Signs of Transformance from the Asylum

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……and we gazed upon the chimes of freedom flashing.

Bob Dylan

This article concerns the persistence of love and caring in a despairing and chronically damaging (iatrogenic) environment called a mental hospital. I'm going to tell you about my experiences, first as a young adult working in one of these hospitals, and, more than a decade later, as a psychologist working in a subsequent iteration of the mental hospital, now called the inpatient unit. I am still processing those early experiences, and they continue to shape my work as a psychotherapist.

This article is also about *transformance* (Fosha, 2007)*,* that driving force within each of us to grow, to heal, to actualize, to preserve and sustain our humanity in the face of forces, both internal and external, which might encourage us to pull

back from human contact, contract and hide our core selves, and submit to

dehumanization and alienation as a means of preservation.

The Mental Hospital

In the United States, the development of the public psychiatric hospital as an intervention for the "mentally ill" has been characterized by injustice, via power and incarceration, in the name of helping (Szasz, 1974). These institutions served to separate severely troubled and psychotic individuals from the "normal" world until they were judged to be able to safely return to society. Confinement in mental hospital was usually court-ordered, the length of stay indefinite, and the rights of the "patient" severely limited. If a psychiatrist decided medication, restraint (solitary confinement, strait jackets), ECT or a lobotomy was indicated, the patient had little or no say in the matter. In fact, a patient's objections might be framed by hospital staff as *prima facie* evidence of the need for those very treatments.

The institutions developed to handle those defined as psychotic were based on the operation of top-down power (Foucault, 1973). Asylums, later termed "*mental hospitals*," which utilized methods such incarceration, solitary confinement, forcible restraint, lobotomy, ice-baths, were the interventions of choice for the severely emotionally wounded ("mentally ill") among us until the advent of strong pharmacological interventions in the 1950's and 1960's. Psychotherapy, as we know it now, was virtually non-existent. These "hospitals" remained in use through the 1970's before the pervasive use of psychiatric medication led to "deinstitutionalization" and the release of previously incarcerated populations to half-way houses, homeless shelters and, for many, to the sidewalks of our cities.

The historical and, in many places, still current linking of the words "mental," "illness" and "hospital" illustrate how ideas from the medical model, including a fixation on pathology, were applied to the dimension of psychological and emotional wounding.

The patients in these hospitals—designated as "unable," "unstable," "unfit" or "insane"—had been forcibly taken and deposited there by the police; the poorly paid workers staffing that institution had little or no training, and were struggling economically themselves, yet possessing and using their own bruised humanity for the good of many.

Roughly, those confined to state hospitals (Black, White, Latino) were generally from poor, working class backgrounds. They had no health insurance, no money for attorneys to keep them in the community and out of the hospital (or prison), no family money to hire private therapists or go to private clinics. They had come to the attention of the police, through complaints by family members, neighbors, people on the street, they had histories of past hospitalizations, they had been diagnosed and sometimes released back into the very situations which had originally damaged them. They had been taken before a judge and a decision had been made to send them to a mental hospital for rehabilitation. Once there, they were completely at the mercy of the institution, its rules, its culture and the staff. They were isolated from the world, and as far as the outside world knew, they were being helped in a benign environment.

My Journey

In the spring before my junior year at a nearby college, I managed to land a job as an orderly in one of these state mental hospitals, which happened to be a few miles from my home. I was still living with my parents back then. I would characterize my emotional state as confused and immature yet wanting to bloom. I had passed the hospital's somber expanse countless times growing up and always felt an uneasy curiosity, which had intensified as I got older, about the distant and forbidding buildings beyond the high fences.

This was my first full-time job and to get it, I had to convince an interviewer that I didn't intend to quit when school started up in the fall, which at that moment was a lie. I didn't feel good about lying, but oh, how I wanted this job. I had such an intense need to get as close as possible to "mental illness," and what better place to confront it in than Creedmoor State Hospital.

I didn't ask myself why I felt such a fascination with mental illness. I wasn't ready for that question.

It was a time when mental hospitals were still filled and fully functioning institutions, even though chlorpromazine (Thorazine) was widely used. At first, I felt fortunate and excited to have my first "mental health" job. When I quit almost ten months later—not when school started—I experienced tremendous relief and enormous guilt. While a heavy weight had been lifted from my shoulders, and a dark dread removed momentarily from my heart, I also felt the pain of abandoning

incarcerated people who, through no fault of their own, were left to the fickle and terribly inconsistent mercy of a very destructive system.

After a while, what remained with me was a sobering sadness and a dedication to return someday with more authority and leverage, more ability to help those unfortunate souls locked for years behind the bars of a so-called hospital.

My conscious purpose in taking the job was to learn about mental illness, about the insane, about insanity from the ground up, as it were. I told myself I was a curious student newly interested in the field of psychology. This would be the perfect job and place to complement my studies. I felt excitement.

My less than conscious intention, driven by my own sense of emotional instability, inner confusion and shaky self-esteem, was to locate myself close to what I imagined was the heart of madness, near to what frightened and fascinated me in myself, and hopefully to master these fears. Now I know I was trying to heal myself, without knowing it, without understanding much of what needed to change.

I was writing songs back then, so after I left the hospital, I wrote a song about my time there, as a way to make sense of it all. The lyrics are appended to these pages, which are my latest attempt at digesting and metabolizing this experience.

If you've ever seen photos of state mental hospitals, or ever visited one even after it's been abandoned and shuttered, you might be struck, with the lonely vastness of the grounds, the really long gaps between buildings, the great distances to the nearest thoroughfare and neighborhood. You'd register uneasily the low forbidding buildings with windows and porches either barred or covered with heavy impenetrable wire mesh.

There was little to contradict the feeling I was entering a different world, far removed from the humming of "normal" existence. In addition to bars and locks, distance also served as a barrier and boundary between sanity and insanity, or so I believed when I began. Here was madness contained, walled in. Out there, after work: sanity and the normal world.

On successive mornings as I'd walk from the hospital gate to "S" building where I worked—"S" for security—my sense of gloom and anxiety deepened. The front entrance to the building required a key to open it, and so did every other door. The key was solid brass, large and heavy, a relic, part of the jailer's equipment, a symbol of prison going far back in time. Every staff member was required to carry one on a thick cord attached to their belt. The key was power, an instant sign of sanity, a pass enabling its possessor access to every door in the hospital, including the doors to freedom and the outside world.

There were three kinds of people at Creedmoor State Hospital: (1) patients, working class, White, Latino and Black; (2) non-medical staff, including orderlies, ward administrators, all male, working class, predominantly (after all I was there) but not all Black; as I was on the male wards; (3) two psychiatrists, White, male, some foreign born (think Eastern Europe), on the premises for 4 hours a day, three days a week, and definitely not on weekends. Nurses, mostly female, mostly White, and pharmacists were in a separate building. The nurses brought medications to S building and gave them out to patients at set times during the day.

The orderlies worked three shifts, 8am-4 pm, 4pm-midnight, and midnight to 8am. The hospital guidelines said that there should be at least four orderlies per

ward per shift. This was the case for the day shift, but on the night shift and the graveyard shift, there were often two and many times only one orderly on duty. Sometimes that orderly was me.

Lest you get the impression this was an adequate staff to patient ratio, here's the breakdown: S building was actually two three-story buildings, one for men, the other for women, connected by a single story segment containing offices for one secretary, the ward supervisors and the psychiatrists. There were three inpatient wards in each building, one to a floor. Each ward contained 120 patients, had two dayrooms and one dormitory.

In the basement of each building was a dining room serving all the wards in that building. Mealtimes were staggered so each ward would get approximately 30 minutes to eat. All doors were locked, so once the patients left the dormitory for the dayroom, they could not return.

Basically there were 720 patients in S building, with the two psychiatrists minimally present (24 hours total time). A nurse came over with oral medications two to three times a day and administered them. There was no psychotherapy whatsoever, only medication and shock treatments (ECT), should they be ordered—and they were. Patients had no say over whether they received medication or ECT. Refusal triggered force, and eventual compliance.

It took a few months, but I gradually came to regard Creedmoor State Hospital as basically a prison and myself one of the jailers. I felt the power of the large key resting in my pocket at all times. I could open any door for myself or anyone else. I could lock people in. I could let people escape—the urge to do this

grew stronger in me over time. I could leave and go home, attend classes, eat what I wanted, be in the world and be treated as a normal person, be respected.

If you were a patient—and had committed no crime—you were a ward of the state. You wore hand-me-down hospital issued clothing, most of the time ill-fitting. You could not wear belts to hold up your pants—suicide and mayhem were constant staff preoccupations—so you were constantly trying to hold them up. Nor were you permitted shoe laces, so your feet suffered chronic blisters from the hand-me-downs which more often than not did not fit your feet.

You were forbidden to accumulate the normal objects of living, things such as letters or photos, a newspaper or just a clipping you might want to re-read at a later time. You were allowed a teaspoon to eat with but it had to be left in the dining room. The spoons were given out one to a patient as you entered the dining room and collected when you left. If your spoon was missing, lost or stolen, you and all the other patients were searched, and the dining room scoured from top to bottom. And although it might become unbearably, suffocatingly hot in the dining hall, you could not return to the ward until it was recovered.

As a patient, you had zero power. You needed permission for many normal things. A walled off area in the rear of S building served as the area for "outside" time for most of the patients, who were allowed to mingle there for 30 minutes a day when it was warm enough.

I hope you are getting the picture—degradation, restriction, humiliation— the very details of normal existence denied. Many patients had simply been abandoned by their families and had no visitors whatsoever for decades. I met

patients who'd been incarcerated for many years, some for decades and were never visited during all that time. This was an endless and dark night for these souls.

Stigma, shame, and isolation characterized the milieu for these patients. They were poor and powerless and their normal needs were viewed by many of the staff—although not all—as manifestations of their illness. The state had locked them away, and that was their lot.

I was not in therapy yet, had no real knowledge of what it could do, how it might help, yet I began to ask myself: Could any of this "hospital" experience actually be therapeutic? I felt more and more certain that if I were a patient, I would surely become worse and worse, riddled with despair, unsafe, frightened, dehumanized, struggling for a modicum of dignity only to have my normal requests treated as if they'd sprung from some "sick" part of me.

I'd want to escape and would have been terrified of trying to, as captured escapees were given restraint, isolation and often ECT (this was therapy not punishment, according to the staff). If the medication didn't numb me, I might have tried to bond with other patients in the ward, maybe even engage in sex with some, which I'm sure would've been seen as more evidence of my "sickness," and would've called for upping my medication, ECT, or "restraint," which could mean an isolation cell, a strait jacket or both.

Daytimes were spent in a large space called the dayroom, and patients would walk endlessly around this room, chain smoking if they had cigarettes, sitting morosely in straight wooden chairs there or on the porch, staring through the mesh

at the world, the streets and cars barely visible over a half-mile away,

chlorpromazine chugging through their bodies.

If you had the misfortune to be confined—by court order—to an indefinite

stay (only the psychiatrists could judge you ready to leave), you were not likely to

get better and most likely in that environment you would get worse, mentally and

physically. You were in the "looney bin," stigmatized, with no voice and at the mercy

of the ward manager and orderlies, exposed to the despair of other patients who,

like you, had been forcefully separated from the outside world, swimming in the

dark emotional ambience of your day-to-day existence on the ward.

You may have been troubled when you came to Creedmoor……turbulent,

beset by unmet emotional and attachment needs, beset by unprocessed trauma,

but over time your problems would be grimly compounded by the absence of any

real therapy and an environment lacking any respect for the essential dignity of

human beings.

I do not want to give the impression that I suddenly saw the iatrogenic

horror of it all and revolted. Not at all. What happened was slow and insidious

change: I became less able to distinguish the mental "illness" of the patients from the

mental anguish they, myself or anyone might develop by simply being imprisoned

there. I developed a nightmare fantasy scenario in which I lost my key and could not

prove to the staff that I wasn't a patient. In other words, I'd be imprisoned, labeled

as mentally ill, and all my protestations would be treated as manifestations of

delusion or worse. Unable to prove my sanity, I'd gradually lose it.

To cope with these terrors—which, in my aloneness and shame, I told no one about—I found myself strenuously, too aggressively asserting my role, my rank, my status as "staff," to the "crazy" patients. Far from healing myself, I began to behave sadistically, deriving a measure of relief and satisfaction from teasing and tempting patients with prohibited possibilities. For example, I'd purposefully leave my key in the lock of the main door leading out of the ward. I knew there were patients longing to escape (a natural response to captivity) and who would see this as an opportunity to "elope," as the official language put it. As soon as one of these desperate folks made a lunge for the key, I'd slip it out of the lock and into my pocket, leaving the patient furious or in some kind of disorganized, disregulated state. Now I knew what it was like to react towards people as a class. They were mentally ill. I was not. I could treat them cruelly and get away with it.

Not pretty, eh? I still feel awful remembering those events and telling you about it so many decades removed. But finding this capacity within myself deeply disturbed me, my sense of who I was and should be. It provided more evidence that perhaps I was "sick" within and not so different from the patients.

I'd begun to walk home after my shift, a distance of about three miles, and that gave me time to reflect on what was happening to me. No longer was I a student of madness and schizophrenia, but a wounded young person, now struggling with inner demons, seeing the grim reality behind the fairy-tale that "mental hospitals" were hospitals, the fiction that "mental illness," if the word "illness" actually applied, existed independently of the culture and the institutions which defined it and "treated" it.

I knew I would need to leave Creedmoor to preserve my own sanity. I dreamed of returning someday as a true mental health liberator, changing the environment to one of dignity and safety, promoting trust, healing them from the wounding of the hospitalization, setting the patients free. I also knew I needed help—I had to quit and I needed a therapist.

Glimmers of Transformance in the Darkness

Yet a part of me had also recognized two different, yet related, sets of phenomena on the ward in "S" building. First were the many and various kindnesses many patients showed towards one another despite their despair and desperation, despite the insanity of their situation. I witnessed affection, support, friendliness, smiles, helping hands, food sharing, a myriad of gestures small and large, shown by those who had so very little in the way of things to give, and yet they gave of themselves. I saw many instances of "self-at-best" behavior shown by those defined by the staff as the most disturbed, the expressions of a still surviving humanity that was not "mentally ill."

Second, the sensitivity and kindnesses often shown to the patients by many of the poorly paid and clearly economically struggling orderlies, some working two jobs, or two consecutive shifts, chronically tired, underpaid, worried about their families, their circumstances, working in a job with the designated insane, where they were clearly on the lower rung of the status ladder.

And yet. And yet. In the midst of this suffering, in the bleakness and despair, the endless days, hopelessness, the indiscriminate use of shock treatments, lobotomies and numbing medications, there were also unexpected and not infrequent sparks of kindness, caring, sharing, empathy, successful and unsuccessful attempts at connection. There was still hope.

Here are just as few events I witnessed: Staff members offering their food and/or cigarettes to patients; patients offering whatever they'd taken from the dining room or even received from a rare visitor; patients offering advice to troubled staff members; staff members literally comforting distraught, despairing patients with an arm around a shaking shoulder, a sympathetic smile, a handshake, a pat on the back, an acknowledgement of how dispiriting life on the ward could be. These were not rare occurrences but were always there. Although I noticed these things, I did not grasp the wonder of it for quite a while.

Of course, there were negative elements, too, such as shaming and mocking patients who were upset or asked for the normal things of life, such as more toilet paper. There were my little cruelties, mentioned earlier. I could detail these abuses carefully and show how the staff, including the psychiatrists and nurses, were able to make the helpless and disenfranchised patients feel even crazier or enraged or suicidal, and then have these reactions presented back to them as proof of their illness. I could do that, but it's not what I want you to take away.

The point is: There were always amazing manifestations of kindness, empathy, acceptance, tenderness, etc. And that is the most important premise and ingredient for any theory of healing. What lay behind these surges of kindness and

connection, patient to patient, staff member to patient, patient to staff member? Isn't that the salient question for us in the present time (2018) where pathology and divisiveness threaten to overwhelm our regulating systems, individually as well as collectively?

Back then, I didn't get it, nor did I try to. I only knew that it gave me hope, for the patients and for myself. Now, as an AEDP therapist, I can make more sense of these phenomena. I was witnessing the presence and action of transformance strivings, the drive to heal, to grow, to be as fully human, as fully alive as possible, despite the awful dehumanizing power, in *both patients and staff.*

The poor and struggling staff members, overworked and underpaid, with no formal training in therapy, with their own unfinished, unprocessed issues, finding ways to care for the poor, stigmatized, banished and forgotten patients. I watched the incarcerated mentally ill connecting with the staff, relationships always forming. Psychotherapy, in the formal sense we know it, not even a distant possibility. But connection and glimmers of growth were possible. Flickers of hope always sparking, refusing to die.

After almost ten months, I left that job, holding on to the glimmers, needing to be back in the normal world. I said goodbye to the patients and staff members I'd gotten to know, with a mixture of relief and guilt. I'd gotten myself into therapy. My sadistic parts were under control and I was trying on their expression as part of a bad dream.

My tender loving self had emerged and had expressed itself intermittently on the ward. Still, a part of me had been deeply frightened by it all. I had to get away.

You cannot witness others being traumatized, or feel your own cruelty being activated and acted out, and not become traumatized. I nurtured a hope that I could return someday to make amends and to make a difference. It was more like a fantasy.

A Second Chance

More than a decade later, armed with a doctorate and a license as a psychologist, I was hired as a group therapist at another still functioning state mental hospital. During the intervening years many of the older hospitals had been emptied, their inhabitants farmed out to group homes, half-way houses, with many winding up on the street. The remaining hospitals tried to keep patients for shorter periods, and had a more psychotherapeutic orientation, and better trained and supervised staff members.

The one I worked in had newer, more modern wards in less prison-like, single-story buildings with no bars on the windows. The environment seemed, on the surface, more conducive to change, to interaction (for example, male and female patients were not always segregated during the day). I began work feeling hopeful.

The patient population was familiar—poor, Black, White, Latino, a few more Asians. While the orderlies were drawn from similar populations, there were more social workers (young, White, middle class) not terribly experienced, and curiously tired and cynical. I quickly saw that many had given up hope that the patients could grow or change. While the institution itself was no longer prison-like, and was more humane and caring, the staff manifested and communicated a familiar pessimism about their mission. Also, many of the patients were long-term wards of the system,

shuttled from inpatient contexts to poorly-run outpatient programs and halfway house, then sent back to the hospital.

My role was to train and supervise therapists and lead groups as part of their group therapy program. At first, I started running groups in a more traditional format: discussion, guiding interaction, supporting patients who wanted to share, etc. However, it soon became clear that this format was a complete bust, not helpful at all with patients who were actively hallucinating, delusional, or terribly withdrawn. The groups were chaotic, with little meaningful interaction and the results were negligible and worse in terms of staff discouragement, which included myself.

This is the story of what happened next…… One afternoon, I was sitting in the dayroom on one of the wards I was attached to. It was hot, terribly humid, no air-conditioning, fans blowing. I felt disheartened in terms of the effectiveness of my work. I was also tired and groggy from the heat. Members of the staff were giving a dance lesson to about ten patients.

At first, the endeavor seemed hopeless to me. The staff members were trying, but it seemed that the patients could not remember, pay attention or replicate in any way the steps shown by the staff. It seemed like one big failure experience for all involved. I felt despair, heaviness, inching up in my heart.

Then somehow—I still don't know how this happened—I was able to look closer, past or through my hopelessness and that of the staff's. Although the music was swing, staff members and patients were mostly dancing in place, but *in close physical contact*, sometimes actually leaning on, actually supporting one another.

There was warmth, there was familiarity, *tenderness.* Below the sadness and weariness permeating the activity and the room, there was love, and it jumped out at me, rocking me to the core. I blinked away tears and told myself I was seeing things, and that, perhaps yet again I ought to consider not working in places like this.

It was even a clearer version of what I had witnessed in that first mental hospital, but now it hit me broadside: Within and despite all the oppressiveness and futility, here was true caring and kindness, protectiveness, tenderness emerging again, unwilling to quit. Back when I was twenty, I had registered it, but not fully. Sure, I had noticed it, remarked upon it, and stored it away. I hadn't known what to do with it. Now, here it was hitting me in the face and in my heart and it stunned me. It was so powerful, I simply could not believe no one else noticed it, acknowledged it or actually put words on it.

The next afternoon, I again sat in the humid dayroom nursing my revelation from the previous day, wondering if I had been imagining it all. No dance lesson happening this time, just patients hanging out and staff hanging out with them, or going about certain chores, delivering meds, messages. Nothing much was happening. Or so it seemed, just another drab summer day in the hospital. But as I looked closer, through the lens of what I'd experienced the day before, I saw again see that deeper level of connection. And like the day before, it took my breath away.

First of all there were smiles, grins, some brief, some longer, twinkle-eyes, faces of delight, lots of them, staff to patients, patients to staff: Smiles in passing, nothing formal, no long conversations. Even the most out-of-it patients received smiles and smiled shyly back. And then there was the touching! So much of it, I

couldn't keep track of it all, staff member to patient, patient to staff, patient to patient. Shoulder pats, hair tousling, back pats, elbow squeezes, cigarettes being asked for and given, the lighting of cigarettes, the saying of names, nods, nicknames spoken in greeting, with affection, familiarity. I watched for hours and it never ceased. I took notes. Staff and patients looked at me quizzically, asked me if I was okay. I said I was. I cried, got more looks. I took breaks and walks, and returned. The *stuff* was still there. No one spoke of it or metaprocessed it.

The next chance I got, I began asking staff members about their experience of the patients on the ward, and the responses were generally noncommittal, tinged with pessimism about their chances of recovery, with slight traces of positive feelings, a kind of fondness, but nothing expressing what I had witnessed. It was as if that level of affection did not exist for them, never occurred to them and again I worried that I was making things up.

Some told humorous anecdotes about certain patients. Others spoke with compassion about the difficult histories of other patients. I took a risk and asked directly about feelings of affection, tenderness. The responses were generally, "You're kidding, right?" then moving towards minimizing and denial. Of course, they cared about the patients, but it was a professional, proscribed caring, certainly not the kind of "love," which might be outside the categories of transference and counter-transference.

I concluded that much of this compassion and mutual affection was implicit, out of awareness, perhaps even unconscious, a stream of relatedness, of healing, of

health and vitality occurring in plain sight yet invisible at the same time. I was not seeing things. They were in denial, and I felt relief.

I became determined to make the phenomena I'd experienced become an explicit part of my group therapy work. To that end, I formed a new group whose structure had the following conditions: (1) under no circumstances would any formal "therapy" take place during the group time. This would be explained to staff members and patients alike, and only staff members who could agree to this would participate; (2) during the group time, staff members were free to interact with one another or not, or with the patients, or not. They were to interact in ways which felt comfortable and genuine. They were invited to behave as if this were a social occasion—without alcohol—and they could converse about anything that interested them or not converse at all; (3) gestures of affection, such as shoulder or back patting, hugging, were totally acceptable *as long as the patients initiated or explicitly invited that type of interaction*; and staff members were to be alert for any sign that touch was not wanted; (4) high quality food would be available *in abundance*—cheeses, fish such as salmon, different kinds of bread, juices, vegetables, dips, juices; and eating would be optional throughout the whole group time. Staff members paid for this food; (5) staff members, at all levels, were encouraged to follow their intuition and feeling states in their interactions; (6) I would be present and available for support and guidance throughout the group time; (7) we would meet as a staff after the group to process what had happened; (8) the six patients accepted for the group had to be considered challenging (in terms of relatedness, reality testing, etc.,); (9) eight staff members—a few social workers, a psychologist and three "ward

assistants" (the new name for the orderly role)—*elected* to be part of this experiment (no one was assigned); and (10) the group would last from November to November, a full year, meeting twice a week for two hours at a time.

We had the difficult patients, volunteer staff members, lots of food and no agenda other than acceptance of each other and ourselves as we were in the moment. Needless to say, many of the hospital administrators were quite leery of this initiative, and often threatened to cut off funds for my position, complaining that their "token economy" was being impaired by the group. Still, we managed to prevail and the group lasted for eighteen months. My position as a group therapist was defunded after a year but I remained a general "consultant," still grudgingly permitted to run the Winter Group—the name given to the group by one of the patients. In the eighteenth month, I was let go completely, my position deemed no longer necessary and cut from the budget, and the group ceased. I have not gone back to this kind of setting. Many of our team ended up in private practice and I have not kept in touch.

Let me describe all this again: 10 a.m., a medium sized room, chairs against three walls, no TV, a buffet table against the fourth wall, on the table are platters of fresh bagels and rolls, an hour out of the oven, about five different kinds of cheeses, lox, onions, lettuce and tomato, some croissants, scones, butter, fresh coffee, milk, a couple of pitchers of cold juices. There are plastic utensils and plastic and hot cups. There is enough food for the 4-6 patients who will come in that morning as well as the 5-8 staff members including myself. Each staff member has chipped in $10 to cover the cost of the food. We will spend two hours together.

The staff arrives first and they go for the food, so when the patients enter they are welcomed, greeted individually, positively but not loudly, not animatedly, as the staff members are focused on eating. The patients arrive. They may be hallucinating, talking to themselves, agitated, or displaying other self-involved behavior. After a while, despite what they may be experiencing, they gravitate towards the food. One or two patients may wander around at first, or even stand in a corner, somewhat immobile. But, as no one is trying to interact with them, they begin to move around and end up at the buffet.

When the staff has filled their plates they find seats and as they eat, begin chatting with each other. They are gossiping, talking about sports, politics or health issues. Some just eat. The patients go to the food table and stand there looking tentative. A staff member walks by and gestures for them to eat. The patients look at one another and then start filling their plates. Most of the time, the patients begin by sitting or standing alone at eating. As time goes by, however, some of them move to the chairs, sitting near staff members. The patients eat and seem to be listening to the conversations.

Eventually, the patients join the conversations, and the back and forth is lively and focused. There is much laughter and everyone seems to be having a good time. No personal problems are being discussed as they might be in a therapy session, and if a personal issue is being discussed, such as what's going around, remedies, etc., staff members are self-disclosing. People go to the buffet for more food and return. There are three or four different conversations going on at once.

The very patients who were unreachable on the ward or in the traditional group therapy format, either withdrawn or hallucinating, are now interacting with everyone in the Winter Group. There is a soft ambiance in the room, a sense of lightness, almost gaiety. Physical contact is also present between patients and staff, patients and patients, staff and staff: light touches, pats, the squeezing of an arm.

Every once in a while a staff member will take me aside and worryingly ask: "Is this really ok to be doing? Is this therapy?" My answer is usually: "I don't know yet, but people seem to be relating well and in good spirits." At times, a patient will enter in a very agitated state, preoccupied with figures only he can see, speaking to someone not present, showing clear signs of stress (e.g., sweating, darting eyes, trembling). The patients are free to choose not to attend the group, so if a patient in such a state enters, we (the staff) do not make any clinical judgments or decisions but wait to see how things play out. Interventions are based on helping these patients join the group. For example, one patient, Charlie, came into the group one morning in a highly agitated state, sweating, and speaking loudly, sometimes shouting seemingly random numbers. He stood in a corner for a while doing this (speaking numbers) while the rest of the group ate and talked. Based on my ward observations, Charlie was a patient liked by the staff, who spoke in clipped phrases that often made no right-brain sense to the staff members who tried to decipher them. He also liked to eat and at times would eat what other patients had left over. In the Winter Group, he had interacted behaviorally, sitting with people, nodding, smiling, repeating his phrases and clearly enjoying himself. He had thoroughly enjoyed the buffet, and words like bagel and cheese were more present in his speech.

This time, a female staff member, with no formal therapy training, spent some time observing Charlie. She wrote down the numbers he was saying. She asked me to look at them. Was there a pattern? I didn't see any. She went back to observing. After a while, she walked up to Charlie and told him, as he was spewing numbers, that she had been observing him, that he might be hungry and that she'd be happy to say the numbers for him while he ate. She waited. He nodded slightly. She waited. He motioned for her to stand next to him. She did and began speaking numbers, evenly. He nodded once more. She touched his arm reassuringly. He walked over to the food. As he ate, he glanced at her, perhaps to confirm that she was continuing. After eating two bagels with cream cheese, Charlie joined a conversation about the Yankees chances against the Red Sox. About a half-hour later, he went back and took over the numbers talking. Now, his voice was softer and there was less pressure in his speech. She relieved him a few more times before the group ended.

Here are a few other examples of surprising phenomena in the group:

Roger, a very paranoid man, sits with two staff members swapping funny stories about parents in general. At one point, he is howling with laughter. At another point, something he says leads to the staff members convulsing with laughter. They toast one another with their juice cups.

A hereto-fore mute patient begins to ask about the cheeses: What kind are they? How are they made? He mentions a trip he went on to a cheese factory back in grade school. He is animated, gesturing, enjoying himself. No one calls attention to the fact that he is actually speaking.

At first many of the staff members found the group experience unsettling, as they were not in their usual authority roles vis-à-vis the patients. They would ask for directions, for specific activities and when I didn't have any, they would express discomfort. One member left the group early on asserting that the structure was not therapeutic. He was replaced by another volunteer aide. After a while, the emergence and acceptance of positive social interactions highlighting friendliness, curiosity, self-disclosing won over the hesitant, the uncomfortable and the skeptical among the staff in the group. They had chosen to stick it out, and many of them had witnessed the therapeutic dead-end of regular group therapy. However, the ward supervisory personnel and other staff members who had not volunteered for the Winter Group, were grumbling more and more loudly about how the group was interfering with the token economy and other ward structures.

And soon enough, these grumblings became more aggressive, and I was asked to justify in writing the usefulness of staff members spending four hours a week in the Winter Group. I was able to document positive behavioral changes in the group patients, but I was told my data gathering was suspect, not sufficient, not scientific enough. Thus, my role a group therapy consultant was terminated, but I was permitted to run the group for another six months before the group was ended by order of the chief psychiatrist as not being aligned with the hospital's treatment philosophy.

I am grateful for the opportunity to contemplate and write about these experiences. I see so clearly now, from the vantage point of much therapeutic experience and from practicing AEDP, that the forces of transformance, healing, love,

and caring are present no matter how bleak the context, no matter how oppressed and stigmatized the person or population may be. Those forces are available if we are only able to invite them out, from ourselves and from within our clients. We need safety, and that is a human right. We are born and live with the capacity to express and to receive love and care, and we need to do both, to experience both, in order to feel most alive. There is no doubt that, historically, fear, misinformation and projection have shaped the marginalization and the approach to treatment of people experiencing severe emotional disturbance (this is not to speak of the negative social, cultural and familial forces influencing the development of such severe disturbances) and that these factors are still operative today. While huge state hospital complexes such as the ones described early in this article are no longer in existence, there are still "intermediate-care" facilities like the second one described. The phased-out in-patient treatment contexts, both past and present, for those undergoing intense disturbance tend to be underfunded, with underpaid and overworked staff working close to burnout levels, managing large caseloads and shortened therapy sessions. Chronically emotionally distressed patients are also serviced by out-patient agencies and clinics, also staffed by overworked and underpaid therapists. All of these treatment contexts are subject to funding cuts and cuts in services, with therapists frequently asked to enlarge their caseloads, with added increases in "admin" functions. Very often, these "intermediate" facilities and outpatient facilities are seen by the therapists as an apprenticeship, an entrance role to going into private practice eventually. In the private practice model, middle-class patients are seen at least once

per week by middle-class therapists, with more resources for supervision, between session contact, and clearly more financial opportunity.

In my opinion, the system does a disservice to the severely emotionally distressed. They have been and still are the underclass of patients. We need AEDP training specifically geared for therapists working with these important clients in these difficult settings. *Transformanc*e is still at play, still the driving force for change, but our approach must be creative and explicitly take into account the (1) factors impinging on both therapist and patient, and (2) the social factors contributing to the patient's distress, e.g., poverty, racism, sexism, homophobia. What would happen if greater monetary resources were funneled to these therapists? How many of these patients come from families decimated by cycles of poverty and racism? How many lived with the destructive agony of hiding their true sexual identity or orientations?

AEDP champions the emergence of the beautiful core self, with all the tools and understandings at our disposal, and so we must do it with these therapists and the clients they work with. Somehow, we must develop an understanding of what we have not directly experienced. How we develop these understandings and put them into our practices is one of the next significant challenges for AEDP.

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