of the social elite in which the doctor resides.

This ridiculous concept that because we have good intentions that we can act for others has permeated our humanity. Will we never learn?

“It is common practice today for physicians to use their medical knowledge and techniques to alter behavior perceived by the community-at-large to be deviant - “hyperactive” children are said to have a disease, Minimal Brain Dysfunction and placed on drug therapy; the drug antabuse is used to prevent alcoholics from drinking; aversion therapy, oftentimes unpleasant and painful, is used in an attempt to alter sexual practices deemed to be aberrant, as well as with children with “behavior disorders”.

All of this is, of course, the use of medicine for social purposes. Physicians are applying their skills, not to heal disease, but to alter behavior. This is similar to the emphasis Third Reich doctors placed on altering people in conformity to the cultural standards of the day. The issue is complicated; it may, indeed, be useful, even beneficial in social terms, to alter socially deviant or abnormal behavior; but the practice is open to abuse.

The Nazi physicians illustrated what will happen when a powerful elite is freed from the usual checks and balances, which society has devised to protect its members.”[Gallagher - 1989]

We can avoid repeating that unfortunate history by recognizing the *humanity* of those we serve and their *responsibilities* for learning to control their own behavior. We must do so without *blame* and with and ethical responsibility *to* people with problems in living and not *for them*.



## Chapter 1. INTRODUCTION

“Mark Van Doren, in his book *Shakespeare*, adds a point to Aristotle’s *Poetics*. Aristotle says that poetry imitates human action, but by the use of the Greek word for poetry, the art of poetry, he presupposed that the poet makes something, something artificial, that can imitate action. If we ask what that something is, Mark Van Doren, in a tone of voice that leads one to suppose that he is saying something that everybody knows, says that the poet makes a world. This was startling when I first heard it from the lecture platform..., but when I read it in the book I found it both disturbing and illuminating.”

“One of the impressive functions of the cosmic idea is to preside over the birth of possible new, and good worlds, and to incite new wills to make them actual.”

Scott Buchanan, *Imago Mundi*, 1952.

This is a book about *ideas*, and the symbols [words] used to convey them. It is concerned with the ideological principles [values] created through ideas and articulated through words that underlie the actions of people involved in the design and implementation of human service systems. It is about the **power** of symbolic representations, or propositions that people believe or disbelieve because of their own personal set of truisms [belief systems]. It is about the coherence of belief systems **formatively**, as they are formed with individual propositions for individual people; **summatively**, as they develop into a set way for that individual to think about themselves, their situations and others [significant and otherwise] and; **cumulatively**, in the way individual truism sets compare to the collective set, which we call culture.

It is about the ability to create the future through the articulation of ideas that contrast dramatically with the **common knowledge** of the present. It concerns the examination of the discrepancies between individual sets and cultural sets that cause incoherence and unacceptable behaviors and how the shaping of both individual and collective belief systems form the reality in which we live and interrelate. It is concerned particularly with the mental health system as the most significant example of this discrepancy between realities and, perhaps because of the degree of incoherence, the most destructive of all human service systems.

It is concerned with the development and articulation of **social policy** and the governance that results. It is concerned with lack of **resonance** the present social policy produces and the magnitude of ignorance due to intellectual and moral laziness held by social policy makers and the public alike.

“It has been frequently remarked that it seems to have been

reserved to the people of this country, by their conduct and example to decide the important question, whether societies are really capable or not of establishing good government from reflection and choice, or whether they are forever destined to depend for their political constitutions on accident and force.”

Alexander Hamilton

“It would now seem that we have retreated from the problem and are moving away from the solution.”

Scott Buchanan, *What Every Man Should Know: Law*, 1960.

This paper is a search for truth, with the recognition that truth, like beauty, is in the eye of the beholder. Truth is merely the congruence of a proposition with the present belief system. This paper suggests that the social policy regarding services to people with problems in living, if examined rigorously, is incongruent and incoherent, even with the present common knowledge or sociocultural belief system. It is believed that rigorous analysis will cause not only the questioning of our present system and the demand for change; but will directly attack the common knowledge beliefs as well. It is an attempt through this process and the power of the ideas to seed rebellion.

The development of rigorous analytical thinking about ourselves, our situations, other people and the social policy that designs how we relate to them is our target. Many of the issues are best examined in the extreme in our concern for people with severe and persistent problems in living that we have successfully labeled the “chronically mentally ill”. This label is one that continues to exist despite the fact that there is 1) no known, scientifically demonstrated, “illness” and, 2) the chronicity is more likely connected to our social policy decisions on how to “manage” people with atypical behaviors, rather than any other factor.

The issues will also often be examined from the perspective of children since it is here that the preventative intervention that present social policy has ignored can be most effective. The ideas which we will discuss, however, whether pertaining to severe and persistent problems in living or with children and their development are quite pertinent to all human service systems.

Finally, the volume focuses on the local government administrator of human services as the key social policy manager with an expectation that through this position is the critical path to implementation of any potential positive impact if social policy was to change.

The growth and development of human service systems is not unlike that of the growth and development of human beings. Individual people develop naive “belief systems” to help them predict

and control their environment by the time they are seven or eight years old. It then become very difficult for them to change, since many new ideas are incoherent to their belief systems and most of us do not like to do the analytical work. But there are human service professionals who are “doing the work” and the values continue to evolve.

### *Models*

When we are confronted with a set of events that are difficult to understand, we may attempt to develop an analogy as a means of delineating it. In human services, we have already defined five theoretical models that are used to think about people with problems in living

It needs to be understood that “In descriptions of human functioning, the model propounded by any particular expert is, at the least, a statement of that individual’s value system regarding what is good and bad in human experiencing, those aspects that should be fostered and encouraged, those that should be discouraged or eliminated. In the case of models of human functioning that are generally accepted at any given point in time, the values embodied in the model are those of the dominant social order” [Wine - 1985].

This being said, an “...examination of the value system underlying such models is imperative, both for those who propound them and those who are their ‘beneficiaries’” [Wine - 1985]. The five models were expressed in a more or less chronological order and express to some extent the dominant [or at least a major] social ethos of their time. However, the oldest [excluding, of course, the demon model] is the biomedical model, which can trace its origins back to Hippocrates although its dominance has waxed and waned in relation to the demon model. These two models have similarities in regard to the management of behavior.

The Dutch physician Johann Weyer [1515/1588] in particular has been credited with being an outstanding forerunner of modern psychiatry, with the views propounded in his book *De Praestigiis Daemonum* [*The Deceptions of the Devil*]. In this book he developed the position that many women convicted of witchcraft were actually insane. He did not refute the witchcraft theory, indeed claiming to know the exact number of witches, which was ‘seven million, four hundred nine thousand, one hundred and twenty-seven, and all of them were controlled by seventy-nine princes [Szasz, 1970] The mental illness model differed from the demonical model of the Inquisition only in its implication that physicians rather than clergymen should be the responsible social practitioners. The metamorphosis of the medieval into the modern mind entailed a vast ideological conversion from the perspective of theology to that of science [Szasz, 1970]. Science replaced theology as the source of explanation for all events, both human and physical in nature. [Wine - 1985]

In America, Benjamin Rush, a proponent of heroic medicine, was a major communicator of the *brazen claim* of the defect model. Heroic medicine was an approach labeled for its drastic measures "The point was to produce the strongest possible effects on the patient, of any kind, as if the physician were competing with the disease to see which - the disease or the physician - could produce the most outrageous symptoms [Ehrenreich & English, 1979]. When one observes the "side effects" of psychotropic medication, one wonders whether there has been any change over the last two hundred years.

Rush's status and influence were considerable. He was one of the signers of the Declaration of Independence and counted among his circle of friends many of the founding fathers of the Confederation, including Thomas Jefferson. Therefore, he made his brazen claim from a position of status and power. Though Rush made no discoveries as a medical scientist, his claims that medicine *was* a science were widely accepted.

In the mid - 19th century another view gained in prominence, a strictly physical defect approach suggested by [*another respected man*] John P. Gray, physician and superintendent of Utica State Hospital in New York and Editor of the *American Journal of Insanity*, who stated that 'insanity was due to defective brains in constitutionally inferior bodies [Albee, 1978]. The discovery of the linkage between syphilis and general paresis in the late 19th century provided timely grist for the medical model mill and further blocked the possibility of insights appropriate to other problems in human adaptation. [Wine - 1985]

Freud was no less committed to the scientific approach and its language than were his contemporaries. As a physician and neurologist he had been conducting research on human functioning for some years... His theories were initially advanced to account for hysteria, and they bear a close resemblance to the medieval theories of demon possession. He acknowledged this similarity on several occasions [e.g., "Do you remember how I always said that the medieval theory of possession ...was identical with our theory of a foreign body and a splitting of consciousness?" [Freud, correspondence. 17 January 1897/1966].

The irony of this "medical model" is that..., the criterion for diagnosis of *mental* illness is gross misconduct, disordered overt behaviors that are socially unacceptable. ...Illness is both inferred from antisocial behavior, and is then evoked as an explanation for it. The severity of mental illness is determined as a function of the degree of social failure it involves... [Wine - 1985] The psychiatrists make *social, not medical judgements* regarding the behavior and then support those judgements through a process of labeling.

"The defect models that have been wielded with the greatest influence in Western culture are those that attribute deviant functioning to either supernatural, physical or psychic causes. These approaches have in common three defining assumptions of defect models: 1) the aspects of human functioning that are most important to observe are those that are deviant and abnormal; 2) these deviant characteristics are assumed to be manifestations of a pathological state located within the individual; 3) the cause of the

intraindividual state, whether supernatural, physical or psychic, occurred at some time in the past. Though traces of the original cause may continue to be operative in the present (e.g. Continued consorting with the devil, imbalances in biochemical substrata, an unresolved Oedipal complex) its original and major impact occurred at a time in the fixed, unalterable past" [Wine - 1985].

Medical terminology permeates the vocabulary of both the physical and psychic approaches (e.g., 'mental illness', 'diagnosis', 'pathology', 'prognosis', 'treatment', 'remission', 'cure'). Psychiatric diagnostic classifications recognize both physical or organic and psychic or functional origins of disturbed behavior: psychiatric interventions include both physical and psychic modes. ... by locating the present impetus for deviance within the person the defect model precludes attention to social-environmental influences, concomitantly defining that individual as a member of a category of persons qualitatively different than persons who are normal, healthy, good.

The dominance of the defect model can be traced to several "power" issues. First, one can expeditiously ignore the preferences of the person with problems in living since they are *not responsible* for their own behavior. Even "...their testimony regarding their deviance is held to be worthless due to their defective classification" [Wine - 1985]. Since their preferences are not important, the reliance for "cure" falls upon the "expert". Thus, defect models are also *expert* models, elevating the expert in status over the lower position of the person with problems in living and empowering them with the capacity to do things for the "person's own good"; i.e., coerce.

But interestingly, while the defect model seems to hold the person with problems in living harmless, it also does the same for everyone else. Clearly the expert cannot be held responsible for failure, since the pathology is so great and the person with problems in living is so often *resistive* to treatment. So while the expert has *carte blanche* authority, they cannot be blamed for failure, particularly since the etiology of the disease is not clearly documented. The very inability to "cure" indicates how difficult the task must be and the presence of resistance and antisocial behaviors elevates the status of the helper almost to that of martyrs. The lay public marvels at the intellectual and moral capacity of these helpers in the face of such difficulties and ignores the failure. *Mundus vult decipi*.

Further, "Locating the original cause of the deviance in the unchangeable past eliminates the possibility of genuine change, further locking the identified person into the category of deviance. This *arrow of time* is a critical issue in regard to helping people manage their own behavior. Given these assumptions the logical means of dealing with persons so identified is either to help them reduce the overt manifestations of their deviance, or to remove the person from society by placing them in the custody of the state, or to eliminate them" [Wine - 1985].

Finally, the value base of the defect model holds family and society harmless. One can only pity the family visited by the disease while we continue "...maintenance of an existing social order through application of a defect model" [Wine - 1985].

Within these very powerful and self serving values, the possibilities that classification of individuals in terms of defective behaviors may be a limited and inaccurate view, that the diagnosed behaviors may not be defective, or that their explanations may lie in another realm altogether are not considered palatable options. To assume that the individual is responsible for the behavior and that the behavior is a *learned one* and that such behavior is malleable opens some untenable questions. If the person is responsible, how do we handle behaviors that offend society? How do we account for professional, family and societal failure? Who is to *blame*?

The question of blame is one of major concern for advocates of the "mentally ill"; particularly parent advocates. But it is not one that is worthy of discussion. Like other factors of the defect model, it defeats the real issues that are concerned with remedy. While, this book will contend that people with problems in living are responsible for both their own behavior and their own growth and development, it does not *blame* them for being who they are. It seeks to help them identify who they are in relation to others and to seek new thoughts and behaviors in that process.

The development of the behavioral model seemed to be a bridge in sociocultural values, having some components of defect, but with a recognition of learned behavior and environmental context. The behavioral approach accepted two of the three defining characteristics of a defect model in that proponents tended to observe defective behavior and believed that the impetus for such behavior originated in the past. However, they did not accept that the cause was a pathology, but believed that such behaviors were learned and reinforced; change the conditions - eliminate or refocus reinforcement - and you can change the behavior. "The behavior specialist became a surgeon of human behavior, 'Show me a maladaptive behavior and I can cut it out.'" [Bradley & Knoll] This, in and of itself, was a new form of optimism not found in defect models. Further, the relearning could happen in the here and now, which moved the arrow of time away from etiology and the past, and toward solution and the future. While some of the aversive techniques could be considered inhumane, the behaviorist soon learned that the *positive* contracts were superior influences for change.

A major difficulty of the behavioral approach is that skills were taught without regard to context causing an increasing concern that you really cannot teach people how to live in a neighborhood and get along with others by putting them in a special setting from which they can graduate into the community. "A key ingredient [to transformation] is a commitment to the community as the place where people should live. From this perspective, the 'community' is not some sort of nirvana, but rather a place where everyone has a right to make their home. The job of the practitioner in this framework is to resolve those issues in an individual's life that impede his or her presence and participation within the community.

Where this perspective has been adopted people no longer speak of 'community-alternatives' or 'community-based services' because there is no alternative to the community". "Real success is achieved when a person [with problems in living] becomes an active participant in the community" [Bradley & Knoll].

"A second part of that commitment to community has to do with providing support to people with disabilities in their families. Just as we have begun to recognize that moving people out of their home communities to specialized facilities severs important ties with natural supports, we have also begun to acknowledge that removing people with disabilities from their families - especially when they are children - ignores the commitment to family, disrupts family connections, and deprives the child of the experiences of growing and developing in a family unit." [Bradley & Knoll].

Such context and value changes are a critical part of the new paradigm. The cognitive, then humanistic/existential models implied such value changes, but had never become the dominant social ethos. In these, the question of self responsibility and self actualization are dominant values as are positive regard and positive expectation and perhaps provided the impetus for the contextual change. Despite these more humane values and concurrent experimental evidence of positive outcomes of achieved *competence*, dominance of the social ethos has remained with the defect modalities; a combination of the medical and psychodynamic models.

Our exploration is concerned, not just with past performance, but with the profound question of **why** we provide services in the way we do and why the biomedical/psychodynamic model is so important to us. To make decisions about whether or not such practices are even coherent demands that we analyze present social policy. Such analysis reveals that management of abnormal or atypical behavior is essentially done **either for the benefit of the person behaving abnormally or for the protection of society**. It is the contention of this paper that the explicit message - benefiting people with problems in living - is not the REAL message; the real message is protection of society or "out of sight, out of mind". "When models are adopted as expressions of the dominant social ethos, they lose their "as if" quality and become deified as immutable statements of reality" [Wine - 1985]. Thus the defect model compiled of biomedical and psychodynamic theories has lost all relevance for the beneficiaries while being accepted without critical analysis by the general public.

Depending on the social policy emphasis, administrative management may be beneficial, benign or destructive. Some would argue that **both** the benefit and protection policies can be met, but if this is true, it is not apparent. This book will argue that both policies cannot be met with present perspectives and can only be met through an effective service delivery system that benefits people with problems in living by dealing with *fundamental issues*.

Because of the message to protect society, human service professionals have chosen to accept the role of policeman; and psychiatrists are the “top cops”. We have no argument with the police role, but believe there are others who play it much more effectively than human service personnel, and they do not hide their restrictive activities behind the rubric of “doing for the person’s own good”. Police work is a perfectly acceptable career choice, but not for professional helpers. The helper serves the client; the policeman serves the public. This does not mean that the process of helping the person with problems in living understand, accept and cope with limits is not a service to the public. It means that, in its primary focus, an empowering attitude toward the client is required as a matter of faith. It means that the helper is **responsible to** the individual, not **responsible for** the individual. The helper is responsible for exhaustive remedies as long as the person is sanctioning and seeking help.

It will be argued that a human service delivery system that helps people with problems in living function successfully in society is the only effective method of protecting society. It will be further argued that actions such as incarceration, inducing mind-altering drugs with toxic effects, electroshock therapy and the like **are not helpful** and would not be possible on a large scale if they relied upon the complete informed consent and sanction of the recipient. The coercion inherent in acting for another’s own good, in fact, causes behaviors which perversely allow the further sanction of society to support and reinforce the need for such actions.

One basic assumption that can be made about acting for someone’s own good is that the person probably does **not** want the action taken. If s/he did, s/he would do it herself. Further, it can be demonstrated that anger and frustration are the result of such actions and such results hold true not only for the person in a “psychotic” state, but for that person in his or her most lucid state.

It can also be extrapolated from experiences, that such coercive techniques lead the more controlling staff to extend coercion to areas and concerns that have no relationship to the social or “medical” need for treatment. Invariably, scandals of abuse and mistreatment can be tied to a situation in which the person in need resisted the desires of the abusing staff person - thus justifying the force.

This resistance is, in turn, often documented as the symptomatic need for help. A cycle of coercion “for one’s own good” leads to resistance, frustration and anger. Rebellion against the system and the people responsible is a natural outcome that completes the vicious cycle. In the case of “psychosis”, the individuals are not only coerced “for their own good” to do things they do not want to do, they are chastised for their fear and anger in the process.

Even assuming that in the best of all scenarios, the individual needs the “treatment” and that the “treatment” is successful, the process has developed a very angry person who might seek to use violent behavior to overcome perceived or real estrangements. The alternative behavioral outcome is that the

coercion has been so significant that it has created “learned helplessness”; i.e., the inability to decisively act because of an expectation of future failure due to a perception of unsolvable problems.

At this point the other polemic of defense for the biomedical model comes to the fore. The idea of eliminating stigma by eliminating responsibility generates the potential for feelings of **immunity**. If I am not responsible for my behavior, then anything I do cannot be held against me. Thus, an act of criminal violence becomes a non-act. The courts, in fact hold that such an individual is **innocent**.

There is “punishment” in the form of incarceration, not for the act the individual may have taken, but for the fact that the individual was not accountable for the act. Thus, shrewd individuals may find ways to act “abnormally” instead of just atrociously, thereby gaining “diplomatic immunity”.

On the other hand, there may be those whose motivation is more abnormal [irrational] than criminal, but for whom the anger towards the coercive and hypocritical nature of the system grows into a desire for “revenge”. Others may believe that they are, in fact, responsible for their nonconforming behavior and, having come to see such behavior as “bad”, seek welcome relief from guilt through self-sacrificial atonement.

This evidence seems to suggest that a new model; predicated upon services which are respectful may have a greater capacity for both growth and development **and** protection for society. Central to this process is a shift in the dominant theoretical perspective or paradigm that at any one time is shared by the majority of workers in the field. Despite increasing efforts at altering the values and technology, the old paradigm perseveres.

In some ways, this book is a series of ideas, thoughts and suggestions about social policy and service delivery, written almost as essays about philosophy, theory, practice and management of human services. The essays are coherent only in their consistent regard to a congruent set of ideological principles; they are all coherent with a new paradigm. They take their lead from “Kurt Lewin’s classic statement that behavior is a function of the interaction between a person and the environment [B = f(PE)] [Lewin, 1935]. In the years immediately after World War II a group of researchers used Lewin’s earlier work and undertook a social-psychological examination of the lives of people with physical disabilities. This work led to the conclusion that most of the limitations on people with disabilities are imposed by society rather than being intrinsic to an individual’s functional deficit” [Bradley & Knoll].

From these roots, many authors have focused on seeing challenging behavior as resulting “from discrepancy between ...skills and abilities and the demands or expectations of...[the] environment” [Apter - 1982]. From this broader view of disability there are three possible areas from intervention: a) change the person, b) change the environment, or c) change societal attitudes and expectations” [Bradley & Knoll]. What Bradley and Knoll do not include is changing the person by changing **their** attitudes about

self, others and prospects. Our emphasis regarding changing persons will be to help people with problems in living sort out their attitudes and learn the skills necessary for competence in *valued* settings. Our emphasis on changing the environment is to use the valued, normalizing environment for nurture and change rather than to create artificial environments. And our emphasis on changing societal attitude and expectations will concentrate on the development and communication of social policy and the retraining of the helping profession.

### *Philosophy*

Etymologically, philosophy means 'loving wisdom'. When technically defined, it is the *critical evaluation* of all the facts of an experience. Critical would include the rejection of bias or prejudice and evaluation would include valuation. To have *value* is etymologically to be 'strong' or 'effective'... and hence have 'worth'. In this context, philosophy differs from science in that it attempts to determine without bias the 'worth' of *every* variable in the experience, whereas the scientist merely seeks to *describe* selected facts of the experience, which lie within his or her special field. The placement of value or worth requires criteria used to distinguish truth from error. "A criteria of truth is a standard, or rule, by which to judge the accuracy of statements and opinions; thus, it is a standard of verification" [Sahakian & Sahakian, 1993].

This process is important, not only to the field of human services, but also to the process by which people with problems in living seek coherence. The individual must decide upon the criteria that can enable him or her to distinguish what is true from what is not true. It should be obvious to most readers that not all criteria have equal validity for this process. Philosophers have used a wide range of criteria including custom, tradition, time, feelings (emotion), instinct, hunch, intuition, revelation, majority rule, consensus, correspondence, authority, utility, consistency and coherence.

The process includes not only criteria of validity, but the avoidance of *material fallacies of reasoning*. Such erroneous ways of reasoning about facts are "numerous, deceptive and elusive - so elusive that a person untrained in detecting them can easily be misled into accepting them as valid" [Sahakian & Sahakian, 1993]. The ability to reason without committing error is an obvious asset. Philosophers list such material fallacies in classifications such as 1) *linguistic fallacies*, or those which involve the abuse or misuse of language; 2) *fallacies of irrelevant evidence*, or arguments which miss the central point at issue and rely principally upon emotions, feelings, ignorance, etc., to defend a position; 3) miscellaneous fallacies which belong to a number of other classifications but which do not readily lend themselves to further subdivision. Some examples are *dicto simpliciter*, or the attempt to apply a general rule to special cases where are exceptions to the rule. To make universal statements about matters to which the rule does not always apply. The paradoxical cliché 'All generalizations are wrong; including this one' is advice against such fallacies and their converse variants.

*False cause* or *post hoc* fallacies consist of reasoning from mere sequence to consequence. That is from mere sequence an assumption of causal connection is made. The fact that *A* precedes *B*, does not necessarily make *A* the cause of *B*.

*Compound questions*, also known as 'poisoning the well', is an error which consists of combining several questions in such a manner as to preclude all opposing arguments, thus placing one's opponent in a self-incriminating position. "Do you still beat your wife" is the quisesential example.

*Petitio Principii*, or begging the question is comprised of circular reasoning such as when in order to prove that *A* is true, *B* is used as proof, but since *B* requires support, *C* is used in defense of *B*, but *C* also requires proof and is substantiated by *A*, the proposition which was to be proved in the first place.

Such examples are not inclusive, but should indicate to the reader that such fallacies are reasonably common. In fact, a list of *cognitive errors* expounded by a cognitive scientist would not appear much different. Such cognitive errors lead to problems in living when they are applied to the problem of truth about oneself, other people and future prospects for it is difficult to avoid projection of one's philosophical position into any definition of truth. Since all persons have a philosophy of life, whether they have consciously considered it or not, this philosophy impedes their ability to define truth, unless they are very *aware* of material fallacies.

A philosophy is vital to the development of coherence. If we seek truth in the delivery of human services, it requires a criteria of validity and a process which avoids error. "*True ideas are those that we can assimilate, validate, corroborate and verify. False ideas are those we cannot.*" Truth happens to an idea. It becomes true, is made true by events." according to the Pragmatists. It is assumed that human beings can therefore obtain only partial knowledge based upon partial experience, which differs from what others obtain. Knowledge, at best, then is opinion, a subjective truth. Since truth is opinion, what is true for you is true only for you. [Sahakian & Sahakian, 1993]

Seeking coherence for in the human service system, therefore requires the development of a "common truth" or common cause. Human services cannot be effectively provided with different perspectives of truth each vying for prominence. The collective discovery of the *summum bonum*, life's greatest good cannot be determined with a discussion of philosophy. "The right act can readily be known once the greatest good has been determined, for it becomes simply that act which enhances the realization of the greatest good, and the immoral act is that mode of behavior which is a deterrent to its realization" [Sahakian & Sahakian, 1993]. Ethics embodies two areas, namely *right action* and *life's greatest good*. Without a clear system definition of life's greatest good, one is unable to determine 'right action'. If in the service of human beings, we cannot agree upon or determine right actions; we enter into the realm of morality.

The relationship between ethics and morals is like that between theory and practice, since the former denotes the *theory* of right conduct and the good life, whereas the latter refers to the actual *practice* of right conduct and the good life. The term *moral* has a dual meaning: the first has to do with the ability of a person to understand morality as well as his capacity to make moral decisions; the second has to do with the actual performance of moral acts. Using the term *moral* in the former sense, we may contrast it with *amoral*, which refers to a being incapable of distinguishing between right and wrong. Using the term *moral* in the latter sense, we may contrast it to *immoral*, which refers to actions which transgress moral principles. [Sahakian & Sahakian, 1993]

In distinguishing between *personal ethics* signifying the moral code applicable to individual persons, and *social ethics*, referring to the moral code of groups, we identify the latter as concerned with the development of *social policy* and the former with the implementation of this social policy in a manner which not only does things right, but does the right things.

Seeking coherence as an individual is to examine closely the criteria of validity. This will require an awareness of one's own beliefs, prejudices and intents. As Socrates said "the unexamined life is not worth living". To know oneself, that is to know oneself completely, one's conscious and unconscious self, makes for power, self-control and success. Individuals encounter difficulty only because they do not truly know themselves - their natures, limitation, abilities, motives, the entire gamut of their personalities. They need a psychological mirror enabling each person to see his spiritual self as it really is, including all its shortcomings, strengths and potentialities. [Sahakian & Shakian, 1993]

For people with problems in living, this psychological mirror is the helper. The examination of *life's greatest good, right action, ethics* and *morality* of social policy and social action is considered a prerequisite for human service delivery. To do otherwise is to create the opportunity for material and moral error.

## **Chapter 2 PERSPECTIVE**

*The future is not a result of choices among alternative paths offered by the present, but a place that is created - created first in mind and will, created next in activity. The future is not some place we are going to, but one we are creating. The paths to it are not found but made, and the activity of making them changes both the maker and the destination.*

John Schaar

Human conceptualizations are limited by the structure of the brain that contains the capacity for logical activity on the one side and intuitive activity on the other. In various eras and locations, societies have opted to value one perspective over the other. Since the way we look at something affects what we shall see, it is important that we find the means to use both our logical and intuitive capabilities at the same time and with the same value. The “creative” or “responsibility” paradigm utilizes the decision making of the individual as a teleological life force, to direct growth towards dignified responsibility.

When addressing any problem, perspective is an important part of possible solutions. Perspective limits the potential variables to be considered because it places the problem as having a specific etiology or cause and therefore, must deal with that cause to effect change. If we change the perspective, we may either resolve the problem automatically or open up totally new areas to be considered as solutions. The present social paradigm concerning abnormal behavior is one of illness; a germ, gene or biochemistry which influences the behavior. This has not always been so.

Over time, societal thinking has fluctuated between two basic perspectives depending upon the level of sophistication and technology. Those societies with little sophistication and technology have tended to view aberrant behavior from a *mystical* point of view and have defined it as either a superstition or religion depending whether or not the observer is a believer. The essence of this paradigm as it focuses on people with severely deviant behavior is the belief that some supernatural force has taken over the body of the afflicted individual. The perceived quality of the force, in turn, defined by its moral essence, ranging from the view of the American Indians, many of whom felt that the afflicted person was blessed by a god and, therefore, to be revered; to the American Puritans, who suspected that the force was a demon, which needed to be purged from the body, often by burning at the stake [ J.R. Gardner - 1987].

Our society, sophisticated and technologically advanced though it may be, seems to be unable to get beyond this mysticism, although the perspective is couched in scientific terms. This so called scientific paradigm suggests that instead of a demon inhabiting the body, there is a vector, an organism or malfunction resulting in disease. This disease or pathology, be it lesion or chemistry, must be physically altered if the individual's behavior is to change to conform to the desired norm.

Although the most common severe mental disorder, schizophrenia, has no known pathology, most mental health professionals and as a result, perhaps, the society at large, accept the reasonableness of such a perspective. In fact, some “professionals” are running around shouting *eureka* - we have found it. However, there is no scientific evidence for such claims, only implications of very poor research. Since the research has continued for years without conclusive evidence [although each generation seems to have

found its own favorite], we might consider why the strength of this archaic perspective is growing instead of fading.

First, social paradigms continue because of the force of their own common knowledge base. Once the earth was considered the center of the galaxy and the planets behaved abnormally, orbiting erratically in a flower petal pattern. Challenges to the base paradigm were treated as heretical and “everyone knew” that this centrist theory was right. Of course, the church, which had the most invested in the concept also challenged dissenters. The language used continues the common knowledge. In our paradigm, we unconsciously refer to mental “illness”, despite the fact that such usage grew as a metaphor. We hope any day now to make it real.

Second, such social paradigms are housed within **good intentions**, since we can now “do something” for [or to] the poor unfortunate soul and not just sit by and watch them suffer. People feel good about themselves as they espouse the fact that they “care”, even though no evidence has been accumulated to indicate that such caring has any beneficial aspect.

Third, social paradigms continue because they serve society’s needs. The mental illness concept allows our society to justify *control* of the abnormally behaving individual “for their own good” and at the same time protects society from seeing or dealing with a very difficult problem. The illness paradigm makes it understandable that professional helpers often fail to be helpful even though they try so awfully hard; makes families less guilty about what they might have done differently; makes individuals so afflicted not responsible for their own behavior and therefore, places everyone in a “hold harmless” position.

In short the “illness” paradigm has a great deal of value for all the people involved. The same, of course, was true for the demonic possession paradigm of our forefathers. In both cases, one based on a mystical or religious belief and the other based on a pseudoscientific or logical belief, some force other than the individual is responsible for the abnormal behavior and therefore, we find it acceptable to use coercive and controlling methods to “solve” the problem while at the same time enhancing the status of the people who deal with extremely severe problems. These intrusive “helpful” interventions included “burning at the stake” in a less sophisticated time; now we consider it to be humane to subject individuals to electroshock treatment or mind-altering drugs, despite the fact that neither of these is acknowledged as a cure and that each has its own irreversible side effects.

But just let us suppose for a moment that the paradigm is wrong. What then? Clearly there is still a problem for both the individual and for society. It seems, however, that society has a mechanism to handle the problems of violent or antisocial behavior through the criminal code. For those very few people whose abnormal behavior is disruptive, the legal system should be able to provide sufficient response. If the legal system isn’t acceptable to deal with people who break the law, then perhaps we need to change that system. On the other hand, judges and juries take into account extenuating

circumstances and certainly such adjudicators would consider severe problems in living as an extenuating concern. After all, even people who are not considered to have problems in living so severe to be labeled “mentally ill” are able to use the “abuse excuse” to get away with murder.

But most people with abnormal behaviors don’t break the law. Most are more afraid of life, than overexuberant. Most don’t want to [or don’t know how to] talk about it, but they do want to emerge from their problems. They have the same goals of success and happiness as the rest of us; they have real life issues that must be resolved; a place to live and work, and a social support network need for positive relationships. Most present mental health services don’t offer help for these issues. Instead they offer medication and talk therapy. The medication is often rejected because the noxious side effects are worse than the original problems, and the talk therapy is usually ineffective. So the problem of helping the individual develop their own capacities is still not addressed.

Most mental health workers persevere in their espousal and use of the “illness” orientation despite the obvious failure. The perspective of the mentally “ill” person being “out of control” bolsters the notion that they act for that persons “own good”; thus supporting the notion of **experts** who know what is good for you. These activities set up a conflictual “treatment” pattern, which generates hostile and/or helpless behaviors which are sanctioned by the “diplomatic immunity” [they are after all, not responsible for their own behavior] for the very behavior which displays that anger or helpless frustration. To add to the irony, the resistance shown by the anger and helplessness is then used to describe the existence of a “mental illness”.

Social paradigms, based as they are on commonly held underlying assumptions, are extremely difficult to change. Albert Einstein, who might reasonably be called at least an “uncle” if not the “father” of quantum physics, maintained his classical physics position despite all of the evidence to his death. “God does not roll dice.”

Despite the almost too bold efforts of Thomas Szasz in The Myth of Mental Illness, George Albee and others, we continue to perseverate on “medical” or “illness” models, not because people with problems in living are helped, but because it enhances the status and power of the helper. A definition for **medical model** might be: an expert model based on the conception that the therapist has a superior knowledge of potential actions, and of an **illness model**: a focus on etiology and a conception which presumes that the “ill” person is not in control of his/her own behavior. These two mental constructs fit well together in that one assumes that the individual in stress is not truly capable of controlling their own behavior and the other suggests that the therapist knows better anyway. One hand rubs the other.

This book suggests a totally different paradigm which focuses not on the “expertise” or the etiology; but on the **people**. It is based upon none of the medical or illness assumptions and is thus, contrary to “common knowledge”. It takes as its primary truth that people are not only goal seekers, but that they

always seek goals which will help them to reach optimal levels of development, regardless of the seeming “psychotic” nature of their choices and behaviors. In fact, the “psychosis” can be seen as a strength; a **creative response** to their perceptions of their environment.

A new perspective of creative personal responsibility seems to indicate the need for some new service interventions. In order to examine this potential more closely, perhaps we should try to elaborate on the possibility of a responsibility paradigm being not only true, but optimistic and helpful as well.

To begin our transition in perspective, we might listen closely to a man named “Bill”, who lived on the streets of Philadelphia.

“There’s a place that I could stay for fourteen days, but I don’t want to go there in a bad condition and something has happened to the lower part of my body - swelling - you might smell the odor - it’s some kind of infection - and I should get some medical help for it but at the moment, I’m just hoping that it will improve a little bit before I have to go through that, but something happened to the body. I think I had it once before and it went away. As it begins to go away then I would get medical help. Now that sounds opposites.

The reason for that would be I know I’m coming back and the help would be there. I don’t want the other way - I hate to feel helpless. It’s the worst thing to feel helpless. That you are completely in the hands of everybody else” [Stehle - 1983]

Yes, the thinking does sound opposites. But the pride, the responsibility, the desire to feel some level of power and control is there. The worst thing is to feel helpless. And yet the focus of responsible mental health professionals is to focus on the helplessness of the individual. His or her “sickness” which will never go away; which causes him to act in ways that we will do things “**for their own good**”.

And what will we do “for their own good?” Isolate, restrain and medicate. These are the adverse strategies that develop anger, frustration and feelings of helplessness in the mental health system. These are the strategies that make us both create and focus on the **violent** people in our systems and make us fear the very people we are supposed to help. These are the strategies that when combined with the “diplomatic immunity” of the “illness”, cause people to understand that they are not responsible for their actions, and thus promote the very violence we fear and coercively restrain while at the same time eliminating the **will to live, learn, grow and develop** - to overcome.

Biology is not the issue. **People are the issue**. People who are affected by the same things as everyone else. Coercive behavior evokes fear, anger, helplessness and resistance. And in perverse style, all of these responses are used [along with the effects of medication and institutionalization] to verify the “illness”.

People's confidence in their ability to cope is highly contingent upon their feelings about themselves, and to a large extent their feelings about themselves is developed through contact with others.

"Patient" is a subordinate role; treatment is an expert application; care is given to helpless people. As wind and rain erode and shape the surface of the earth to a much greater extent than earthquakes and volcanoes, so too, repeated words and attitudes erode the functioning of those to whom we relate.

What message do we want to give? Do we want people to feel their strength, their capability to be responsible, even in need? If so, we need a new perspective.

*Some people will ...*

The molecular biologist, Jacques Monad, in his book "Chance and Necessity" wrote:

"...it is tempting to draw a parallel between the evolution of ideas and that of the biosphere. For ... ideas have retained some of the properties of organisms. Like them, they tend to perpetuate their structure and to breed; they too can fuse, recombine, segregate their content; indeed they too can evolve,..." [1972].

Evolutionary biologist Richard Dawkins in "The Selfish Gene" developed this theme further by naming the unit of replication and selection in the ideosphere as the counterpart to the biosphere's gene - a **meme**. He writes:

"examples of memes are tunes, ideas, catch-phrases, clothes fashions, ways of making pots or building arches. Just as genes propagate themselves in the gene pool by leaping from body to body via sperms or eggs, so memes propagate themselves in the meme pool by leaping from brain to brain via a process which, in the broad sense, can be called imitation" [1976].

Such memes can be perceived as the carriers of culture and it is important for us to identify memes in order to see how all of us are influenced by this process. It seems that a meme of some importance to human services in general and mental health services in particular is - **some people will**. As it propagates itself from brain to brain through imitation, from supervisor to subordinate, worker to client, client to family, it provides much of the destructive thinking which generates the presumed "coherence" upon which a coercive system is predicated.

Dawkins has suggested that there need not be an exact copy in each person's brain. Memes, like genes, he says, are susceptible to variation or distortion - the analogue to mutations. Various mutations then must compete with each other as well as with other memes for attention. Part of the element of a successfully competing meme must be that it has **coherence** [truth] to the brain receiving it. If through rigorous

analysis, the meme is proven to be false [incoherent] it will not be propagated. Thus the most powerful memes are simple to understand and relatively difficult to refute.

**Some people will** has such a construct. It is, in fact, irrefutable. While, as with all generalizations, it is wrong; it cannot be so demonstrated. The context of its truth hinges upon two variables. First, is the indefinite quality of some. Some can be as small as one. Any more merely emphasizes the correctness of the implication.

But even one is a definite number and the successful continuation of the meme seems to rely more significantly on the other variable: the extensive diversity of human nature. As can be shown by the traditional bell curve, while most of us are within the body of the bell, **some people will** be at either extreme end. Thus the compilation of indefiniteness of number and the inevitability of the bell; the truth of the statement becomes obvious.

One additional variable also seems to come into play in the propagation of this meme and that is the “self fulfilling prophecy” quality of it. Once stated, it seems almost inevitable that someone, somewhere at some time in the future must carry it out. What wo/man can conceive, s/he can achieve.

This would of course, create no difficulty to the meme pool of mankind, if the tag end of the meme **some people will** was a positive proposition. In fact, such positive proposition memes, as we will see later, are vital to the development of a culture of positive expectation. Some people will care about their neighbors; be good role models for young people; be honest in their dealings’ etc. would be very nice memes indeed. Unfortunately, this meme seems to have become malignant. It connects mostly with negative propositions.

In the past, we are told, society had a code of honor. A man’s word was his bond. We had handshakes, not contracts. But then someone began to think **some people will** lie, cheat and steal. And as this meme passes from brain to brain, it of course, turned out to be true and on those occasions folks rued the handshake and wished they had a contract.

The irrefutability of the meme, along with some horror stories, led to more and more people believing it and so it began to evolve into **most people will** lie, cheat and steal. This led, of course, to the self-fulfilling aspects of this meme since marginally honest people began to believe that since **most people will** lie, cheat and steal, they should do unto others *before* they did unto them. Thus we have gradually developed a society which is more and more distrustful and dishonest with bureaucratic regulations which make it virtually impossible for an honest person to function.

The cancerous nature of the meme has wormed its way into every aspect of our lives. Most problematic to the human service community is how it has impacted upon the field of mental health. **Some people will** commit suicide; commit murder; need hospitalization; need long term restriction.

These statements are irrefutable and self-fulfilling. They drive the mental health system to create the hospitals [jails] first and then fill them. Any number of beds built will be filled. The essential optimism required of human services becomes difficult to maintain in light of the horror stories that prove that **some people will**. We create a system for **some people** and then use it to serve everyone. The very coerciveness required to **control** some people, makes them resistive, frustrated and angry, proving the point.

Since this self replicating idea, or meme, of **some people** will not go away; it is incumbent upon those who believe in the importance of positive attitudes to develop some immunizing agents which will root out and kill off the malignancy caused by the meme. Following the lead of biological scientist, we must attempt to develop a nearly identical entity, having many of the same characteristics, but without the cancer, as a vaccine.

**Some people will** be able to grow and develop into functional citizens, the positive replication. We must state it over and over to professional peers, friends, relative and perhaps it will take hold and evolve into **most people will** be able to live independently, grow and achieve. The statement is irrefutable and true. It is supportable; it cannot be rejected through rigorous analytical review, only overwhelmed by the malignant meme.

We must struggle first to purge ourselves by imagining a positive growth and development of the people we are serving. Using the imagery developed for cancerous tumors whereby the individual imagines the immune system as knights slaying the dragon; we must imagine that people with problems in living are capable of being independent. It will be hard at first, and there will be lots of horror stories to overcome, but all but the most unimaginative will begin to see a society where people with problems in living are seen as people with dignity.

As we begin to purge our own toxic memes, we will be better able to understand how the infectious nature of the word symbols which support and enhance this malignant meme. **Patient. A word, a symbol. Dependant. Sick. Disabled.** Each of these words carries a connotation which is not helpful to the idea that persons with problems in living might be able to take some responsibility for their own growth and development. If we hope to change, such terms must be replaced. Once rid of the malignant meme, we must get rid of these viral syntaxes which carry the memes central message.

But we should also approach the toxic meme with other curative methods. Immunize ourselves by demanding specifics of those who propagate the malignant meme. How many is some? Quantify your

terms. When someone says to you **some people will** become violent; make them quantify. Certainly fewer violent people among people with severe and persistent problems in living than among *normal* people. Any quantity they name can be refuted. It will either be too small to support the coercive nature of the system or cannot be verified by research [which shows that most people when given the opportunity can not only live in the community, but consistently improve their ability to function effectively while in the community].

Like wearing a mask in the presence of communicable disease, the demand for quantification will provide a buffer between you and contamination. It is not ironclad, because we all know that **some people will**, but it provides at least a margin of protection.

But the real change in the meme pool will come about only by the recognition that the positive **some people will** meme is superior for the purpose of enhancing offers of help. Inevitably, we will be required to come to the conclusion that **some people will** be better off if professionals take a more positive, optimistic, upbeat approach to predicted outcomes.

“Ideas cause ideas and help evolve new ideas” [Monad - 1972]. “The “spreading power” - the infectivity, as it were - of ideas, is ...difficult to analyze. ...It depends upon preexisting structures in the mind,....” “...the ideas having the highest invading potential are those that *explain* man by assigning him his place in an immanent destiny,...” [Monad -1972]. What greater objective could the human service profession have than to alter the abstract kingdom of ideas with the profound notion that man is ultimately worthy of our trust and respect.

#### *Thoughts on a belief system*

From an optimistic professional standpoint, one major value stands forth as the pinnacle upon which rests the entire helping practice. This principle is the belief that **human beings strive towards optimal growth and development**. This rather simple statement of belief places humankind with other living beings in a nonmoralistic growth pattern which tries to emulate the best possible maximization of self within the context of one’s environment. Few would argue with this belief concept if we limited its application simply to the genetic development of the physical being. Too many examples exist of the seedling circling the rock to reach the sun or the tree with limbs tied down which insists on striving to reach its normal growth pattern. A teleological life force is acceptable in living creatures and we often refer to its explicit demonstration as “instinct”.

But this teleological force is also applicable to the psychological aspects of human beings, or at least we must believe that this is so if we are to be helpful. Despite the apparent anomalies of human behavior, we believe in the **emergent** behavior which strives toward optimal development [becoming what it was

intended to become] and we believe that this emergent behavior is rationally, through often unconsciously, controlled through what we call the **will**. The will arbitrates much more in the human than simply how to get around obstacles and reach the sun. It must also decide between multiple options of maximization, influenced by past experiences and future expectations to decide; what is the best alternative, not simply what is good.

This thinking process is plagued by the dualistic nature of human beings which results in **paradoxical thought**. The structure of the human brain is a separation into two brains, one which generally deals with intuitive thinking and one generally with logical thinking. Coordination of these two contrary brains is not as easy as it might appear, for the more powerful intuitive brain is less knowable and gives the other only that which it is capable of putting into symbols and thus, using. The logical brain, of which we are quite conscious, is thus the recipient of only limited stimuli/knowledge, and is able to articulate/symbolize even less. Its strength, however, lies in the ability to make patterns out of nothingness. These patterns create the symbols of perception and communication; **reality**. If our reality is less than real, it is important that it be so. Not only would total knowledge overwhelm us, it would decisively end our freedom to choose. It is only the limits of knowledge that give us either/or dilemmas. While total knowledge would give us either/other/or; infinite options, it would, of course, also tell us the correct course of action.

Paradoxical thinking gives us the ability to choose, while making the teleological choice very difficult. We are creatively able to shape our own lives and the reality within which we live, but we are ambivalent, at best, as to how to proceed.

This ambivalence is further escalated by the I/Thou<sup>16</sup> perspective. The I is shaped to a large extent by the Thou. Human beings develop their self concept basically through the eyes of others. We respond to what we perceive others think of us and feel about us. It is important to remind ourselves as to the limits of our perceptive abilities, because it is possible to be shaped by a misperception of what others really think. But correct or not, the individual will often find it difficult to dismiss what it perceives others' think. Thus it must decide whether to please the other or to please itself in reaching optimal development.

The aberrations of human behavior thus become attempts to strive towards optimal self development while avoiding the pitfalls of real or perceived obstacles placed by others. Just as the plant that twists around obstacles and appears bizarre; so to individual persons appear twisted from their **creative efforts** to maintain themselves in the midst of a reality which seems incoherent.

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With respect to Buber who used the I/Thou as a religious or spiritual relationship, it is meant here perhaps as I/other; but most importantly, the significant others.

If what is suggested here is coherent to the reader, enabling another to strive towards optimal development of self becomes a relatively simple, though not easy process. First, we must clearly delineate *what the person with problems in living wants*. Second, we must support that desire and commend the individual for their intent, although not necessarily the methods they choose to reach their intent. Third, we must provide realistic options as to how they might maximally achieve their goal and help them examine the primary and subsidiary consequences of implementing each choice. Finally, we must support the choice by teaching behavioral skills that are necessary to implement or act out the choice and then help them to evaluate the outcome.

As simple as the process is, it is extremely difficult to implement especially because of the problem of establishing trust with individuals who are very unsure of themselves. The very fact of deviation from the collective norm indicates that there have been dissatisfactory relationships in the past. Paradoxically, when this is so, the individual in need rejects a positive relationship as this is the only one that can truly hurt them. The more I like/love you; the more you can hurt me. Therefore, vulnerable people often make every effort to be unlikable in order to avoid being hurt further.

The provider of helping services must be ready to accept the hurtful individual as one who is striving to maintain an optimal level of self. Only with this continued and **unconditional** acceptance of the person [although not necessarily the behaviors] can human service professionals be useful in the process of change. Only as we refuse to make the hurting reciprocal can we break down the barriers and become loved. Once there, our obligation is clear.

#### *A life force*

The zoologist E.S. Russell writes:

“The directiveness of vital processes is shown equally well in the development of the embryo as in our own conscious behavior. It is this directive activity, shown by living organisms that distinguishes living things from inanimate objects. The fact is that the common ground of both organic and psychological activity lies in the directiveness or “drive” which is characteristic of both. We must regard directiveness as an attribute not of the mind, but of life... Purposive activity, as seen in its highly developed form in the intelligent behavior of man, is a specialized and elaborated kind of directive activity, concerned mainly with the master of his material environment.”

A feeling for the power of the **life force** that inheres in each fertilized ovum is strikingly conveyed in the writing of George W. Corner, embryologist. “The growth of the embryo from 1 cell to 200 billion cells, during a period of 9 months; from 15 ten-millionth of a single gram to 3,250 grams, staggers the imagination. The orderly course of embryonic development and the capacity of the embryo to deal, within its own limits, with unfavorable environmental circumstances in its inexorable move toward

realization of its purpose of growth suggest an inner direction, force and flexibility which can be assumed not to cease at birth, but to continue to characterize man's biological and psychological capacity for coping and creating throughout his life."

"The spirit, with the body, must grow and differentiate, organizing in its inner self as it grows, strengthening itself by contact with the world, earning its title to glory by struggle and achievement" [Corner].

Corner refers to the power of choice and decision and exercise of the will as **rooted** in human biology:

"We are led...by the evidence of comparative anatomy to ponder upon the freedom of the will, or at least freedom of action, which we have because our bodies are versatile, untrammelled by specialization for extreme, but particular skill, and capable of any task the mind may imagine.... The scope of the human mind, the freedom of human decision, are bound up inextricably with the generalization of the body."

Edmund Sinnott, biologist, writing of the biology of purpose, speaks of living things as "seekers and creators" and of striving for goals as the essence of all life, adding that in man these goals have risen to heights before undreamed of, and suggesting that man can set them even higher at his will. He refers to the organizing, goal-seeking quality of life, of life as regulating, purposeful, ascending, of each human being as being as "an organized and organizing center, a vortex pulling in matter and energy and knitting them into precise patterns," and capable of creating new patterns never known before. Sinnott does not deny or minimize the effect of the environment on the life of the organism. Indeed, he writes that the exact character of the organism will depend in some measure on the environment within which it develops. "In all these cases the genetic constitution of the organism is not changed, but the way in which this expresses itself in development is very different depending on the conditions under which development takes place."

Sinnott's essential thesis is stated in the following words:

"The insistent tendency among living things for bodily development is to reach and maintain, as a means or goal, an organized living system of a definite kind, and the equally persistent directiveness or goal seeking that is the essential feature of behavior, and thus finally the basis of all mental activity, are fundamentally the same thing -- merely two aspects of the basic regulatory character all living stuff displays. Regulation implies something to regulate **to**, a norm or a goal. The goal in embryonic life may be regarded as a series of stages that lead to a mature and properly functioning individual, and *the goal in psychic life as a purpose or series of purposes, simple and unconscious in primitive instinct, but rising in the mind of man to far higher levels.*" [Emphasis ours]

Sinnot's hypothesis that living organisms move toward definite goals both in their bodily development and their behavior provides a unified conception not only of man's nature, but also of his relations to others and to the universe.

This "life force" or directive activity of Russell, Corner and Sinnot, however, must overcome a series of obstacles beginning with **differentiation** from others.

In the "Dilemma of Growth", Allen identifies the slow course of development in the symbiotic period, in which the infant is provided with the essentials of existence without the stress of independent living. At birth, a physiological differentiation makes separate living possible, but the reality of conscious separation is yet relatively undifferentiated. Awareness of self as a separate individual does not yet exist. Growth as a psychobiological phenomenon takes on reality as the directive energy generates the process of discovery.

But it is the contribution of Otto Rank that makes the understanding of the psychological "life force" clear, for it is in the conception of the ambivalence of the will that the complexity of human response is best understood. If the "will" as Rank defined the life force, continued only towards predefined goals or norms, then the choices available to human beings would be limited simply by the obstacle. However, human behavior often is beset by paradox, almost going in two directions at once.

Rank's definition of the person is rooted in his perception of the experience of birth. Within the womb, the embryo functions as a unit of symbiosis with its surroundings as Allen suggested. Birth means the *death* of this union. It is the archetypal problem of the struggle of relinquishing the old integration in adopting the new one; i.e., dying in order to be reborn. On the one hand the individual strives to reinstate the unity between himself and his environment; that same individual experiences every advance towards independence as a threat. On the other hand, the emergent **will** is assertive and potentially creative. It strives toward separations and individualization. Thus, from this perspective, the symbiotic union is seen as a sort of death, a regression, a loss of individuality and "life". Thus union also becomes a threat, something to be feared.

The essential point in all of this is the polarity between separation [individuation] and union [loss of individuality]. This necessary and inherent human conflict leads to both the essential life ambivalence of the will or "life force" and the potential for **creative** responses to the conflict.

This self-willing creative response can be positive or negative in the perception of society, but it is ultimately an attempt to find the way to be a part of **and** separate from others. The need to "have our cake and eat it too" provides the paradoxical nature of human existence. All things can be seen from this dual perspective. And each individual must creatively **choose** his or her own existence.

This life choice has been epitomized by Frankl as he suggests that "Life ultimately means taking the responsibility to find the right answers to its problems and to fulfill the tasks which it constantly sets for each individual." "Those tasks, and therefore, the meaning of life, differ from man to man, and from moment to moment. Since each task is unique, each must decide for himself what s/he will live for; what has meaning. We cannot always control the circumstances in which we find ourselves, but we must always choose how we will behave in these circumstances." Will we seek unity or separation, or attempt to find some creative response to do both. "When we are no longer able to change a situation ...we are challenged to change ourselves." Is a choice of believing oneself to be Napoleon to be considered as a creative strength seeking resolution to life's problems, or as a pathology. A strength or a weakness. "Rational man adapts to the world" - and if the world is an untenable place, it may require unique responses.

Thus the "life force" frees the individual to choose between union and separation; or for Frankl, conformism and totalitarianism. The individual willfully chooses what the optimum level of development will be within the constraints of the environment. This is substantially different than the "life force" of the embryo, but is still rooted in the biological nature of life itself.

Because the choice exists for each of to **give** meaning to life, we cannot find it. "S/he who searches for herself is lost, but s/he who gives herself to another, will find herself" and the meaning of life - thus defines the paradoxical nature of our existence. Life is meaningless, we are born, we live, we die. Unless we **choose** to give it meaning, by creatively and wilfully setting a **future** goal.

A second paradox exists, however, in that we cannot find ourselves capable of choosing a meaning for our lives unless we find ourselves as worth meaning. If we are not worth living, life can not have a meaning; but if we are worthwhile, we can give meaning to life. We must have meaning first; and we get that meaning or self affirmation from others. While every human being has the freedom to change at any instant, and can therefore choose to be worthy or unworthy, the major honing influence in the "belief" in self is based upon our perception of how others view us.

The enormous complexity of attributions placed upon us by the roles we are assigned, the words used to describe us, and the tones used in conveying the words cannot be underestimated. While the individual **will** can choose to accept those attributions [seek union] or reject them [seek individuation], the cumulative impact of negative attributions is eroding to any individual.

Nor can the cognitive aspects be underestimated since the individual must codify and conceptualize what is being assigned to him. We learn best not by words, but by experience, We experience rejection or degradation, and the words may support or deny that circumstance.

Despite the worst of experiences, the will can choose a meaning; “suffering ceases to be suffering at the moment it finds a meaning, such as the meaning of sacrifice” [Frankl - 1985]. But too often it will search for meaning outside itself and fail, for there is no meaning to life. The individual must find himself to be different and find the difference to be acceptable. Since we tend to reject difference in others, we tend to equally attribute to our own difference - unworthiness.

What is needed is a different kind of experience; a new and fortifying relationship. One which will engage the individual’s positive will and affirm his/her right to be different from others. Having had this difference accepted by others, the individual can now accept him/herself. Self acceptance becomes possible through what Rank calls the “love experience”. The valid love relationship requires acceptance of the **self-willing** in another, bestowing worthiness in preparation for choosing meaning. Thus worthiness is not in ourselves and our behavior, but the acceptance of that behavior by someone significant to us.

For people with problems in living, such an experience can often only occur with a professional helper. Yet too often professionals fail to become significant, and even if they do, they find it difficult to deal with powerful emotions such as hostility. When the professional helper approaches the core of the person with problems in living who has never felt love - the response is fear; if I like/love you - you can hurt me. And because the protection of self often presents itself as hostility to that person who gets too close, and because professionals tend to fear those they work with [because they do not feel that people with severe problems in living are “in control” of their own behavior], the response is anything but accepting. But if professional helpers or anyone else can provide that love experience; that acceptance of the person **regardless of their behavior**, the potential for change can be established.

And the experience can be enlarged in valued settings. Man is a social animal. S/he grows in a family and learns the activities of life from peers. It is the group that supplies the final validation of belonging. A positive group experience demands a great deal of us. Each of us must find a place within the group and choose to give up some of ourselves [conform] for the need to belong. Kurt Lewin has suggested that belonging is second only to love as a human need. We need a function, role, to be needed - to belong. A deterioration of this need caused by rejection will lead us to accept roles and functions that are negative, rather than to be ignored. For after love and belonging comes recognition; know that I am.

The need for love, belonging and recognition focuses on the desire for union; but the group offers yet another paradox. For within the group, one can belong **and** be different. The group demands both conformity to norms and differentiation of roles. Thus, within the group a creative response to the union/differentiation conflict can most easily be found.

While society is a group and a feeling of belonging to this larger whole is important, the major impact comes from acceptance by those who we believe are significant. Thus, it stands to reason that those

closest to us are most important to find compatibility with. Each of us needs a **thou**, a significant individual with whom we find love, acceptance and worthiness. Lacking this we seek to belong to small significant groups. The most important, the family, followed closely by peers. Failing that, people often seek acceptance in the large social arena; the lonely “hero” or “idol” who is “lonely” amidst adulation. We cannot always choose our circumstances, only how we will act within those circumstances.

To choose a meaning for life, one must first understand the need for the choice. When individuals engage in a choice making activity, they may attribute the perceived outcomes to either personal forces such as ability and effort, or to impersonal forces over which they have little control such as the situation or bad luck. Having made a choice and having evaluated the potential outcome, those who externalize the attributions for such outcome often decide that they “can’t win”. Life is out of their hands. In the extreme, they learn helplessness, and it becomes a way of life.

For an individual to choose to do something different they must believe that they are capable of accomplishing the task; believe that the achievement will have a positive reward; and believe that the reward is sufficient to merit the effort. Individuals who have identified no meaning to life and feel unworthy of living rarely feel that achieving tasks is within their potential. Thus, the love experience is a prerequisite to worthiness and worthiness is a prerequisite to meaning and meaning is a prerequisite to significant achievement. The need for constant positive reinforcement for people with feelings of unworthiness supports the idea that they **are** and they **can**; important beliefs to creating a relationship of trust and change

Even this is not as easy as it sounds, for meaning is a dynamic, not a static state. Achievement of goals can obliterate meaning. Each achievement becomes a stepping stone to a redefinition of the meaning of the individual’s life. Growth and development is based on a certain degree of tension between what one has already achieved and what one feels still ought to accomplish; the gap between what one is and what one should become.

What human beings “need is the striving and struggling for a worthwhile goal, a freely chosen task” [Frankel - 1985]. The achievement of the task demands another task of a higher level. We must “experience” achievement to qualify ourselves for the next level of growth. But such growth is not contingent on a mechanistic or deterministic series of steps; the individual will can choose to skip over the past and experience the future. The incessant dwelling on the past done by both the helpers and people with problems in living needs to change, the arrow of time points to the future. What is important is the future, for it is only there that goals and meanings can be placed.

“An essential task of helping is conceived as freeing the other to claim and use his will positively toward his own self-chosen ends, within the social purpose of a particular ... relationship” [Smalley - 1967]. This supports the life task of the other as a **process**. Peter Drucker [1957], in another context captures the

dynamic, futuristic and paradoxical nature of human growth and development and the helping process: "We need a discipline ... that explains events and phenomena in terms of their direction and future state, rather than in terms of cause, a "calculus of potential", rather than one of probability." "We need a dialectic of polarity, one in which unity and diversity are defined as simultaneous and necessary poles of the same essence."

Smalley states: "An understanding of process leaves room for the emergent, the unknown, the unpredictable, for continuous creation from a center within rather than susceptibility to or reliance on control from without for essential change." Process is not a mechanistic stepscale from one level to another, but a change experience in which the individual moves in many direction at the same time.

"The self of another cannot be known through intellectual assessment alone. Within a human, compassionate, and caring relationship, selves "open up", dare to become what they may be, so that the self that is known by the worker at once human, caring and skillful is a different self from that diagnosed by one who removes himself in feeling from the relationship in an attempt to be a dispassionate observer and problem solver" [Smalley - 1967].

In summarizing, we can turn to physical science to help place this perspective. The science of Newton was largely responsible for the development of a mechanistic view of the universe. Newton's science was based upon the clarity of cause and effect and the mechanics of that process. Present day physics does not view the universe in quite the same way. Reality is *observer* created. Light is neither a particle nor a wave. These are not properties of light, but rather are properties of our interaction with light.

In that same manner, we must put away the deterministic and mechanistic perceptions of man and his development as propounded by Freud and his followers. Like Newton, Freud's contribution was vital. His brilliant insights opened the door for its own repudiation. His thesis demanded antithesis, and now a new thesis. Aggression is not a property of the individual, but is the property of the interaction of that individual with others. It is contextual and situational. Hallucinations may or may not exist for the individual, but the real issue is what s/he chooses to do with them.

This new perspective shares with democracy and the situation ethic, the demand for individual decisions based upon rational thought. While the judgements in any given circumstances might be wrong, if they are rooted in the best possible information, are rigorously analyzed, and made from the most accepting and caring perspective, they will be significantly, if not absolutely, correct.

*The Arrow of Time points to the future*

It seems that the population who have severe problems in living also have a consistently bleak view of the future; if they view the future at all. It seems that an important part of any new human services

perspective is that the client's view of the world must be renegotiated into a "here and now to the future" perspective and away from concentration on the past.

Unfortunately, the most prevalent perception of the mental health professional is also on the past. We persevere in our insistence upon history usually based on the Freudian perspective that people must redo those parts of their past that they are "stuck" on. We not only look back, but we then focus on the worst events in the person's life experience; those moments when they were the weakest, least in control, felt the most humiliated. Little wonder that people with problems in living have little humor. This constant look at the empty part of his/her life, rather than the full must be excruciating.

Viktor Frankl talks about his time in the concentration camp as a "provisional existence of unknown limit". It was impossible to foresee whether or when, if at all, this form of existence would end. A man who could not see the end of his "provisional existence" was not able to aim at an ultimate goal in life. He ceased living for the future. ...The whole structure of his inner life changed; signs of decay set in .... [They] suffered from this strange "time-experience". ...A small time unit, a day, for example, filled with hourly tortures and fatigue; appeared endless. A larger time unit, perhaps a week, seemed to pass very quickly. How paradoxical our time-experience was!" [Frankl - 1985]

The people with severe problems in living must experience a similar existence - without a future and without a goal. There is a tendency to look into the past, to help make the present with all its horrors less real. But this robbing of the present of its reality has a danger since it becomes easy to overlook the opportunities to make something more positive of it. Regarding this "provisional existence" as unreal is itself an important factor in causing the individual to lose their hold on life; everything in its way becomes pointless.

Mower holds that "time is the distinctive dimension of human personality." The capacity to transcend the immediate boundaries of time, to see one's experiences self-consciously in light of the distant past and the future, to act and react in these dimensions, to learn from the past of a thousand years ago and to mold the long-term future, is the unique character of human existence.

The most significant events in a person's psychological existence are likely to be the ones which are "immediate", breaking through the usual steady progression of time. These "crises" are of the here and now and must be contended with in that context, not as "the tip of the iceberg" for the historical etiology.

These experiences can cause severe anxiety and depression which blot out time, annihilate the future. Or, as Minkowski proposes, it may be that the disturbance of the individual in relation to time, his inability to "have" a future, gives rise to his anxiety and depression. In either case s/he is unable to imagine a future moment in time when s/he will be out of the anxiety or depression.

Personality can be understood only as we see it on a trajectory towards its future; a man can understand himself as he projects himself forward. The self is to be seen in its **potentiality**.

We must not neglect the past, but we hold that it can be understood only in light of the future. The past is the domain of contingency in which we accept events and from which we select events in order to fulfill our potentialities and to gain satisfactions and security in the immediate future.

Alfred Adler pointed out that memory is a creative process, that we remember what has significance for our “style of life”, and that the whole “form” of memory is, therefore, a mirror of the individual’s style of life. What an individual seeks to **become** determines what s/he remembers of his **has been**. In this sense the future determines the past [May - 1983].

If the role and expectation is that of a “patient”, the “style of life” is oriented around the effects of the “illness” and its first onslaught in the past. If, instead, the role is that of a “trainee”, the perspective must be towards the future graduation and anticipation of what s/he will **become**.

It is in this **emerging** personality that change will take place, not in a creative interpretation of the past. The view of the future must be honed in the expectation of new roles and new experiences, not in perpetuation of the roles and experiences of the past. The view of the future entails hope and belief. **Hope** that things will change and **belief** that they will. Any attribution which indicates permanence instead of this potential state of change and growth, contributes to the inability and unwillingness of the individual to *imagine* themselves as different in the future.

We are thus not retrospective nor introspective, but **prospective**, seeking with the client what Viktor Frankl calls the “meaning to be fulfilled” [1985]. The goal, target, aim or intention of what one wants to become. The suggestion of emergence from the present state of affairs towards a new and better one. Selecting a goal for future becoming is often frustrated by the circumstance in which we are mired. What is disconcerting is the present perspective of human services and the attitudes of helpers because it provides so much of the frustration by focusing the client’s attention on the past problem rather than the future solution.

Nietzsche remarked, “Man is the animal who can make promises.” The person’s capacity to be aware at the moment that he is responding to the social expectation, the one choosing [or not choosing] to guide himself according to a certain model. This distinction between rote social conformity on the one hand and the freedom, originality and creativity of genuine social response on the other; the mere awareness of oneself as a being in the world implies the capacity to stand outside and look at oneself and the situation to assess and guide oneself by an *infinite variety of possibilities*.

Man has the capacity to transcend the immediate situation for understanding his being and to *take responsibility for it*. What feeling, knowledge or will an individual has depends in the last resort on what **imagination** they have. Imagination is the possibility of all reflection, and the intensity of this medium is the possibility of imagination itself.

Thus it is the ability to imagine oneself in the future; to set goals and take steps to meet those goals that gives the optimistic quality to human striving. This process demands an end in time.

Whether or not an individual can even recall events of the past depends upon his or her decision with regard to the future. The problem is not at all that people happened to have endured impoverished or traumatic pasts; it is rather that they cannot or do not commit themselves to the present and future, being consistently diverted by the very people who propose to help them. The essence of responsibility to self and behavior, however, is embodied in the willingness and ability of the individual to define his own meaning and goal. This responsibility can only be articulated in a here to future perspective. *Taking responsibility for past events is only a thoughtful process; taking responsibility for future demands action as well as decisions*. The decisions center around whom we will be responsible to while the actions are the behaviors which become the tangible evidence of the thought.

When we are no longer able to change a situation, we are challenged to change ourselves. Mankind's concern is not to gain pleasure or to avoid pain but rather to see a meaning in whatever activities, event and experiences that occur. [Wo]man is every ready to suffer on the condition that the suffering has meaning. If the suffering is uncontrollable, we must find the meaning by reorganizing our attitudes and actions in regard to the circumstances.

Man is not fully conditioned and determined, but rather determines him/herself whether s/he gives in to conditions or stands up to them. People are ultimately self determining; they do not simply exist, but always decide what the existence will be, what will s/he become in the next moment. Every human being has the freedom to change at any instant. Therefore, we can predict the future only within the large framework of a statistical survey referring to a whole group; the individual personality remains essentially unpredictable. The basis for any predications would be represented by biological, psychological, or sociological conditions, yet one of the main features of human existence is the capacity to rise above such conditions, and to grow beyond them.

This lack of predictability is borne out within the mental health population not only by the continued inability of mental health professionals to predict violence, even on the basis of past history, but also in our seeming inability to understand and recognize the continued positive outcome displayed by the very people we suggest by our semantics are "chronic".

Five studies done within the last fifteen years have all found marginal or deteriorated outcomes states as the exception, not the rule. "Schizophrenia does not seem to be a disease of slow progressive deterioration. Even in the second or third decade of illness, there is still potential for full or partial recovery" [Vermont Longitudinal Study]. Ignoring the fact that the implications of the study seem to deny the "illness", one wonders to what degree the recovery is linked to a desire for a future despite what other have told them.

Together these five studies found that one-half to two-thirds of over 1200 subjects, who were studied for longer than twenty two years, achieved significant improvement. This outcome assumed that the individual could be fully employed in gainful work and that s/he could resume the former role in society; be able to maintain a sensible conversation and display generally normal overt behavior. This despite being told that they are "incurable"; the destruction of hope.

The implications are clear. We need to talk to people with problems in living about **when** they are ready to requalify in society and what do they want to **be** in the future. Part of the pessimism of the present perspective has been that we have seen the behaviors created by the "treatment" [medication side effects, institutional behaviors, etc] and age as part of the symptoms of the presumed disease. The social skills lost thus become the indicators of the problem; an interesting, but destructive circle of self-fulfilling prophesy.

To date, research on neurostructural and biochemical abnormalities which suggest relationship to chronicity have been exciting, but inconclusive and contradictory. Many organic abnormalities appear to cut across diagnostic categories, have little prognostic value, shift over time, or represent small subgroups in the population. This should emphasize the importance of energizing the individual's "will to meaning" as a significant helping focus. This cannot be done without a view to the future.

It seems likely that even if there were some tendency to a "natural history" for schizophrenia tending towards an outcome of deteriorated states, the role of the individual and of the environment aiding or interfering with the expected outcome would be too powerful to permit uniformity. It is unconscionable that the medical profession is concerned about maintaining the positive outlook of AIDS patients, but not those labeled with schizophrenia. Pessimism of outcome not only contributes to the inability or unwillingness of the individual to seek for meaning, but contributes directly to a future of deterioration.

Frankl has suggested that the "innermost core of the patient's personality is not even touched by psychosis" [1985]. We are not always responsible for the circumstance in which we find ourselves, but we must take responsibility for the attitudes and actions within those circumstances. True mental health [or emotional stability] is based upon a certain degree of tension, the tension between what one has already achieved and what one still ought to accomplish, of the gap between what one is and what one should

become. What people actually need is not a tensionless state but rather the striving and struggling for a **real and worthwhile goal**, a freely chosen task.

“He who has a **why** to live for can bear with almost any **how**”

Nietzsche

Man must believe in the future in order to create it. The present method of providing help, as epitomized by the mental health system, **systematically destroys hope**. We need a hopeful, optimistic perspective which helps people with problems in living help themselves. A perspective which **leverages** the strengths of the person, not their weaknesses.

### *Comparing*

Each helping person must decide for him/herself which perspective they will choose. The following compares the traditional with the transformational perspective. While these differences are posed in terms of the extreme, they are developed so as to force consideration of the potential for helpfulness.

Question: **How can society best manage people with abnormal behaviors?**

Assumption: The primary population to be addressed regarding this question are those who have been labeled “chronic schizophrenic”.

Albert Einstein suggested that how you look at a problem limits the solutions that you will find. There are several dimensions involved with the question posed which include etiology, inner/outer control and outcome. Within those dimensions, we pose two extreme propositions for consideration and discussion.

### Etiology

- A. Abnormal behavior, particularly that labeled schizophrenia, is caused by a biological pathology.
- B. Abnormal behavior, particularly that labeled schizophrenia, is caused by the individual’s reaction to environmental stimuli.

Based on the first proposition (A), Dr. Benjamin Rush, theorizing that mental illness was caused by the blood rushing through the brain, invented a machine that spun people around violently, seeking to alleviate symptoms. The outcome, of course, was a violently sick and dizzy individual. Done under different circumstances, this treatment might have been considered a torture. The point, however, is that Dr. Rush was not likely to look at social intervention as a possible means of resolving the problems behavior because he started with a basic assumption that there was a physical etiology.

Unfortunately, the biomedical perspective tends to diminish people to subjects in an experiment and perhaps loses sight of the individual in its zeal to find the pathology.

The second perspective clearly focuses the person in need as the point of intervention although it is possible with some theories to simply consider them as little more than actors in a play in which the script and outcome are clear. The outcomes are premeditated by the scriptwriter and the individual is empowered to do little other than follow the script.

Both perspectives thus have some ability to ignore the individual in need and concentrate upon the intervener's own need to successfully achieve their own goals.

It becomes important, therefore, to consider other dimensions and their impact upon the question. What is the individual's ability to *control his or her own abnormal behavior*?

- A. The individual displaying abnormal behavior is psychotic and unable to control their own behavior.
- B. No matter how psychotic individuals are, they are responsible for their own behavior.

It should be apparent that the perspective taken in the first dimension has an impact upon the potential choices made in the second dimension, although not a controlling one. If the behavior is caused by a pathology (A), it is far easier to believe that the individual is not responsible for their own behavior. It is possible, if not likely, however, that one could accept the thesis of a pathology which influences, but does not control behavior. Thus, the individual would still be in a position to choose to ignore the symptoms caused by the pathology and behave normally.

The second perspective (B) in the first dimension, that "the behavior is learned" seems to open much more opportunity for the individual to control behavior through choice, although s/he may need to learn new behavior in order to do it. It is not guaranteed, however, that this choice would be made. Some people would suggest that the individual reacts rotely to environmental stimuli, and therefore, is not really in charge of anything.

The perspective is critical, however, in setting the stage for determining a solution to the question posed. If individuals have **no** ability to control their own behavior, the most caring response of the intervener is to **protect them from themselves**. However, if they are **responsible, and therefore, in control**, the most caring response is dramatically different. In this case, the caring position may include the potential of punishment as well as reward through examination of choices and consequences.

The final dimension needs to be considered in regards to our question, and that is outcome.

- A. To protect society from individual aberrations in a way that is least restrictive to the individuals with problems.
- B. To help these individuals achieve optimal levels of personal, social and economic development.

Both of these are clearly acceptable and important outcomes and most caring interveners would hope to achieve both. Unfortunately, where you place your priority and how you have determined the propositions of the first two dimensions leads to some critical limitations in potential intervention to best address the question.

If you believe in the statement of one extreme, that the individual displaying abnormal behavior is a victim of pathology over which s/he has no control and that the symptomatic behavior leaves little or no room for choice and that the primary outcome is protection of society [Order A], you must strongly support the need for an easier way to place people in institutions away from the general public where the behavior can be “handled” by medication and control.

If your beliefs go to the other extreme, however, that the behavior is learned and can be unlearned; that the individual controls both the process of learning and the behavior itself; and the primary outcome is to enable these individuals to reach the optimal level of independent functioning [Order B.], then you cannot responsibly incarcerate through the involuntary commitment procedures.

Each of us must decide for himself where, between these two extreme orders, lies what Aristotle has called the fundamental truth upon which all systems of knowledge are built. This truth is not provable or unprovable, but is taken as a basic fact and upon this fundamental building block, the mosaic, as von Daniken describes it, is built.

In determining this fundamental truth, it must be acknowledged that all that is built is upon a faith, or belief system. That is so because it rests upon an original assumption that cannot be proven. Thus, all science, built as it must be upon a fundamental truth, rests upon the faith, implicit or explicit, of the scientist. It is for this reason that scientists can seek for centuries to prove something that is incoherent. Stephen J. Gould, in the “Mismeasurement of Man” shows extraordinarily well how the desire of some scientist to prove that negroes are inferior has led to ten or more conclusive proofs, only to later be proven wrong.

In developing our independent “fundamental truth”, it is important that we understand the “common knowledge” attributions which sway our thinking. The term “**mental illness**”, initially used as a metaphor, carries the subliminal message to us all that abnormal behavior is pathological. The psychiatrist, as “doctor”, supports the same message. This social paradigm is clearly oriented toward Order A, not Order B. Thus we have all grown up assuming that a pathology exists.

There is some evidence that might make one consider differently. Among the most persuasive evidence is the Vermont Longitudinal Study of Persons With Severe Mental Illness, which indicates that, contrary to expectations, significant improvement and recovery for even the most severely diagnosed, backward individuals, labeled with schizophrenia, can occur. It is suggested that previously prognosis-confirmed diagnoses were a self-fulfilling prophecy, which stripped hopes of recovery from the individuals and their families. The team, despite an acceptance of the “fundamental truth” of pathology, found that over half of the study cohort had significantly improved or recovered! To assume recovery, the individual needed to be fully employed in gainful work, resume his or her former role in society, maintain a sensible conversation, and maintain generally normal overt behavior. Nowhere do the researchers attribute this recovery to a biomedical intervention. In fact, they represent that a community based rehabilitation program may have had a major impact even though it only lasted for the first five years of the study.

They also indicate that much of the continued perception of the individuals as “sick” may have been based upon the institutional behaviors learned in their average of six (6) consecutive years of hospitalization. “... Institutionalized people became socialized into the “good patient” role. [The] list included: to be dull, harmless, and inconspicuous; to evade responsibility, minimize stress, ignore others ,to retain the right to behave unpredictably and have a certain “diplomatic immunity”.

They suggest that “it has been difficult to separate the residual effects of the disorder, the effects from institutionalization, the socialization into the patient role, the lack of rehabilitation, reduced economic opportunities, lowered social status, the side effects from medication, the role of lack of staff expectations, self-fulfilling prophecies, and the loss of hope.

While the study does not challenge the premise of pathology, and in fact, starts from that perspective, it clearly indicates the role of the individual in maintaining hope, learning new behavior, etc. In all, the research significantly implies that movement away from the biomedical extreme is necessary if we are to find the most positive answer to our question.

This data [and subsequent major research which support its findings] is not alone in its perspective that the “illness” perspective is not as secure as it might seem. Information continues to indicate that recovery within the community is much more possible than within the hospital. It is important to note that much less medical treatment is available in the community [and easier to avoid] and that relearning methodologies have been the most effective rehabilitation programs. Whether the relearning is the elimination of the **original behavior** or the behavior learned in the institution is not clear, but in either case, “remission” is more apparent in the community.

All things being equal, however, there is no substantial proof that there is or is not a pathology, let alone how controlling a role it plays, if it exists. Therefore, your belief system is as good as mine, if it satisfies your outcome goals. Such satisfaction is not easily reached whatever your faith and perspective.

It is important to note, however, that belief systems that border of the first order [A] have certain “Catch 22” dilemmas to contend with. These have caused substantial problems for the intervener, the individual in need, as well as society.

If individuals are not responsible for their own behavior and it becomes necessary, at times, to control them “for their own good”, how is that decision to be made?

Of course, the decision needs to be made by taking social factors into account, since no scientific evidence can be shown to exist upon which to base the decision. The intervener is thus in the position of either reacting to an event and judging its potential consequences, as in the criminal justice system; or predicting an act and its potential consequences, as in the medical system. Since this is a **social** decision, the potential for error exists, but is clearly more prevalent in predicting than reviewing. This aspect of the dilemma affects most cogently the individual in need, since it is s/he who ends up incarcerated.

However, when the decision is based upon prediction, there is an additional “Catch 22” for the intervener. If incarceration or control is based upon a prediction of future behavior, usually of harm to self or others, release must be based upon a similar type of prediction. If the need for hospitalization based upon a prediction of violence to self or others is false, no one is the wiser since the action obviates the expected behavior. However, if the release prediction is false, the intervener is required to “own up” and take responsibility for the act of attempted suicide or violence. The “catch”, of course, is that there are severe malpractice penalties for mistakes, so the intervener tends to disown his or her ability to predict the future behavior on release where the prediction can be checked out against reality; but insists on the validity of the prediction where the action taken precludes the future event from ever taking place.

The greatest dilemma posed by taking the first order extreme is in the confluence of the legal and medical systems. Certainly there are precedents within other legal/medical confrontations, such as when a parent denies, for religious or other reasons, a medical application which is deemed necessary for continuation of life. Even in these circumstance, the parameters are broadly prescribed to protect the rights and privileges of the individuals involved. The major difference, of course, is that in these cases, the medical personnel can point to specific and provable cases of pathology; the dispute is about the impact of the pathology, not its presence. Without such concrete citation of pathology, the process becomes even more delicate.

In the case of involuntary commitment, we have a serious abrogation of civil rights. Here, there is not only the application of a medical procedure upon an uncertain “illness”, but the actual incarceration of an unwilling participant based solely on the social judgement of the physician. While there is due process to determine whether the individual is threatening to self and others, this is a different application of the law than is applied to others. Criminals cannot be incarcerated based upon threat; only crime. No one else

in this society can be incarcerated upon threat; only crime. From a purely legal perspective, the civil rights of the individual are abridged by even considering the issue. Adding to the dilemma is the fact that there is no identifiable pathology that the physician can point to as needing treatment. In fact, there is only the physician's *belief* that there even is a pathology.

Using the most negative connotation for the practice, we could refer back to the scientists mentioned above who insisted on proving the inferiority of negroes and imagine the concern we would have if people who were black could be incarcerated for threatening behavior while the rest of the population could not. In this analogy, we could, at least in most cases, demonstrate that the social judgement of blackness was in many cases really observable and existed. Could we accept that individuals who could be proven in a court of law with due process to be potentially harmful to self or others and were black could be incarcerated **for their own good**?

If not black, what criteria? Female, poor, unlikable, obnoxious, dangerous, vulnerable? Of course all of these criteria are used as part of the social judgement. The criteria essentially is one of the identification of the group unable to garner the resources to defend itself - and any devalued population segment is likely to fall into this category. It should not be surprising, therefore, that the majority of individuals labeled schizophrenic happens to be from devalued classes, while the majority of physicians happen to be from the more elite.

This dilemma of legal/medical interplay creates difficulties in being able to answer the question which we have posed. Undoubtedly, the availability of a legal/medical exception to the Constitution, which is implemented by the opinion of someone who rarely understands the lifestyle and culture of the individual s/he testifies about, leaves a dramatic gap in our value system through which the most unsavory and manipulative can walk. Even if it is necessary, based upon our best understanding, belief and intention, that we "treat people for their own good", we create a dilemma that can be terribly misused.

The second order extreme [B] does not need to deal with these dilemmas, although it does create one of a different nature. If individuals who have problems in living are responsible for their own behavior, they can be punished for the behaviors that are anti-social **and** their families can be **blamed** for instilling this behavior in the first place.

Simplistic as this notion is, it appears to be a major deterrent to the concept of individual responsibility. Guilt and blame are not remedial and, therefore, we as a society should dismiss them out of hand. But they will not go away. "Illness" is treated with some deference and respect. Individuals with an "illness" can be pitied, but never blamed. Certainly, one could not hold their families even remotely responsible.

For too long, professionals, accepting the simplistic notions that families were, in fact, generally to blame [although how this was true within the pathology paradigm is one of the dichotomies that people apparently live with], have created the “illness model defense mechanism”, which is used to protect families, too often at the expense of the individual, from the onslaught of professional advocates.

Families cannot, as a group, be blamed, even if all of the behavior is demonstrably learned. Human beings are much too complex to make such generalizations. This does not mean that families might not have done things differently or even that some might have done something “wrong”. But generally speaking, people do the best they can under the circumstances and often their best is not enough. Many families, like their “mentally ill” children, will need to relearn behaviors, to find a remedy to the never-ending cycle of confrontation and conflict. Others will simply have to continue to love. Other will simply have to let go.

In the final dilemma of our mental health system, we are faced with a service system that simply does not work for clients or their families. The services that seem viable to the families are not acceptable to the clients, and those that are most acceptable to the clients are often not acceptable to either family or society because they don’t “control”.

Part of this is because each seeks to achieve different goals. Society wants these troublesome individuals to go away, families want them to act the way they expect them to, and the individuals themselves, the clients, want to get on with their lives. Different perspectives of different dimensions. Strongly held belief systems on mental health, like those of politics and religion, cannot be debated, but must be accepted on faith. And to a large extent, what we believe is contingent on our view of “whose ox is being gored”.

It appears that we have two extreme systems to meet the two extreme orders of perspective; state institutions for the first extreme and cognitive behavior management for the second. Placed along a continuum in between are various private and public agencies which orient towards one or the other; usually without any rigorous analysis or awareness of why they behave as they do. We struggle as a society to find the common group in between as “ecumenical” space, but it does not exist. Too often, the perspectives are mutually exclusive. Without a choice, we allow the unsavory to use our positions against us, playing one against the other for the benefit of special interest. The professional guilds, the pharmaceutical companies, the labor unions, the elaborate bureaucratic structures all have a stake.

Although the importance of the acquisition of basic living skills to allow functional independence of those with abnormal behavior has been highlighted in the scientific literature as early as 1922, it has taken mental health governing authorities and national associations over fifty years to incorporate such concepts into their language and policy.

“This shift in the ideology and approach to treatment corresponds to the findings of mental health research. For example, a positive correlation has been found between a client’s level of skilled activities and the important outcome criteria of recidivism and employment.”

Yet, despite this apparent shift of policy and the supportive documentation, it remains largely rhetorical. The standard budgetary equation continues to support the institutional approach with approximately 65% to 70% of the states mental health budget going towards state institutions and 30% to 35% going to community services. The latter allocation of community mental health funds are then further reduced by a split between the traditional medical therapies and a rehabilitation approach; that split is not nearly equal. Finally, medicaid funds are used for “medical” services and while this is occasionally fudged, they are required to be under the supervision of a psychiatrist.

Thus, we have a self-fulfilling prophecy for ourselves, with our circular thinking and actions.

- Hospital beds remain available at exorbitant costs “in case” they are needed.
- Because of the cost of the hospital system, funds are not available for community programs.
- Funds that are expended in the community are heavily oriented towards those medical services most resisted by those most severely disabled.
- Services do not exist to provide expected outcomes for individual growth and development.
- There are few preventive services because we don’t know what the “pathology” is and therefore cannot protect against it.
- We will need to re-open hospitals to serve those who are not or will not be served in the community.

That this will be a disaster is a foregone conclusion. The “snake pit” which aroused public opinion in the fifties is still in our midst. This has been most recently documented by State Senator Richard Codey of New Jersey, who, hired as a hospital employee despite deliberately using the identification of a known felon, “found patient abuse and incidents that made “one Flew Over the Cuckoo’s Nest” look like a picnic.” Rape and beatings were the norm. New Jersey is not alone; “out of sight, out of mind” and controlling people “for their own good” makes for bad values.

The State of Washington showed that “Broadening involuntary commitment laws did **not** protect the community from dangerous people, it did **not** solve the problems of homelessness, it **wasted** precious resources and it created a dependency on the involuntary commitment system that brought people back to it again and again.”

The answer to our original question is that we must change our faith, our values and our perspective. As long as this society is conflicted about whether people with abnormal behavior can be “treated for their own good”, we cannot find the best way to manage. “The road to hell is paved with good intentions.”

Our values of freedom, dignity and responsibility must be pure, not compromised. There is **no middle ground**.

The alternative perspective and resultant services are there and have been since the Moral Treatment of the late 1700s and early 1800s. The death knell of that movement came with a statement of policy developed first at the New York Hospital in 1831 when the Asylum Committee determined:

**The physician alone is responsible for the cure of patients and the grand means of effecting this object is moral treatment; it therefore of right belongs to him.**

Thus, in a grand statement of acknowledging the “grand means of effecting cure”, the means were doomed. How you look at the problem limits the solutions you will find. The physicians looked at the problem pathologically.

The question is one of **social policy**. The social policy concerning people with problems in living is being driven by a pathology perspective which has years of demonstrable failure. It is time to reconsider that social policy and look for alternatives. It is time to create systems with clear goals and measurable outcomes. It is time for critical and rigorous analysis of evidence and the belief systems that support such failure. It is time for coherence.

### **Chapter 3      PHILOSOPHICAL FOUNDATION**

*The responsibility for growth and development lies fundamentally with each individual; the responsibility for providing the opportunity for growth and fulfillment lies with society.*

*Durand, Lance & Durand, John, **The Affirmative Industry***

Just as a seed naturally unfolds to become a tree, so each of us naturally seeks greater progress in life. All living things have as a primary need the opportunity for growth and progressive fulfillment. Therefore, happiness is the natural outgrowth generated through ever expanding achievements and accomplishments. Each new achievement brings new meaning to life, restructuring our relationship to our self, our society and our environment.

The responsibility for growth and achievement lies fundamentally with each individual. The decision to progress can only come from within. It is impossible for one individual to assume direct responsibility for the growth of another.

Perhaps the most important area in the development of the decision to progress is the relationship of the self to the self. The development of a strong and positive self image is a vital foundation for personal

growth and achievement since it establishes the basis for one's interaction with others. A strong self image, characterized by self acceptance, self affirmation, love and a sense of self worth and dignity, is a prerequisite for risk.

Although one's self image is determined to a great extent by the state of one's physical and mental condition, considerable impact is made upon it by the quality of one's interaction with the environment, including particularly the people who inhabit it. A key element to the actualization process, then, is to make available to the individual the opportunity to develop a positive self image through successful interaction with the environment.

Without first being provided the opportunity to be self sufficient and to **contribute** meaningfully to the welfare of society, the individual is left only to his or her dependency. Our **expectations** of an individual, of his or her ability to grow, progress, and contribute, are directly related to how we see that individual. If we perceive that individual as helpless and dependent, then we will, of course, expect only helpless and dependent behavior from that individual.

These limited expectations encourage us to place that person in a highly structured "protected" environment where helplessness and dependency are only reinforced. The end result provides us with a confirmation of our original expectation -- that of helplessness and dependency.

In order to break this cycle we need to provide supports in living, learning and working environments where the stimuli and opportunities for growth and expansion are matched with the individual's potentialities. An effective means for structuring such an enlivening , challenging, yet individually appropriate environment is to simply focus our attention and subsequently our efforts on the positive or potentially progressive aspects of the individual's life. It is not necessary to deny the existence of any of the limitations that an individual may possess; we simply emphasize the positive, growth producing qualities. All of us have limitations -- some more than others. We must view these limitations as a unique opportunity for greater growth and achievement.

Opportunity nurtures all expansion, development and growth. Each new situation brings a chance for personal expansion. The providing of opportunity for growth and development is the most important of all services, since it is all we can ever give in our attempt to help another. Opportunity for growth carries the possibility of failure. With every attempt there is the element of risk. If growth truly implies change for the better, then it must also carry with it the chance that there will be no change, no improvement, or even failure.

When a person's environment is over-protected in such a manner that there is little or no chance for failure, then in reality there is little or no chance for real or significant success. To keep from someone the opportunity for significant achievement because of an associated element of risk is to deprive them of

their potential for growth toward self sufficient, progressive and dignified state of life. There is a *dignity of risk* if there is a *respect for failure*.

To provide opportunity for failure and therefore growth, in a valued activity in a valued setting is to offer dignity to and respect for the strength of an individual person. This is the best of all services.

The teleologic directionalism of human growth and development towards becoming is experienced in the personality by Hegel's "desire for a desire" or the quest for "recognition" which can be understood as none other than the human passion we generally call "pride" or "self-respect" [when we approve of it] and "vanity" [when we don't]. [Fukuyama - 1992<sup>17</sup>]

But the roots of the desire for recognition is much older. It was first described by Plato in the *Republic*, when he noted that there were three parts to the soul, a desiring part, a reasoning part, and a part that he called *thymos*, or "spiritedness". Much of human behavior can be explained as a combination of the first two parts, desire and reason; desire induces men to seek things outside themselves, while reason or calculation shows them the best way to get them. But in addition, human beings seek recognition of their own worth. The propensity to invest the self with a certain value, and to demand recognition for that value, is what in today's popular language we would call "self-esteem" of which we will have a great deal of further discussion. The propensity to feel self-esteem arises for Plato out of the part of the soul called *thymos*. It is like an innate human sense of justice. People believe that they have a certain worth, and when other people treat them as though they are worth less than that, they experience the emotion of *anger*. Conversely, when people fail to live up to their own sense of worth, they feel *shame*, and when they are evaluated correctly in proportion to their worth, they feel *pride*. The desire for recognition and the accompanying emotions of anger, shame, and pride, are parts of the human personality critical to ...life.

The intimate relationship between self-evaluation and anger can be seen in the English word synonymous with anger, "indignation". "Dignity" refers to a person's sense of self-worth; "in-dignation" arises when something happens to offend that sense of worth. Conversely, when other people see that we are not living up to our sense of self-esteem, we feel *shame*; and when we are evaluated justly [i.e., in proportion to our true worth], we feel *pride*.

But esteem is not a "thing" like an apple or a Porche: it is a state of consciousness, and to have subjective certainty about one's own sense of worth, it must be recognized by another consciousness, most importantly by a consciousness that the individual respects and trusts; one who is *significant*. The feeling of dignity or self-worth that is at the root of *thymos* is related to man's view that he is in some way a

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<sup>17</sup> For the following discussion of Hegelian and Platonic philosophy [much of which is taken verbatim], This discussion is focused on the development of the "perfect state": that is, the form of government which is ultimately most satisfying to human beings. Therefore, the material is taken out of context and any flaws in the interpretation are mine. I am indebted to Francis Fukuyama and the *End of History and the Last Man*.

moral agent capable of real choice, and that this self-perception is innate to or characteristic of all human beings.

According to Hegel, human beings like animals have natural needs and desires for objects outside themselves such as food, drink shelter, and above all the preservation of their own bodies. Man differs fundamentally from the animals, however, because in addition he desires the desire of other men, that is, he wants to be “recognized”. In particular, he wants to be recognized as a *human being*, that is, as a being with a certain worth or dignity.

Indeed, for Hegel, an individual could not become self-conscious, that is, become aware of himself as a separate human being, without being recognized by some other human beings. Man, in other words, was from the start a *social* being: his own sense of self-worth and identity is intimately connected with the value that other people place on him. He is, in David Riesman’s phrase, fundamentally “other directed”.

He is capable of true *moral* choice, that is, choice between two courses of action, not simply on the basis of the greater utility of one over the other, but because of an inherent freedom to make and adhere to his own rules. And man’s specific *dignity* lies not in a superior calculating ability that makes him a more clever machine than the lower animals, but precisely this capacity for free moral choice. For by risking his life, man proves that he can act contrary to his most powerful and basic instinct, the instinct for self-preservation. To risk his life for *prestige*, is in some sense what makes human beings human.

If we take the teachings of modern natural science seriously, the human realm is entirely subordinate to the realm of nature, and is equally determined by nature’s laws. All human behavior can ultimately be explained by the sub-human, by psychology and anthropology, which in turn rests on biology and chemistry, and ultimately on the workings of the fundamental choices of nature. This, of course, negates the humanness of humans and reduces all behavior to its minimalist form.

Whether or not true free will exists, virtually all human beings act *as if* it does, and evaluate each other on the basis of their ability to make what they believe to be genuine moral choices. Human beings seek not just material comfort, but respect or recognition, and they believe that they are worthy of respect because they possess a certain value or dignity. A psychology that does not take into account man’s desire for recognition, and his infrequent but very pronounced willingness to act at times contrary to even the strongest natural instinct, would misunderstand something very important about human behavior. The reduction of people with problems in living to animals who must be controlled “for their own good” fails to recognize *thymos* and is required to deal with the results of loss of dignity. Human freedom emerges only when man is able to transcend his natural, animal existence, and to create a new self *for himself*.

For Hegel’s “desire for a desire”, or the quest for “recognition” is the part of the personality which is the fundamental source of the emotions of pride, anger, and shame, and is not reducible to desire, on the one

hand , or reason on the other. It is the part of the personality that makes the individual capable of making choices about himself and others.

“The freedom to choose, to make one’s own decisions, is **fundamental** to the American concept of liberty and democracy. Simply put, in earlier societies one’s rights and privileges were determined by one’s **status** in the group; today, under American law, such rights and privileges normally are determined contractually by individual choice” [Mental Disability Law: A Primer]. And the primary factor is not the contract, but the individual preference; the valuation and moral choice.

“Critics of the psychiatric establishment have observed that contrary to this general legal trend to move from status to contract, the law regarding mentally disabled citizens are often based on status. They have observed that the laws that take away a disabled person’s freedom to choose reduces that person from a freely contracting, freely acting individual to the status of a ‘mentally ill person’ whose choices must be made by family, guardians, or the state” [Mental Disability Law: A Primer].

The beginning of any transformational process requires the understanding of the client’s desire, preference, moral choice and is crucial to any kind of competent service option. We contend that the overriding professional obligation is that the helper should, as far as reasonably possible, follow the individual client’s preferences, and to discuss and negotiate areas in which it seems impossible to follow.

Since the clients are partially or wholly incapacitated, whose definition of the client’s best interest is going to prevail? Properly advised and assisted even most mentally disabled clients are capable of making decisions on important matters. Even legally incompetent clients may have the ability to understand, deliberate upon and reach conclusions about matters affecting their own well being. More importantly, perhaps, is the recognition that these people **are** making decisions about how much they will participate in the life style that the professionals have chosen for them. We often cover over their decision making by calling it “resistance”.

The critical weakness of the biomedical/ psychodynamic model is a failure of legitimacy - that is, a crisis on the level of ideas. Legitimacy is not justice or right in an absolute sense; it is a relative concept that exists in people’s subjective perceptions. Human beings are not just moral agents who place value and make choices, they are learning entities as well. Their learning processes are developed in the fashion of Hegelian dialectic: thesis, antithesis, synthesis. The Hegelian dialectic is similar to its Socratic predecessor, the *dialogue*, that is, a conversation between two human beings on some important subject like the nature of good or the meaning of justice. Such discussions are resolved on the basis of the principle of contradiction: that is, the less self-contradictory side wins, or, if both are found in the course of conversation to be self contradictory, then a third position emerges free of the contradictions of the initial two. But this third position may itself contain new, unforeseen contradictions, thereby giving rise to yet another conversation and another resolution. A “problem” does not become a “contradiction” unless it is

so serious that it not only cannot be solved within the system, but also corrodes the legitimacy of the system itself such that the latter collapses under its own weight.

Thus the Hegelian dialectic become a *description* of the learning process, which in itself, is teleologic as it moves toward *more satisfying* solutions. The mere fact that human nature is not created “once and for all”, but creates itself “in the course of historical time”, does not spare us the need to talk about human nature, either as a structure within which man’s self creation occurs, or as an end point or *telos* toward which human historical development appears to be moving. Thus human consciousness - the way in which human beings think about fundamental questions of right and wrong, the activities they find satisfying, their beliefs about gods, even the way in which they perceive the world - has changed over time. Both the individual human being and the human systems of thought that underpin social systems, change in a manner which seeks greater satisfaction and evidence of greater ability to predict and control the world and future events.

But, some human beings are more adept than others at rigorous analysis of evidence and willingness to defend their prestige; each person is capable to a greater or lesser degree, of coming to terms with living within the lie. *Mundus vult decipi*. For the great mass of people whose *thymotic* sides are not nearly so well developed as to die for their dignity, normal life can mean acceptance of petty, day-to-day moral degradation. Such is the experience of people with problems in living. The biomedical/psychodynamic approaches have tended to *humiliate* such people by forcing them to make a myriad of petty, and sometimes not so petty, moral compromises with their better nature.

The transformational responsibility is to listen to the clients carefully and to give people with severe and persistent problems in living the benefit of the doubt when judging whether or not s/he understands his or her best interest. When in doubt, the expectation is that the helper would develop a formal dialogue and negotiation around the appropriate issues which is posed in such a manner as to help the individual with problems in living rigorously analyze, with the professional helper, their own thesis and antithesis to determine contradictions which will require a new system of thinking.

Thus, the onus is not upon whether the delivery system does or does not provide the services in a particular manner, but rather whether the delivery system is adequately learning and acquiescing to the person’s own decisions as to whether the involvement is an appropriate one or not. Within this context, the provider must provide the setting most appropriate to the person’s **expressed** needs.

Each person must be approached as a person accountable for self, with strengths and weaknesses, beliefs and projections, a desire to know and a desire for justice which is inherent in his/her nature. Each human being possess certain unique strengths and well defined rights to be recognized as a person whose freedom of action is limited only by willingness and ability to assume responsibility for self in relationship to fellow citizens.

Because each person is autonomous, they can choose to grow and develop, or not. The role of the helper is not to make a different choice **for** the person, but to provide the person with the information necessary for them to make a different choice. This is done through exhausting all remedies to help the individual re-evaluate, through rigorous analysis, their thoughts, beliefs, decisions, actions and consequences from a positive, caring, and supportive perspectives. There must be affection, reassurance and support for what is able to be done at the moment. Because the number of remedies is infinite; limited only by the creativity of the helper, there is no end to the professional responsibility to support analysis; but the decision to act belongs only with the person with problems in living. They can choose to be self destructive, antisocial, "crazy", or act in a manner of which the helper does not approve.

Such incidents tend to make helpers uncomfortable. They are embarrassed by clients who behave in ways that seem to reflect on the helper's ability to help. They are truly concerned for the self destructiveness which may occur. They are afraid of the anger, hostility or violence that might directly affect them. On such occasions, there is often a need on the part of the helper to **control** the person to assure that they do no harm to themselves or others; or to finally relieve their own anxiety. These are *personal* concerns and are not helpful. Control of the person with problems in living is most likely to reduce trust and increase frustration and anger. Control is easy, but not helpful. This does not mean that the helper simply allows the person to act on their thoughts, fears and fantasies. The helper continuously uses his or her expertise to refocus the individual on what s/he is doing and re-examination of why. Reframing thoughts to more positive scenarios. Identifying and articulating schema that is maladaptive and pointing out errors in thinking. Helping the individual through unending caring and new informative ways to view the world.

An articulated recognition that the person is autonomous and able to act may be needed to underline the fact that they are in control and therefore can either act or not, as they choose. A use of the trust relationship to indicate the respect for the person, the love and the desire to help, the concern for the consequences as they will affect that love and others who love them may help the person with problems in living to see that their problems are not so significant that they cannot deal adequately with them in some other manner. In the final analysis, only the decision to change is significant. Only that is growth to build upon. And that decision can only be made in the context of living though an emotional state *differently*; which can often only happen with the help of a trusted ally.

Control of the individual in such panic only delays the decision until such time as they are able to carry it out. It leads to a convenient way out for the helper, but not for the individual who has still not rationally considered another way. And it has made the next encounter more difficult since the bond of trust so necessary to change has been eroded; the attribution that they are out of control and not able to take control has been established and justifies atypical behavior. Control is a necessary fact only when the helper has proved inadequate to the task. To stop the act. The decision as to when this control is necessary is built into the psyche of the helper and his/her relationship with the person with problems in

living. The stronger the bond, the greater the belief of the helper that the person they serve is capable of making good decisions, the greater the respect and acceptance of the individual over time and previous experiences; the less likely control will be the outcome. These are intangibles that must be decided in the moment. There must be encouragement for the person to accept as much responsibility as can be handled in the present; giving as much freedom for spontaneity as can be managed - at the same time providing protection from impulse and a feeling of security by a firm, tactful, consistent and reliable response.

It is required that there be a clear understanding and separation of the client's and the helper's needs - if control is used for the convenience of the helper it will be known. If such a decision must be made because the helper has exhausted all remedies and themselves in the process; this should be acknowledged - with apologies; not "for the client's own good", but because "I care for you, but am unable to find any other way in the present". We must not rationalize our own failures any more than the failures of those we serve. Acknowledgement is a form of growth through failure.

If control of the act of destructiveness is necessary; such should be the articulated expectation based on an honest appraisal by the helper - "If you act in such a manner, I see no alternative but to act against it - I will not allow you to do something which I believe has such disastrous consequences to you and your life." Gang members often "leak" information of a rumble to gang workers on the trusted assumption that the worker will "drop a dime" to stop the rumble from happening and protect the gang members lives. So too individual clients may "test" the relationship to see how protective the helper will be; how much s/he cares. But such incidents are a two edged sword which place the client in a protected and unrespected position. The helper must help the person to rigorously analyze such behavior and its purposes - else the catastrophe when the client cries "wolf" once too often.

There must be respect for and acceptance of the person and his or her level of functioning. This includes a lack of fear of hostility or other "symptoms" that may be presented. There must be hopefulness and expectation in the ability to change and confidence in such a development. While it is generally recognized that a helper cannot be "all things to all people"; there is rarely recognition of limitations and recommendation that another helper take over. This is personal pride that is not helpful. Failure to establish a relationship is not a mark of inadequacy unless it is a consistent experience. Professional helpers know when they are not helpful and seek out helpful solutions. Professional helpers understand their own needs and separate them from their professional involvements.

Each human being possesses certain needs for help in pursuing the activities of day-to-day living; as well as in meeting the expectations of today's world. But these severe, emotional incidents are rare indeed in the life of most professionals. If they occur often, one would be correct in reviewing personal intolerance and coercive behavior. The severity of incidents that occurs with the helper is a result of the interaction. Human behavior varies to fit the needs of the situation within the limitations of the person's understanding of that situation and behavioral repertoire. Continued crisis is indicative.

The transformation that we seek honors and preserves a certain moral dimension to human life that is entirely missing in that conceived by the biomedical/psychodynamic approaches. We must understand our clients as moral agents, whose specific dignity is related to an inner freedom from physical or natural determination. It is this moral dimension and the struggle to have it recognized that is the motor driving the dialectical process.

Fukuyama reports that Hobbes, contrary to Hegel, believes that the desire for recognition and the contempt for “mere” life is not the beginning of man’s freedom, but the source of his misery. Not unlike modern biomedical/psychodynamic practitioners, Hobbes would eschew dying for mere *principle*: suicide being an untenable, and therefore undiscussable option, requiring restraint through force. Hegel’s aristocratic master risking his life in a prestige battle is only the most extreme example of the human impulse to transcend merely natural or physical need. Is it not possible that the struggle for recognition reflects a longing for self-transcendence that lies at the root of not only the violence of the state of nature and of slavery, but also of the noble passions of patriotism, courage, generosity and public-spiritedness?

The unwillingness of the traditional practitioner to entertain the potential of suicide as a legitimate option, impugns the moral dimension and dignity of the person. One does not need to accept such dire consequences as an imperative, but rather as a point of dialectic dialogue which helps the individual reach his own preferred synthesis which will enable them to transcend their present experiences and reach a new plateau of functional competence and affirmation.

## Chapter 4      PRINCIPLES

As we begin to define the principles and values upon which a new, transformational human services system might operate, we must face several basic considerations. The first is uncertainty. Human behavior is unpredictable. Each individual chooses his or her attitude and action in the given moment and context. There is no action/reaction in the generally accepted sense of the concept. Yet, paradoxically, *all human behavior is influenced by others*. These two mutually exclusive concepts present us with the environment within which we must function.

We must also overcome our desire to comfort. Emotional stability and security is based upon a degree of tension. The unsettledness that demands that we reach and grow.

Aristotle suggested that in order to build any sound body of knowledge one must start with a basic building block; one **fundamental truth**, that could be neither proven nor disproved, but had to be accepted. This fundamental truth has a corollary in strategic planning, called the **driving force**.

The driving force is defined as the **key determinant** in decision making about the future. In business, it is the critical edge that is used to decide whether the business endeavor will accept or reject an opportunity. It is supported by what are called "secondary scanners" or secondary factors that help to determine whether the action suggested is appropriate.

The basic decision making driving force of the new perspective needs to be the power of the person with problems in living and their preferences regarding their person, their relationships and their prospects. This life force, which directs their actions must be tied to our actions. Thus the fundamental truth which will become the driving force of a new human service system can be stated as follows:

**People always make behavioral decisions which are instinctively aimed towards the becoming who they were meant to become.**

It comes down to a fundamental question as to whether a person is determined by or determines his/her own existence. This core question is the critical variable to the shaping of our efforts. The belief that the person is an interactive entity whose properties are the product of that interaction. A belief that "a stimulus does not cause a process on an inert system; but that it can merely modify existing processes in an autonomically active system which is constantly directed toward the realization of certain goals and values" [Overton]. And perhaps, most importantly, a belief that the goals of all individuals are the same: they desire success, happiness, power, dignity and respect.

Therefore, we wish to create a human service delivery system which is based upon a fundamental belief in the active developmental qualities of human beings; an organismic world view. There are two basic world views of human beings; the organismic and the mechanistic. "The basic metaphor for the organismic model is the living organism such as perhaps a plant, and the metaphor for the mechanistic model is a simple machine such as a windup watch..." [Overton].

Out of this organismic perspective we state the basic building block or fundamental principle:

**Change initiative lies with the client; not the practitioner.**

The wish, power, and ability to begin and follow through with a process of change is **solely** within the purview of the person being served and neither the responsibility nor the authority can be usurped by the helper.

If we can accept this as a fundamental truth, a building block that can neither be proven or disproved, but is accepted as a basic tenet of our new perspective, we can begin to develop the other principles which can drive a new human service system and define the roles of the people who work within it.

Of the five basic models, the humanistic/existential model, with its focus on the will and responsibility is the closest to our fundamental truth. Certain aspects of the other models become more or less usable. The biomedical model and the psychodynamic models become mostly untenable. This is a fundamental way of looking at the world. It cannot be fudged, you cannot believe that both the mechanistic [medical] perspective has merit as does the organismic; one must decide. If you cannot decide: read on - for analytic work takes information and evidence. If you are a believer - welcome - the following material may have relevance to your future practice. If you do not accept this principle - stop reading- for what follows will only frustrate and anger you.

It is a little bit like an optical illusion. If you cannot see the "other" picture, you get frustrated, angry and a little embarrassed. Once you see it, you can always draw on it and find the new way of looking at the illusion. But it will often be hard and you will need to concentrate; be aware.

This fundamental truth or driving force cannot be discounted by statements or beliefs such as "doing for ones own good" or by "they are too disoriented to decide". These are self-serving statements that do not deal with the basic acceptance of the individual "I" as the force for change. Any decision regarding the acceptability of an intervention must be drawn along this edge.

There are secondary axioms or principles which support the self determining nature of the fundamental truth and the most important of these can be stated simply:

**Unconditional positive regard is attributed to the client [Rogers].**

An attitude, not a feeling, of a constructive nature towards the person being served must emanate from the worker. This attitude acknowledges the dignity of the individual as a responsible person capable of making decision about his/her own life.

It should be clear that this attitude of unconditional positive regard supports and reinforces the power of the individual. It is unrelated to the individual helper's "feelings" about whether or not the client is "capable" of making decisions. It **assumes** that the client can, will and **is** making such decisions.

**There must be a pervading climate of positive expectation.**

While it is important to determine that the desired performance is reachable; an overall belief that clients can change and achieve if they desire to do so is critical to the change environment.

Behavior is determined by a combination of forces in the environment and in the individual. Different environments tend to produce different behaviors. Individuals have "psychosocial baggage" from past experiences and a developmental history which has given them a unique set of needs, way of looking at the world, and expectations about how people will treat them.

Each behavior has associated with it, in an individual's mind, certain outcomes [rewards or punishments]; and each outcome has a value. The decision to try a new or difficult behavior will be associated with the person's expectation or probability of success.

Part of the personal decision is based on whether others of significance view the potential of success positively. Belief in oneself is highly contingent upon how one perceives others' belief in them. People inherently tend to underrate or undervalue what others can achieve. People will make decisions about how they will behave contingent upon the way they believe that the behavior will lead to outcomes that will satisfy their needs. Therefore, they are inherently neither motivated nor unmotivated; motivation depends upon the situation they are in [May - 1983].

**The arrow of time must point to the future.**

The person in need must be helped to find meaning in future events and prospects, using the "here and now" as the means to reach some future goal.

Interventions that dwell on the past are of far more benefit to the interest and knowledge of the helper than they are to the changing individual. All too often the future is framed on the past. One must

remember that Freud was trying to learn about the dynamics of human psychology as well as offering help. It is the conflict of these two which lead to an inordinate focus on the past.

“One of the more common illusions of Freudian orthodoxy is that the durability of results corresponds to the length of therapy” [Gutheil]. The individual does not receive help by reliving the past, but from finding the courage to live and feel differently in the present and a preferred future.

These are the major principles which underpin the new perspective. There are other axioms of importance: **the service must deal with interactions, not insights**. How an individual functions with others is the outcome issue. This does not preclude concern about how the individual “feels” about the interaction, but emphasizes the participatory nature of the interaction.

A focus on “**real life**” issues is also important. We want to help people deal with the problems in living, not some abstract idea drawn from some experience from the past. In like manner **activity oriented, not talk oriented** interventions are more likely to be helpful. “Tell me, I might forget; involve me, I will understand” [Chinese proverb]. This does not mean that we do not talk to our clients or even that such conversations cannot deal with abstract issues. What it does mean is that the essence of our help is in the doing.

These axioms lead to two final **powerful** principles:

**Each individual must be helped to establish an altruistic responsibility.**

The egocentric orientation of people with problems in living on themselves continues to support a focus on the problems, not on the solutions. Each of us must feel that we are capable of contributing to the enhancement of others.

What we seek is a social intervention which enables people with problems in living to learn to create and present unique and accurate responses to each particular experience as confronted through the provision of the **means** [behavior repertoire] and **opportunity** to work out, find alternatives for, contend with, or, in other self-directed ways, deal with conditions [interpsychic, interpersonal or environmental] which interfere with productive social living. We are governed by the recognition of the individual as a unique and **active** organism, the social environment as a **dynamic** force, and the effects of their reciprocal interactions [Buber - 1973].

Finally, the recognition of the person with problems in living as having strengths as well as problems and the focus on the need for meaning in life leads to a final principle which is concerned with the context of helping:

**People learn how to participate in valued settings by participating in valued settings.**

Moving people to “programs” in order to work with them is inappropriate. Homogeneous groupings of people with problems in living takes away the socialization opportunities afforded to others. The attributions of such removal is salient in itself; but the overriding concern is that people do not learn to participate in society by not participating. They may need supports, even intensive supports, but they need to experience real life as others do.

Despite the fact that recent moves have been develop to implement some of these principles, these attempts continue to a large extent to be facility or institutionally based. The concept of “community based” is too often understood as having the institution located in the community. It is difficult to perceive of the fundamental truth being implemented in a large facility or program with many impersonal procedures. While it may be beneficial to sensitize the institution, this misses the point. The critical aspect is that the individual would have to choose to be served in such institutional settings **after other options were made available.**

Just as the fundamental truth implies that people with severe needs are the same as other people in desires and goals, so too, does it demand that they be “normalized” even while services are being offered. Where people with disabilities are being served is closely tied to one of the most sacred symbols of our mission; **least restrictive environments.** The “least restrictive environment” as a policy derived from the concept of normalization and was focused towards “maximum feasible integration”. Unfortunately, in practice, it quickly developed into a continuum model, i.e., “from the most to least restrictive”. It thus was used as a standard and guide to **legitimize** restrictive environments. The concept has also allowed us to confuse segregation and integration on the one hand with intensity of services on the other. “When viewed from this perspective, it follows that people with severe disabilities will require the most restrictive and segregated settings.” “ The question has become not **whether** people with severe disabilities should be restricted, but to **what extent**” [Taylor - 1988].

While the fundamental truth might allow for institutional settings, it does **not** allow for restrictive settings. Restrictiveness must be interpreted as something imposed on an individual, not chosen by the individual. From that context, it is unlikely, if not impossible that a new services delivery system could effectively use institutional settings except for people who have already been trained in institutional living.

Even further, it rejects the “readiness” principle which leads to defining the mission in terms of creating “facilities”, first larger ones and then smaller ones, and “programs”, rather than providing services and supports to enable people with problems in living to participate in the same settings used by others. The **change environment** must have dynamic qualities which enhance the person’s desired preferences for the future.

### *The helper*

Based upon these values there are certain expectations and requirements regarding the person who gives help.

**The helper must establish him/herself as a *significant individual in whom the client can trust, as a condition of the relationship, to act in the right or proper way.***

This commitment means that the helper, and through him/her, the agency, will do exactly and consistently what they say they will do; although not necessarily what the individual would desire.

This trust is based not upon a **personal** commitment, but upon the professional commitment of the total organization that it will respond on **behalf** of the client. In order to accept this, we must also recognize our responsibility to the greater society and articulate to the client **exactly** when and how we would invoke this potentially contrary commitment and how in doing so, we are responsible to his/her needs. There can be no conflict between our responsibility to society and to the individual. This is an ethical dilemma which demands ethical response.

In the introduction to Buber's I/Thou, the translator, Walter Kauffman, says something important regarding this concept.

"The basic "I/Thou concept establishes the world of relations. As a thou, I have no right to use the I before me as an object with which I may take liberties." "It is not for me to play with or manipulate. I am not to use it as a point of departure, or anything else. It is a voice of a person that needs me. I am there to help HIM speak."

Service delivery designs, which assume the strengths of the client, orient themselves towards a change experience which is a prototype role-learning situation; thus the helper's role is, in many ways, a teaching one. Since the client directs the process, the helper must try to **influence**, not control. Coercive interventions have no effect other than resistance. The authority to provide services must be **sanctioned** by the client and it is this sanction that is at the root of the success. And individuals who sanction dominance, must be helped to seek independence.

The predominant issue that precedes all else in the practitioner attempts to engage the involuntary, "resistant", "unmotivated", or "hard to reach" clients is that **nothing can be achieved until authority has been granted and influence attained** [Goldstein - 1973]. This sanction of the authority of the helper to elicit change is the essence of the trusting, significant relationship.

The extent to which the person with problems in living is open to change corresponds to the extent to which the presence of the helper is recognized, experienced and authorized by the person in need. The helper's "value and effectiveness is contingent on the extent to which the **right to be influential is granted**" [Goldstein - 1973].

Thus our help can only be offered when both trust and sanction exist. To attempt to offer the service otherwise is coercive and often met with intransigent resistance. There are other **keys** to effective helpers.

- They are **enablers**: they qualify and empower others to act.
- They **do not judge**: They are effectively amoral in their perceptions of the acts of those they serve; listening without judgement and accepting without condemnation. People often do "bad" things in reaction to "bad" things which they perceive having been done to them. Judgements and condemnation reinforce the "righteousness" of their acts. Acceptance offers the potential for re-evaluation and remorse. Otto Rank describes the "love experience" as the acceptance of the other persons will[fullness]. This does not necessarily condone the behavior, but allows for the separation of the behavior from the person.
- They have **no points to defend**: defense mechanisms are normal and inherent; they are not professional. They justify our self importance over others. In the professional relationship, such defense is inexcusable. It denies the right of others to have perceptions, judgements and views which differ from our own. Since we are in the **status** positions, defense **automatically gives offense**.
- They see their **status as responsibility** rather than as rank or privilege: it is a duty that demands that they give of themselves to exhaustion without expectation of receipt.
- They believe in the **inherent desire of everyone to reach success, happiness, power and status** and recognize the need to offer new opportunities and new learning to accomplish such achievement.
- Their beliefs and actions are at least **compatible, if not congruent**. They need not be clever, only consistent.
- They are **fiduciaries [beneficent]**: they act only on behalf of others, never for the self interest of themselves. Their professional lives are not for themselves, but for others. Personal satisfactions are acquired in personal areas of their lives.

Those attempting to enhance the lives of people with problems in living must:

- establish a relationship of significance based on bonds of trust inherent in the dignity of risk and the respect for failure as a precursor to growth;
- support the individual's efforts to assess themselves in relationship to their potentialities and opportunities through rigorous analysis of personal beliefs and projections;
- animate through provision of opportunities and encouragement of effort attempts to practice new thought, feeling and behavior in those areas where personal assessment has identified need for growth; and
- reinforce the positive of the experience of success and/or failure as a developmental step in the process of life.
- have a process world view that suggests that human existence, human behavior, or human endeavor is a complex of diverse social/emotional, biological and cognitive adaptations and interactions. Personality integration is the overall *creative* process of the individual's adapting and responding to myriad internal and external needs, challenges, crisis and changes.
- recognize all human beings as **persons-in-process**. We are ever in the process of experiencing, learning and growing; involved in a constant evolution of higher cognitions and motivations. We are in the process of **becoming**.
- value our individual differences. Because of our genetic inheritance, the circumstances of our birth, and our distinct life experiences, the way each of us processes life events is highly individual. How each of us assimilates, accommodates, adapts and responds to life's experiences reflects our individual differences.
- value the individual differences of others. Just as we appreciate our own unique process patterning, we appreciate the process style of other with whom we live, work and serve. Our individual differences reflect the multidimensional parameters of human possibility. Each of us has an individual path, an individual interpretation of reality, and individual character and an individual processing-in-the-world.
- accept that personality integration is a never-ending process. Living is a dynamic flow of psycho-physical events. Self-knowledge is not achievement that happens at this or that time in our life. Self-knowledge is a continual process of self-discovering and self-realizing.

- understand that a person is an **interactive entity** whose properties are a product of that interaction. A stimulus does not *cause* a process in an inert system; it *modifies* existing processes in an active system which is purposively directed towards the realization of certain goals and values.
- view all experience, no matter how difficult or painful, as grist for further human evolution.
- experience themselves as life-forms capable of conscious choice and transcending change.

## Chapter 5      DISCUSSION

“We are now convinced that we must make another try, that it is our duty to hope.”

“The individual ...thinks he knows nothing, and waits for fate to tell him what he can hope for and what he ought to do. I think there is a great general will in the world that will finally articulate and answer these questions, but it will take a long time for this idea of the world to express itself in individual minds.”

Scott Buchanan

*Imago Mundi*, 1952

If we are to continue to seek coherence, we have a duty to **will** the future. In order to do so effectively, we must rigorously analyze our social policy with regard to people with problems in living and the way we implement services in regard to them. We must overcome our tendency to intellectual and moral laziness and decide whether or not this society is really capable of establishing good government by reflection and choice, or whether it will continue to operate by accident and force. Each individual is responsible for the evils of governmental policy; either through unwillingness to understand or unwillingness to act. In democratic societies, such failures are unacceptable. Full consent must be given to allow social priorities and coercive activities to proliferate. “...consent is the will that something be done or not be done” [Buchanan - Eleven Propositions, 1962].

“...government is not and cannot be omnipotent; totalitarian government is an illusion of the school of power and managerial politics. Therefore, at its maximum, government would always leave a residue of strictly individual freedom” [Buchanan - 1962]. Clients of human service systems implement their individual freedom through resistance. That even the most severely mentally disabled often learn how to function better despite a systematic erosion of hope, individual dignity, and medicated stupor is a tribute to their strength and valor.

Buchanan [1962] states a proposition that “*all men by nature will that justice be done*” “It is because men by nature will justice that they are responsible for evil and injustice.” . Buchanan then goes on to indicate that although this proposition is to him true [coherent], “By ignorance and confusion in the face of life’s complexity, and by the consequent perversion of the natural will by particular and passing desires, the responsibility for justice may be forgotten or denied temporarily, but in the long run natural will, will reassert itself and acknowledge justice as its proper object.” It is time for justice. Mere acceptance of individual responsibility for the evils inherent in a social policy which protects you above helping a person in need does nothing to ameliorate your personal guilt.

Buchanan's proposition was written in imitation of the first sentence in Aristotle's *Metaphysics*, "All men by nature desire to know." Knowing, *awareness*, enlightenment is a principle factor to be explored regarding the reasons that some people behave in a manner which is incoherent to sociocultural norms. Awareness of the general public, however, is necessary if we are to **will** change. We have not only a biopsychological need to seek coherence; we have a moral and ethical responsibility to do it well.

It seems that a perspective of people as goal seeking, autonomous entities has merit as a basic driving philosophy for the development and human services **regardless** of whether or not it is true. The deterministic and reductionist perspective, *a priori*, eliminates hope and desire; two critical factors in change. Thus the deterministic, reductionist approach is self fulfilling, but not growth producing. The organismic perspective leads to what Courtney Harding has called "rationale hope and optimism" which provides a platform for change.

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