

Impossible Choices

By Maia Duerr

I used to live in a state mental hospital, the kind you see in the movies: red brick buildings sitting on a lone hill, screams emanating from the barred windows, people wandering around the well-manicured grounds talking to themselves.

I wasn't there as a patient—I doubt that I would feel comfortable disclosing this honestly to you right now if I had been. My job as a music therapist brought me inside those walls every day, and for a while, I lived in the hospital dormitory with other staff. My first day there, I was petrified and wondered if I would be hacked to death by someone in a psychotic rage—a fear no doubt greatly influenced by headlines like one that actually appeared in the *New York Daily News*: “Get the Violent Crazies off Our Streets” (11/19/99). My fears gradually dissipated as I came to know the patients as people

rather than diagnoses. After three years of working at the hospital, I felt safer there than on many city streets. But it always pulled at my conscience that I locked up patients in the wards behind me as I went home each day.

Over the next 10 years, I worked in a number of other positions in the mental health system. Eventually, I became burned out, but not for the reasons you might think. It wasn't the people I worked with who frustrated me—it was the system within which we all had to navigate. I witnessed the revolving door of patients going out of the hospital and into the community only to be readmitted a short time later. It seemed to me that we were missing an essential piece. My work required me to come up with treatment plans for the “rehabilitation” of my clients, but I kept wondering how being avoided, feared, pitied, locked up, and medicated to the point of oblivion affects a person's mental health, beyond any psychiatric challenge they face.

I reached a low point one day when I was working as an outreach counselor in Oregon. I was scheduled to see my favorite client, Joe. Joe and I couldn't have been more different—he was a large man in his 40s, with a nose ring, homemade tattoos, and a diagnosis of paranoid schizophrenia. I was in my early 30s, trying to be an upwardly mobile professional. He'd spent

most of his life in the Oregon mental health system, a good part of it hospitalized for psychotic episodes that were worsened by his use of marijuana and harder street drugs. I had lived a fairly conventional, privileged life, and my knowledge of drugs was limited to a few puffs on a joint (I did inhale). And yet, after three years of working together and getting to know each other, Joe and I had developed a strong bond. I knew the things he loved best—going fishing and drinking coffee—and I was lucky enough to work for an agency that realized the therapeutic value of developing genuine, trusting relationships with our clients. So Joe and I did plenty of fishing and coffee-drinking in between more mundane tasks like finding him a safe place to live and straightening out his Social Security benefits.

On this bright spring day, I drove to his house in

the ancient, rattling agency car and

caught a glimpse of snow on

the MacKenzie

Mountains in the distance. I wondered

what I would encounter when I

saw him: reports from co-workers

were that he had been

acting “crazy” lately.

When I got to the house, I

noticed that the hallway light bulb

had been painted red, giving the room an eerie glow. I

found Joe in the backyard burning a pile of magazines.

In the friendliest voice I could muster, I told him that

he needed to stop because the city fire code prohibited

burning and the neighbors might call the fire department.

Though he usually gave me a warm greeting, this time he glared at me and growled, “I have to do this.

And don't call me Joe. That's not me. That's some other

sorry son-of-a-bitch who was locked up in the hospital.

Why are you calling me that?”

I got a glimpse of his hands; the skin was peeling

off and it looked like he had burned or poured some

chemical on them. I sighed heavily. “Here we go

again,” I thought to myself. I walked around to the

side of the yard and saw a can of gasoline.

“Joe, have you been sniffing gas?” (This was some-

thing he did when he began to, in the professional jargon,

“decompensate.”)

He became angrier. “I told you not to call me that!

Why do you accuse me of doing these things? Why

can't I get any peace around here?”



Boston Hospital for the Insane, circa 1865.

His voice was hoarse. It was obvious that he had been yelling at other people besides me. His housemates, who looked like they'd had just about enough of Joe, moved around discreetly behind us and left the house. I found out from them that he had been up all night flushing large objects down the toilet and keeping his housemates awake. He told me there was nothing wrong, then he told me that he was Johnny Cash.

I lectured to him about taking his meds, and I told him that I was concerned for his safety. Joe replied that all he needed was a pat on the back and a cup of coffee, but it seemed to me that we were beyond that point. My presence was only agitating him more, so I returned to the office and worked out a plan with my co-workers to get him into the hospital. There was a deep pit in my stomach. He would not go to the hospital willingly; I knew this from experience. If I called the police, they would handcuff him and load him into the squad car like a criminal, in full view of all the neighbors. In the hospital (which was located in the same building as the county jail), he would be stripped of his clothing and possessions, locked in a small "cell," and tied down and forcibly injected with Haldol, an antipsychotic drug notorious for its wretched side effects. I knew this routine from experience, too. If I didn't call the police, he might end up, as he had in the past, standing in the middle of a highway and daring people to run him over. (Though he looked intimidating, Joe never hurt anyone; his angst was always turned on himself.) What could I do?

I ended up calling the police, and the scenario played out much as I expected. But after a week of hospitalization, Joe was discharged and back to his friendly self. He was even grateful to me for getting him there, though he retained horrible memories of the "incarceration" itself. He had a few more "good" months before the same cycle repeated itself, as it had many previous times in his life.

I no longer work in the mental health system, and it's been a long time since I've had to choose between calling the police to commit someone to the hospital or letting them self-destruct. Still, as I walk through downtown San Francisco and pass a young man talking to himself in tortured tones, I know that some other mental health worker is faced with these same impossible choices. The questions and moral choices I faced during those years continued to haunt me. Eventually, I found that subsequent training as a cultural anthropologist and my Buddhist practice helped me to understand those experiences from another point of view.

The issue of how to treat people with mental illness brings up many ethical questions: What do we do when a person clearly needs some kind of psychiatric help yet refuses it? To what extent do we let self-determination rule over societal safety? At what point does

freedom of expression cross the line into harassment or endangerment?

But maybe there is another way to look at things. As socially engaged Buddhists, we can reframe these questions to encompass a larger perspective. How is our view of mental illness grounded in a dualistic viewpoint? How can we heal the separation that comes from dividing people into "mentally ill" and "normal"? How can we create treatment approaches that operate from an assumption of healing, not coercion? How can we cultivate a society that has more openness to different ways of being in the world?

A Buddhist perspective calls for us to apply our understanding of interconnectedness to this issue. Mental illness is no longer an individual matter, a case of one person's psyche gone awry, but rather it sits in the context of our society and culture. Emotional suffering and mental distress may be a universal experience, but the ways they manifest are unique from place to place. By way of illustration, a 1980 study by the World Health Organization found that the incidence of the bundle of symptoms known as schizophrenia was about the same in nine different countries, but people in developing countries without formal mental health services recovered more quickly than people in areas that had hospitals and medications.

In working with Joe, I noticed that there was a distinct difference between his "normal" craziness and the kind that got him into trouble. He could often keep a handle on things until faced with a Kafka-esque maze of social service systems that he had to navigate to get his disability benefits. I also saw him go into spirals of psychosis when he felt socially isolated and not seen by others. In contrast, I saw him blossom when someone thanked him for his efforts to clean up the town. (He saw it as his job to keep the streets clean and spent hours picking up trash in the most squalid neighborhoods.) It was a gift to see his face light up in a coffee shop when a waitress was kind to him rather than dismissive because of his admittedly strange appearance, and several "good," lucid days would usually follow. It was clear to me that it wasn't simply the whims of his psychiatric condition that dictated his mental state.

The biomedical system, the predominant approach to illness in the West, has done an excellent job of making us believe that the most effective (and often the only) way to treat mental illness is with medications. But you don't often hear about the horrific side effects of these medications, sometimes worse than the symptoms they are intended to treat, and the fact that drug prescribing is still essentially a guessing game. You don't hear about the conflict of interest in having psychotropic drug research funded by pharmaceutical companies with a huge financial incentive to generate certain findings. The biomedical model,

with its focus on biological causes, also tends to cut off dialogue on other conditions that can affect mental health. A number of ex-patients whom I interviewed found that medications were beneficial to them at some points in their life, but that there should be awareness that it may obscure the deeper, social dimensions of the problem.

A socially engaged Buddhist perspective will lead us to inquire about our obligation to treat not only the person but also the environment that has contributed to the conditions that create suffering. Thich Nhat Hanh wrote about this eloquently in *The Path of Compassion* (1995):

Restoring mental health does not mean simply adjusting individuals to the modern world of rapid economic growth. The world is ill, and adapting to an ill environment cannot bring real mental health...Psychiatric treatment requires environmental change and psychiatrists must participate in efforts to change the environment, but that is only half the task. The other half is to help individuals be themselves, not by helping them adapt to an ill environment, but by providing them with the strength to change it. To tranquilize them is not the Way. The explosion of bombs, the burning of napalm, the violent death of our neighbors and relatives, the pressure of time, noise, and pollution, the lonely crowds—these have all been created by the disruptive course of our economic growth. They are all sources of mental illness, and they must be ended.

Wonderful words—but still, what do you do when you see someone in immense mental suffering and on the verge of either harming themselves or someone else, and they refuse help? Maybe we need to rethink our definition of “help.”

It may seem that the choices are limited, as I experienced during my time working in the field. Since then, I have learned about other kinds of treatment approaches, some of them even rooted in Buddhist practice. Windhorse, for example, is a treatment community in Northampton, Massachusetts, that places the cultivation of attention to body, mind, and environment and the development of compassion at the center of its philosophy of healing. The first Windhorse center was established in 1981 through the Naropa Institute in Boulder, Colorado, by Jeff and Molly Fortuna and Dr. Edward Podvoll, who drew on their background in East/West psychology to develop a holistic treatment approach. Medication may or may not be a part of treatment, but when used, it is within the context of other health-enhancing practices such as nutrition, stress reduction, rest, and exercise.

Another key to deepening our understanding is to listen to the people who are really the experts on this subject: those who have received services from the mental health system. A growing number of these

people identify themselves as “consumers” and “survivors.” Collectively, they make up a movement similar to other social movements that address issues of institutionalized oppression. The Psychiatric Consumer and Survivor Movement challenges us to think outside of the medical definition of “mental illness,” and to consider human rights concerns and how economic and political realities affect people living with a psychiatric disability.

A number of consumer-run groups and organizations also offer innovative treatment and support services. You can find out about some of these by contacting the Support Coalition International and the National Association for Rights Protection and Advocacy. The National Empowerment Center, for example, offers an audiotape and training designed to help people with psychiatric disabilities handle the experience of hearing distressing voices (see resource box below).

There are no easy answers to the ethical dilemmas inherent in taking care of those who are emotionally troubled or who operate outside the social norms. At one time or another we will all be in those categories. It's easy to get tangled up in debates about the “myth” of mental illness, to use Thomas Szasz's phrase. But this is more than a philosophical debate—it's about the level of compassion we have for those of us in dire straits. Perhaps the best contribution we can make as Buddhists is to ask the questions differently and to offer our understanding of the endless web of conditions, biological and otherwise, that are part of the joy and suffering in each of our lives. ❖

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