A Tale of Two Centuries: Voices of the Past and Present

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This article compares the reported experiences of children and adolescents receiving inpatient treatment in contemporary psychiatric hospital settings with those of women institutionalized in mental hospitals from 1840 to 1945. Qualitative data include case study material from former psychiatrically hospitalized patients and archival narratives. Analysis includes matching themes from in-depth interviews with archival narratives. Nine representative experiences emerged and are presented in a typology under broader themes of structure, process, and outcome. Similarity of patient experiences over two centuries leads to questions about the meaning of advances in understanding mental illnesses in the context of attitudes, biases, and staff behavior toward patients that remains disturbingly unchanged.

> When I was in the asylum I saw a concentration of evils in a condensed form; and when I said anything to the Doctors about the wrongs of the house, they would tell me that it was my insanity. I told them that a fact was no less a fact because it was told by a crazy person. (Davis, 1850, p. 51)

THIS ARTICLE CAME about through serendipity. While analyzing data from a qualitative study on the experiences of former mental patients, I read *Women of the Asylum* (Geller & Harris, 1994). This book chronicled first-person experiences of women held against their will in mental institutions from the years 1840 to 1945. I was struck by the similarities in the narratives related by these long-forgotten women and what their modern counterparts had described to me. Specifically, I was haunted by a concern that the voices of past and present would be lost or dismissed as exaggerations, exceptions, or delusions. This concern is rooted in my observation that overall, as mental health professionals, we spend far too little time in self-reflection and on activist endeavors on behalf of persons with mental illness.

In the wake of recent reports of further abuses in the mental health industry (Weiss, 1998a, 1998b; Still questions about boy's death, April 24, 1998; Cart, 1998; Snipe, 1998; Virginia under fire for deaths of mental patients, April 13, 1998; Cohen, 1998) it seemed appropriate to once again bring the issue of abusive practices and their longevity to the attention of psychiatric mental health nurses. In this article a typology of categories and exemplars that emerged from raw data taken from interviews with former patients hospitalized from 1985 to 1991 is presented and matched with examples of the narratives of the voices of the past.

BACKGROUND

In the 1800s the operations of the typical mental institution were strictly administrative. Psychiatrists, who were the hospitals' medical superintendents, were less concerned with the science of mind and more concerned with running efficient organizations. A review of the *American Journal of Insanity* during the first half-century of its existence showed that the dominant subjects of discussion were those concerned with the pragmatics of institutional management rather than with scientific study of mental illnesses. Although progressive treatment philosophies in Europe increasingly favored nonrestraint, humanitarian milieus, and an

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emphasis on patient autonomy and rights, American psychiatric hospitals evolved little in response to these philosophical trends (Mora, 1985).

As late as mid-20th century, appalling conditions in mental hospitals were documented in numerous personal accounts by former patients, several sociological studies, and a journalistic survey, complete with ghastly pictures by Deutsch (1948). Various forms of "treatment," including shock therapies, were administered inappropriately—more often for punishment than for any therapeutic effects. Wards were staffed primarily by attendants who had the most contact with the patients and who were the least educated, least well paid, and most poorly treated by the organization. These attendants generally maintained the most negative attitudes toward patients and often engaged in brutal and exploitive behavior toward patients (Perrow, 1965).

Patients had no civil rights to speak of and, until the 1960s, they had little in the way of legal protection (Brown, 1983). They had no opportunity to express grievances, and for the most part they were rewarded for playing a compliant and subservient role. Their discharge from the institution depended on their having "learned" certain conforming social behavior (Goffman, 1961).

Over the years little changed in reports of the culture of psychiatric hospitals. Rosenhan's classic study (1973) found that pseudo-patient investigators were systematically objectified, ignored, discounted, and presumed to be insane despite their engaging in seemingly normal behavior. His research team discovered that patient and staff segregation was the norm, with the staff emerging from nursing stations only when they had some task to perform. He observed that the staff (including nursing staff) spent so little time with the patients that it seemed "almost as if the disorder that afflicts their charges is somehow catching" (p. 254).

Having conducted a participant observation study on inpatient milieus, Morrison (1990) found that toughness and patient control were pervasive norms. Indeed, nonprofessional staff engaged in rough handling of the patients despite her presence as an observer. She suggested that despite much discussion of therapeutic milieus, psychiatric settings are coercive, regimented, over structured, authoritarian, and inflexible, placing far more value on security than on therapy.

The passages that serve as the contemporary counterparts to the narratives from the past underscore these norms. They were related by individuals who were incarcerated in for-profit psychiatric hospitals during the years 1985 to 1991. During these years the state attorney general in Texas received multiple complaints about patient care. These were subsequently investigated, and hearings were conducted before a state investigatory commission. Testimony from former staff members and patients disclosed the following abuses: excessive medication and therapy; questionable and potentially abusive therapies; exorbitant charges and charges for services never rendered; overly aggressive and deceptive advertising and marketing; "headhunting" fees or "bounties" paid to deliver patients to treatment facilities; threats and coercion used to detain voluntary patients; holding voluntary patients against their will without medical justification; isolating patients from family, friends, and legal counsel by withholding telephone, mail, and visitation privileges; falsifying diagnoses to match insurance benefits; "dumping" patients regardless of their condition once insurance benefits were exhausted; and unnecessary hospitalization of patients whose conditions could have been treated in a less restrictive environment (Mohr, 1996).

The time during which these abuses occurred was characterized by the prevalence of market-based ideologies, a concern with deregulation, and a disposition by insurance carriers to cover inpatient psychiatric care in favor of out-patient care. Federal insurance programs for military families and victim assistance programs created moneymaking opportunities for hospitals, as did state-mandated mental health and substance-abuse benefits. The expansion of large, investor-owned hospital chains, which took advantage of a potentially lucrative market, accelerated, as certificate of need legislation was repealed (Eisenberg, 1985; Gray, 1991). Exemption of the psychiatric and substance abuse inpatient programs from the prospective payment system of diagnostic-related groupings (DRG) reimbursement procedures also provided fertile ground for profit with minimal government oversight (Strumwasser, et al., 1991). The ensuing abuses and excesses may have reflected an intense drive for profits over human concerns. But the fact that it took many years to come to the attention of the authorities underscores the idea that the maltreatment, neglect, and abuse of the mentally ill are condoned—and that stigma

still pervades society's attitudes toward the mentally ill.

METHOD

The study, conducted with former clients of Texas for-profit psychiatric hospitals, employed a multiple case study design (Yin, 1989). Semistructured interviews between 3-½ to 5 hours long with parents and their children were conducted in their homes over the course of a month. I had access to all relevant demographic information, a previously administered in-depth questionnaire, archival data from patient charts and records, and several standardized measures that provided for augmentation, triangulation, and validation of the interview data.

Data Sources

The material for this article consists of the following: (1) excerpts from the book *Women of the Asylum* (Geller & Harris, 1994); and (2) matching excerpts taken from interviews conducted during the course of a larger study of the experiences of 20 former clients. The 20 informants were drawn from a screened population of over 600 individuals who were institutionalized between 1985 and 1991. The 20 selected paradigm cases chosen for the study represented a theoretical sample of former clients who had memories of their hospitalization. They were matched on gender and diagnosis, represented varying lengths of stay, and were hospitalized in different hospitals throughout an investor-owned corporate hospital chain. Criteria for inclusion in the study included the informant's willingness to participate in the study, age under 18 years during hospitalization, and hospitalization before the year 1991. Collection of data proceeded beyond redundancy to strengthen the study and to achieve maximum variability.

Data Collection

After receiving institutional approval, potential participants were contacted and asked to participate in the study. Each participant and their parents (where appropriate) were asked to complete an informed consent form. Informed consent procedure included verbal and written instruction as to their rights. Data were collected at a time and place convenient to the participants. Eighteen participants (and their parents) chose to be interviewed in their homes. One chose to meet the researcher in an office, and another chose to meet at a hotel. The in-depth demographic questionnaire included queries on age, gender, ethnicity, educational level, diagnosis while in hospital, length of time in hospital, reason for admission, and major complaints about hospitalization.

The second component of data collection was a semistructured, open-ended interview designed to elicit the participants' stories. These were audiotaped. Follow-up telephone interviews were conducted with each participant after a 3-month interval. This included a shortened form of the original interview and consisted of questions based on the initial analysis of the data obtained from each case. Data collection took 5 months.

Data Reduction and Analysis

After reading and rereading the transcripts and documents and listening to the taped testimony, the data were analyzed for thematic content. Intuitive tags were assigned in the margins of the records (Miles & Huberman, 1994). After isolating key phrases and statements, further analysis involved identifying, coding, and categorizing primary patterns in the data. These aspects were extracted on the basis of emergent thematic content and were then subjected to a first and second analysis that involved clustering themes that came together coherently. The themes that recurred with regularity were then clustered into categories. Approximately 1,824 pages of client documentation as well as the 350 pages consisting of Geller's and Harris' (1994) book were reviewed and coded. Summary forms were created on a computer for each medical record. Relevant entries from each client, as well as the matching entries from Geller & Harris (1994) were entered on the form under the broad categories. Definitions of each category were developed from a perusal of the key phrases and the context within which they were embedded.

Limitations

Some readers might disagree with the categories, the analysis, or the presentation as being overly negative and not reflective of all psychiatric hospitalization experiences. However, historical accounts are not written on the survival of positive reports (Tuchman, 1985). Records frequently deal with what was wrong rather than what was done well. Even charting and record keeping is skewed to the problematic. Thus, the review of investigatory documents, hospital records, and former pa-

tients may indeed reflect an overload of the negative. Moreover, I am not attempting to present a picture of all psychiatric hospitalizations but to call attention to patterns that may be indicative of long-standing difficulties.

Trustworthiness

Following Lincoln and Guba's (1985) and Sandelowski's (1986) criteria for trustworthiness in qualitative research, the features of (1) truth-value, (2) applicability, (3) consistency, and (4) neutrality were employed. The procedures for trustworthiness were employed throughout the entire study, including the analysis of the former child informants' experiences, as well as the analysis of all contextual material that included relevant documents and data from parents' interviews. Experiences of the study participants were linked to the context and validated with the study informants.

Informants were asked to consider the interpretation of what had been gleaned from their charts and interviews. Because content analysis can be considered to be a quantitative method (Silverman, 1993) as well as a qualitative one (Lincoln & Guba, 1985), categories and exemplars from the study were submitted for interrater reliability review to two doctorally prepared psychiatric nurses who are clinical specialists, a doctorally prepared nurse whose expertise is qualitative analysis, and a psychiatrist. Interrater reliability for categories and exemplars subsumed under those categories was 96%. An independent researcher conducted a confirmability audit.

RESULTS

The categories and passages are presented and arranged by way of presenting the structures of hospitalization encountered, the process of hospitalization experienced, and the outcomes that constituted the results of both.

Structure

Table 1, Exemplar 1 shows the phenomenon of deindividuation as experienced by both groups of people. Both report a degree of distress at losing their identities as individuals with singular or particular needs and the metamorphosis into the undifferentiated role of patient. Moreover, the contemporary group of study participants expressed distress at being subjected to the same group interventions as everyone else.

Group work can be used as a form of therapy in institutions as a way to socialize but also to satisfy certain pragmatic goals, such as efficiency or cost effectiveness. Individual care is a very costly commodity, and the rational, efficient organization must reduce individual needs if they want to continue to operate without disruption. The blanket approach to patients often proved to be therapeutically ineffective, however, when it failed to engage them and most especially when it elicited negative reactions.

Cost effectiveness notwithstanding, the group experience can also constitute a form of coercion that is designed to distance the staff from the patient group. When patients become categorized in the aggregate group "patients," and staff members become "staff," life on a unit may begin to take on a "me versus them," "good versus evil," "right versus wrong" quality. There is no middle ground and individuals who are being marginalized into the "them" category are forced to become dependent solely on the "them" group to provide validation (Clinard, 1983; Weick & McDaniel, 1989). Given enough of this invalidation, "them" groups will become angry because the process of being grouped is an act that disregards that which makes them unique. Differences or diversities become nonvalues, and homogeneity becomes a desired norm (Williams, 1979). The irony of norming is that although staff members may believe that they are bringing patients in line, the process of invalidation may give rise to underlying resentments that eventually lead to conflict or resistance activities.

The passage shown in Table 1, Exemplar 2 represents what Morgan (1986) called the psychic prison mentality of institutions and their emphasis on following rules, discipline, duty, and obedience. Whereas certain discipline and orderliness are necessary for smooth functioning of organizations, its distortion into mindless regimentation becomes counterproductive in the care of human beings. The control to which the former patients referred was similar to that of Goffman's total institution (1961) and was achieved by constant scrutiny of patients and of their body and bodily functions. Staff supervised what the patients ate, when they slept, and when they went to the toilet. The ostensible purpose was to achieve a structured milieu, but regimentation took on a life in which inconsistency and the capricious enforcement of petty rules kept

Table 1. Structure

De-individuation (Exemplar 1)	
This moral confinement allows not one iota of individual scope or latitude, but would hew men and women down to the similitude of sticks and stones. (Lunt, date unknown, p. 120)	Everybody did the same thing. Everybody went to the same classes. It didn't matter what was wrong with you, you went to the same groups as everyone else. #026
Their sole idea seems to be to fix the patient to a routine of life identical with the asylum itself, and bound up with its regulations, which must be adopted at the first step for every patient alike, without individuality, a regular course of deprivations, denials, disappointments until the patient himself is fairly vanquished. . . . (Lunt, p. 122)	Well, I kind of felt like, like they weren't interested in me. I mean, they talked to me and they were fairly nice and all, but they weren't interested in my problems and what I had to deal with. I was just kind of, like, somebody else that was on the floor—that was in the hospital, but not as an individual patient. I was just part of the group that was there. #018
Regimentation (Exemplar 2)	
The great trouble in Lunatic Asylums is, they want to cure them by rule. They have their written rules, and all who cannot be cured by being subjected to their code of laws are pronounced incurable at once; and their rules are enough to make a rational person crazy. (Davis, 1850, p. 57)	It was always rules. I kept wondering whether this was a hospital or a prison. . . . and I mean you would at least think that there would be some bend, you know like for individual cases or exceptions—after all the world isn't black and white. But no, the rules were the rules and they were like sacred or something. #025
There is absolutely no escape from obedience here, no matter what is required. I have many times, seen even tardy or reluctant obedience punished with fearful severity. (Olsen, 1862, p. 73)	I don't know how much I understood my freedom at the time, that I was—I had a right to freedom or whatever. You were pretty much just to follow orders . . . do what you're told. I didn't like being restricted so much. I mean, I, I understood, I guess, for them to need to be able to control everyone . . . but I guess I just didn't like the type of control they were showing . . . just, just how strict they were and in enforcing the rules also . . . Just there was no slack whatsoever—in their rules. They were enforced all the time. It also made me feel angry because they were showing their complete control over me and saying that I, I couldn't basic—I basically couldn't do anything. #004

NOTE. See Geller and Harris (1994) to reference citations included in the body of Table 1.

patients off balance. Deviation from the prescribed rules of behavior threatened to derail the organization from the pursuit of its goal—the smooth running of a milieu. This sometimes resulted in a disagreeable backlash as shown in the next category of punishment.

Process

Exemplar 1 in Table 2 represents the process variable of punishment. Punitive treatment stems from authoritative structures that demand swift retribution for failure to comply with rules. Punitive treatment was typical in the United States in the late 18th century, reflecting the vestiges of punishment for sinful behavior that characterized the Christian approach to deviancy. In mental hospitals punishment was an integral part of the approach to treatment (Deutsch, 1949). Ostensibly in the interest of patient safety, confining restraints or the use of seclusion has also been used as punishment for past violent outbursts, or to forestall future ones (Miller, 1986).

In some contemporary hospitals, the "time out" was also used as a form of punishment as well. Patients complained bitterly of repeated "time outs" for extended periods. In addition, staff members devised a modern-day version of Benjamin Rush's infamous "tranquilizer chair." The treatment was a form of "time out" known as "chair time," and the idea behind it was the imposition of a consequence for certain undesired behaviors. During "chair time" the children were instructed to think about their behavior. Any form of communication was forbidden during "chair time," and if the child smiled, turned his or her head to the left or right, or made any facial gestures that the staff deemed to constitute "an attitude," the length of time in the chair was increased in 5 to 15 minute increments. The chair was also turned around so that the child was facing a blank wall. In many

Table 2. Process

Punishment (Exemplar 1)	
I soon felt the weight of the attendant on me, with one knee pressing directly on my stomach, and one hand, like the grip of a tiger on my head. (Smith, 1865-1871, p. 134)	. . . They jumped me and then they put my hands above my head and held them there, and one guy, he had his knee in my gut. All because I told them to fuck off. #003
My hands were bound, my feet were tied to the foot of the bed with a cleverly made noose. I watched the process with interest. I did not mind. It was something new; broke the monotony. It was a bother to my keepers and I was in a mood to appreciate that fact. (Hillyer, date unknown, p. 239)	So they tied me down in four point leathers. And at that point it was like I didn't really care. I mean, hey, what's the point in getting upset? It broke up the boredom, though, and it really got them going. #011
Lack of advocacy (Exemplar 2)	
I knew, perhaps for the first time, pure fright, but I was unable to speak. Only groans and whimpers came from me. I looked at the nurse, begging her with my eyes to help me, but she seemed busy at the wall cupboard. She was aware of what was going on but she was removing herself from the episode. (Farmer, 1943-1950, p. 319)	And now and then you would get the idea that the nurses and those in charge would just turn their heads when the attendants tried to push your buttons [provoke]. #016
Capriciousness (Exemplar 3)	
In this prison was exacted the most immediate and uncompromising obedience to rules and requirements which a slave holder would have blushed to inflict upon his human chattels. Our own preferences were never consulted. "you must do this because I want ye to," was all the reason given. (Olsen, 1862, p. 71)	Girl, there was no question. None at all, you did what they said, just because they said it. No reason given. #008

NOTE. See Geller and Harris (1994) to reference citations included in the body of Table 2.

instances day long "chair time" was imposed. This was known as "extended chair" or "indefinite chair" (U.S. Government Printing Office, 1992).

Punishment as a means of behavior control is known to be highly ineffective in the long term. Yet, stories of punishment as treatment are not new, nor do they surprise seasoned professionals. Among some reasons for its ongoing use are countertransference on the part of staff members; ignorance of behavior dynamics, developmental and trauma theory, and other principles of therapeutic care; and retaliation against the patients for the disruption of the organization.

The absence of advocacy is reflected in Exemplar 2, Table 2, as a process variable stemming from noxious structures in which persons either fear speaking out about structures (Mohr, 1996) or have so bracketed their feelings that they function solely as fulfillers of tasks (Mohr & Mahon, 1996). Human feelings aside, legal requirements, standards of practice, ethical directives, and ideals were formulated with the presumption that these standards would be adhered to, or implemented by, individual professionals. Yet these striking examples speak to patients' expectation of help, altruism, and advocacy of the professionals who chose to look the other way. Perhaps situations in which a professional's own position becomes threatened, such as in difficult job markets or during situations of deprivation, the pull of self-preservation becomes stronger than the pull of beneficence (Mohr & Mahon, 1996). In addition, the tug of loyalty to one's group can sometimes result in a temptation to turn the other way to avoid negative sanctions. This benign ethical numbing can too often becomes a structural normative practice that has a potential for making anyone who works with people regularly perceive and treat them as nonhuman, statistics, commodities, or interchangeable diagnostic categories.

The capriciousness of staff members as experienced by both populations is reflected in the passages presented in Exemplar 3, Table 2. Most humans have a need for certainty and security. As a result, inconsistent and unpredictable outbursts of violence and arbitrary enforcement of unit rules may result in great uncertainty and subsequent anxiety, hypervigilance, and fear. Unit policies often have no basis in logic, and certainly no basis in empirical research. For example, the rationale behind formal and informal conventions such as the reading of mail and restriction of visitors that

regulate the most minute and intimate of patients daily activities is obscure and poorly explained, if at all. Policies may be integral to the disciplinary program (or for the efficient running of the unit), but the rationale is not often explicitly articulated to patients. Patients often see these conventions as being especially arbitrary, and in their minds they assumed an inordinate significance. The effect of these rituals is to convince the patients that staff members are in control, resistance is futile, and their lives depend on winning staff approval through absolute compliance. Long discharged former adolescent patients continue to remember the inconsistency of rules or the unfairness of blanket restrictions rather than any therapeutic issues that may have surfaced.

Outcomes

Table 3, Exemplar 1, shows the true meaning of compliance—to submit or acquiesce to the wishes of another. Compliance suggests a lack of self-direction and a loss of control. Moreover, it is an expected outcome for which patients are praised; the "noncompliant" individual is seen by the nursing and medical establishment as a problem (Mohr & Noone, 1997). Yet evidence suggests that the malignant emotional sequence associated with loss of perceived control that often occurs among people who are ill or incapacitated not only increases subjective suffering but impedes recovery (Rutter, 1985; Newcorn & Strain, 1992). The daily lack of control over the smallest aspects of their daily life and the trauma of being taken out of their familiar home environment must have been shocking to both the Victorian women seeking empowerment and to the children and adolescents who were trying to negotiate the development of their autonomy. When this shock was accompanied by the unsupportive atmosphere of an institution, patients were faced with a formidable task of adaptation. They had to find a way to sort out their sense of trust in people whom they might view as untrustworthy, such as their relatives who put them in the hospital. They also had to negotiate a relationship with their institutional caregivers who were unknown entities, and they also had to find safety in situations that were perceived as unsafe and as posing the threat of emotional and physical punishment. Finally, they had to preserve a sense of control in situations that were unpredictable and a sense of power in situations in which they were uncertain. Those who refused to comply and give up their sense of autonomy searched for control in resistance activities.

Patient resistance activities are represented in Exemplar 2 of Table 3. Although these behaviors were considered noncompliant, they could also be viewed as a healthy response to changes or situations that threatened integrity. Although certain activities seem to be strategically legitimate from the standpoint of treatment staff, if they result in an assault on an individual's feelings of competence, self-worth, or independence, they inevitably lead to resistance. Throughout history, patients (dissenters, political prisoners) have repeatedly shown that they are not simply puppets who move in whichever directions those in positions of power wish to direct them.

When patients noticed that protective actions had little observable effect in bringing an end to their experience, their initial reaction was an upsurge of anger and protest. Anger and outrage was a common reaction pervading the hospital experience. It is one example of how patients reacted in indictment and accusation of their environment and its contingencies. They were appalled at how they were being treated, they came up with ingenious ways of resisting further dehumanization, and many swore to get even with the system. Indignation or outrage as an almost completely other-directed emotion came through in the process of fighting back, which is illustrated in Exemplar 3 of Table 3.

Although the professional organization was seemingly ineffectual at providing treatment (at least in one participant's estimation) fellow patients provided comfort and validation. This collegial support, when it happened, was a way of making connection with others who could give the kind of support, affirmation, care, and strength that only another person who has experienced the same events can furnish. This traumatic bonding is illustrated by Exemplar 4, patients turning to each other in the midst of their distress to share stories, to borrow strength, and to endow their environments with meaning. They put names to a suffering that too often remained unspoken in therapy. When they could no longer bracket off the worry, anxiety, and pain, or when they could no longer ignore what was happening, they found comfort and mutual validation in each other.

Table 3. Outcomes

Compliance (Exemplar 1)	
I am making an effort to win my dismissal. I am docile; I make efforts to be industrious. (Starr, 1901, p. xix)	Basically you go along with the game and you get out. #014
Resistance (Exemplar 2)	
. . . for the reward of merit. This requires but a piece of acting; they are assured that silence is safe, that to suppress a natural characteristic flow of spirits or talk is an important step for them . . . [this results in] being patted panergyrically on the head by the head itself and pronounced by that important functionary, "better." . . . It need not be necessary to say that these patients were more agreeable and companionable when acting themselves, than after their submission. Whoever is strong enough to condense his nature after this fashion may reach the goal . . . (Lunt, p. 120)	They wanted you to talk—well, I had nothing to say. I really thought my parents had over-reacted by putting me in there; I was pissed (that) I was there. So for weeks I would sit there glaring at the nurses and the CADAC (certified alcohol and drug abuse counselor), and they would chart that I had a shitty attitude. One day I finally got a clue. Hey, if I do this then I am only screwing myself, so if they want me to talk, by god, I'll talk. So I played their game and I talked, and the more (that) I talked, the better they liked it. I made up the weirdest stuff. I would listen to what some of the other kids were saying and then I'd go them one better, and then they'd do the same thing. Boy, oh man, did we give them earfuls of garbage. And they loved it—I mean they absolutely went ape shit over some of this stuff. The wilder the better. It felt great at the time because it was like screwing them over, but in the long run I think I screwed myself cause all this goofy stuff is on my record. They made a liar out of me, and now no one will believe that I made it all up, and it feels like I will never get out of this never-never land that I got myself into. #020
Fighting back (Exemplar 3)	
. . . When I was in the asylum they locked me up when they pleased, but what did I care for that as long as they had no key that would fit my mouth. I knew that I should live through it all, and I told them I should, and that when I got out they would hear from me. (Davis, 1850-1853, p. 51)	There we all were like prisoners in a concentration camp. We would all take turns being the victim of the day. Sometimes everyone was a victim and we would all sit chair. Some days we would sit chair over and over—the whole unit would. It got to where we would get real pissed and we'd start to think of all different ways to communicate. We'd wait until their backs were turned and we'd flip them the bird, or we'd throw spitballs, or we'd pass notes, make up hand signals. It got to be a game to see how much we could get away with and how much we could push the envelope. Of course, if you got caught, you'd get another 15 or 30 minutes. Then there was extended chair—that's what you got if they got an attitude about you. Extended chair became a kind of status, and if they isolated or put you in restraints, that was really the ultimate, because you knew that you had really gotten to them. You made them lose control. And they thought that you'd lost it. Boy, did that make you feel alive! It sounds like a little thing—but it kept us going. It was a sign that the bastards hadn't driven the fight out of you. #011
Traumatic bonding (Exemplar 4)	
My limits will not permit me to relate the scene of parting with my sisters in bonds. It was such as to confirm my affection and devotion to them and to all who bear the dreadful name of Lunatic forever. (Olsen, p. 78)	The only people that actually showed any interest in the reason why we're there, why I was there, were some of the other patients. I mean, that's who I felt I had the, you know, got the most response from—was the patients, not necessarily any of the staff members or anybody. Code #020

NOTE. See Geller and Harris (1994) to reference citations included in Table 3.

DISCUSSION

The striking parallels between what was said by patients over 100 years ago and what they tell us today oblige mental health professionals to reflect on how far our society has really come in attitudes toward mental illnesses. Moreover, the recent events that resulted in the death of patients at the hands of or because of neglect by staff members in Connecticut, Arizona, and North Carolina, as well as reports of abusive situations in Virginia and California, should concern us as professionals and as patient advocates. The unexamined idea that we have made great progress may be more mythical than real. The purpose of myths is to help humans to make sense of a complex world, but these myths may also serve to obscure rather than reveal important realities.

The progress myth contains unspoken elements that are not often examined critically. One such element is the idea of how far we have come in our attitude toward and treatment of the mentally ill. The progress myth is seductive and appealing to a culture that is future oriented, enamored of advance, and too often ignorant of the wisdom of the past and the lessons of history. To be sure, scientific, technological, and medical progress has been made and has benefited many people. Advances in the biological bases of behavior and the treatment of mental illness are remarkable when viewed in the context of historical superstition, ignorance, and fear. However, as much as we would like to believe that we have made great strides in the care of the mentally ill, the notion of progress may be accepted far too readily and used to obfuscate rather than to illumine.

In the last 100 years there has been a series of cycles in the treatment of the mentally ill that many regard as periods of progression and regression, with no clear accumulation of knowledge regarding treatment. The possible exceptions to this are the research strides that have been made in the biological bases of behavior and the development of new and more effective psychopharmacological treatments. But the psychopharmacological treatment of psychiatric patients does not take place in a vacuum; patients are human beings who operate in a milieu, and professionals must avoid abdicating fiduciary responsibility or advocacy for anything but the narrowest concerns—such as medications or other somatic therapies. Notwithstanding biological interventions, how differently are mentally ill patients treated in clinics, institutions, or in legislative and funding arenas from the days of Deutsch's (1948, 1949) exposés or the times reflected in *Women of the Asylum?* (Geller & Harris, 1994).

Brown (1983) posited that "abusive conditions endured by the mentally ill would not be tolerated unless sane people disliked, distrusted, and feared (them)" (p. 190). Mentally ill individuals are often difficult, frequently unattractive, disruptive, and trying. Unlike babies dying of cancer, they do not inspire the sympathy of groups of individuals with money and time to donate. Thus, the lack of access and care and abominable conditions are left to fester until exposed by an outraged family member, or press, or more recently by professionals whose self-interest has been threatened.

In the wake of the dismantled investor-owned psychiatric hospital system, Jellinek and Nurcombe (1993) posited that psychiatrists were in danger of being professionally disenfranchised and that in the current health-care environment patient care is being severely compromised. Other professionals likewise complain about compromised care in the wake of health care reform. These voices were notably absent during the years of the Texas scandal (State of Texas, 1992), and they do not appear in the newspaper accounts of the latest deaths and accounts of incompetent and abusive conditions referred to earlier in this article. It is disturbing to think that self-interest may have motivated this latest professional outcry on behalf of patients and patient care. Yet, despite all of this concern for patient welfare, there continues to be little in the professional literature about abusive systems—as if ignoring them will render them invisible and therefore nonexistent. Media exposure remains virtually the only way that these problems come to light. We, in the caring professions, can only benefit if we engage in more honesty and forthright acknowledgment of ongoing, long-term, needed attention to unethical behaviors, self-interest, incompetence, fraud, waste, and abuse as unwanted but attendant components of the ecosystem of health-care environments. This lack of attention to continuing abuses and other problems warrants a collective look at our professions and the contexts of practice "through a glass darkly" from Pretending that they do not exist benefits no one, erodes trust in all of us as professionals, and reduces our social contract to mere words on paper.

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