Women and Mental Illness: A Cultural Systems Perspective
By Ruth Miller

Scenes from Girl, Interrupted

(Susanna, a woman in her late teens, self-admitted to a psychiatric hospital for attempted suicide, is sitting in the psychiatrist’s office. It’s the early 1960s. They’re both smoking cigarettes; the psychiatrist is sitting behind her big desk with books and a folder open in front of her; Susanna is sitting upright on a low sofa facing the desk, looking up at the doctor, clearly resentful)

S: “Ambivalent… It’s my new favorite word.”
Psych: “Do you know what it means?”
S: “I don’t care … That’s what it means: I don’t care.”
S: “That’s not a choice!”
Psych: “For some, dear, it is. ...Will you commit yourself to hospital for life?”

(Months later, Susanna is curled up in her bed, in tears over failing to stop another young woman’s suicide. The head nurse enters the darkened room and approaches the bed. She inquires as to Susanna’s state, then...)

Head Nurse: “You got to put it down, put it in your notebook, put it somewhere—get it out of yourself so you can’t curl up with it anymore.”

A Culture of Pathology

We live in a culture that, for many historical and economic reasons, pathologizes many of the normal processes and responses of human growth and development—especially for women. The cultural reasons for this are deeply embedded in a 6,000 year-old process of systematic overrun of indigenous peoples by a culture based on exploitative, empire-building patriarchal values. Daniel Quinn, in his award-winning novel, Ishmael, calls these “Taker” values. People operating from these values assume that any object is for the taking and any person who is perceived as “other” (different skin color, different language, different clothes, different skills) is an object.

These assumptions, in turn, lead to the economic reasons. “Taker” values require a shift from the gift-exchange economy of small villages and tribes to a cash-based
economy, in which every service and object has a monetary value and a few people can acquire most of the goods. It’s “good for the economy” in such systems for people to pay for goods and services, so it’s “good for the economy” for a significant number of people to be “sick” and pay for “treatment.” The people who are identified as “sick” then become “other” and therefore objects to be controlled and exploited by those identified as “healthy.”

Women become objects in this culture in a number of ways. First of all, they are not as physically strong as, and so are not “equal” to the men who embrace “Taker” values. Second, women are genetically “programmed” to perceive things differently: using the dispersed awareness of a multi-tasking gatherer and homemaker, rather than the focused concentration of a hunter. Third, women’s brains are structured so that there’s more interaction between the right, “relational-holistic-metaphoric” side of the brain and the left, “linear-analytic” side of the brain—leading them to use different systems of logic and memory than most of their male counterparts. These differences make women “others” to men with “Taker” values, and so makes them “objects” to be controlled and exploited.

Clinical Perceptions of Women

A number of studies have demonstrated that the psychotherapeutic profession conforms to this culture pattern. One of the earliest of these was cited by Phyllis Chesler in her classic, Women and Madness [Doubleday, 1972]. In this study, by Broverman and colleagues, a series of contrasting characteristics relating to mental health and illness were rated by clinicians—both male and female, with no significant differences among them. What was significant was the differences in their classification of the characteristics of mental health and illness in men and women. She describes the results:

Their concepts of healthy mature men did not differ significantly from their concepts of healthy mature adults, but their concepts of healthy mature women did differ significantly from those for [healthy] men and for [healthy] adults. Clinicians were likely to suggest that [healthy] women differ from healthy men by being more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, more easily hurt, more emotional, more concerned about their appearances, less objective and less interested in math and science. [Chesler, Phyllis, Women and Madness, Doubleday, 1972; p. 104].

The fact that both male and female clinicians consider a substantial range of behaviors to be “healthy” among women and at the same time to be “unhealthy” for an adult in our culture raises all kinds of questions about the legitimacy of diagnosis and treatment in psychotherapeutic practice—and the role of the social institution of psychotherapy in the culture.
As an example of this bias in diagnosis, Chesler quotes Nathan Rickel describing certain highly-successful women professionals as “neurotic” because they exhibit such (typically masculine) behaviors as,

An inability to brook criticism or competition; bursts of uncontrollable temper; the use of foul language; possessiveness or jealousy; the use of alcohol or drugs; and consorting with spouses who accept such behavior [ibid].

Chesler goes on to assert that the standard assumption in both textbooks and clinics is, “‘Real’ women all are mothers—but once you’re a mother, anything that goes wrong is your fault,” pointing out that mothers are held to be “the cause of neurosis, psychosis, and criminality in their children.” [ibid. p. 108]. Finally, she points out that “Freud’s views and self-professed confusion about women have been embraced, often romantically and devotedly, by female … and by male theoreticians” alike [ibid p. 112]. As a result, the official view of “normalcy” in women became one of bearers and breeders of children, with strong emotional reactions, little talent for logic or analysis, and a childlike dependency on men.

Over two decades later, Denise Russell, a philosopher from Australia, challenged the logical and evidential basis for psychiatric diagnoses in Western culture. She states flatly:

From the perspective of biological psychiatry, nearly all women are disordered. … Even if we take into account only depression and premenstrual syndrome … women are viewed as psychiatrically disordered. One of the themes [of this book] concerns women’s rebellion against the constrictions of the female role, and the power of psychiatry to pathologize this rebellion and to recommend treatment. [Russell, Denise, *Women, Madness, and Medicine*, Cambridge, UK: Polity Press, 1995; p. 96].

Clinician Paula Caplan, in an assessment of the categories used in the therapist’s standard diagnostic manual (“the DSM”), states:

They call women mentally ill when they follow traditionally ‘feminine’ socialization … they say that ‘female hormones’ make women psychiatrically disordered. But they don’t consider the results of rigid ‘masculine’ socialization to be a problem; they don’t have a category of ‘Macho Personality Disorder’ … and … ‘Testosterone-Based Aggression,’ even though there is evidence that men are far more violent than women and that one part of this may be due to their hormones [Caplan, Paula, *They Say You’re Crazy*, Addison-Wesley, 1995; p. 168].

Of course, this kind of, as Caplan calls it, “Doublethink” within the psychotherapeutic profession is not confined to the diagnosis and treatment of women. She points out that the elderly also experience classifications of “normal” or “abnormal” based on “strange assumptions,” as do “members of racialized groups, people with disabilities, people considered overweight, homosexuals, and bisexuals” [ibid p. 71-73].
In large part, she suggests, this is because the categories—and treatments—are very nearly arbitrary, with little research to support them. In category after category (some of which are outlined below) she demonstrates that the research used to substantiate the diagnostic guidelines of the DSM is flawed, based on inaccurate assumptions, or lacking entirely.

Finally, reminding us of the fundamental cultural issue, Caplan points out that mentally ill people tend to be considered not just more or less of something than the rest of the population but ‘other than,’ … Diagnosing people in distancing ways encourages the use of dramatic interventions, such as psychotropic drugs and electroshock therapy. … If we think people are very different from us, it is easier to be unaware of their pain [ibid pp. 25-26].

Doctor-Patient Relationships

In 1993, in The Creation of Health, Caroline Myss described a needed revolution in health care: a shift of power from the doctor to the patient. She points out that, in the scientific model, the doctor is all-powerful, the patient is passive and completely dependent on the doctor’s directives. Such a model, Myss says, is not a psychologically healthy situation for the patient—and probably isn’t for the doctor, either.

The clinical model of psychotherapy was first set by Sigmund Freud over a hundred years ago as necessarily that of “a superior and a subordinate.” The parental nature of the therapist’s role is commonly understood, and virtually all observers accept that the therapist is, at the least, the “expert” in the therapeutic process. This places the therapist in a position of authority and control that leads to a variety of ethical conundrums—particularly if the therapy lasts over a long period of time or occurs in a relatively small community.

Dorothy E. Smith, editor of Women Look At Psychiatry, says “Sociologists view psychiatry as among the ‘mechanisms of social control’ in contemporary society” [Smith, Dorothy E. & Sara J. David, editors, Women Look At Psychiatry, Press Gang Publishers, 1975; p. 4]. Concerned that the people being controlled are women who don’t conform to the current socially accepted norm, she points out that, as practiced, psychiatry deprives women of the opportunity of ... talk[ing] without shame...Behavior that doesn’t fit [the societal expectation] is treated as a ‘symptom’ ... understood as pointing to the sickness of the individual ... The patient must learn to understand herself in terms of her sickness ... to find out what went wrong and where; to learn the causes of her failures ... to be a woman on men’s terms [ibid p. 5].
Institutionalization

This power relationship is multiplied many times over when the patient is placed in an institution. As Mary Elene Wood suggests in her compilation of autobiographical material from asylum inmates,

The association of insanity with the female body, the tendency of asylum ‘family’ structure to cast patients as dependent and submissive, and the assumption that insanity, like other illnesses, rendered patients passive and deprived them of the will-power required of men—all contributed to the association of madness with women.

The paternalistic perspective of asylum discourse in the nineteenth century, a perspective implying that the feminized patient was unable to judge the quality or nature of care, helped obscure the violence still intrinsic to asylum management in the United States [Wood, Mary E, The Writing on the Wall, Chicago: University of Illinois Press, 1994; p. 7]

These women were among the 200,000 inmates of such institutions at the turn of the nineteenth-twentieth centuries—nearly one person for every 500 in the U.S. at the time, and almost evenly split between men and women.

Thomas Szasz equates modern-day Institutional Psychiatry with the Roman church’s Inquisition, suggesting that

... both provide an intellectually meaningful, morally uplifting, and socially well-organized system for the ritualized affirmation of the benevolence, glory, and power of society’s dominant ethic. From without, or to the critical observer, these institutions might appear harsh and oppressive; but from within, or to the true believer, they are beautiful and merciful, flattering at once the masses and their masters. ... Each seeks to protect the integrity of an excessively heterogeneous and pluralistic society and its dominant ethic. To accomplish this end, each represses certain individual and moral interests, and, in general, sacrifices the “one” for the “many” ... to strengthen group cohesion...[Szasz, Thomas S., The Manufacture of Madness, New York: Harper & Row, 1970; p. 57-58].

This sacrifice is painful indeed, for the ones who are targeted for repression or elimination.

Twentieth-century asylum inmates voice that pain in a collection of poems and essays called Beyond Bedlam. In a chapter entitled “When the World Can’t Face Its Fear, We Get Locked Up,” Rae Unzicker is one of several women sharing her experience:

I have, finally, discovered the lie, the fraud that is ‘help’ in a hospital. Help is Thorazine. Ritalin. Mallaril. Help is making ceramic cups. Help is the day room, day after day after day after day. Help is volleyball. Help is confinement and imprisonment. Help is forced labor. Help is learning not to see the violence, when the very air you breathe is heady with violence.... Help is denying the injustice you see with your own eyes and hear with your own ears. And always, help is compliance, cooperation, passive acceptance, and, ultimately, gratitude [Unzicker, Rae, “From the Inside” in Grobe, Jeanine, editor, Beyond Bedlam, Chicago: Third Side Press, 1995; p. 15].
In the mid-twentieth century, the European “village” model, discovered serendipitously through the evacuation of institutions during the World Wars, began to work its way over to the U.S. Sheltered workshops and occupational therapy emerged as acceptable forms of therapy, and the focus of treatment shifted from management to rehabilitation. Family and home-based care “promoted the socialization of patients.”

During this period, some practitioners became aware that long-term institutional care was in itself detrimental to the mental health of patients. The syndrome of ‘institutionalization’ was described in the literature. Some writers referred to a ‘prison stupor’ in patients whose social contacts diminished and who became passive and unmotivated. Hospitals, while beneficial in the early stages of an illness, seemed to become detrimental after a while...actually worked against the free expression of an individual’s healthy personality [Geller, Jeffrey L. & Maxine Harris, *Women of the Asylum*, New York: Doubleday, 1994; p. 262].

So the asylum, or mental hospital, has slowly begun to be seen as contributing to a given mental health problem—perhaps even exacerbating it—rather than solving, or even ameliorating it.

This shift in understanding, while extremely useful in addressing the needs of individual patients, became the Reagan administration’s justification for closing hundreds of publicly funded hospitals in the 1980s, causing thousands of inmates—now trained to dependency upon the system of hospital care—to be released into public housing, group homes, and the streets. And today, it’s generally agreed that a large proportion of America’s homeless population suffer from untreated mental disorders, which may, in a disturbing circularity, be the underlying cause for their homelessness..

**General Diagnostic Issues**

In large part due to Freud’s work, women’s emotional and spiritual problems and challenges during the 19th century tended to be lumped under the heading “hysteria.” By the mid-twentieth century, the common diagnosis was “schizophrenia,” with all the trauma and stigma that goes with such a categorization. Now, in the late 20th-early 21st century, it’s “depression” or “ADHD,” easily “treatable” with a variety of costly drugs, or “Premenstrual Syndrome,” easily allowing the discounting of any rebellious activity or discontent.

Whether this is happening in spite of, or because of the DSM (the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association) is a matter of debate.

As indicated above, Paula Caplan, Denise Russell, and others say that the methodology used in preparing the DSM is flawed and its application is too often haphazard at best. Caplan points out that many of the categories lack the rigorous
scientific research necessary to support them and are, as a result, too often subjective and biased in favor of the assumptions and prejudices of the editors. She is concerned that the categories “masquerade as solid science and truth” [Caplan, Paula, They Say You’re Crazy, Addison-Wesley, 1995; p. xvi].

Russell goes a step further to suggest that the fundamental notion of “mental disorder” is, in itself, flawed. She points out that many of the defining characteristics of specific “disorders” are vague, at best. Then she expresses the concern that a focus on the individual without consideration of a social context “is likely to encourage diagnoses of ‘mental’ disorder when there is far more disturbance in the social environment than in the mind of the diagnosed person...” [Russell, Denise, Women, Madness, and Medicine, Cambridge, UK: Polity Press, 1995; p. 40].

Making her case for the inadequacy of the assumptions underlying the DSM categories, Russell targets familiar diagnoses.

Depression is the most common psychiatric diagnosis in the twentieth-century Western world, and up until recently it has been thought to be primarily a female problem. ...Medical psychiatrists believe that most people who are depressed ... have a biological fault. There is, however, no agreement on what this fault is, so diagnosis cannot come from detection of a biological problem. ... [Russell, Denise, Women, Madness, and Medicine, Cambridge, UK: Polity Press, 1995; p. 51].

She goes on to assess the research that is supposed to support the diagnostic guidelines for depression and concludes that “the research to date has not established a biological base.” Even for “post-natal depression... there is no evidence that these [hormonal] changes give rise to depression” [Russell, Denise, Women, Madness, and Medicine, Cambridge, UK: Polity Press, 1995; p. 58].

Addressing the diagnostic category of Schizophrenia, Russell states, “Firstly, there is a problem in definition and diagnosis.” She points out that recent research suggests that the term was originally applied to what today is called encephalitis lethargica, “the odd collection of behaviors and experiences ... [illustrated in] the film Awakenings...” and that “no one common defining characteristic has been used.” Her review of several editions of the DSM shows that

... the definitions of ‘schizophrenia’ have changed right up to the latest scheme, where the key characteristics are poor performance in the areas of work, social relations and self-care, together with delusions or hallucinations or thought or feeling disorders with delusions or hallucinations [ibid p. 73].

However, her review of the research supporting the three main theories of schizophrenia found no substantial support for this latest definition.

Looking at the schizophrenia research overall, ... none of the detailed theoretical lines have established biological markers for schizophrenia or the biological cause. Yet this is supposed to be
the area of greatest strength for biological psychiatry. The studies do not even lead to clarification ... they produce greater confusion... [Russell, Denise, Women, Madness, and Medicine, Cambridge, UK: Polity Press, 1995; p. 83].

Even the DSM notes that ‘no single feature is invariably present or seen only in Schizophrenia’ [ibid p. 150].

Russell concludes that, after 200 years, biological psychiatry still has not developed a research program to substantiate its diagnostic claims. Its growing influence, she suggests, is not so much a function of its effectiveness in diagnosis and treatment as of its support by the pharmaceutical industry, which has profited greatly from the treatments prescribed by psychiatrists. She also points out that psychiatry also has been very effective in maintaining its original position as moral guardians—controlling the behaviors of those—especially women—who rebel against the social order.

**Spirituality, Creativity, and Mental Illness**

Within some cultures and even within some religious groups in Western culture, to hear voices that others do not hear is a special ability that is valued by the group. Also to doggedly hold on to beliefs which others reject is often taken as a mark of faith and something to be valued. [Russell, Denise, Women, Madness, and Medicine, Cambridge, UK: Polity Press, 1995; p. 150].

There must be a better way to determine what is a healthy mind than only requiring that it be functional in its social environment ... Some definition is required, in any case, for those higher states of awareness inhabited by the geniuses and spiritually awakened persons of the world who not only cope but carve out the frontiers for other members of society. Most often their behavior is anything but normal ...[Schul, Bill, M.D, “Madness: An Exercise in Growth” in The Psychic Frontiers of Medicine, New York: Ballantine, 1977; p. 108].

True sanity entails in one way or another the dissolution of the normal ego, that false self competently adjusted to our alienated social reality ... and through this death a rebirth, and the eventual reestablishment of a new kind of ego functioning [Laing, R.D., The Politics of Experience, 1967].

Much of what has been diagnosed as symptoms of a “mental disorder” has, in fact, been the indicator of movement into or through a stage in a developmental or creative process. For example, much that has been diagnosed as “depression” is, in fact, unexpressed or repressed grief—held back out of a need to “get back to work,” or fulfill others’ directives to “get over it,” or simply out of ignorance of the nature and process of grieving. Similarly, it’s a truism among students in religious seminaries that a good
deal of what they are encouraged to experience as part of their religious training would “get them committed” outside of the religious institution.

Bill Schul, a clinician with the Menninger Foundation, found that traditional distinctions between “ill” and “healthy” fail when confronted with other spiritual or cultural norms. In an essay entitled “Madness: An Exercise in Growth,” he explores descriptions of shaman’s trainings and mystical experiences. Quoting Dr. Julian Silverman in *Psychology Today*, he reminds us that “many religious figures—St. Paul, St. Theresa, and George Fox, the founder of the Quakers, for example—have gone through experiences that today would be regarded as full-blown psychoses…” [Schul, Bill, M.D, “Madness: An Exercise in Growth” in *The Psychic Frontiers of Medicine*, New York: Ballantine, 1977; p. 108, quoting Dr. Julian Silverman in *Psychology Today*, 1975].

He points out the great similarity between the mental illness called schizophrenia and the behaviors observed in traditional initiation rites in many other cultures...

“In many non-Western cultures the psychotic-like transition ordeal is accepted—there is no social stigma for the initiate. In our culture, however, the schizophrenic must make his fantastic voyage alone, ashamed, in the hands of hospital personnel whose purpose is to interrupt his schizophrenic trip...” [ibid].

Schul states, “Much that is generally regarded as ‘madness’ is simply characteristics of the mind operating in a different fashion from that expected in everyday life” [ibid p. 109]. He suggests that the reason for this is simply that we lack the psychotherapeutic categories to deal with it, because, he says, “psychology and sociology historically have relegated transcendence to an inferior order of reality” [p.110]. He points out that R. D. Laing, Julian Silverman, and John Wier Perry all found that certain people experiencing “ego-loss” were, in fact, moving through a process well-described in the spiritual literature of several religious traditions.

In the chapter, “Reactions to the Spiritual Awakening” in *Psychosynthesis*, Roberto Assagioli, once a student of Freud, describes the emotional and mental states experienced by someone who has had an ecstatic mystical experience and then discovers that it must come to an end.

Necessarily this is a very painful experience and is apt in some cases to produce strong reactions and cause serious troubles. The personal ego re-awakens and asserts itself with renewed force. All the rocks and rubbish, which had been covered and concealed, emerge again. The man, whose moral conscience has now become more refined and exacting, whose thirst for perfection has become more intense, judges with greater severity and condemns his personality with a new vehemence; he is apt to harbor the false belief of having fallen lower than he was before. Sometimes it even happens that lower propensities and drives, hitherto lying dormant in the unconscious, are vitalized by the inrush of higher energy, or stirred into a fury of opposition by the consecration of the awakening man—a fact which constitutes a challenge and a menace to their uncontrolled expression.
At times the reaction becomes intensified to the extent of causing the individual even to deny the value and reality of his recent experience. Doubts and criticism enter his mind ... He becomes bitter and sarcastic, ridicules himself and others, and even turns his back on his higher ideals and inspirations. ... [Assagioli, Roberto, *Psychosynthesis*. New York: 1965]

Assagioli compares this state to traditional diagnoses of pathology, stating that it may produce depression, despair, or even impulses of suicide:

... a close resemblance to psychotic depression or "melancholia" which is characterized by an acute sense of unworthiness, a systematic self-depression, and self-accusation; the impression of going through hell, which may become so vivid as to produce the delusion that one is irrevocably damned; a keen and painful sense of intellectual incompetence; a loss of will power and self-control, indecision and a incapacity and distaste for action. [Assagioli, Roberto, *Psychosynthesis*. New York: 1965]

However, Assagioli, reminds us, for people going through the process of spiritual awakening, “the troubles should not be considered as a mere pathological condition;” they are part of a specific psychological process. Then he points out that these symptoms are not confined to people going through spiritual crises, but are associated with creative crises, as well.

Artists have often complained of periods of aridity, frustration, inability to work. At such times they ... may be affected by many of the psychological symptoms mentioned above. They are apt to make vain attempts at escape or evasion of that painful condition by means such as alcohol or drugs. But when they have reached the depth of despondency or desperation there may come a sudden flow of inspiration inaugurating a period of renewed and intense productive activity.

Often the work of art appears as a virtually finished product elaborated without conscious awareness at some unconscious level or region of the artist's inner being. As Murray has stated in his brilliant essay, “Vicissitudes of Creativity,” (p. 107), ... "there must be sufficient permeability (flexibility) of boundaries, boundaries between categories as well as boundaries between different spheres of interest and... sufficient permeability between conscious and unconscious processes... Too much permeability is insanity, too little is ultra-conventional rationality." ... [Assagioli, Roberto, *Psychosynthesis*. New York: 1965]

Recognizing the nature of the crisis is, in Assagioli’s view, the essence of treatment:

The proper treatment in this type of crisis consists in conveying to the sufferer an understanding of its true nature and in explaining the only effective way of overcoming it. It should be made clear to him that the exalted state he has experienced could not, by its very nature, last forever and that reaction was inevitable... The recognition that this decent or "fall" is a natural happening affords emotional and mental relief... [Assagioli, Roberto, *Psychosynthesis*. New York: 1965]

**Toward Health**

I was so stiff and so tense and so fearful... I had to stay away from interactions with people and events. ... I couldn’t even drive a car. ... When visitors came I would go down [to the basement]. I
had a lounge chair there ... I would wash dishes and I would say ‘washing’ and check whether I really knew it [Boucher, Sandy, Dancing in the Dharma: the life & teachings of Ruth Denison, Boston: Beacon, 2005, p. 122].

Every human being has experiences that hurt and every culture has ways of healing those hurts. Western industrial culture, with its emphasis on things and the machines that build them, relies on technology to heal—in the form of “the latest” machines and medications. By contrast, indigenous, “primitive” cultures, organized around the principle of harmonious balance and emphasizing the energy of relationship, rely on that energy to heal. They modify existing relationships and create new ones.

In that way, they are very much in alignment with the emerging form of medicine that has been called “Transpersonal.” As defined by psychiatrist Frank Lawlis,

Transpersonal approaches assume within each individual planes of wisdom beyond the primary intellectual strength of the ego. They use therapeutic strategies that attempt to bring out from inner sources the knowledge of the unconscious. ... [Transpersonal medicine] views healing as the result of harmonizing and balancing the body-mind-spirit dynamics within a person’s sphere of being. ... It sees fellowship with others—community—as one of the strongest influences on our own transformational potential. .... At its root, transpersonal medicine recognizes that the power of love, compassion, community, and intention are as important to healing as any of our pills and medicines, and possibly more powerful [Lawlis, G. Frank, Transpersonal Medicine, Shambhala, 1996,, p. xvii].

Lawlis, who discovered this approach in his work as director of a pain clinic in Texas, suggests that Transpersonal medicine is coming into use in our culture as the result of two major trends the first being “frustration with the allopathic model” and the second being a “lack of attention and respect given to the emotional and spiritual needs of people who are ill.” [Lawlis, G. Frank, Transpersonal Medicine, Shambhala, 1996, p. 7]. The Association for Transpersonal Psychology was founded in the mid-1970s to more clearly define the field.

Among the methods employed in transpersonal therapies are ritual, guided imagery, humor, and relaxation.

**Ritual**

According to Lawlis, ritual is thoughtful action made with intent that includes others and forms community. In his experience with rituals used in his pain clinic, ritual ...takes us beyond the personal realm, to sources of support founded in the collective dynamic of others’ intentions and relationships. It can tap into the power of love and energetic resonance, which ... are important components of healing and change. ... The community spirit has a power of its own. ... We discover that we have the capacity to reach into our depths of understanding and find clarity and peace beyond what we might simply explain as “learning.” [Lawlis, G. Frank, Transpersonal Medicine, Shambhala, 1996, p. 7].
Imagery

Imagery is defined as the range of visual, kinesthetic, aural, and tactile experiences people have when recalling or imagining themselves in a situation. Clinicians like Lawlis and Carl Simonton have used both guided imagery, in which a facilitator reads or suggests possible situations to the patient or client, and personal imagery, in which the individual chooses specific images and sensations to experience. They’ve found, as have trainers of astronauts at NASA and athletes at the Olympics, both types of imagery to be effective in reducing pain and anxiety, increasing skill and competency in specific tasks, and reducing or eliminating certain biochemical activities in the body. In addition,

Although intervention imagery has not won complete acceptance in psychological research, the medical community has quickly adopted diagnostic imagery protocols. ... drawing techniques...as diagnostic tools and as aids in patient education and communication. ... What the disease means in the patient’s life is also communicated through the imagery. [Lawlis, G. Frank, Transpersonal Medicine, Shambhala, 1996, p. 110].

Similarly, imagery rehearsals also help the dying person deal with the impending transition. ... Relaxation and coping imagery also have been very helpful in dealing with the management of pain and discomfort on a physical level and with the issue of suffering on a psychological level. [Lawlis, G. Frank, Transpersonal Medicine, Shambhala, 1996, p. 170].

Healthy images increase your sense of power, well-being, and peace of mind. They strengthen your sense of connectedness with your inner wisdom, with others, with the world and universe. Neutral emotions also can be healthy in terms of promoting calmness, peacefulness ... [Quoting Carl Simonton, Lawlis, G. Frank, Transpersonal Medicine, Shambhala, 1996, p. 132].

In The Future of the Body (1992), a remarkable compilation of the published research on human development, healing, and consciousness, Michael Murphy points out that “psychophysical changes” are far more common than we normally assume, noting that bodies often “rely on common modalities of change,” in “largely dissociated processes.”

Hysterical stigmata and false pregnancy demonstrate the . . . precision with which highly charged images can shape somatic processes,... Placebo effects and spiritual healing, too, depend on suggestive imagery ... [Murphy, Michael, The Future of the Body, 1992, p. 544].

Humor

Laughter and expressions of humor may be among the most ancient healing methods in human experience. We find references to laughter making “a merry heart” in the Old Testament and on through recorded history.

Philosophers, psychologists, and physicians have studied humor for its medicinal effects. Plato and Aristotle considered laughter an adaptation response, and Darwin researched laughter as a stress resolution feature. ... Gordon Allport, Abraham Maslow and Carl Rogers have each acknowledged humor as a major attribute of healthy personalities.
Pete Conchos, spiritual leader of the Taos Pueblos... When ... asked ... what ingredients to build into the healing process, ...answered, “Forgiveness and laughter.” ...

When patients are asked what components of their programs were the most significant in their recovery, ... “Once I begin to laugh, my pain starts to recede and I can see life from a different perspective.” [Lawlis, G. Frank, *Transpersonal Medicine*, Shambhala, 1996, p. 178]

...psychologists from Freud forward attest to its role in the reduction of suffering. ... fourteen basic contributions: clarifies self-defeating behavior ... interrupts paradoxical ... thinking ... reduces helplessness ... reduces anxiety, stress, and tension ...facilitates learning ... helps break through resistance ... helps confront “sacred cows” [Lawlis, G. Frank, *Transpersonal Medicine*, Shambhala, 1996, p. 185]

Lawlis refers to one of the many studies on the effects of humor relevant to mental health, published in *Motivation and Emotion*, which concluded: “... people who responded to the comedy did have higher concordant EEG readings compared with those who did not...” [S. Svebak, *Motivation and Emotion*, vol. 6 No 2, 1986, 133-146].

**Relaxation**

Mental and physical relaxation are essential to any healing process, and are most consistently experienced in the state of consciousness known as meditation. Cardiologist Dean Ornish includes meditation in his process for reversing the effects of heart ailments. He says:

Meditation is the practice and process of paying attention and focusing your awareness. . . . When you . . . concentrate any form of energy, including mental energy, you gain power. When you focus your mind, you concentrate better. When you concentrate better, you perform better—you can accomplish more . . .

... you experience a profound state of relaxation, deeper even than sleep ... blood pressure decreases, your heart rate slows, your arteries dilate, you think more clearly... you enjoy your senses more fully ... Anything that you enjoy—food, sex, music, art, massage, and so on—is greatly enhanced by meditation.

... your mind quiets down and you experience an inner sense of peace, joy, and well-being...It is our true nature to be peaceful until we disturb it.

Finally, you may directly experience and become more aware of the transcendent interconnectedness that already exists... Most spiritual and religious traditions are based on people who experienced God directly: Abraham, Moses, Jesus, Mohammed, and Buddha, to name only a few... [www.ornish.com, 2006]

The research on the role of relaxation and meditation in the healing process is tremendous. In one of the earliest studies, in the 1960s, two physicians at the University of Tokyo studied brain-wave changes during meditation by Zen teachers and their disciples from the Soto and Rinzai Zen centers. In these studies, four stages of
meditation were observed, measured in terms of the brain-wave patterns on electroencephalograms (EEGs).

Stage 1: Characterized by the appearance of alpha waves (the brain-wave pattern associated with dreaming, daydreaming, and being “in the zone”).

Stage 2: Increase in amplitude of persistent alpha waves (associated with a stronger sense of being “in the zone”).

Stage 3: Decrease in alpha-wave frequency (associated with relaxation).

Stage 4: The appearance of rhythmical theta trains (the brainwave pattern associated with deep rest).

These findings indicate that Zen practice promotes a serene, alert awareness that is consistently responsive to both external and internal stimuli [Murphy and Donovan, *The Physical and Psychological Effects of Meditation*, 1999, p. 41].

During the 1970s, studies at Harvard Medical School under the direction of cardiologist Herbert Benson and medical researcher Joan Borysenko, demonstrated that “the Relaxation Response” has remarkable effects on the human body and mind. In 1975, Dr. Benson published a well-received non-technical book, *The Relaxation Response*, describing the shift of function to a hypo-metabolic, or internally slowed, state that was experienced in his laboratory, and called this state the Relaxation Response (RR). He pointed out that practicing the characteristics of the RR state (for example, slow, deep breathing) can elicit the state, and he encouraged people to do this practice as part of a healing process he called “wellness remembered.”

Borysenko observed that those engaged in RR experienced the following characteristics.

Breathing rate and oxygen consumption decline because of the profound decrease in the need for energy. Brain waves shift from an alert beta-rhythm to a relaxed alpha-rhythm . . . Blood flow to the muscles decreases, and instead, blood is sent to the brain and skin, producing a feeling of warmth and rested mental alertness. It was by learning to induce the relaxation response that I began to reverse symptoms that were severe enough to send me to the emergency room. [Borysenko, Joan, *Minding the Body, Mending the Mind*, 1988, p. 13]

Their research demonstrated that the practice of RR improves biologic function, lowers blood pressure, slows heart rate, and reduces oxygen consumption. It rests metabolic activity, leaving more oxygen available for other functions. “As far as science knows, the calming effects of the relaxation response cannot be brought about as dramatically or as quickly by any other means” [Benson, Herbert, *Timeless Healing: Optimal Medicine*, 1996, p. 132]. Other medical benefits of this form of meditation observed in the Harvard Mind/Body Clinic research include:
• Patients with hypertension experienced significant decreases in blood pressure and needed fewer or no medications over a three-year measurement period.

• Patients with chronic pain experienced less severity of pain, more activity, less anxiety, less depression, and less anger, and they visited the managed care facility where they received care 36 percent less often in the two years after completing the program than they did prior to treatment.

• Patients with cancer and AIDS experienced decreased symptoms and better control of nausea and vomiting associated with chemotherapy.

• Patients who suffered from anxiety or mild or moderate depression were less anxious, depressed, angry, and hostile.

• Patients undergoing painful X-ray procedures experienced less anxiety and pain and needed one-third the amount of pain and anxiety medications usually required.

• Working people experienced reduced symptoms of depression, anxiety, and hostility and had remarkably fewer medical symptoms.

• Patients who had open-heart surgery had fewer postoperative cardiac arrhythmias and less anxiety following surgery.

In 1979, Jon Kabat-Zinn established the Mindfulness-Based Stress Reduction (MBSR) clinic at the University of Massachusetts Medical Center (UMMC), the Boston area’s fourth largest hospital. Extensive research conducted at UMMC demonstrated that a meditation method called “mindfulness” produced significant reductions in present-moment pain, negative body image, inhibition of activity (movement limitation), psychological disturbance, anxiety and depression, and the need for pain-related drugs [Kabat-Zinn, Jon, Full Catastrophe Living. 1990, p.77–78].

These results occur because, using these methods, people see that they can distinguish between sensations of pain and what the mind does with them. They see that their mind likes to avoid being present by making a big deal about the pain. They learn to avoid letting their mind agonize and waste energy reserves. They see that they have a choice to prevent distress and build inner strength in the process. They learn that staying with present-moment pain releases endorphins, the body’s natural painkillers, which then increase the ability to stay present. The more one is present with the sensation, the higher the endorphin levels. Endocrinologist Deepak Chopra writes:

... the brain [and nervous system in general] produces narcotics up to 200 times stronger than anything you can buy... with the added boon that our own pain-killers are non-addictive. Morphine and endorphins both block pain by filling a certain receptor on the neuron and preventing other chemicals that carry the message of pain from coming in, without which there can be no sensation of pain, no matter how much physical provocation is present [Chopra, Deepak, Quantum Healing, 1990, p.62].
In addition to increasing endorphins, self-calming meditation has been shown to directly reduce adrenaline and cortisol secretion, naturally restoring hormonal balance in general and normalizing immune system function. In addition meditation produces elevated levels of the major hormones melatonin, DHEA, and serotonin. As a result, Murphy and Donovan, in their Physical and Psychological Effects of Meditation [1999, p. 81 ff.], describe extensive research establishing that the following psychological skills and activities are enhanced through the practice of meditation:

- Perceptual Ability
- Reaction Time and Physical Motor Skill
- Field Independence
- Concentration and Intelligence
- Empathy
- Creativity
- Self-Actualization

These benefits correspond to the expected effects of meditation described in The Yoga Sutras of Patanjali at least a thousand years ago. The ancient Sanskrit word yoga is commonly translated as “union” and is the root of the English word “yoke.” It’s defined in the Bhagavad Gita as “the breaking of contact with pain.” In practice, yoga is a path—often described as a shortcut—to the continuous experience of nonlocal, nonattached awareness called, in Sanskrit, moksha, or samadhi. “The Atman [Real Self] shines forth in its own pristine nature, as pure consciousness” [Isherwood and Prabhananda, How To Know God, Vedanta Press, 1953, p. 221]. All the practice, all the principles, and all the variations of yoga are designed to achieve this one end.

Section One of Yoga Sutras of Patanjali includes the following aphorisms:

30. Sickness, mental laziness, doubt, lack of enthusiasm, sloth, craving for sense-pleasure, false perception, despair caused by failure to concentrate and unsteadiness in concentration: these distractions are the obstacles to knowledge.

31. These distractions are accompanied by grief, despondency, trembling of the body and irregular breathing.

32. They can be removed by the practice of concentration upon a single truth. [ibid., p.64–66]

The translators go on to say, “In order to achieve this concentration, we must calm and purify our minds” (ibid. 66), which, Patanjali tells us, may be done by changing our attitudes toward the people and events around us, and “The mind may also be calmed by [breathing] prana” (ibid., 68).
With these understandings in mind, it’s not too surprising that German refugee Ruth Denison, the woman quoted at the beginning of this chapter, was able to overcome a significant physical and emotional crisis by a combination of “sensory awareness” and meditation:

Ruth focused her attention on simple tasks such as sweeping, cleaning, doing the dishes. Standing in front of the sink, if she could not feel the plate in her fingers in the warm water, she brought her attention to her body. ‘I would stand and just let go everything and would relax and do this movement, shifting weight, to one side and to the other side. … And that I could feel … I had a sense of the healthy wholeness of life, so I knew this wasn’t enough. I needed more steady paying attention in a witnessing, mindful way... I felt I was knitting myself back together’ [Boucher, Sandy, *Dancing in the Dharma: the life & teachings of Ruth Denison*, Boston: Beacon, 2005, p. 122].

She is now the director of a Buddhist retreat center in California.

**Toward a Culture of Mental and Emotional Well-being**

Some things simply work, wherever they are applied. Among the practices common across indigenous cultures’ healing traditions are the following:

- disciplines to turn off “normal” thought processes to become silent inside and listen to the body and the environment;
- disciplines to learn to manage the sensations of the body;
- study of the culture’s traditions that explain how the world works and how people’s minds, bodies, and communities function and develop;
- study of one’s own thought processes, dreams, and imaginations;
- specific movements and sounds to enhance awareness, physical strength and agility, and overall well-being;
- use of various movements, chemicals, mental disciplines, to achieve states of consciousness in which awareness moves beyond the range of normal senses, space, and time.

These practices may be found among the Maori of New Zealand and the Inuit of Alaska, among the hill tribes of Southeast Asia and the “witches” of Bulgaria, among the indigenous tribes of North America and those of the Amazon and Congo. They are also found in Buddhist, Taoist, and Hindu temple communities and in mystical Christian, Muslim, and Jewish communities; and they are the essence of the Sufi tradition. In these cultures, across time, they’ve demonstrated their effectiveness in preventing, reducing, and eliminating physical and psychological symptoms of both distress and disease.
In his book, *Timeless Healing* (1996), Herbert Benson proposed that if people were educated in the use of mind-body methods, such as meditation, they would be able to take an empowering role in their own health. Consequently, he suggested, pharmaceuticals and surgery would be used only as they supported self-care, which needs to be the primary mode of care.

Phyllis Chesler’s “prescription” for healthy women’s psychology supports this idea:

Women must convert their ‘love’ for and reliance on strength and skill in others to a love for all manner of strength and skill in themselves. Women must be able to go as directly to the ‘heart’ of physical, technological, and intellectual reality as they presumably go to the ‘heart’ of emotional reality. … Only resourceful women …can either share them with other women or use them to accumulate more … Woman’s ego-identity must somehow shift and be moored upon what is necessary for her own survival as a strong individual. Women must somehow free themselves … [Chesler, Phyllis, *Women and Madness*, Doubleday, 1972; p. 319-321].

Sometimes, however, it’s simply not possible to do it alone. Sometimes a wise listener, an understanding friend, or an experienced guide is needed to move through the process that is healing. This is the perceived role and presentation of the “new” therapist, as well as the “pastoral counselor,” “spiritual director,” and “coach.” In this role, providing these functions, the categories of the DSM aren’t particularly relevant. The patient’s or client’s desires, intentions, actions, feelings, and environment, however, are.

Sometimes, though, not even that shift is enough. Through his years of practicing both traditional and “new” methods, psychiatrist Gerald Jampolsky came to believe that it’s only when the therapist is willing to not only be the listener, friend and guide, but to accept that the “patient” is doing the same for the “therapist,” that true healing happens [Jampolsky, Gerald, *Teach Only Love*, 2000].

**The Lessons Renée Côté Offers**

In *She Would Not Submit* Renée Côté tells us the story of her mother’s nearly-lifelong incarceration based on a diagnosis of schizophrenia, and gives us a number of pointers to consider as we look toward a culture of well-being. Here was a young woman, intelligent and curious, whose gifts were repressed in the expectations and physical experience of motherhood. Here was a farm girl living some distance away from her family and feeling isolated, trying to meet the expectations of the *bourgeoisie*. Here was a woman whose body produced nine babies in ten years, then went through some intense experience in an effort to avoid more, and ended up having more, anyway—only to watch them die. Here was a young wife whose husband believed he had the answers and that she must be controlled. Here was a religious structure that
reinforced his position and discounted her distress. Here was an institution designed to “warehouse” women just like her.

From the perspective of today’s “feminized” culture, the solutions to many of these issues are self-evident. According to today’s norms (and most women who have read this story), this woman needed a support group of similar women—to learn from, to vent with, and to provide opportunities to shine among, to serve, and to be served by her peers. She needed some good contraception provided by an understanding gynecologist or family planning clinic. Either of these would have made a difference, and both together could well have prevented the symptoms that led to her institutionalization. Counseling for the couple would also be in order, with the intention of giving her a safe place to voice her needs and him the skills to hear them and respond lovingly, replacing his desire for the appearance of doing well with the actuality—rather than to label the “disorder” either of them might be suffering from. Play days for the children would have given the mother a break, and the occasional visit from grandparents would have given the couple the opportunity to get away and renew the romance in their relationship. Renée’s mother might stay home with the children until they were in school, but then she might go back to school and pursue a dream of her own. So, in today’s culture, the extreme imbalance and disharmony of this story might be averted.

From the perspective of a future culture of harmony and well-being, Renée’s mother and father might actually have experienced a joyful, healthy, loving life. They would have been offered training in harmonious relationships and parenting skills long before they were married. Both of them would have learned to honor their bodies and maximize their health—for their own benefit and that of their children. Neither of them would have been isolated, or left to suffer their fears without the loving support of mentors and peers. In such a culture, their spiritual support system would give them the tools to experience the power and presence of the divine in all situations, to develop their own spiritual gifts, and to share those in the deep intimacy of a true spiritual marriage. Both of them would have appreciated, honored, and respected themselves and their spouse, and beyond them, all beings on this planet. Both of them would have circles of friends—individual and shared—who would listen to them and know them well enough to reflect back to them their highest potential, as well as areas ready for improvement. Should an economic crisis occur, in such a culture, the whole community would work together so no one, and no family, would feel unduly pressured—and each household’s excess would be shared so that no one need do without. In such a culture, no child would ever need hide in terror nor wonder what had happened to her mother, and the appearance of well-being would be the actuality.
Actions for Consideration

What does all this mean for the institution and practice of psychotherapy in Western culture? A number of suggestions emerge from the comments and research described thus far.

First, the profession might examine the underlying assumption that “acceptable” behaviors for women are different from “acceptable” behaviors for men—or for healthy adults. It’s time to drop sexist assumptions and accept one standard for mental health across genders, races, and subcultures within the overall culture. In all likelihood, such a standard will be very similar to the standards suggested in the Bible, the Quran, Lao Tsu, Kun fu Tsu, the Vedas, and those unwritten standards adhered to by indigenous populations around the world.

Second, the profession might accept the possibility that certain behaviors, under certain circumstances, are not signs of “disorder” so much as indications of stages in a process—of grief, of creativity, of spiritual development, etc.—and learn enough about those processes to understand when to refer the patient to an appropriate guide.

Third, the profession might take into account the family constellation, as well as the physical, social, and economic environment of the patient when assigning diagnoses and treatment plans—recognizing that what may appear to be abnormal or unhealthy behavior may, in fact, be a very healthy response to a highly abnormal set of circumstances. The theories and tools of Family Systems Therapy may be quite useful here, along with the principles and practices of clinical social workers.

Fourth, the profession might consider the possibility, raised by Jampolsky, that any healing process necessarily includes the therapist as well as the patient, and that the two are walking down a path together, with each one contributing some expertise to the process.

Fifth, the profession might find a way to overcome the temptation to “medicate first and treat later.” In spite of pressure and promotion from the pharmaceutical companies, most human challenges can be coped with without the mind-bending effects of drugs, and there is no such thing as “no side effect.” The body is an intricately complex set of biochemical interactions, and, as with all systems, “you can never do just one thing.” As soon as a new chemical is added into the mix, the person is no longer the same system and must be recognized as such.

Finally, the profession might learn to let go of any attachment to “being in control.” Asylums and mental hospitals are artifacts of the need for control, as are the use of most drugs, the design of most therapist’s offices, and the process for “case management.” Human beings are not controllable—if they are, they’re by definition
“unhealthy.” Human beings are constantly creating and exploring new possibilities for understanding and action, and any attempt to limit or control those processes is destructive of that person’s well-being. Meditation is a wonderful tool for such learning.

As most of the researchers cited above have affirmed, the stated goals and intentions of the institution of psychotherapy are essentially beneficial for the individual and the society. But, as so often happens in our culture the practice and the ideal are frequently too far apart to accomplish the desired goal. The above suggestions are offered in the full realization that there are numerous therapists today who already practice each and every one of them. The field as a whole, however, and the training systems that produce new practitioners, have yet to exhibit the behaviors and language that indicate such shifts in the psychotherapeutic model.

Let’s hope that the new generation of therapists, raised in a less gender-conscious culture, will take us to a higher level of operation.

This article is the basis for Ruth Miller’s Afterword in Renee Cote’s book SHE WOULD NOT SUBMIT (formerly titled, Was My Mother Schizophrenic? Available through Portal Center Press).

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