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# Canaries in a Coal Mine: Conceptualizations and Treatment of Mental Illness in a Therapeutic Community for the Mentally Ill

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A dissertation submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

University of Washington

2001

Program Authorized to Offer Degree: Anthropology

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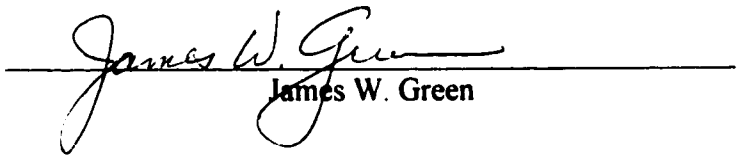

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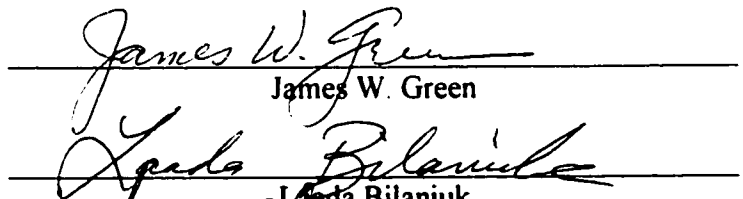

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Abstract

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This dissertation is an ethnography of a therapeutic community for the mentally ill conducted in the US in 1996. It begins with a review of the experimental movement in psychiatry that occurred during the late 1960s and 1970s in the U.S. Tracing the ways in which this movement is reproduced and opposed in an "alternative" treatment location, we learn that the range of treatment options for mental illness have been greatly reduced by biomedical psychiatry's hegemony.

Foucault's notions of power helps to situate this therapeutic community in a web of state, local, and internal power relations. This web serves to contextualize other influences on the Community, such as the construct of community as therapy, new age philosophies, and Catholic notions of benevolence. These influences shape the Community's eclectic thinking about mental illness and care-giving practices. But, given the extensive reach of biomedical supremacy via the current political, economic, and legal landscape of mental health services, its ability to conceptualize and treat mental illness outside of the biomedical model is limited. The Community struggles with its position, caught between an unconventional therapeutic community model and biomedical hegemony.

In contrast to mainstream psychiatric hospitals and institutions, where time and space are highly regulated, the Community afforded patients enormous freedom and independence. Independent, higher functioning, socially interactive patients were served well in this setting. However, patients who were socially isolated needed more structure and direction, which at times was dangerous and seemed to worsen their illness.

Table of contents

## Preface

This ethnography is based on fieldwork conducted at Menar, a therapeutic community for the mentally ill. In the interest of anonymity, the name of the community has been changed, as well as all names of patients, staff, and community members. Identifying details about the community and individuals are purposely absent or have been changed.

Acknowledgement

Writing a dissertation is like taking a long, long journey without knowing the itinerary or true destination. Without the backing of my entire family and friends, I would not have found the road, or the courage to create it.

I thank my husband for his patience and ability to be peaceful while I was not. I want to thank my mother for her ocean of wisdom. I am thankful for my father's much needed sense of humor. I am grateful for Eliza's endless encouragement. And, to my grandparents, who were always there in spirit, thank you.

# Chapter I: Introduction

In 1973 David Rosenhan, a professor of psychology, performed an experiment in which he and several students acted psychotic and were committed to various mental hospitals (Rosenhan 1973). Shortly after being committed they started acting "normally." Prior to the start of the experiment, only a few administrators in the hospitals were informed of the experiment and the true identities of the pseudo-patients. The pseudo-patients determined at the end of the experiment that their fellow mental patients were able to tell that they were not actually schizophrenic, however, the hospital staff maintained that they were insane. This experiment cast doubt on the diagnostic techniques of psychiatry and the scientific "facts" underpinning its power and authority.

Scottish psychiatrist, R.D. Laing, was the medical director at Tavistock psychiatric hospital in London in 1970 when he decided to test his theory that mental patients are kept in institutions so institutions can survive. He devised a radical experiment where he removed nearly all of the medical staff and turned much of the mental hospital over to the patients. He wanted to find out what would happen to patients; particularly whether they could do a better job treating themselves than the medical staff. The experiment created organizational chaos and six years after the experiment began all of the patients left the hospital "cured" and it had to be shut down. Laing concluded that psychiatric professionals contributed to patient's dependency on the psychiatric system and their role as patients. There was no sense in the patients being crazy anymore once they were no longer responsible for sustaining the institution.

These two experiments were of particular interest to me because they questioned power relations in psychiatry and problematized the objectivism underlying the medical model. Laing and Rosenhan simultaneously reflected and contributed to the social constructivist theories and cultural transformations of the 1960s and 1970s. Like Kuhn(1970) and Foucault(1965, 1973) they saw scientific knowledge as situated, dependent on context for its meaning. Through their experimentation, Laing and Rosenhan

asked why we (broadly, as a culture and specifically, psychiatric patients) would put our faith in psychiatrists and institutions to act in patients' best interest. They questioned the belief that mental health professionals know what is best for patients and act on what is best for them based on their knowledge of objective scientific truths about mental illness. Additionally, they questioned psychiatry's claim as a disinterested, neutral agent acting on patients' behalf. They interrogated the notion of the dispassionate mental health care professional as expert applying unbiased science to alleviate patients' suffering. Questioning the assumption that patients should place faith in doctors' objective knowledge and application of this knowledge served to critique both psychiatry as an institution and the power dynamics between doctor and patient.

Laing and Rosenhan inserted themselves in a social experiment in order to illuminate the ways in which psychiatric knowledge, mental health professionals, psychiatric patients, and institutions are embedded in a socio-cultural and economic context. This technique appealed to me greatly. Much like myself, Laing and Rosenhan acted as participant-observers, possessed psychiatric knowledge, and were critical of its claims to objectivism. I did not model my own ethnographic study on their projects, however, I was heavily influenced by the construction of their experiments and the depth of their findings. I wanted to engage in fieldwork at a therapeutic community at the level of a community member/participant-observer so that I could closely involve myself with the community. Unlike Laing or Rosenhan, I did this without being a mental health care provider or a psychiatric patient, but rather as a medical anthropologist.

Medical anthropologists conducting ethnographic research have employed the anthropological cornerstones of relativism, holism, the comparative method and understanding culture via the emic perspective. Within the last 20 years in the U.S. medical anthropologists have applied these methods to fieldwork in locations such as clinics, hospitals, and institutional sites with therapeutic purposes. Examples of these sites vary from a nursing home for the elderly (Meyerhoff 1980), to an emergency psychiatric unit (Rhodes 1991), to an outpatient psychiatric community treatment program (Estroff

1981), and a community hospital unit for people in a persistent vegetative state (Kaufman 2000). Conducting participant-observation research in these settings is appealing because they provide small, self-contained communities. They are also desirable sites because they are richly imbued with multiple layers of data where therapeutic purposes, practices, knowledge, and experiences converge. And of particular interest to medical anthropologists attempting to comprehend a local culture within one of these settings, the interaction of organizational dynamics, therapeutics, doctor/patient(provider/client) relationships and experiences can be observed and analyzed. It is this tradition that I am working from in this dissertation. My intention is to contribute to this body of knowledge with my ethnography of a therapeutic community for the chronically mentally ill.

This dissertation marks the intersection of three inquiries: The first is the exploration of the question, what happened to the experimental moment in psychiatry in the US in the late 1960s and early 1970s? Second, how and where do the worlds of New Age psycho-spiritual theories and practices and mainstream psychiatry interact? Third, how does the larger web of power relations influence Menar's practices? Third, what are relations like between caregivers and patients at this therapeutic community?

**Why I chose a therapeutic community for the mentally ill as my field site**

As a clinical social worker, I was trained during the early 1990s in the bio/psycho/social model. This model drew heavily from biomedical traditions of hierarchical, expertism, monological, top-down, and Newtonian, objectivism and science. At the same time, social work challenged these traditions and embraced a critical perspective on provider/patient relationships and the role social workers could play in disrupting the status quo and advocating for social justice. One of social work's core values is looking at patients holistically and assessing the range of elements that are involved in creating and maintaining mental illness in order to help mentally ill people. My social work training was sometimes supportive and sometimes critical of psychiatry's claim that "Truth" and knowing are guided by objective science. Social work doctrine

alternates between borrowing and resisting the notion that social workers are objective experts whose practices are based on scientific facts applied to help patients.

While working as a clinical social worker, I became interested in the ways in which social service organizations for mentally ill people are structured by the medical model due to funding, research on outcomes, and legal parameters. I was interested in how the structure of these organizations affected the range of clinical practices and mental health practitioners' beliefs about mental illness. Almost all clinicians I worked with believed that brain chemistry and genetics were major elements in causing mental illness. One of the reasons they championed this model was because they saw it as a move away from the psychodynamic model of blaming families and/or patients for their mental illness. However, many of these social workers were concerned about overmedication of mental patients in order to get them to comply and the possibility of psychiatric drugs putting social workers out of business. Some of these clinicians also believed that there was a part of mental illness that was spiritual in some sense.

It was at this point that I started investigating the history of how the mental health service I worked for became the way it was. I researched the history of American organizations that helped mentally ill people and the ways mental illness had been thought of over time. I discovered that my observations as a social worker about the relationships between how people thought about mental illness, treatment of the mentally ill, and the structure of institutions set up to care for them, were in good company with an entire history of looking at these connections. Further, I learned that many of the organizations that dealt with mental patients were modeled on English and Western European institutions, which lead me to the history of therapeutic communities and their experimentation with how best to take care of mentally ill people. It was not until two years later that the concept of the therapeutic community would come up, this time in the context of anthropological fieldwork.

The multiple rights movements of the 1960s era, such as women's rights and gay rights, spawned the patients rights movement which advocated for the right to refuse

treatment, informed consent, and the right to medical information. During this climate, the potential for abuse of power was highlighted when the rights of prisoners and mental patients came under scrutiny. This led to a transformation that took the shape of the deinsitutionalization movement, which attempted to move the mentally ill out of institutions and into communities where they would receive psychiatric services at community psychiatric clinics. Deinstitutionalization brought about a brief period of time where psychiatrists were able to experiment with different treatment options for the mentally ill once they were let out of institutions. This was an unclear moment when the terrain of appropriate treatment of mental illness, and the power dynamics among patients, institutions, and mental health professionals were undergoing intense negotiation.

As part of the background research prior to my field work, I conducted several interviews with psychiatrists who were involved with these social psychiatry-driven experiments in treatment: a description emerged of an exciting period that ended quickly with the state and county involvement through detailed legal and medical regulations. Some of these psychiatrists are currently involved with therapeutic communities in the US and England,but the majority are either in private practice or mainstream psychiatry.

They described a fascinating historical "moment" when deinstitutionalization was underway and the community mental health system was in its infancy. Other cultural dynamics going on such as psychedelic drug use and social disobedience over the Vietnam War created an opening for experimentation in ways of thinking about and servicing mentally ill people. It was in these discussions that I learned that much of the enthusiasm for experimentation and creativity came out of LSD and other psychedelic and psychoactive substances and experiences; the rise and fall of this experimental moment in psychiatry paralleled the psychedelic movement.

This historical moment is easily traced in the writings on power and social control, psychedelic experimentation, and mental illness by psychiatrists such as Perry (1974), Szasz (1974), and Laing (1967, 1975). This period ended in the mid-1970s as the general cultural trend went towards conservatism, and the medical and legal professions began to

dictate narrowly proscribed ways of treating mental illness. This in turn shaped the current landscape of services, practices, financing, and conceptualization of mental health and illness.

When I interviewed (by phone) several psychiatrists who were involved in this era of experimentation in the US, they were delighted that I was interested in this historical moment in psychiatry and that I was going to explore its trajectory. In response to my queries about what happened to that experimental moment, they believed that it had transformed, not necessarily disappeared. They had several suggestions for where to look for current threads of this period: literature on New Age spirituality and mental illness (Assagioli 1986, Bragdon 1993, Hastings 1983, Lukoff and Everest 1985, Miller 1990, Nelson 1994, Watson, 1994), the Spiritual Emergency Network (Nolan 1986), and therapeutic communities for the mentally ill (DeLeon and Beschner 1977, Kennard 1979, Maller, 1971, Manning 1989, Mosher 1983, Ochberg 1980, Stein and Test 1980).

I wanted to know in the mid-1990s, a highly medicalized and litigious time for mental health services, how much of a residue of this experimental period during the 1960s was still detectable. What was currently possible in terms of treating mental illness? Were there alternative institutions or settings treating mental illness outside the medical model? Were there still people who believed in a spiritual or altered states of consciousness explanatory model of mental illness?

After abundant research, I found that indeed there was a space where this experimental spirit was still alive in the US; therapeutic communities for mentally ill people. I decided that a therapeutic community was the place where I wanted to investigate questions about the structure of mental health service and clinicians' beliefs about mental illness. I was interested in looking at the ways in which a therapeutic community was constrained by legal and medical realities and to what extent there was room for experimentation. To what degree was a therapeutic community a medical model institution? What was possible in terms of alternatives to the biomedical way of thinking

about mental illness? What was re-created from the medical model and what was different? When things were different, what were they?

After researching multiple therapeutic communities, I found Menar (see description of "getting in" in the methods chapter). Upon visiting decided that Menar was the place to investigate the interaction between a therapeutic community and the overarching biomedical culture in terms of its beliefs, practices, and organization, because of its spiritual bent and its sixties experimental sensibility. I was excited by the fact that Menar was a non-traditional place. I was open to the idea that the absence of mainstream psychiatric training and education about mental illness might indeed make it a more humane place for patients than traditional institutions. I thought that caregivers that did not have formal training and thus had no preconceived ideas about the course of particular mental illnesses or attributes of a diagnosis would be able to respond to patients without judgment or clinical distance. The concept of the therapeutic community appealed to me because of its roots in experimentation and the long history of courageous caregivers taking risks to demonstrate the possibility of looking at mental illness and the mentally ill differently. I conceived of therapeutic communities as an expression of resistance to the medicalized version of the patient/provider relationship. My role as a clinical social worker had been highly regulated by medical and cultural standards of what was appropriate distance- physically, socially, psychically- from the patient. I wanted to know what patient/provider relationships were like at a therapeutic community, particularly in terms of treatment and power relations.

Menar is a community experimenting with ways of treating mentally ill people. By examining institutional dynamics, organizational politics, explanatory models of mental illness, and patient/caregiver relationships, a picture of Menar emerges. It is simultaneously a highly regulated organization influenced by the wider social dynamics of power and medicalization and an attempt at a New Age utopian community where mentally ill people are cared for humanely. Menar reflects the Western European and American trajectories of the way mental illness has been conceptualized and treated,

including the contradictions and tensions. One can see the influences of moral therapy, milieu therapy, deinstitutionalization, the New Age movement, and biomedicine all reflected in the day to day operations of the community. Menar both challenges and embraces the bio-medical, objective, expert driven model of care for mental illness. Menar simultaneously encourages patients to take their drugs prescribed by psychiatrists while alternative forms of healing such as Anthroposphy and Eastern Orthodox Catholicism inform their thinking about mental illness. As Hellas (1996) describes in his book, "The New Age Movement," Menar is one of many communities struggling with capitalism, business, New Age spiritualism, and ideology.

**Literature review**

While there is an extensive body of literature on therapeutic communities written from the sociological and social psychology perspectives, little is written from the anthropological perspective. There are several sociology dissertations that are ethnographies or qualitative studies of individual therapeutic communities: they explore social control and role blurring (Wiley 1988), social control, social structure, deviance, and the cult aspects of a therapeutic community (Ayella 1985), conflicting ideology between the medical model and a therapeutic community (Meade 1990), a comparison of a therapeutic community and Goffman's notion of the total institution (Carter 1984).

The social psychiatry and social psychology literature discusses several aspects of therapeutic communities, including alternatives to hospitalization (Warner 1995), mental health policy (Ochberg 1980), moral therapy (Cherry 1989), milieu therapy (Rossi and Filsted 1973, Jones 1953), cost analysis (Sladen-Dew, et al. 1995) and outcomes (Hinshelwood and Manning 1979). There are numerous anthropologists who have been interested in the conceptualization of mental illness (Estroff 1982, 1981, Fabrega 1974, Green 1985, Osborne 1969), its treatment (Luhrman 2000, Rhodes 1991), the social construction of mental illness (Lunbeck 1994, Good 1990, Kleinman 1996, 1985), and cross-cultural comparisons (Manson 1985, Nichter 1981,). But although anthropologists

have been interested in mental illness and its treatment in specific locations in the US (Estroff 1981, Rhodes 1991) the literature on therapeutic communities from the anthropological perspective is limited to a few dissertations (Soloway 1977, Frankel 1974) and books (Sugarman 1983, Frankel, 1990), that look at therapeutic communities for drug and alcohol abuse treatment. There are two other anthropological studies that look at therapeutic communities for the treatment of the mentally ill in foreign countries: a multi-disciplinary study conducted in Geel, Belgium (Shapiro 1975), and an ethnography of a Yoruban therapeutic community (Osborne 1969).

On the subject of New Age spirituality and mental illness, sociologists have created numerous works (Richardson 1980, Saliba 1993, Galanter 1982, Kilbourne 1984) as have social psychologists and psychiatrists (Grof and Grof 1986, Grof 1988,1992, Gellhorn, Ernst and Kiley 1972, Lukoff 1985, Lukoff, Lu, and Turner 1992, Podvoll 1990). Anthropologists, however, have not studied the interaction between New Age spirituality and mental illness, nor the intersection of New Age spirituality, mental illness, and therapeutic communities in the US.

Ayella's (1985) ethnography of a therapeutic community that is a "cult" and Wiley's (1988) ethnography of a "holistic therapeutic community for schizophrenics" both describe therapeutic communities for the mentally ill with New Age spirituality and practices. My dissertation is similar in that it also attends to the convergence of these areas, but there are substantial differences. First, my clinical social work training informs my experience and analysis of Menar, whereas neither of these authors have a background in providing mental health services. Second, Ayella's dissertation describes the therapeutic community where her research took place as a cult with narrowly defined beliefs and practices, which, as we will see, is not the situation at Menar. Third, while my ethnography is comparable to Wiley's in that we both explore the influence of the 1960s on our respective research sites, she focuses on the sociological themes of social control and role blurring. I am interested in the historical trajectory of spirituality, mental illness, and therapeutic communities and analyze the ways in which Menar's ideology and

treatment of mental illness contributes to several areas of central concern in anthropology: the nature/culture debate, arguments about the dichotomy of modern/traditional, the notion of unilinear evolution, culture, and mental illness, and the constituent forces of power, knowledge, in meaning making and the historicization of "truths" about mental illness. I also review the ways in which the political economy of mental health care affects therapeutic communities and contributes to larger social forces, and the way mental illness is thought about and treated.

This ethnography explores the tensions at Menar stemming from divergent philosophies about patient care, mental illness, and the role of the medical model in a therapeutic community. It examines these themes through a reflexive and dialogical approach to ethnography. The research questions outlined above directly informed the methods of participant observation, open-ended interviews, structured interviews, and focus groups conducted during a 3 month period in 1996. Although this is a relatively short period of data collection (see chapter on methodology for explanation), the description of Menar and the data collected provide important contributions to understanding the landscape of alternatives to biomedical ways of treating and conceptualizing mental illness in the US at the close of the 20th century. In particular, it provides insight into how wider power relations influence the continued dominance of the biomedical explanatory model of mental illness and care-giving to the mentally ill. Additionally, they add to the discourse about mental illness within larger debates about nature/culture and traditional/modern, specifically in a self-marginalized community designed to treat mental illness. The ethnography also explores ethical dilemmas particular to the dynamics of conducting ethnographic research while living with mentally ill people and their caregivers.

## Chapter II: Setting

### Therapeutic communities, mental illness, and religion

In order to situate Menar, a therapeutic community, it is important to have a sense of where it fits in a larger historical picture. To this end, it is useful to review the history of therapeutic communities in Europe and the US, changes in thinking about mental illness and its treatment, institutional reform, and the role of religion in these developments. By developing an overall sense of the historical debates about mental illness and its treatment, we can better understand in what ways Menar reflects and reconstructs these cultural and historical trajectories.

The first European therapeutic community for the mentally ill remains in operation today in Geel, Belgium. It was founded in the thirteenth century by a renegade Catholic Father who wanted to construct a haven for mentally ill people, an alternative to the common medical practices of bleeding, leaching, burning, and physically restraining the mentally ill. He created a community where mentally ill people could come from the city to live with a rural family, work on their farm, and be free to wander around town with other mentally ill people or mingle with the regular townspeople. This was economically beneficial to families needing assistance on their farm and the only opportunity for patients to escape their usually torturous confinement.

It is said that Geel's formula for dealing with mentally ill patients was the foundation for what is now called "milieu therapy". (Roosens 1979) Rossi and Filsted explain the concept of milieu therapy as "a generic concept covering the multiple ways in which social psychological forces can be actively and intentionally utilized in the development and implementation of a treatment process." (1973:12) Therapeutic communities based on milieu therapy are a "method of organizing the social structure of a treatment setting to cultivate and take advantage of social relationships... an organizational plan designed to utilize natural social relationships as therapeutic change agents."(1973:11) The logic that socio-environmental factors can contribute to and maintain mental illness and that modifying the patient's environment can improve the

patient's efficacy, was at the core of Geel's humane approach to relations with mentally ill people. Patients' labor, particularly farming, was an important element of treating mental illness since it occupied patients, got them outside in the open air, and made them productive.

During the eighteenth and nineteenth century, mentally ill people were put in mental institutions, jails, and poorhouses. The goal was to contain them from society at large. The development of moral therapy, "treating the mentally ill as human beings and developing the full capacity of individuals by making use of their social setting"(Rossi and Filsted(Ibid.:5), was in direct opposition to the pervasive thinking about mental illness and its treatment, since it took the perspective that patients could be cured, treated, or at least treated well. French physician Philippe Pinel wrote about showing kindness and respect toward patients, teaching them to control themselves by treating them with dignity and modeling normal functioning. In 1794 he successfully applied his theory of moral therapy by removing the chains and severe restraints from patients at the largest mental hospitals in France (Manning 1989).

The concept of moral therapy paralleled changes in religious thinking about mental illness, its cause, and treatment. It represents a shift in the etiology of the relationship between the religious/spiritual and madness; from believing mental illness was caused by the devil to thinking that mental illness was caused by the mystical forces of God. This transformation led to more compassionate thinking about the mentally ill because it shifted thought about the cause of mental illness and the responsibility, or role, the mentally ill played in their own illness. It made madness seem less dangerous since the Devil was not involved: a mentally ill person had not done something to invite the Devil nor were they somehow a conduit for evil (Kirchoff 1895). This suggested that the symptoms displayed by the insane were not demon-like, but reflective of God and his mysterious ways. Although the cause of mental illness was still in the religious/spiritual realm, there was a major change from its genesis being viewed as stemming from mysterious dark forces to its genesis in mysterious light forces. In the same way that ascetics' behavior, experiences, and words were important puzzles to be solved because they represented Gods enigmatic

ways, mentally ill people were seen as representing something significant that God was trying to communicate.

Correspondingly, this new belief generated more sympathetic and humane ideas about the appropriate treatment for mental illness. The prevailing wisdom about treating mental illness had been linked to the thinking that mental illness was akin to the Devil and thus needed to be burned, leached, or in some way tortured and expelled from the body of the mentally ill person. The concept that mentally ill people were Godly in some way led to an era of experimentation in the best way to manage and treat them. The ideas about treatment ranged from healthy diets, exposure to air and light, modeling normal behavior, benevolence, music, literature, movement, religious education, and living with them in communities. Living with the insane in communities was one of the most radical ideas of this type because it represented the notion that mentally ill people were safe enough to live with and that they were deserving of that type of kindness.

It is important to note that I am privileging the history of Quaker therapeutic communities here because Menar's heritage is deeply informed by Quaker ideas about mental illness and its treatment in the U.S. Pinel's ideas and writings influenced William Tuke, a Quaker and major leader of the asylum reform movement in Britain. In London in 1796 Tuke founded The York Retreat for mentally ill persons; a therapeutic community founded on the concept of moral treatment of mentally ill people. As Quakers came to the U.S., they brought their beliefs about mental illness and its treatment with them. The Friend's Asylum in Frankfurt, Pennsylvania was the first Quaker asylum for mental illness in the US and opened in 1813. It was a therapeutic community based on moral treatment and offered occupational therapy setting in the form of patients assisting with farming. Patients' labor helped contribute to the Friend's Asylum's ability to be an economically independent entity and practice moral therapy.

At Friend's Asylum educational programs were established to occupy the patient's mind and bible study was encouraged, but Quaker meetings and religious activities were not central. Most important was actively demonstrating their belief that kindness was important in restoring patients to mental health. In "A Quiet Haven" (1989) Charles L.

Cherry describes the Quaker approach to treatment: "close personal attention to each patient was required in order to identify specific therapeutic possibilities such as manual labor, intellectual diversion, or religious worship. Health was achieved in a family or communal setting where every staff member and attendant was sensitive to the patient's needs."(202) This ideal of compassion was woven into Quaker conceptualizations of mental illness that were less mystical and more humane, medical, and somatic: "The strong conviction that all mental illness could be traced to lesions or inflammation of the brain did not preclude the possibility that moral treatment could diminish the lesions and restore the patient to sanity." (202)

The controversy over the jurisdiction of mental illness, including its explanation and treatment, was evidenced by the heterogeneity of approaches within the medical sectors and the religious sectors. Medical treatments for mental illness used until 1840 in the U.S. consisted of laudanum, tincture of digitalis, blistering, bleeding, bathing in hot water, and binding. Simultaneously, Quakers, although proponents of moral therapy, used straight jackets, confined patients to bed, secluded them in a dark room, employed hand and foot straps, and used cold showers to subdue patients. Restraints or punishment were employed only after reasoning with a patient had failed. (Dain and Carlson 1960) During this time whips, chains, and beatings were all still used as a means of controlling patients. Theoretically and conceptually Quakers diverged considerably from other secular and non-secular groups in the U.S. Viewing madness as a physical disease as opposed to a moral or supernatural disease, Quakers were committed to research in the realm of physical medicine for psychiatric problems. This shaped their belief that mental patients were not morally responsible for their behavior or illness. They were also committed to developing individual patient treatment plans based on the individual patient's severity of symptoms and abilities. This was a major break from the idea that all patients should be treated similarly since they were all suffering from the same basic moral or spiritual disease.

Interest in therapeutic communities resurfaced in the US shortly after World War II ended. (Ochberg 1980) At this time, a team of US psychiatrists visited England to explore ways of treating psychological trauma as a result of the war. During this visit, the

British demonstrated successes they were having with treating veterans in therapeutic communities that emphasized social aspects of treatment.(Rossi and Filsted 1973) However, American psychiatry focused its attention on the role social forces play in creating and treating patients for only a short time. Developments and innovations in medications to control mental illness were already competing on the landscape of treatment options and biological knowledge about mental illness.

The 1950s in the US mark a move away from caring for mentally ill people in institutions and into community-based out-patient treatment for psychiatric patients. Part of this move was a recognition of "damaging effects of the repressive style of the large mental hospital"(Manning 1979:303) on patients and the poor quality of care in these institutions. Additionally, the work of Maxwell Jones (1953), a British psychiatrist, was influencing American psychiatry to take interest in the potential of therapeutic communities in the 1950s. Jones' success occurred in treating world war II veterans with psychiatric disorders in a flattened-hierarchy hospital unit cum therapeutic community Another influence in the trend toward deinstitutionalization was psychotropic medications, which were becoming more effective in the management of mental illness and presented a less costly option than custodial interventions (Ochberg Ibid., Manning Ibid.) .

The deinstitutionalization movement was expanded during the 1960s when psychiatry was criticized heavily for its abuses of power and lack of patient rights. It was at this time that another surge of interest in therapeutic communities in the US was ushered in, this time via the writing of British psychiatrist R.D. Laing (1967). In the 1960s Laing built on Maxwell Jones' achievements and continued implementing nineteenth century treatments based on moral management at the Philadelphia Association in London. (Warner 1995) His writings about the achievements of therapeutic communities, the damage institutions do to mentally ill patients, and the ways in which social control and hierarchy are perpetuated in such institutions were influential on some American psychiatrists and other critics of mental institutions. Additionally, in "The Politics of Experience" Laing politicized the agency of individuals to have psychotic episodes or altered states of consciousness. He questioned why it was that British society either

confined or medicated people who were actively insane and implicated psychiatrists and the medical profession as acting as social containers drawing the boundaries of possible experience. He also likened psychosis stemming from mental illness to altered states of consciousness brought on by the use of psychedelics.

American psychologist Timothy Leary was also interested in the similarities between psychosis and psychedelic experiences and even the possibility of treatment of mental illness with psychedelics. Leary and Laing were writing and experimenting on mental patients and themselves, developing the connections between spirituality in altered states of consciousness and the positive, transformative aspects of psychedelic drugs. Both were advocates of the psychological benefits that could be gained by potent mind altering drugs. They were interested in the ways that these drugs could blur boundaries and alter reality. In Britain and the US these drugs were quickly becoming illegal for general consumption and use in experimental psychology and both were concerned with the State's ability and jurisdiction to restrict people's seeking altered states of consciousness. The similarities between the state's concern over controlling psychosis and use of psychedelics were explored by Laing, Leary, and Perry. The conclusions were that these types of experiences, non-usual consciousness, were a threat to the state and to consensual reality, whether in the form of psychosis or psychedelics. This politicization of one's mind and experience was adopted by some advocates of mentally ill who believed that just as psychedelics have potential for spiritual and personal growth potential, so does psychosis. Mentally ill people experiencing psychosis should have the option to have the experience of psychosis without being locked up or drugged to thwart it. In the same way that the State did not have the right to limit access to psychedelics and thereby altered states of consciousness, the State also did not have a right to interfere with people's psychotic experiences. The notion that society could learn and benefit from altered states of consciousness, psychedelic experience and psychosis, was grounded in the critique of the Vietnam War and the review of alternative courses of action for society other than warfare.

It was in this context that experimentation with consciousness, openness to spiritual practices, critique of State powers, and the multiple rights movements converged to create an examination of mental illness, spirituality, and social dynamics. In the climate of the 1960s, therapeutic communities again became attractive because they presented a radical departure from coercive, hierarchical, institutional settings and a positive model of treatment for the mentally ill where mental illness, and the role social forces played in it, was viewed as having growth potential.

**Contemporary US therapeutic communities**

Barriers to widespread support for therapeutic communities as a post-deinstitutionalization option range from the vague definitions of the construct of therapeutic community (Crocket and St. Blaize-Molony 1964), therapeutic communities' lack of interest in research (Kennard 1979), the fact that "health insurance mechanisms do not support their use" (Warner 1995:XV), and the difficulty in evaluating treatment outcomes (Manning 1979). Of all of these forces, the most important may well be that in a competitive mental health care marketplace, being able to cite research that demonstrates efficacy compared to other treatment possibilities is essential. The methods and philosophies of therapeutic communities do not lend themselves to rigorous scientific testing needed for this type of competition. Manning sums the problem up well:

> Perhaps one of the most general concerns has been the question of the relationship between outcome studies (of the results of 'treatment') and studies of process (what happens in 'treatment')... The dilemma is that unless the change-inducing techniques can be described in sufficient details to reproduce them, then the knowledge that some unknown thing is effective is not very effective. (1979:304)

So, why have therapeutic communities remained as an option on the mental health care landscape? First, therapeutic communities are able to provide lower cost in-patient services than hospitals (Fortuna 1995, Sladen-Dew, Young, Parfitt, Hamilton 1995). Second, they are one of very few options for patients whose symptoms are not severe enough to require hospitalization but are not well enough to maintain themselves through community mental health services (Sladen-Dew, et al. Ibid.). The other options are half-

way houses and group homes, which are not popular because of poor living conditions. Additionally, they are custodial rather than therapeutic. Third, therapeutic communities provide a type of residential care that is seen as non-institutional and humane. Warner (Ibid.) notes that, "People receiving services in a non-institutional setting are called on to use their own inner resources. They must exercise a degree of self-control and accept responsibility for their actions and for the preservation of their living environment. Consequently, patients retain more of their self-respect, their skills, and their sense of self-mastery." (xvi) It is interesting that this conceptualization of an in-patient option for mentally ill patients reflects the old ideals of moral therapy.

In 1995, my research of American therapeutic communities for the mentally ill started with articles written by researchers and personnel at assorted communities and published in the journal Therapeutic Communities and the International Journal of Therapeutic Communities. I then discovered the Handbook of Intentional Communities, a source that listed therapeutic communities in the U.S. I sent letters and called all of them, quickly learning that many of the twenty-five therapeutic communities listed were no longer in operation due to financial problems. I found fifteen communities that were willing to give me assistance by sending me their written materials or talking with me by phone. Through conversations with directors and personnel at these communities I learned of additional therapeutic communities that existed, but were not listed or "on the map." Menar was precisely this type of low profile, word of mouth community that did not appear in journal articles or handbooks. It was an experimental, marginal, unknown community, and that is why I chose it.

In examining the geographical distribution of the therapeutic communities for the mentally ill in the U.S., I found that they are concentrated on the East Coast and in the West. The majority of East Coast communities are either Quaker-affiliated or incorporated Quaker ideals, which is predictable given that the area was the original home to such communities. Therapeutic communities in the West were not linked to the Quaker lineage and had diverse approaches to thinking about and treating mental illness. Almost all of the communities in the U.S. emphasize the spiritual aspects of mental illness and its treatment,

and I believe this is the fourth, and most important, reason for their survival. As I mentioned previously, therapeutic communities compete with other types of mental health care in terms of cost-benefit, efficacy, and outcomes. They also compete with different notions about mental illness and how to treat it; the main competition coming from the biomedical model .During my phone conversations with personnel at other therapeutic communities, I found that most patients at these communities have private health insurance or have families who pay out of pocket for their treatment expenses. This means that patients, their families, and their mental health care providers can choose where to receive mental health treatment. Medical anthropologists have looked extensively at the relationship between health care consumers' beliefs about the cause of their illness, their perception of beliefs held by health care providers, and their choices of where to seek help.(Chrisman and Kleinman 1983, Nichter 1981) Therapeutic community's represent an alternative model to other forms of thinking about mental illness and treating it and according to the market place, are desirable.

In looking at therapeutic communities operating currently in the U.S., it is easy to see the impact and history discussed above. Quakers still run many of them and the remainder have some type of non-secular affiliation or spiritual dimension. All of them draw on concepts from milieu therapy and moral treatment such as showing patients dignity, interaction with "normals" as well as other mentally ill patients in community setting, and many incorporate farming as part of patient's routine. These therapeutic communities care for chronic, yet mid to high functioning mentally ill people. Regulatory management and licensing of therapeutic communities is done through the state.

**Psycho-spiritual ideology and mental illness**

Although different approaches and beliefs about the cause and explanation of mental illness have fallen in and out of favor, the great divide between belief about mental illness being grounded in socio-cultural/spiritual/religious dimensions versus a physical/medical basis has continued to the present moment. These remain the two most divergent and combative perspectives on the issues of mental illness. There are still the

same debates about treatment, responsibility, categorization, and definition. One of the major areas where the perspectives of mainstream psychotherapy and the socio-psycho-spiritual perspectives diverge is in the meaning and treatment of psychosis. Mainstream psychotherapy teaches that psychotic material is not meaningful and should be limited, if not eliminated, through the use of anti-psychotic medication. Mainstream psychotherapy claims rights to the realm of psychosis based on economic, physical, and social authority and is invested with the power to do so by borrowing heavily from the power of the medical profession. The mainstream psychotherapy stance on psychosis is that not medicating it is unethical, inefficient, inhumane, and socially and economically costly.

In great opposition to the mainstream approach, the socio-psycho-spiritual camp claims that psychosis and other altered states of consciousness can be therapeutic and transformative if properly handled(by them). Their claim is that traditional psychiatry does not recognize the difference between mystical and psychotic experiences and often people are drugged, imprisoned, or misdiagnosed due to the lack of knowledge, fear, and motivation to make money from psychotic patients. They firmly believe that many types of psychosis are instances of spiritual emergence, which is a valuable experience that should be honored and respected, not medicated out of existence. The main organization which represents, organizes, and lobbies against mainstream psychotherapy's claim to ownership of the mind-space of psychosis is the Spiritual Emergency Network or SEN. (Nolan 1986) Formed in the early 1980s in California, their mission is to assist people suffering from spiritual emergence (Grof and Grof 1986) by referring them to knowledgeable alternative practitioners who can help them with the spiritual awakening process, they also provide information on the facilitation and understanding of altered states of consciousness, including spiritual emergence. SEN also educates the public and mainstream psychotherapeutic community about how to facilitate the spiritual awakening process. If we use SEN's public discourse as a model for the socio-psycho-spiritual perspective's back talk to mainstream psychiatry, we tune into debates about therapeutic territory, the power of meaning-making and knowledge production, political economy of psychiatric treatment, patient needs, and professionalization and medicalization. Psychosis

particularly, and severe mental illness generally, constitute some of the most fascinating, frightening, and contested areas of human consciousness, which make it valuable territory.

The socio-psycho-spiritual camp says that psychiatry pathologizes spiritual, religious, and mystical content in peoples lives, labeling it mental illness and then giving it to the medical or quasi-medical establishment to deal with. The socio-psycho-spiritual perspective, informed by the writings of Stanislov Grof, John Weir Perry, RD Laing, Andrew Weil, Timothy Leary and other 1960s era writings on altered states of consciousness, not only accepts, but embraces the notion that there is nothing intrinsically pathological about the experience of ego-loss associated with psychosis. This is in direct tension with the biomedical psychiatry camp which, via sources such as the DSM IV, describes psychosis as abnormal and dangerous. The word "dangerous" is often applied to the theoretical and treatment perspective of the socio-psycho-spiritual camp by mainstream psychiatry. This is an important cover term whose unpacking reveals multiple meanings: dangerous to the patient, dangerous to the person treating the patient, and endangering self-restraint, self-control, and the need for punishment or severe treatment to stop the individual who is out of control.

It is important to note that there are indeed factions within the biomedical psychiatry camp. Attempts were made by groups outside the mainstream to include material in the DSM IV on socio-psycho-spiritual interpretations of psychosis under the rubric of a suggested "Z Code" (Turner, Lu, and Lukoff 1991). The Z Code presented the argument for including alternative interpretations of psychosis from a cultural sensitivity perspective rather than invoking the historical and controversial argument over the "politics of experience"(Laing 1967). The result of these attempts is that a very small appendix mentioning the cultural sensitivity issues raised in the Z Code is found in the DSM-IV. An insightful behind the scenes look at the politics and positioning of this effort is discussed by Lukoff, Lu, and Turner (1992) in their article "Toward a More Culturally Sensitive DSM-IV: Psychoreligious or Psychospiritual Problems," published in the Journal of Nervous and Mental Disease.

Recently the socio-psycho-spiritual camp has been accusing mainstream psychiatry and the law of working together to create a situation where if psychotic patients want to go unmedicated and experience their full-blown psychosis, they are legally not allowed to do so. Their concern then is over the ability of the medical and legal professions to draw the boundaries of experience by limiting the realm of altered states of consciousness and thus, limiting experimentation of altered states of consciousness and the boundaries of reality. The conflicts between these two groups, reflected in the argument about the appropriate interpretation and treatment of psychosis, has resulted in formal biomedical psychiatry channels and parallel informal networks of information such as SEN, therapeutic communities for the mentally ill, word of mouth, and extensive popular publications.

A common theme in these publications is a critique of the lack of attention to spirituality in psychiatry. In "A Sourcebook for Helping People With Spiritual Problems," Emma Bragdon makes a typical argument

> Mental health professionals have not accorded religious and spiritual issues in clinical practice the attention warranted by their prominence in human experience. Surveys show that religion and spirituality play a central role in the lives if most of the population, including psychiatric patients. Religiosity and spirituality are linked to psychological well-being, involve issues of love and relatedness, and provide a source of meaning and purpose in life. Yet, theory and research in psychiatry and psychology have largely ignored the religious and spiritual dimensions of life. (1993:278)

Another popular author addressing the role of spirituality in mental illness is John Nelson's "Healing the Split: Integrating Spirit Into Our Understanding of the Mentally Ill," where he advocates an integrated perspective, viewing madness as a multi-faceted phenomena involving an altered state of consciousness, mysticism, the occult, spiritual emergence, and creativity. He argues that, "No area of Western thought is more in need of input from the spiritual disciplines than our understanding of the psychoses." (xviii: 1994) These authors' perspectives were exemplified at Menar through the notion that one major role of the therapeutic community is to introduce or re-introduce spirituality into patients' lives.

What does all of this tell us about our culture? First, it demonstrates that mental health and mental illness are cross-roads where political, economic, religious, and cultural disputes are negotiated. These groups may be opposed. However, both sides reflect and

constitute social negotiations. Second, the nature and form of these debates point to the underlying socio-cultural pattern and significance of Western dualism. Although we are looking at this from a particular time and position, these debates depict some very basic tensions which confirm and confuse our cultural existence: mind/body, sane/insane, cause/effect, blame/responsibility, dangerous/safe, control/chaos, nature/culture along with the additional interpretations of our moment in history as well as our positioning in time and space.

**Ideology, theology, and healing at Menar**

Like other contemporary therapeutic communities, Menar's treatment of mental illness is based in moral treatment ideals. It is typical in its philosophy that a patient's therapy takes place as he/she learns to successfully negotiate day-to-day existence in a non-institutional setting and forms relationships with other patients and community members. Similar to several other communities, it is rural and makes use of farming as therapy for patients, and has a religious affiliation with the Catholic Church. Unlike other communities, it also encompasses a wide variety of other spiritual beliefs and practices among members of the community.

Reflective of the history of therapeutic communities for the mentally ill, Menar has strong anchors in these traditions and draws on them both consciously and unconsciously. They make the value of taking care of the mentally ill, living with them, and not fearing them explicit through citing Christian scripture and its tradition of taking care of less fortunate people. The staff often expressed the concept that the patients were conveying important things and it was imperative to listen to them. Many staff said that they thought the patients might indeed be a savior or have the information to save the world. Additionally, they held the notion that patients were trying to teach them lessons and it was imperative to figure out what they were trying to communicate. This reminded me of the energy and fervor of people who read about mystical experiences of ascetics in order to gain knowledge from them.

In order to comprehend Menar as a community as well as its spiritual and ideological underpinnings, it is helpful to examine the ideological history of which they are a part. Romanticism emerged in the late 18th century, making its mark in European art and literature, particularly in the writings of Rousseau on the "mythical state of nature." A philosophical movement that stressed subjectivity, nature, and emotion, it was in direct opposition to the positivism and objectivism of 18th century Enlightenment. The core aspects of Romanticism were adopted and amended by Madame Blavatsky, who founded the Theosophical Society in 1876. Theosophy was heavily influenced by Romanticism, esoteric Christianity, the occult, and Oriental mysticism's notion of the self as sacred. Rudolph Steiner, a German philosopher, transformed Theosophy into Anthroposophy, applying mysticism and spiritual evolution to science and education in the late 19th and early 20th century. (Reese 1993) During the 1960s in the US, Steiner's ideas were incorporated by counter-culturalists seeking a move away from traditional, organized religion and toward the self as the site of religious practice.

In Paul Heelas' book "The New Age Movement" (1996) he describes the history and evolution of the New Age and delineates underlying characteristics found in disparate New Age philosophies, teachings, practices, and groups. One theme that he identifies is a tendency to invoke the past:

> New Agers are inclined to go back to the past. Some dwell on ancient India or Egypt; others on the pagan times of Europe. Some refer to the early Gnostics; others draw on the Christian mystical tradition, perhaps concentrating on its flowering in northern Europe during the Middle Ages. Some favor the Romantic Movement; others turn to the esoteric, metaphysical, or occult. (41)

Indeed, Menar dwelled on the past. However, it was not one past, but rather several pasts, simultaneously. Menar was not concerned with one particular tradition, but an overall past that was connected by underlying universals of mystical traditions and relationships to nature, and that could be learned from and modeled. This tradition of viewing multiple pasts together and extracting their universal spiritual truths has its roots in Romanticism, Theosophy, and Anthroposophy. Buddhist psychology was interwoven into this network of beliefs and ideas. The core Buddhist concepts of balance and harmony, care of nature,

care of the self through mindfulness, interconnectedness, and inter-dependency were embedded in Menar's treatment philosophy and practices. The Buddhist model of suffering and healing (below) was represented in much of the casual conversation about healing and illness I witnessed at Menar.

Unawareness > feelings > craving > clinging > suffering/illness > awareness > calm/cure

The cycle of suffering is broken through insight, awareness, and wisdom.

New Age philosophy was a significant component of theology and healing at Menar. The term New Age refers to a broad and diverse set of religious practices and organizations, however, Heelas outlines common themes underlying New Age religion and healing traditions (1996):

· the unity of mind/body/spirit

· individual will, positive thinking, and intention of thought and consciousness is the key to healing

· highly values self-reliance, individualism, and individual responsibility

· transformation can occur through illness, illness is an opportunity, illness is feedback on life and contains a spiritual message

These principles were essential to Menar's ideology about healing, particularly the power of the individual will to influence illness and health. On the one hand, patients were seen as having an important spiritual message within their madness and because of this they were honorable, different, the ultimate "Other." On the other hand, given the overall construction of illness and well being as connected to individual will, patients were responsible for creating their own suffering and illness and not getting better. I perceived a tension between these two notions since the former concept indicated that mentally ill people were not at all responsible for their illness with implications that "normals" should take care of them mercifully. The latter concept indicated that the mentally ill are completely responsible for their illness, possibly implying that since they do not will their own cure, "normals" should not take care of them. Informants did not perceive a tension here. In my fieldnotes I mused, "... it seems like a combination of blaming the victim while honoring them. What would mindfulness look like in a mentally ill person? How can

mentally ill people develop insight into their suffering and stop it, if lack of insight is part of their suffering? Which came first, the chicken or the egg? Zen riddles within Zen riddles."

Menar's adoption of Catholicism, New Age, Anthroposophy, and Buddhist elements make it a departure from the Western European Christian theology from which therapeutic communities originated. Menar's setting on a farm, its attention to nature and agriculture, and reliance on the milieu for therapeutic properties is deeply rooted in the lineage of therapeutic communities and milieu therapy. Therapeutic communities embody milieu therapy's core notion of modeling desirable, mainstream behavior and normalizing mentally ill people by environmental manipulation. However, Menar is also rooted in the traditions of utopian and intentional communities that establish themselves in contrast to the mainstream culture. What does that mean in terms of Menar as a community "normalizing" the mentally ill and modeling ideal behavior? Community members would answer that question by saying that they are indeed the best people and the best place to treat the mentally ill since they actually care about them, provide a beautiful setting, and whereas the outside world is bad for mental illness, being at Menar is good. I often heard community members say of Menar, "It is a healing place."

## ORGANIZATIONAL BACKGROUND

### The history of Menar

I began to learn of the history of Menar after numerous conversations with a variety of people familiar with it: current and past staff members and patients, neighbors, and various other people who had been connected to Menar for some length of time, such as nurses or social workers who visited its patients. The following outline of the history of Menar is a synthesis, based on these conversations.

The story of Menar begins with its founding in rural New Mexico (in an effort to maintain the Community's anonymity, I have substituted the actual location with this comparable locale) in 1979. Dora Miner, a professor of sociology, Father Ben, a former student of hers, and Dora's son, Samson, started discussing their desire to live in a more

extended community where people worked and lived together while cultivating a life where spirituality was valued and played a central part in daily living. The idea of starting some kind of residential community together where this could be accomplished seemed very attractive to all three. In 1979 they agreed to pursue this social experiment together and purchased the 14.1-acre farm in the rural town where Menar is located. The land was purchased with funds given to them from a private donation. I was unable to get the details about this gift, who gave it, whether it was solicited, etc. Every time I brought it up with Father Ben or other key informants they would routinely change the subject or re-direct the conversation.

The three founders asked their friends and others who might be interested in the concept to join them in establishing Menar. Approximately 15 people began building, occupying, and developing the community in 1979. Originally they supported themselves by offering spiritual retreats, selling produce from their organic garden, and contracting with the county to provide housing for homeless people and battered women. Then a friend from a nearby town asked if they would consider taking care of his emotionally disturbed wife, a schizophrenic who had been hospitalized and had not been responding to treatment. He thought that the beauty of the farm and the relaxed atmosphere might help her recover. In a 1981 newspaper article on Menar, Dora Miner reflected on the event saying, "She came to live with us and we worked with her continuously, and she got so much better in a short time that her psychiatrist sent us another and another and it has just been unending." The community took on more and more mentally ill people mainly because they had the space and doing so created revenue for them.

Dora Miner was born and raised in Germany and came to the United States in her early 20s. Interested in the intersection of spirituality and education, she was a scholar and practitioner of Anthroposophy, a German occult-spiritual-philosophical tradition started by Rudolph Steiner around the turn of the 19th century. Anthroposophy which, "attempts to explain the world in terms of man's spiritual nature, or thinking independent of the senses," (Reese 1993) is part of a larger group of New Religious Movements, including Theosophy and Christian Science, that sprung up during the latter part of the 1800s and

were concerned with healing, mysticism, and esoteric Christianity. Anthroposophy is still vibrant today with strong associations to the New Age Movement and a following based mainly in the United States and Germany. In the United States, familiarity with Anthroposophy is mainly through Walden Schools, which are based on the theories of Rudolph Steiner.

Miner envisioned the community as a learning center where people would live together while studying philosophy, sociology, spirituality, and the arts. She hoped that the community would have a strong educational and practical grounding in Anthroposophy. She died at Menar at the age of 80 in 1995. Her ashes are housed in a wooden gazebo at Menar and every management and Accordance meeting begins with a gathering and meditation in the gazebo so that Dora can still be "involved" in the decision making process about running Menar.

Dora's son Samson, an architect/artist/visionary, also thought that creating a community where people could come to practice and study Anthroposophy was ideal. His main contribution to Menar was the architectural planning and implementation of all of the buildings at the community, which now number 14. He firmly believed in Rudolph Steiner's ideas about architecture and energy; corners and squares were to be avoided because they restricted the flow of energy while open spaces and soft angles were paramount. Wood was used in construction rather than other material since it was seen as being in harmony with the spirituality of the community.

The overall appearance could best be described as a series of buildings made of wood with Bavarian and local Native American architecture. It is unique in its size and architecture as well as the fact that wood structures are not found elsewhere in this rural neighborhood. This calls a lot of attention to Menar. Most people in the surrounding area are quite poor and live in small concrete or metal and concrete structures. Many of them thought that Menar was some sort of cult or "drug community" since it had money for building with expensive materials and its occupants were mainly European-Americans with a few Europeans.

By the time I arrived at Menar in 1996, Samson no longer had much influence in the community. The staff forced him out of decision-making, complaining that he had drifted too far into the spiritual realm and was no longer able to hold a meaningful conversation or make decisions about the community, that he "had his head in the clouds" to such an extent that he was "worse than the patients."

Father Ben is an ordained priest in the Catholic Church. He wanted to start an ecumenical community where spirituality was central and people of different ages and religious backgrounds would live together. He was well-versed in Anthroposophy, but remained committed to teaching and practicing his own perspective on spirituality based on his theological training in the Catholic Church. Menar has a Catholic church on its premises and has a small congregation made up 15 to 20 members from nearby towns that attend Sunday mass and other events put on by the church. Neither patients nor staff participate in services with any regularity. Father Ben reported that Menar does receive some funding from Catholic and Episcopal churches, but that the majority of its funding comes from state grants, private foundation grants, state funds for contracted services for patients, patients with private insurance, and private donations.

Father Ben decided to ask his friend, Hillary, a psychiatrist and a Maryknoll Sister, to move to Menar to be involved with patient care so that they could expand and get state funding. She came to Menar in 1980 and lived there until 1990. Several current staff members who lived at Menar while she was there explained to me that her relationship to the community was a complicated one. Once she arrived at Menar, she set up a private psychiatric practice on the premises and established a thriving practice. For the most part, she was not interested or involved with caring for Menar's patients. However, she contributed a great deal of the money she made from this private practice to Menar. She also gave Menar her clinical expertise and credibility so that they could become a state licensed special treatment facility. Eventually the community grew into its present status as a 15 bed long-term treatment center, which the state describes as "designed for those persons who would be living marginally in the community, returning many times to the hospital for support... a rehabilitation focus is emphasized."

Among staff members, both past and present, whom I interviewed about the organization's history, one point was mentioned almost universally as being a significant aspect that shaped and continues to shape Menar today: that Menar came into the business of caring for mentally ill people quite accidentally. In fact, the original intention behind founding the community was to create a cultural/religious/educational/arts center, not a therapeutic community for the mentally ill. The fact that the community was not founded, organized, or run based on the notion that taking care of mentally ill people was its central mission was very much a Menar creation myth that was told and re-told to new members of the Community.

The founders of the community were generally unaware that there are other communities like themselves that currently exist in the US, or of the long history of therapeutic communities, and had no links to other such communities. When I discussed these topics with staff members they were excited to learn that there was a long tradition of other communities trying to do the same type of work and that there were similar communities currently operating in the US. But they were not motivated to form relationships with these communities. Menar's resistance to engaging with the outside world is common among therapeutic communities: "[There is a]...general tendency in therapeutic communities to withdraw from reality and to regard the outside world with egocentricity" (Lout vanEck 1988:115). I came to understand this as Menar's, and particularly Father Ben's, way of shielding the community from the gaze of clinical and State powers by maintaining a marginal identity (on the local and global stage, e.g. as opposed to the famous Findhorn Community in Ireland). This marginal identity assisted in recreating the power relations of the wider culture at Menar and in turn this enhanced the ability of Father Ben, and a few other of his close confidants, to reinforce their own power and monitoring of community members.

The members of Menar were often at odds with one another over the direction and purpose of the community. When I reviewed the history of Menar with Larry, a clinical staff member that had been living there almost since its inception, he traced this problem back to the beginning of the organization:

This has always been the least likely group of people to get along... totally different ideas and beliefs about what this place is and does. It also has to do with Dora. [She] never went straight, always through the back door. She used you like a tool. We keep trying because of the investment we've all made in this thing, the challenge... like Menar is in its late teens; the body is set but the mind isn't. [It] pulls toward regression, pulls toward maturity depending on the day... In the early years there was a lot of construction, expansion. We all worked on that together. The patients participated too. Those that didn't just wandered around. It's different since we're not building all the time. You know, I'm not sure what we're doing now.

Larry's comments about the community communicate several ways in which the early stages of the community's development are still present today. His description of Dora's way of going around, rather than straight remains the norm in terms of how the community's leadership communicates and conducts business within the community and in external relations. There is a prevailing feeling that there was more cohesion among members of the community during its earlier stages when the focus was on building a place to live and creating a community. Between 1979 and 1990 development, expansion, and improvements to the grounds itself took up an enormous amount of time and energy. This sentiment was echoed by several staff who had been there as long as Larry. The current phase is marked by the uncertainty of renewed questions about the purpose of the community, its internal and external identity, and how the community should be run. His statement "she used you like a tool," reveals the current environment where people such as Larry, who are not in the inner-most circle of power and leadership, are critical (though not publicly) about the way they have been and continue to be treated by the leadership (A discussion of current community power relations will be addressed in the chapter on power).

**Situating Menar as a business**

In what ways is Menar similar to and different from other therapeutic communities? Akin to other therapeutic communities, Menar has financial woes associated with being a non-profit social service and receiving only small amounts of funding from the Church and community charities. However, at other communities the majority of patients pay for their in-patient care through their private insurance, which eliminates

having to interface with the state around insurance billing procedures. In contrast, Menar contracts for their services to patients through the state, which obligates them to have administrative, financial, and regulatory interactions with the state. Patients at Menar generally receive state insurance money for their residential psychiatric treatment and have chosen to come to Menar (and Menar has accepted them). According to three informants close to the financial management of Menar, its financial problems come from the fact that the state is often delinquent in paying their fees for the services Menar performs for patients.

The state's adult residential mental health system is a tiered system of descending levels of intensity of care. At the first level is the state psychiatric hospital. Then there are the special treatment facilities (STFs), which are grouped into long-term, indefinite stay residential treatment programs (Menar is the only one in the state) or transitional residential care programs with a maximum stay of 2 years (two facilities, one of which was operating without a state license). Next, there are adult residential care homes (one facility) and adult foster care homes (6 families). Finally, there is semi-independent living (ten homes). After reviewing this system, in 1994 the Federal Department of Justice filed a lawsuit against the state concerning its over-crowding in the state psychiatric hospital. According to a 1995 state report responding to the lawsuit, its mental health system had a gap of 306 beds for mentally ill adults in need of long-term residential treatment.

Menar is an essential provider of services to mentally ill patients in a state that has lacked adequate services for this population for many decades. In light of this context, there are three significant reasons why Menar is championed by the state mental health system. First, it provides needed beds for long-term residential patients. Second, it has a high staff to patient ratio of one staff to two residents, whereas the law requires a ratio of 1:8. Third, it is able to offer residential patient services at a rate of $65 per day as compared with the state hospital's $400 per day, creating savings for taxpayers and health insurance. Menar is able to be selective about the patients it is willing to take since the state needs its services, patients want to go there, and providers want to send them there.

They try to choose patients who do not have histories of being violent or dangerous, who can participate in community life, and are fairly high-functioning.

Most inpatient psychiatric facilities function under pressure to get patients stabilized and discharged so that new patients can take their place and the cycle can continue. In "Emptying Beds"(1991), Lorna Rhodes describes this drive to move patients quickly out of the hospital. This is a stark contrast to the situation at Menar. It is in Menar's best interest to keep patients for long periods of time once they are there because turnover is expensive in terms of staff time spent on setting up arrangements, getting paper work from insurance and state, coordinating with other social service agencies, setting up medication schedules, assembling information and creating charts. Once a patient is integrated into the Menar community, dosing medications, charting, and scheduling psychiatric care takes minimal time to maintain. Menar is paid per patient so the main pressure is to operate at the maximum number of patients possible to yield the most income. This was not a problem since there is a shortage of space in psychiatric facilities and Menar had a good reputation among patients and mental health bureaucracies involved in placing patients. While I was at Menar the community was converting a few units of existing staff housing into patient housing so that they could take on more patients. This was easily accomplished by modifying rooms to comply with state rules for patient housing.

Menar was also considering expanding its business into contracting with the state for providing housing for homeless families in the county. During my fieldwork, discussions with state and county agencies were under way regarding Menar contracting with them for transitional housing. Architectural plans were drawn up for building housing for approximately ten families. The new housing was going to be located on an undeveloped piece of Menar's property just above where the Community is located.

I went with Father Ben to a county meeting where he presented his plan and discussed it with county officials and members of the surrounding area. Father Ben's plan was supported by county officials because Menar was willing to fill in the gaps of need by providing housing and services to a poor county. However, some of Menar's neighbors

were at this meeting and voiced concerns about having homeless families moving near their homes. They argued that the traffic, people, and noise from Menar and the patients were already a disturbance in the community. When it came time for Father Ben to comment on the criticisms of the proposed project, he evoked his kind, priestly authority and positioned himself and Menar as a Chrisitian social service agency working to take care of the less fortunate people, whether they be homeless or mentally ill. Leveraging his duty as a religious figure, he had quieted the neighbors complaints by making them feel ashamed for not wanting to help the less fortunate. He successfully diverted any questions about Father Ben as a business man or Menar as a business. It was this type of maneuvering that indeed made him a success at Menar and advocating for Menar.

At the time of my departure from Menar the plans for getting permits to build the housing for homeless and outlining the details of contracting was underway. When the project was discussed at large Menar community meetings, Father Ben and the Management Committee presented this as an opportunity to make money that Menar needed while taking care of homeless people. Some members of Menar were excited about this expansion and wanted to be involved in building and administering the housing program. Other members wanted the adjacent piece of land to go undeveloped, didn't want to be involved with the project, or were concerned that it would change the character of Menar.

Menar's expansion into another branch of social services for additional revenue echoed the fact that they were not particularly committed to caring for mentally ill patients as the central role and duty of the Community. I recall wondering what influence this project would have on the patients and worrying that less attention would be paid to their needs when a new project started. I also thought about the proximity of this new family housing project and patients being curious about their new neighbors and wanting to interact with them. My concern was that Menar would not protect them from being taken advantage of or mistreated by their new neighbors. Larry and Leah, clinical staff members shared these concerns. They were committed to taking precautions for patients as this new project went forward.

One of the most intriguing things about Menar as a business is its savvy understanding and ability to navigate the landscape of social services, flow of state and insurance money, public relations, accounting, and non-profit tax and business strategy. Its ability to do this was squarely based on Father Ben's understanding of the landscape and his competence as a sophisticated, persuasive businessman. But at different points Menar rejected, embraced, or ambiguously interacted with capitalism and consumerism. I had thought that the business aspects of Menar would have been seen as mundane or distasteful because they interfered with spiritual clarity. But the business aspects of the Community seemed to be welcomed as a challenge and an arena to prove that applied spiritual energies could translate into financial security. Heelas explains,

> A significant number of New-Agers have in fact moved beyond counter-cultural antagonism to the capitalistic mainstream. Instead, they incorporate the creation of prosperity. A basic assumption-shocking for the spiritual purist or counter-culturalist- is that there is no need for those questing within to withdraw from capitalistic institutions, specifically the world of big business. One can be active and successful in the mainstream whilst pursuing the goal of Self-sacralization. (1998:68)

Despite all of the efforts to generate income for the Community, according to Father Ben and other long-time community members, Menar fluctuated between running just at the margin or slightly at a loss and was unable to save money. Although Menar did not have the overhead of a hospital, it did have a fairly large operating budget. This financial situation meant that the Community was always fund raising or generating ideas for additional sources of revenue. Tight money meant controlled spending, prioritizing projects, creativity in cost cutting, and a "we do-it-ourselves" mentality.

**Consumerism**

People at Menar prided themselves on living differently from mainstream America and being successful as an intentional community where the values of spirituality, self-awareness, living off of the land, and being with nature were achieved. Consumerism was seen as empty, devoid of soul and contrary to the simplicity for which the community was striving. These values were seen as important pursuits for all members of the community and particularly significant in their healing properties for the patients. Consumerism was

something that got in the way of relationships with other people and with oneself. It was often cited as what was wrong with America- selfishness and lack of self-reflection- and at the root of problems such as violence, environmental degradation, drug use, and mental illness. Consumerism symbolized the move away from spirituality, self, each other, humanness and the loss of connectedness to the Earth and God.

Building and maintenance materials, food, electricity, water, gas, phone, and office supplies were the main expenditures. Furniture, cars, lamps, desks, carpets, appliances were paid for either by donations from Church groups or were purchased second-hand. All purchases had to be cleared and signed for by Father Ben. It was evident that some people had more money or resources than others. The management team had the most desirable living quarters, which were well appointed with mid-level rugs, computers, televisions, VCRs, stereos, telephones, and air conditioning.

Staff members were supposed to each receive a salary of $50 a month from Menar. However, staff told me that the allowance varied and that Father Ben was more likely to sign off on expenditures from some staff members than from others. Staff lived in a range of situations from converted Quonset huts to nice apartments depending on seniority, needs, and status. These dwellings were mainly furnished with belongings that staff had brought with them when they moved to Menar and items that were in Menar's vast storage building on the premises.

To a great extent patients were not participants in the consumer culture because they were given only a $10 a week stipend from the state. They bartered among themselves, staff, and townspeople and it was widely known that some patients stole. The building where the majority of the patients lived was the barest building with the least decoration and accouterments. Some of the patients had nothing but clothes and a few belongings in their rooms while other patients had old computers and boom boxes.

## ORGANIZATIONAL STRUCTURE

### The charismatic founder/leader

At forty five years old, Father Ben is the patriarch and charismatic leader of the community. This became apparent almost immediately upon my arrival and continually thereafter. He was ever-present; even when he was not physically present, it still felt like he was "there" through impression and consciousness of patients and staff. This sense of his always being at hand manifested itself via the often stated, "ask Father Ben" or "Father Ben said..." He was very much like Ken Kesey in the "Electric Kool-aid Acid Test" (Wolfe 1968): a smart, charming, and adventurous leader directing a group that was on the margin of society.

His devotion to Menar combined with his enthusiasm and certainty was infectious. In any situation where there was a criticism or threat to Menar, he creatively found an explanation or solution that was not just satisfactory but impressive. His mastery of argumentation and oration enabled him to redirect any questions aimed at denouncing or blaming him or his leadership. He was able to make members of the community feel proud to be a part of Menar and feel good about themselves. He was also able to make them feel guilty or ashamed for questioning his authority or motives by employing religious themes, Menar ideology, or psychiatric jargon. His ability to deny, rebuff, or rationalize reproach also helped to stabilize his authority. He was charming, appealing, interesting, and able to convince people to participate in Menar.

Much of Father Ben's legitimacy to lead Menar came from his ability to successfully create and maintain the appearance of a well orchestrated organization. By carefully coordinating two key symbolic representations of the organization, the Community's grounds and the Community's paperwork, he protected the organization from deeper probing from internal and external sources. His ability to do this served to prevent people from questioning his rhetoric or the organization.

Father Ben had an eye for beauty and took pride in embellishing the buildings, lawns, trees, walkways, fountains, foliage, and garden. It resembled a vacation resort (and in fact at one point in the community's history it did make some revenue this way). The continuous labor required to produce and maintain the grounds created opportunities for rituals and rites of intensification, reinforcing membership and commitment to the

community. Developing plans for the grounds, buying materials and tools for building, landscaping, and remodeling required teamwork and dedication. It brought community members, staff, and patients(who were able and wanted to participate) together with a common goal; to enlarge, beautify, and maintain their community. Succeeding at creating tangible, physical things that adorned the community was a point of pride and it took time and cooperation to achieve. The socializing and interaction that took place around all phases of a project, from conceptualization to celebrating its completion, was intense. It was also joyous. I observed that members of the community cooperated and enjoyed each other most while working on these projects together.

The time, money, tools, and materials that went into adorning Menar were an essential symbol. They signaled the community's financial, spiritual, and moral accomplishments and strengthened the sense of well-being. A visually pleasing community was a source of communal pride, thus fortifying Father Ben's leadership. It also set a tone of a utopian Menar where members and non-members alike were encouraged to focus on the external representation of the organization. Because it was so attractive and was a communal accomplishment, it was easy to engage with the community at the cosmetic, surface level.

Father Ben also built and maintained the appearance of a complex, well-functioning organization by concentrating on paperwork which was orderly, seamless, and professional. This was true of progress notes on patients, the organizational/staff structure chart, stationery with letterhead designed to address Menar's different objectives, and grants and budgets submitted to the state.

The organizational chart was a particularly good example of the way paperwork was invoked to represent the ultimate reality of Menar. Anytime anybody had a question about Father Ben's authority in a particular area they were referred to the chart [Fig. 1]. There, plainly laid out at the top rung of each of the three basic organizational structures the management committee, the executive committee, and the board of directors, was Father Ben's name. Why he was the director of the Community, the treatment facility, the management committee, the small congregation, and thereby at the top of each

organizational structure were questions that had never been publicly asked. The organizational chart had become both the symbol of the organization's reality and the justification for it.

Although there were programs and committees listed on the chart that had not existed for 10 years, they were treated as though they were still operating and functional. Similarly, it did not matter that the "Therapeutic Horsemanship" program had not been in operation for years or that the "Menar Art Foundation" was a working title for a program that had never come to fruition. These ideals were reified by the organizational chart. Father Ben succeeded in making the ideal seem real by being proud of the document and what it represented and treating it like it was real. Staff members were not interested in questioning the validity of the document or what it said, because that would be seen as a lack of commitment to Menar. Patients criticized Menar when I talked with them individually, but were fearful of voicing their opinion publicly and losing privileges or making staff angry.

James C. Scott's discussion of the public transcript is useful in understanding the significance and impact of the organizational chart in creating reality. He posits that in societies where power relations are stratified, dominant and subordinate groups have an official culture and an unofficial culture. Public transcripts (official culture) are the on-stage dramas that each group performs for the other, whereas hidden transcripts (unofficial culture) are associated with what happens off-stage, that which is invisible to the other group. Rules determine appropriate writing, speech, and behavior, etc. in each domain of culture. Members of each group are constrained by their official roles in public transcripts, but are permitted to transcend these roles in hidden transcripts. Scott suggests that members of the dominant group have the ability to define the terms of reality: "Finally, the power to call a cabbage a rose and to make it stick in the public sphere implies the power to do the opposite, to stigmatize activities or persons that seem to call into question official realities." (1990:55)

The organizational chart is a crucial piece of the public transcript; it is the official story, containing necessary assertions and omissions while mapping what is included and

excluded from the public transcript. It is also a visual map of the community's power and authority structure. It is a public transcript that froze the structure in place and silenced the possibility of change. Everybody was required to comply with the organizational chart. Anybody who mentioned or implied that the organizational chart was incorrect or should be changed, was placed under suspicion of trying to un-do Menar. Pointing out the difference between the ideal and the real was seen as sinful by Father Ben and required discipline. For the staff this could mean not being permitted to use certain equipment, not having access to Menar discretionary funds, or being marked as someone who was trying to undermine the mission of the community and therefore not a team player. (See the discussion chapter for a more detailed description of power relations at Menar.)

Patients were also required to play by these rules. Discussions about the lack of actual programs for them or complaints about care could result in losing privileges or being treated as in some way "sicker." Tom, who had been at Menar for two months, suffered from major, chronic depression, and was the highest functioning patient. He told me in utmost confidence that one of the things preventing him from recovering from his depression was the "lack of programs and things to do" and his extreme boredom at Menar. He had been told by his doctor that Menar was a great place to be; it was out in the countryside, had lots of activities, and would be a nicer environment for him than the state hospital where he had been several times before. Tom thought this sounded great and decided to come to the Community. He said that at times he regretted coming to Menar since "at least at the (state)hospital there are things to do, they make you get up, there's a schedule. That's good for me, otherwise I stay in bed. I need to do things and talk to people. I'm a financial analyst, I like to keep busy, read the paper, talk politics, people don't do that here." When I asked him what might make things better for him at Menar he responded, "...start a patient council here. I think that's needed. They say there are art classes and horseback riding here, things to do. That's bullshit. Nothing is going on except for a video or outing every so often. The boredom is the worst... A patient council? That would be too threatening, I don't want to get on Father Ben's bad side." When I asked him what exactly he thought would happen if he brought this up with Father Ben he explained

that his wife had recently left him because she was unable to cope with his depression. Father Ben had talked to her several times about reconciling with Tom when she called to check on him or came to Menar so he could see their children. Tom was fearful that Father Ben might not continue mediating between him and his wife, thus losing hope that they would get back together.

Father Ben's ability to maintain an image of a competent, successful, healthy organization (despite contrary evidence, which is more difficult to obtain) was not just limited to physical surroundings and paperwork; it was more pervasive. Father Ben was known at Menar for making all of Menar's surfaces shiny; the organization could be temporarily out of money or be short six clinical staff members over a weekend, but if state employees were to show up this could be glossed over. And in fact, on one particular day such a scenario actually unfolded and I was able to see the mechanics of how such interactions worked.

When the state licensure renewal team showed up for its scheduled on-site inspection one afternoon, a patient had been missing for the previous 13 hours. However, everything appeared to be running smoothly. Father Ben and several other clinical staff kept the two state officials focused on the paperwork and patient charts. When the officials arrived at lunch time they went to the dining room where a nice lunch had been prepared and everyone was on their best behavior. Menar's physical setting was beautiful so they ate outside, overlooking the organic garden, stable, and mountain backdrop. Everything looked great and seemed like a competent, caring, relaxing, therapeutic environment for patients.

A state inspector or licensing official would have to spend a few days at Menar, or at least 24 hours on-site, before seeing any hint of what might be underneath the shiny surfaces. But if community members were motivated to put on a show for the regulators, state officials, for their part , were willing to engage Menar at a superficial level. This allowed them to feel that the patients were well taken care of and so their job was easy.

As Murray Edelman explains, bureaucrats from the state are highly motivated to determine that institutions like Menar are indeed safe, benevolent places because to do otherwise could destabilize society politically and socially:

> The lay public by and large adopts the professional perspective; for its major concern is to believe that others can be trusted to handle the problem, which is potentially threatening to them but not a part of their everyday lives. This public reaction is the politically crucial one, for it confers power upon professionals and legitimizes their norms for society generally... In consequence the professional and the public official whose function it is to "help" the inadequate, the powerless, or the deviant is willing and eager to play his role, equipped with a built-in reason to discount or reinterpret qualms, role conflicts, and disturbing facts. To comfort, to subsidize, to limit, to repress, to imprison, even to kill are all sometimes necessary to protect the client and society, and the conscientious professional or political authority plays his role to be true to himself. (1974:304-310)

**Conflicts of Interest**

As the clinical director, Father Ben was in charge of handling patients' money and routinely advising them about their finances and was supposed to have the patients' best interest in mind. As the general director of the community his duty was to act in the best interest of the community. This situation created several potential areas for conflicts of interest. I witnessed such a conflict when a patient named Simon was punched in the head by another patient. He went to Father Ben and told him that he wanted to press charges against the other patient and wanted the police to come out and take a report about the incident. Father Ben told him that that was not possible and that he would handle it. This deeply troubled me because I knew that there was a mechanism in place called an "external patient advocate" that Simon should have known he had the right to contact in this situation.

I recall one night when several patients were drinking and one of the patients brought a prostitute to the treatment house. The fact that this took place seemed to be common knowledge the next day, but the patients involved were not reprimanded; the only official mention of it was that the noise level had been too high for some of the patients and staff to sleep.

Similarly, one night several of the male patients and male staff members, including clinical staff, went to town to a strip bar and all got drunk together. With staff and patients

participating in such activities together, it is not hard to see why the clinical staff were reluctant to enforce rules with patients. At one point while I was there, one of the patient's brother and friend came from England to visit. The two visitors were clearly shooting heroin, giving it to the patient, and getting other patients high with marijuana. As long as the visitors were willing to participate in labor at the Community- painting, building, gardening- they were permitted to stay. The visitors stayed for free as guests of the Community for a month. In the case of a different patient, Father Ben was her legal guardian and the custodian of her trust account.

## DETAILS OF STUDY POPULATION

### STAFF

| NAME | AGE | TIME AT MEANAR | POSITION |
|---|---|---|---|
| Adam | 45 | 2 yrs. | physical labor/maint. |
| Barb | -- | -- | business manager |
| Ben | 45 | 16 yrs. | director/founder |
| Betty (married to Todd) | 54 | 1 yrs. | artist |
| Biff (Father Ben's foster son) | 36 | 2 yrs. | warden |
| Daisy Miner (Samson and Karen's daughter) | 12 | 16 yrs. | student |
| Don | 37 | 2 yrs. | clinical staff |
| Dora Miner (Samson's mother) | -- | -- | deceased founder |
| Gwen (Laura's daughter) | 18 | 3 yrs. | stables/grounds maint. |
| Hans Steen (married to Ursula Steen) | 40 | 2 yrs. | cook/clinical staff |
| Hillary | -- | -- | moved:nun/psychiatry |
| Jason | 45 | 13 yrs. | gardener/clinical staff |

| | | | |
|---|---|---|---|
| Jay | 45 | 3 yrs. | assist. cook |
| Jessie Miner (Samson and Karen's son) | 14 | 16 yrs. | student |
| Karen Miner (married to Samson Miner) | 40 | 16 yrs. | mother/homemaker |
| Larry | 50 | 16 yrs. | artist/clinical staff |
| Laura (Gwen's mother) | 40 | 3 yrs. | gardener |
| Leah | 62 | 1 yrs. | assist. clinical director |
| Lynn | -- | -- | patient house manager |
| Molly | 55 | 4 yrs. | housing project direct. |
| Myra | -- | -- | administrative assist. |
| Samson Miner (married to Karen Miner) | 43 | 16 yrs. | architect/founder |
| Scott | 55 | 5 yrs. | construction |
| Stan Steen (Hans and Ursula's son) | 6 | 2 yrs. | student |
| Steve | 35 | 5 yrs. | assist.dir./clinical staff |
| Summer | 52 | 5 yrs. | construction |

| | | | |
|---|---|---|---|
| Todd | 55 | 1 yrs. | minister |
| Tom | 90 | 4 yrs. | retired priest |
| Tonya | 37 | 2 yrs. | nun/clinical staff |
| Ursula Steen (married to Hans Steen) | 38 | 2 yrs. | mother/homemaker |
| Will Steen (Hans and Ursula's son) | 2 | 2 yrs. | -- |

**PATIENTS**

| NAME | AGE | TIME AT MENAR | DIAGNOSIS |
|---|---|---|---|
| Andrew | 32 | 4 yrs. | pedophilia |
| Brad | 50 | 10 yrs. | schizophrenia |
| Dennis | 45 | 5 yrs. | obsessive compulsive |
| Elsa | 45 | 13 yrs. | depersonalization |
| Fred | 21 | 3 yrs. | personality disorder |
| Gloria | 35 | 5 yrs. | schizophrenia |
| Greg | 30 | 6 mos. | bi-polar disorder |
| Julia | 85 | 6 yrs. | Alzheimer's |
| Kurt | 40 | 7 yrs. | schizophrenia |
| Paula | 35 | 10 yrs. | schizophrenia |
| Simon | 35 | 1 week | hypochondria |
| Tim | 45 | 5 yrs. | post-traumatic stress |

| | | | |
|---|---|---|---|
| Tom | 47 | 2 mos | major depression |

## STUDY POPULATION

### Staff

The term "staff" was applied to anybody who was a community member but not a patient. Staff were divided into two categories; "clinical staff", who had responsibilities for patients, and "regular staff" who did not. Since regular staff lived in the community with patients and interacted with them, they did seem to feel some degree of patient responsibility. However, they did not share the same level of responsibility or commitment to patients as the clinical staff.

Menar's "personnel policies and procedures manual" lists several classifications of staff that can be divided into two groups: salaried employees (full-time, part-time, exempt, non-exempt) and non-salaried volunteers (religious, non-religious). I was able to determine that the majority of staff were volunteers who received free health insurance, room and board, and a $70/week stipend in return for their labor and general participation in the Community. The following staff members received free health insurance, room and board, plus a salary: Father Ben, Steve, Hans, Larry, Don, Molly, and Leah. There may have been additional financial/employment arrangements made between the Accordance, or governing body of Menar, which was responsible for hiring volunteers and employees, and staff that I was not able to access.

It was difficult to collect data on which staff members were employees, what their salaries were, how salaries were determined, and the process of becoming a salaried employee. Publicly staff members did not want to discuss financial matters. However, in my private conversations with both volunteers and employees, they voiced dissatisfaction with the amount of money they received as compensation for their work. Many staff members, particularly individuals who had been living at Menar for several years, were concerned that they did not have the skills or abilities to find adequately paid work "in the real world." Volunteer staff frequently complained that they worked harder than the other volunteers and should be salaried. They also voiced financial concerns about not being able to purchase things they wanted, saving money, and their being able to depart from the

community since they were only making $15/week. Some members said that although their wages were low, they could not afford to live in the comfort and style that Menar provided if they lived outside of the community.

Simultaneously, I often heard the staff say that accumulating money was not important to them; living in a community of people and "creating something bigger" as Hans often said, was far more important. Like Larry, many of the "old timers," had put their time, labor, and lives into building and participating in the community and had a sense of history, pride, identity, adventure and, investment in the community. The amount of labor members put into growing the community was incalculable. They sacrificed privacy, boundaries between their work lives and their private lives, and forfeited being paid the market value for their labor for the community. Why? Because they lived in a comfortable, beautiful setting, had people around to share their lives with, and participated in something they thought was worthwhile, a community. Even though members of the community thought of their involvement and the meaning of the community differently, they all held the value that living in "a community" was an important thing to do.

All staff lived at Menar except for three women who lived in the nearby town, commuted to Menar, and worked 9 a.m. to 5 p.m. Monday through Friday. These women were all paid regular salaries at the market price for their services and were seen as essential to the successful operation of Menar: •Lynn did laundry, custodial work, and generally looked after the physical well-being of the patients housed in the Special Treatment Facility's (STF) main building. •Myra was Father Ben's administrative assistant. •Barb was the general business manager.

The regular staff consisted of the following people:

•Laura was responsible for a very large organic garden that provided fresh fruits and vegetables to the community, as well as a surplus that was sold to a local food store for additional revenue. She was 40 years old and had been a community member for 3 years. Prior to coming to Menar she lived and worked in Alaska. Her friend Larry, (a clinical staff member) whom she knew from Alaska, suggested she visit him at Menar and shortly thereafter she moved there.

•Gwen, Laura's eighteen year old daughter, participated in maintenance of the buildings and cared for the two horses and the stable. She was a high school senior enrolled in a home schooling program that Laura administered.

•Adam, 45, had been taken in by the community approximately two years before I came there. He was recovering from a drug problem and the community worked out an agreement where he could live there and receive free room and board in exchange for physical labor, mainly construction on the premises. He found Menar via a suggestion from his drug counselor .

•Jay's job was to help Hans (a clinical staff member) run the kitchen and do some gardening and construction. At 45, he had been living there for 3 years. He had participated in several other intentional communities in the U.S. and was a self-described "good natured hippie from Berkeley."

•Father Tom, at 90 years old, was the oldest member of the community and helped run mass on Sunday mornings. He had been at Menar for 4 years and required significant assistance in his daily routine.

•Biff, one of Father Ben's many foster children (I never did meet any other of them), helped out with odd jobs around the community and commuted to his job as a prison warden nearby. He was 36 and had been at Menar for 2 years.

•Molly had a background in community organizing and was the director of Menar's adjunct community project, which involved providing low-cost, government subsidized, housing to poor families in the area. About 10 small, single-family houses had been built by Menar with state funds and donations and were located on an additional piece of property up the road about a quarter mile from the rest of Menar. She was 55 and had been living there for 4 years.

•Todd and Betty were fairly recent additions to the community, they had moved there about a year before I came. Todd, who was both a minister and a clinical social worker by training, had been on the community's board of directors for quite some time when he decided to actually move into it. He was 55 and his wife, Betty, was 54. She was

in charge of teaching ceramics to the patients and other community members and was herself a professional artist.

•Samson, 43, and his wife Karen, 40, and their two children, ages 14 and 12, lived at the community part of the time and lived in the city the rest of the time. Samson was a recluse who imagined himself as the Menar visionary. Although his mother was a founder of Menar, and he had been essential during the early phases of the community, his power to influence the direction or operation of the Community had become slight.

•Sister Tonya, 37, who had been sent to Menar from her order in Canada took care of Father Tom, assisted in patient care, and made repairs to buildings on the premises. She had been there for 2 years and left about three weeks after my arrival. When I interviewed her about her decision to leave she conveyed to me her struggles with Father Ben and other members of the Management Team about the leadership and direction of the community.

**Clinical staff**

The Menar clinical staff consisted of Father Ben, Leah, Steve, Larry, Hans, Don, and Jason. Father Ben, Leah, and Steve were the core people responsible for the management, operation, and administration of the STF.

•Father Ben, director of patient services, had a master's of divinity degree, which included training in pastoral counseling. He coordinated patient care, communicated with their families, directed the clinical staff, negotiated fees for service with the state, and attended to the business aspects of the clinical program.

•Leah was the STF's assistant director/clinical supervisor. She had a master's degree in geriatric rehabilitative psychology, with a background in elderly patient management, treatment, and discharge in a hospital setting. She was Menar's liaison to the state and the county, in charge of making sure all documentation for licensing- building codes compliance, charting- and billing for insurance reimbursement were kept up to date and running smoothly. She had been at Menar for one year and was 62 years old.

•Steve had a BA in liberal arts and was the staff supervisor/administrative assistant. He was responsible for patients' records, doctor's appointments, insurance, medication, finances, and billing. Performing building maintenance and overseeing construction projects on the premises were his additional duties. He was 35 and had been at Menar for 5 years.

•Hans,40, was a counselor and cook. He brought his family to Menar from Germany approximately 2 years before I came. They had participated in numerous intentional communities in Europe previously and found a want ad for a cook at Menar in a "New-Age magazine" in Germany. He ran the kitchen, purchasing and preparing food, and supervising two other community members who assisted him. Hans' wife, Ursula, and their two sons ages 6 and 2 also lived at the community, so he also had child rearing duties. Ursula generally took care of her children and helped Hans manage the kitchen.

•Don, 37, carried out miscellaneous activities having to do with the management of patients, taking them on excursions, renting and showing videos to them in his quarters, taking them on errands, and in general being the most available person to patients at all times of the day and night. He had been a patient at Menar and transitioned into his staff position about 2 years ago. His schizophrenia and drug addiction was sometimes still problematic for him. To my knowledge, he was the only patient that became a staff member in the history of Menar.

•Larry, 50, performed case management duties and taught art and jewelry making to the patients. He came to Menar from Alaska sixteen years ago, where he had been an artist and student of Native Alaskan shamanism (he was Caucasian, not Native Alaskan).

•Jason, 45, was from Germany and had moved to the U.S. during the 1970s. He looked after patients and assisted in the garden. He had been at Menar for 13 years. About one month after my arrival at Menar, Jason left the Community after an incident with another staff member who worked in the garden. Some gardening equipment had been stolen from the tool shed and Jason blamed the theft on Laura because she had a habit of not locking the door. He changed the lock on the door and decided that Laura was too irresponsible to own a key. Upon discovery that he had locked her out of the shed, Laura

become enraged and during a confrontation hit him. Jason was very unhappy about how the Community, particularly Father Ben, handled the situation by blaming him and not chastising her. Just prior to his leaving the Community I had a long conversation with him about his decision to leave, in which he communicated his concern that this event conveyed to patients that violence would be tolerated at Menar.

None of the clinical staff had received formal education in the treatment of chronically mentally ill adults, the core patient population at Menar. Father Ben and Leah had some exposure to psychological counseling during their graduate education, but not with mentally ill inpatients. The remainder of the clinical staff had no formal clinical education or training. A review of the state's Department of Public Health guidelines for the minimum standards for licenseure of STFs reveals that this type of education is not necessary for licensure. Under the section detailing the minimum standards for personnel it reads, "An individual shall be designated as administrator who will be responsible for the overall operation of the program and facility... An individual shall be designated as program director of the residential program."

There is a discussion of the duties associated with these positions but no mention of either qualifications or training. The guidelines for general STF staff is equally lacking in specifics regarding skills and training required for patient care:

"The administrator shall be responsible to produce written statements as to the education, experience, and personal characteristics required to carry out adequately the assigned duties and responsibilities of each position employed by or arranged for by the facility. These written statements shall address the issue of demonstrated knowledge, skills, and attitudes regarding human relationships by staff who have direct contact with residents... staff development that includes orientation and training of all new staff and continuing education opportunities for all staff." (98-9)

This is a broad set of qualifications with room for interpretation of what "education", "experience", or "personal characteristics" mean. The majority of the section on staff focuses on immunization records, recent TB tests, CPR and first aid training, and "... A minimum of one direct service staff to each eight residents."

**Patients**

Thirteen patients lived at Menar during the period I was there. Ranging in age from 20 to 85, there were four women and nine men. Patients had been living at Menar anywhere from one week to 13 years, with five of the patients having lived there at least eight years. Diagnoses ranged from bipolar disorder to obsessive-compulsive disorder to schizophrenia and all patients were viewed by their physicians as having a severe, persistent, or "chronic" mental illness. All but one patient was on a regimen of prescribed psychopharmacological drugs (the exception being an elderly, demented woman).

Although they did not need the supervision or intensity of care provided by the state hospital, they required the attention and monitoring of a long-term, residential, "inpatient" setting. Menar was the only STF in the state providing services to patients in need of this level of care on a long-term basis. The majority of the patients had spent at least some time in the state hospital and were happy to be at Menar rather than the hospital.

Of the thirteen patients, ten of them paid for Menar with their state disability benefits. One patient came from a wealthy family, which was privately paying for his care. Two of the patients were funding their care through trust accounts their families had established for them. Patients were given a state allowance of ten dollars a week to spend at their own discretion. Menar was the liaison between the state and patients' families for other financial transactions.

•Julia, at 85 years old, was suffering from Alzheimer's associated hallucinations, but her doctors were not inclined to medicate her for these symptoms given her frailty. Menar's dictum was to follow doctors' orders regarding prescribed medication.

•Elsa, who had been there for thirteen years, was a 45 year old with depersonalization disorder who had severe burn marks over much of her body from an incident where she had set fire to herself fifteen years earlier. Menar agreed to take her in two years after the incident, when she was released from the state hospital. Soon after she arrived, several of the staff members built her a cement, fire-proof, bunker-like structure

to live in where she has resided ever since. This gesture is a good example of the type of kindness and unique care that Menar was able to give to patients. Nobody wanted to take this patient after she set fire to herself; facilities were scared she would set another fire, but the Community was willing to take her in and build her custom quarters. She is very much a part of the community and staff that have been at Menar for as long as she take great pride in the fact that she has not tried to hurt herself or set a fire since then.

•Greg, a 30 year old manic depressive and marijuana addict, had been living at Menar for 6 months. Prior to Menar he had been in and out of the state hospital for the last 5 years.

•Dennis,45, had been a resident at the Community for 5 years and suffered from obsessive-compulsive personality disorder. He had been in several group homes before coming to Menar and was from a well-to-do family that sent him a handsome monthly allowance.

•Kurt, 40, had schizophrenia and had been at Menar for 7 years. I do not know his history prior to coming to Menar. He was a talented artist who liked to paint and throw pots at Menar's art studio.

•Tim, 45, suffered from alcoholism, crack addiction, and post-traumatic stress disorder. He had been at a Veteran's Administration psychiatric facility until he came to Menar about 5 years ago. He was more volatile than other patients and therefore tended to intimidate them.

•Brad, 50, had alcoholism and schizophrenia. He was in a state hospital before coming to Menar about 10 years ago. I always enjoyed his great sense of humor about Menar and Father Ben's "authoritative guy personality."

•Gloria, 35, was a professional artist who had schizophrenia. Before coming to Menar five years ago, her family took care of her and she was enrolled in a day treatment program at a community psychiatric clinic. She had a talent for relentlessly insulting people and getting away with it by claiming she was "too crazy to hurt peoples' feelings."

•Fred was 21 years old and had a developmental disability and a personality disorder that was characterized by a pronounced lack of fear. He had been in several

groups homes and then landed at Menar 3 years ago. Fred was my key informant, which does not do justice to our friendship that I enjoyed.

•Tom, 47, had major, chronic depression and a history of state hospital stays. He was a financial analyst and had been at Menar for 2 months. His depression had become so bad that he was being treated with shock therapy. He would check into the hospital for two days for his treatment and then return to Menar with short-term memory loss, which he confided in me, was quite dehumanizing. When he was feeling well enough, he liked talking with me about politics.

•Simon, 35, had a developmental disability, crack cocaine addiction, alcoholism, and hyperchondiasis/somatization disorder. He was in and out of the state hospital and had the dubious honor of holding the record for the individual with the most visits to emergency rooms in the last two years. He had been at Menar for one week when I arrived and left about one month after that because his behavior was disruptive and he would disappear for days at a time. This was the type of patient that Menar was not set up to handle.

•Andrew suffered from impulse control disorder and pedophilia. He was 32 and had spent time in group homes, jail, and the state hospital until he came to Menar four years ago. My perception from talking with him and observing him was that constantly working on projects helped him avoid boredom that might result in predatory behavior.

•Paula had borderline personality disorder and paranoid schizophrenia. She was 35 and had been in the state hospital prior to coming to Menar ten years ago. She was wheelchair bound due to some type of damage arising from a suicide attempt in her teens, however, I did not get the details of this episode.

**Gender dynamics**

Patterns of male and female division of labor at Menar were a combination of diversified and conventional roles in North America. At the organization's decision making level, the Accordance and the Management committee, there were equal numbers

of men and women. There were men involved in cooking and gardening and women in construction and building maintenance. Yet, the office support staff as well as the person in charge of laundry and cleaning of the main patient's facility were all women from the nearby town. Leah was the only woman on the clinical staff team.

When I asked staff members and patients questions about gender, they responded that gender is not an issue at Menar because people bring different skills to the table and cooperation is of utmost importance. Hans' statement typifies the approach to gender: "My wife can't build and she has to spend time on taking care of our kids. But, she knows massage, yoga... she knows about herbs, she knows about Anthroposophy, and she makes Homeopathic remedies for people when they're sick."

I did observe what he was describing about each member contributing their skill set to the community and that diminishing gender inequality. However, I also saw subtle gender inequalities in that female staff members' requests for repairs on their dwellings, and decisions about equipment or furniture purchases for them seemed to take slightly longer than for their male counterparts. Male and female patients were equally effective at getting what they needed from the community. However, they accomplished it differently. Male patients tended to be more aggressive; waking staff members up and yelling in the middle of the night, fighting with other patients, and threatening staff members. Female patients tended to put rocks in the toilet, pee in their bed, light trash cans on fire, and refuse to cooperate with staff.

I was aware of several types of romantic relationships occurring at Menar while I was there. However, I assume that I was not privy to information about all of the current or past relationships. There were heterosexual and homosexual relationships between staff members. Although homosexual relationships were acknowledged, they were not discussed and those involved in them were not "out" and openly gay in the community. There were heterosexual relationships among patients, but to my knowledge not

homosexual relationships. I was not aware of any relationships between patients and non-patients or any history of such at Menar.

While I was at Menar the notion that women were more in touch or had easier access to the spiritual realm was advanced by four men and six women out of a total of approximately thirty. The underlying sentiment was that women were able to connect to the spiritual because they were more in touch with nature and socialized to be in touch with their feelings. In a conversation I had with Father Ben he told me that men needed to unlearn what they have been taught by society in order to be spiritual, whereas women are naturally in tune. The women echoed the notion that men have to try harder than women to be spiritually connected since women are equipped with "mother's intuition" and aware of natural cycles through menstruation and giving birth. Women at Menar were seen as superior in spirituality, connectedness to nature, and relationships and these abilities were core cultural values at Menar. Women leveraged their perceived closeness to nature by providing more "insight" and spiritual knowledge. Although ultimate decision making power was in the hands of Father Ben, he was very interested in the insight and harmony female members of the community could provide.

## Chapter III: Methods

### Authorial voice and representation

Contemporary ethnography encourages ethnographers to candidly and visibly address the problems of ethnographic authority and authorial voice (Rosaldo 1989; Wolf 1992): in my case, how I, as an ethnographer, represent patients, staff, Menar as a whole, and myself in this ethnography. Sometimes in this ethnographic account patient or staff voices are directly "heard" in the forefront in quotes or paraphrasing of my discussions with them. Other times sources such as Menar literature and brochures, hospital notes in charts, or legal and state documents depict multiple voices informed by other remote voices such as the state, "God", or a spiritual force.

In this ethnography I represent people who are considered to be, in many ways, the ultimate "other" in our culture; those who are insane, without reason, without control over themselves, without responsibility, and who are sick in their minds. It is a political act to represent Menar's patients, staff, and the community. It is the nature of ethnography that questions always remain: How did I choose what to write about and what to exclude? What voices are and are not heard in this ethnography? What is my authority to represent Menar and its members? One way I handle these questions is by including direct quotes by members of Menar as often as possible so that they can speak for themselves. However, I am situated in my particular cultural and personal perspective, and thus use my frame of reference and values to interpret and assign meaning to what informants say.

As an ethnographer I am limited to what I experienced, heard, and saw during a short period of time in the life of this community. It is also clear that even while I was in the field, I was not privy to all discussions, nor was I able to be everywhere at once.

Obviously, I was not there to experience actual conversations and events that preceded my arrival and took place when I left. Given these parameters, it is part of my job as an ethnographer to take on the role of investigator; to identify and understand silent and remote voices as well loud and apparent ones. For example, this means it is my duty to think about and identify the discourses, voices, and performances that are invisibly embedded in what is written and what is excluded from patient charts. Additionally, I have to pull apart the intermingling influences layered within quotes, laws, values, ideas, behavior, and even silences and inaction. It is my responsibility to uncover and understand the visible and invisible forces of power, context, history, economics, politics, and meta-narratives and how they interact with federal and state laws, state bureaucracy, therapeutic communities, New Age spirituality, the medical establishment, and the members of Menar.

This ethnographic account is laced with interruptions, potholes, unanswered questions, absurdity, struggle, and ambiguity because that is how I experienced and continue to experience Menar. There are places in this ethnography where I insert my internal conversations, comments, and even comments on comments. In other places I argue internally(non-verbally) with members of Menar, state laws, and myself. There are also transcriptions of conversations with members of Menar where my voice can be "heard" directly.

It becomes clear throughout this ethnography that I struggled with the multiple identities I arrived with when I came to Menar and that I interpreted experiences that unfolded from different perspectives within myself. It is my hope that the reader will become familiar with the ongoing exchange I had with myself about maintaining my agenda as an anthropologist who wanted to conduct dissertation research in this community, while being a person with mainstream clinical social work knowledge and

experience and a person who considers herself to be a humanist. The combination of being both a trained social worker and an anthropologist added layers to the usual insider/outsider dilemma. In fact, to this day, four years after leaving Menar, I still have conversations with myself about my Menar experience, though they have diminished in intensity over time.

Members of Menar, both patients and staff, constantly joked about how crazy Menar was; how "if you hadn't lost your mind before" coming to Menar you would lose it there. I got that feeling often. Living in a therapeutic community with mentally ill people twenty-four hours a day, seven days a week is exhausting. It is hard to keep up with what is going on at the organizational and business level, with patient and staff needs and activities, and gossip. The lack of organization and structure of communication had reverberations throughout all elements of the community and made the atmosphere stressful. Larry, a clinical staff member and member of the community for sixteen years said, "We go from crisis to crisis. we're flying by the seat of our pants." This was true in all realms, from finances and maintenance to patient needs. Staff members, particularly, clinical staff, were fulfilling several roles, which created a sense of coming and going all of the time.

**My background**

And what about me, the narrator, anthropologist in training, person with clinical social work knowledge and skills, and a human being? Current trends in ethnography encourage me to discuss candidly my perspective, experiences, reactions, responses, and uncertainties in a situation that was deeply challenging to me. I situate myself in this ethnography because you, the reader, are going to rely on me to be your "experiencer", storyteller, interpreter, and information analyst. By giving you some information about

my background I hope you gain a sense of what informs my eyes, voice, the areas that hold the greatest interest for me, as well as the biases that come through in this ethnography, regardless of my desire to be fair and objective.

I knew I wanted to conduct my fieldwork at a therapeutic community for the mentally ill somewhere in the United States. As a clinical social worker I questioned the mainstream psychiatric establishment's theories of mental illness and treatments. As a budding medical anthropologist my analysis of western bio-medical psychiatry grew deeper as I was introduced to comparative ethnomedicine, economic, political, and historical inquiries into where we had been and how we got to this place in thinking about and treating mental illness. I was very interested in the place therapeutic communities held in the past and their current possibilities and where they fit into the landscape of contemporary thinking and treatment of mental illness. They seemed to be an option that was on the margin and were still experimental while operating in a highly regulated and constrained atmosphere under the jurisdiction of psychiatric medicine.

**The relationship between social work and anthropology: empathy, ethics, and roles**

By looking at the similarities and differences in the roles and ethics of social workers and anthropologists, my aim is to establish some background for the reader regarding my points of view and training. Additionally, it is helpful to examine the rapport between the two disciplines by reviewing some of the barriers and successes in the relationship between the two disciplines. My hope is that this will help the reader to further understand the framework that informs my perspective.

During my education and training as an anthropologist and social worker, I experienced mainly indifference and some animosity between the two disciplines. Unlike nursing and anthropology, there seems to be a barrier between social work and anthropology. Understanding this tentative relationship requires a review of the history of social work during the last eighty years. In the early 1920s social work was mainly community oriented and advocated for better basic living and health conditions in poor

and marginalized communities. During the 1960s social workers became highly politicized, working against poverty, racism, and for civil rights. The 1970s ushered in an era of professionalization where social work began to redefine its role in society: Much of this came in the form of reviewing the social work education curriculum and its theoretical core. This review lead to a greater borrowing of core theory and concepts from psychology and sociology. The intention was that these disciplines would help to inform social work practice, which was aiming to become more involved in individual client care and clinical practice. During the 1970s social work was looking to shed its perception of a loose job description that ranged from ministering to the poor, to doing doctors' dirty work in hospitals, and educating people about public health. It wanted to be a recognized profession with a defined skill set, academic recognition, and clinical credibility.

In "The Psychiatric Persuasion," Lunbeck (1994) describes how during the early part of the 1900s psychiatry gained prestige and respect by grounding itself firmly in the medical model and establishing itself as an associated discipline. Social work followed in these footsteps during the 1970s and 1980s by borrowing natural science concepts such as systems theory, person-in-environment, and the American Psychiatric Association's essential guide to practice, the Diagnostic and Statistical Manual of Mental Disease (DSM). This move profoundly enhanced its reputation and professional definition. Social work also aligned with the medical model in order to capitalize on changes in health and mental health care economics. Social workers were able to provide clinical services such as diagnosis of mental health problems, psychotherapy, case management, and treatment plans at a cheaper rate than either psychologists or psychologists. This assisted social workers greatly by giving them a strong, independent economic base; insurance companies wanted to enter into contracts with them and reimburse them for their services.

Social work's enthusiasm for the medical model is demonstrated by its nearly ubiquitous use of the DSM currently. However, behind the scenes of this large-scale embrace of the medical model, there is an ongoing debate about the medicalization of social work. Some factions in social work view the DSM and psychiatry's medical bias as at odds with social work's mission to reveal wider social dynamics contributing to mental

illness. These critics of the DSM's place in social work training and practice question the medical model's appropriateness for a discipline originally grounded in the fight for social justice. This ongoing internal conflict is represented in a pair of pro and con articles debating the question, "Should social workers use the DSM-III-R?" in the book "Controversial Issues in Social Work." (1992) A quote from the pro side of the debate argues that the use of the DSM is essential for the success of the discipline and suggests that social work further align itself with psychiatry:

Social work is an accepted partner in the mental health field. The DSM may not be the only guide for reference, nor even the most important one for social work; however, it is a standard manual used by mental health practitioners. Social workers should use the means available to them to communicate via a shared technical language with other mental health practitioners. To disavow its psychiatric connection, which social work would do by abandoning use of DSM, would be to place itself outside the arena of contemporary mental health professionals. They would become out of step with the vast health and human services enterprise, which, for better or for worse, is thriving today. Instead, social workers should master use of DSM and other psychiatric references. (Annello 1992:141)

In great contrast, the con side argues that when social workers employ the DSM, the medical model's dominance in mental health services is bolstered and social work's unique perspective on mental health problems gets diluted:

...DSM embodies a particular viewpoint emanating from one professional organization, the American Psychiatric Association, that is being mandated by insurance companies, mental health agencies, and other organizations for use by all mental health workers and clients... Social work has a viewpoint that is different than psychiatry's regarding mental health problems, a perspective that is much more focused on interpersonal relationships and social conditions. Despite claims to the contrary, the social work approach has not been incorporated into DSM-II-R... The repeated use of psychiatric diagnosis for non-therapeutic, oppressive purposes forces us to consider carefully and critically psychiatry's attempt to create new diagnostic categories and claim an ever-expanding jurisdiction over community life and personal troubles. (Kutchins and Kirk 1992:148)

This debate about the medical model and the DSM's proper role in social work is seen again in the article, "Should DSM Be the Basis for Social Work Education?"(1995) in the Journal of Social Work Education. It is important to review the central line of reasoning used in the pro argument here because it is the perspective that is taught to

social workers in training. Williams and Spitzer claim, "Because the DSM is the most advanced classification of mental disorders, we would therefore argue that social workers should be trained not only to be familiar with the common diagnoses contained in the DSM, but to evaluate clients for the presence of these disorders..." (1995:149) In essence, this reasoning promotes the notion that a thorough understanding of the DSM is essential for students to master. It never questions whether the DSM should be used by social workers and it subtly supports the medical model's system of classification and diagnosis of mental illness.

Anthropology points out that since social work became grounded in the medical model, it is unable to critically look at the medical model or deconstruct its role in it. My experience is that social workers are able to conceptualize this and spend time processing their role in larger systems such as the medical system. Often social workers operate parallel to the medical model, offering a more holistic approach in clinical settings, for example, by contributing a psychosocial perspective to a psychopharmacological intervention. An example of leveraging as social workers work in clinical teams they are able to bring social work's unique perspective to clinical thinking and practice, as the following exemplifies:

"Social work is well suited to the of comprehensive assessment of individual distress because it has never narrowly invested in either organic or intrapsychic causality. Social work's more comprehensive, holistic approach has traditionally recognized the importance of physical and environmental health on personal well-being as well as the psychologic motivations and adaptive value of deviant behavior. Personal distress, in the social work view, is a consequence not only of personal variables but also of external social and economic contingencies." (1992:143)

Social workers often critique anthropologists for having the luxury of theorizing about culture and subjects as opposed to having to provide services and take clinical responsibility for clients. They are not burdened by having to take action, intervene in peoples' lives, provide "good outcomes", or act immediately in life and death circumstances. Nor are they privy to the same type of satisfaction of positively impacting a client's life or a family's. Social workers are called on to use their care, empathy, and judgment to create relationships and build trust quickly. Often social workers conceive of

anthropology as too relativistic and inactive to actually be of assistance to them. On the other side of the fence, anthropologists critique social workers' unintentional recreation of the precise social injustices that they are attempting to change. They hope that teaching social work students about power from a multi-disciplinary perspective will improve the situation. Additionally, anthropologists are concerned that social workers don't really *get* culture and fear that that lack of understanding negatively influences their ability to help clients.

What would help this situation? Anthropologists would be most helpful to social workers if they followed in the footsteps of Jim Green's and James Leigh's approach, "professional subcultures are like cultures anywhere." (1989) Learning the culture of social work, including its professional accomplishments and turf battles, and particularly the strains on social workers due to the lack of resources to appropriately provide services to clients. Part of learning the emic perspective of social work culture is understanding what empathy means in the social work context, which is heavily informed by notions of accountability and responsibility for clients. Any approach to educating social workers about anthropological concepts or the anthropological imagination should be informed by these dynamics, otherwise it will not be seen as useful. Below is an example of how Green and Leigh incorporate emic knowledge in order to effectively teach social workers their ethnic competence model based on ethnographic interviewing skills:

> It is a truism of social work education that workers are expected to show interest and empathy at an early stage of the interview. In the ethnic competence model, however, those goals are subordinate to the task of generating discourse, a point which many workers find awkward since they are trained to focus on the person, not on language, even to the point of 'reading through' language to see what is 'really' behind what is being said. ... Social workers, like all professionals, are concerned with time and the best use of it. One objection some workers make to ethnographic inquiry, at least as they know it to be traditionally practiced by anthropologists, is that it is too time-consuming. Social workers do not have the luxury of months in the field working with a small number of respondents nor do their agencies normally permit such latitude. In training we ask them to consider how a carefully planned global question-cover term routine is in fact highly efficient since a small amount of salient ethnographic information can be obtained from each client. (1989:8-9)

Thinking like a social worker is what makes this a successful piece of social work education and skill-building. This in-depth understanding of the work environment and various constraints placed on social workers is also what makes Green's widely-used "Cultural Awareness in the Human Services" (1982) appealing to social workers. Another important dimension for anthropologists to consider is that social workers are taught to do critical thinking about their role as social workers as well as study economic, social, and political causes involved in their clients' lives. It is important to capitalize on this. Deep structural critiques, deconstructing texts, and examining power relations at the level that anthropologists work may not be helpful, or essential, to social workers. Most social workers are painfully aware of how institutions and agencies, sometimes the ones they work for, contribute to or perpetuate their clients' underlying problems. Although social workers are focused on how to provide services for clients, they have insight into larger social forces. To assume that they do not is insulting.

In 1989 an entire volume of the Society for Applied Anthropology's newsletter, "Practicing Anthropology," was dedicated to "Anthropology in Social Work Training." This collection of articles written by social workers and anthropologists focused on identifying valuable anthropological concepts and teaching them to social workers. Social relativism and ethnographic interviewing are two major anthropological constructs that are presented as insights that enhance social workers' practice. I agree that social workers benefit from anthropological insights and that these techniques should be adopted and taught in the social work curriculum. However, for anthropological concepts to be translated into useful tools for social workers, it is essential to consider the similarities and differences between the functions and responsibilities of social workers and anthropologists.

Several articles in the volume fall into this trap by inadequately addressing the distinctions between the professional aims of the two groups. An example of this is an article titled "Empathy and the Anthropological Imagination," in which deRoche says, "How does anthropology speak to a 'profession' that includes marriage counselors, probation officers, welfare workers, etc.? ... What can anthropology offer all those whose

jobs involve intervention into interpersonal processes? ... it can, and must, offer the 'anthropological imagination', which I believe is closely allied to that quality of mind which social work educators call empathy." (1985:6) Certainly social workers may gain insight and empathy through the "anthropological imagination," the corner stone of which the author says is cultural relativism. Indeed there are similarities between empathy for a social work client and empathy engendered by an anthropologist for informants. But, there is a distinct difference in the professional roles and application of empathy and insight gained via the anthropological imagination. For anthropologists the function of anthropological insight or empathy is to aid in the mission of describing and interpreting cultures. This is unlike the mission of a social worker whose role is to advocate for and treat clients, with the responsibilities and accountability that includes.

Social workers are taught to work for social change, be advocates for their clients, and, perhaps above all else, empathize with them. These directives are outlined in the National Association of Social Workers code of ethics:

> Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice. These activities seek to promote sensitivity to and knowledge about oppression and cultural and ethnic diversity. Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.... Social workers engaged in evaluation or research should protect participants from unwarranted physical or mental distress, harm, danger, or deprivation.

This is a very different job description than that of an anthropologist. The primary job of an anthropologist is to understand a culture from an emic perspective, which requires a considerable degree of neutrality. Where the two professions deviate substantially is in the social workers' mandate to advocate for clients. Social workers must advocate for their clients, which often includes taking some degree of responsibility and accountability. In the case of social workers that assist chronically mentally ill clients, this responsibility includes ensuring the well being and appropriate care of clients. Anthropologists who study mentally ill people do not enter into client-social worker relationships with their

subjects; they are not providing services, thus they are not bound to the same ethics, responsibilities, and liabilities.

The American Anthropological Association's code of ethics states:

Anthropological researchers must do everything in their power to ensure that their research does not harm the safety, dignity, or privacy of the people with whom they work, conduct research, or perform other professional activities... **Anthropologists may choose to move beyond disseminating research results to a position of advocacy. This is an individual decision, but not an ethical responsibility.**

Unlike anthropologists, social workers are expected to work for broad social change and social justice, in the hope that social change will effect the deeper social structures that create or maintain many of their clients service needs. Anthropologists are participant-observers, not activists by design.

**Discovery of community and contact**

About a year before I went to Menar I started the process of researching therapeutic communities; where they were located, the types of patients they served, size, treatment philosophy, organizational philosophy, staff's level of training, etc. I narrowed down the choices to two or three places and I was in the process of talking with the directors about coming to visit their communities.

I got a call from a friend of a friend of my family, whom I had never met, who had heard that I was interested in conducting anthropological research at a therapeutic community for the mentally ill. She informed me that she and her husband were community members at such a place and were delighted that I wanted to do a research project on this subject. We had a long conversation in which I discussed my background and interests and she gave me an overview of Menar's patients, staff, and the community's commitment to humanely treating mentally ill people.

This first conversation in August, 1995 started the ball rolling in terms of my "getting in" to Menar as an anthropologist. During our next phone conversation she told

me that she had introduced the idea of my coming there to do research to the community members and their response was positive. She recommended that I write a proposal for my research and submit it to the management committee. Her suggestion was that I send it to the director of Menar and the director of the management committee, Father Ben. I did so.

In December of 1995 I went to Menar for two weeks to check out the community as a potential research site. The community and the surroundings were incredibly beautiful. I liked the funkiness of the buildings and the laid back style of the staff and the community as a whole. I met our family friends and they introduced me to the director, management team, staff, and patients. Since they were well liked in the community, I was welcome. The community members were friendly, curious about me, and wanted to talk about my doing research on the community. I got the feeling that they were excited that the community was important enough that someone would do research on them. During this first visit I had interesting conversations with staff members and patients. I enjoyed the community's sense of humor about itself and mental illness and was fascinated by the ideas community members had about mental illness, spirituality, and what the community was all about. The community seemed like a warm, family-like place where I would be welcomed.

When I explained to Father Ben what exactly cultural anthropologists do day-to-day as part of their research I thought he might be uncomfortable with the notion of having me hang around, observe, participate, and otherwise be involved with the community, but that was not the case. Father Ben liked the notion of having a researcher on site. I had anticipated more resistance to "getting in" because I saw anthropologists as being somewhat invasive myself. I was worried that his lack of concern meant that he did not really grasp the level at which an anthropologist is involved with a community.

As I had more interactions with Father Ben, it became clear to me that he saw me as a confidante who would be in his corner when I arrived there to do research. He let me in on the fact that most of the community members and the clinical staff members were "only slightly better off than the patients" and that he was overburdened with responsibilities for the community, the patients, and the community members. He saw me as well educated and well adjusted- a scarce type of person at Menar. He was enthusiastic about my understanding and interest in spirituality and mental health. At one point during my visit he told me that I was the gift to the community that he had been praying for. I wish I had had the presence of mind to probe what exactly that meant at the time. Instead I was enjoying the fact that I was actually going to have a research site and delighted by the idea of how much access I would have when I returned. My conversations with him about his take Catholicism and mental illness were fascinating and I can remember thinking, "This is going to be such a fascinating project."

During this first visit I wanted to nail down a specific arrangement for me to come there to do research. This was hard to do because he is an extremely busy man, but we did hammer out a deal where I would be come back in May and stay for a year. I was to live for free on site in exchange for working within the community, as the rest of the community members do. He initially pushed for me to have a clinical role, but I made it clear that I would have to perform some other duty, that it would be a conflict of interest to do both patient care and research. Although he appeared to understand this, he never stopped pushing for me to have a clinical role once I arrived there to do my research.

One of the things that I found remarkable upon this initial visit was that there was nobody on the clinical staff who had formal training, credentials, or a degree in mental health care for adults, except for Leah, who had a Master's Degree in social services for

senior citizens. My thinking about this was there were pros and cons to the situation and understanding Menar's perspective on mental illness would really force me to question my own assumptions about mental illness and its treatment. I was excited by the possibilities the situation presented; since nobody at Menar had formally been indoctrinated into psychological theory, training, ideology, or practice, they were not constrained by it. Menar did not have the expectations or detailed ideas about the course of illness, symptomology, meaning, etc., established by mainstream psychiatry. My perspective was informed by my experience as a clinical social worker where I had seen fellow clinicians that were burned-out, sometimes negligent, and often despondent. I also perceived that there was a general lack of creativity in thinking about and interacting with mentally ill people therapeutically. In essence, I was highly critical of mainstream psychiatric theory and practice and wanted to see what other models of patient care existed outside the highly structured medical and legal establishment.

On the other hand, I was concerned about how this lack of formal education and training might affect patients' care. How did people know how to care for mentally ill people? If this was not a board and care facility, but a therapeutic community, what was the therapy? There were psychiatric nurses and social workers that dropped by Menar to see patients and doctors who oversaw patients' care. Thus trained people interacted with the patients. After all, I figured, Menar would have been shut down long ago if they had done something really bad or if patients were mistreated.

Over the next several months I communicated with Father Ben about the details of my coming there. This was difficult because he did not return my phone calls or attend to faxes for several weeks after I would attempt to contact him. I wondered if this was because he was having second thoughts or was angry that I did not want to have a clinical role at the community. Eventually, I was able to get what I needed from him for

the human subjects clearance and other paper work necessary for my research and laid the plans for my fieldwork. I kept in touch with him and let him know when I was arriving in May.

The day I arrived for my stay, I took him and the community by surprise. They were not ready for me because they thought that I was not coming for a few weeks. He scrambled to find me a place to sleep and put my stuff and determined that the best place for me was in a bedroom in the rectory attached to the church on the premises. I had never heard of a rectory, and being a Jew, thought it was humorous that I'd basically be living in a minister's residence in a church. When I shared this with Father Ben and a few other staff members they thought this was very funny and they were happy that the anthropologist had a sense of humor about things.

**Routine and methods**

Since I lived at Menar I was able to participate and observe the community around the clock, which meant that I got to see and experience events ranging from patient disruptions in the middle of the night to birthday parties for kids. Interviews with patients and staff were primarily conducted at Menar because it provided easy access to talk with people and I spent the majority of my time there. Meals, which took place in a central dining hall, were a prime opportunity to talk with patients and staff. It was an ideal place to observe social organization and learn what was going on. Since meals were the only time when a majority of community members were all together at the same time, a large share of business and communication was conducted at meals. This type of business was not high level decision-making, judgments, or settlements, since that occurred in private meetings behind closed doors. The public discussions at meals

ranged from maintenance issues to scheduling clinical staff, to discussions about patients.

This was the appropriate time that was available to exchange information, share concerns or progress, and make decisions about patients' care. Communication between staff, both clinical and non-clinical, regarding patients' behavior, medication, or their complaints was done in public. Patients were also given their medications at meal times in small packets that clinical staff handed out.

During my first few weeks at Menar I was disturbed by the lack of respect for patient confidentiality or privacy and was distressed that it was not of concern to anybody. Staff would hand out medicines to patients at the dining table. Non-clinical staff would talk to clinical staff about interactions with patients, sharing concerns and commendations for patients publicly. Clinical staff would discuss how patients were doing in front of other patients and they would discuss patients in front of them as if they were not present. For me, the fact that patients did not say anything while staff stood in front of them and discussed their case as if they were not there was more disturbing than clinical staff talking about them publicly. That signaled that patients either did not care, did not know they had a choice, or felt hesitant about asking why people were talking about them as if they didn't exist.

I remembered that the last time I had that happen to me was when I was in high school. Not only did it make me feel like I was five years old and therefore did not count, it also made me feel weird, in the sense of somehow distrusting myself. Maybe I was not really sitting in front of my teacher and my mother since they were talking as if I were not there. If that experience had brought about existential questioning for me, what does it do to people who have a far less rooted sense of self and reality? So, on those grounds it seemed clinically contraindicated. Furthermore, empowering patients to be

involved in their own treatment helps their self-esteem and encourages them to use their thinking skills. But the thing that really got me was that it is impolite and disrespectful to talk about anyone in front of them, in my cultural upbringing. The only potential exceptions to this might be for very young children or seriously ill elderly, in both cases people incapable of participating in conversations. It just did not seem the right thing to do to talk about mentally ill people in front of them. In fact, it offended me. Why? Because these mentally ill people were capable and the staff knew it.

But soon my thinking started to transform and it became apparent that it was not that patient confidentiality was not a concern. Rather, like so many things at Menar, it was a non-existent construct. This blew my mind. How could a therapeutic community for mentally ill people not know about the concept of patient confidentiality? Was this a sin of commission or omission? Was it negligence? Stupidity? Even if you had never heard of "patient confidentiality" wouldn't you come up with a similar concept realizing that a lack of privacy is offensive, disrespectful, or uncaring? I discuss this further in the discussion chapter.

Patterns quickly emerged of who sat with whom, who stopped by to talk to whom. However, it became important to conduct interviews with staff and patients off of the Menar grounds, where other Menar people were not around. I was constantly pursuing neutral, private atmospheres; cars, supermarkets, restaurants, video stores, and bowling alleys. Walks became ideal places to interview people. Errands provided great opportunities to be alone with staff members, so I always volunteered to accompany them. Days when a staff member would take the patients on an outing, usually to a park, presented a chance to take a walk or sit with patients individually and converse with them. I also tagged along when patients went to their psychiatrist's appointments and got a chance to talk with them alone in the waiting room.

Because Father Ben and the rest of the clinical staff were interested in my performing clinical duties, I was given full access to patient records. It was helpful to review these records because it gave me an opportunity to see the "official" version as opposed to the patients' version of their background. The charts contained an enormous amount of accumulated information about patients' psychiatric diagnoses, hospitalizations, institutionalizations, families, medications, and legal paper trails that documented their histories as chronically mentally ill people.

For me the most interesting aspects of the charts were the treatment plans, progress notes, and other documentation that Menar logged. Menar's charting was consummate; thorough, organized, and in accordance with the professional style of the documents created by other mental health professionals. Patient charts were important documents because they were seen by state and county bureaucrats, health insurance officials, nurses, doctors, and social workers. Charts were significant in all decisions about financial allocations to Menar. Father Ben and Steve were particularly proud of the charting because it was official documentation of their legitimacy and equality with other mental health service providers. Charts demonstrated Menar's ability to serve patients well.

**Ethical dilemmas**

Patient charts, progress notes, medication documentation, and the STF's policies and procedures were of utmost importance because they represented the Community's financial security to Father Ben.[1] He realized these were the areas that counted in terms of demonstrating appropriate care for patients to state bureaucracies. It did not matter that most of the time progress notes and charts were not kept up to date. What did matter was the STF's ability to know when the state licensing team would be visiting Menar and update the charts so that it could present itself as a highly systematized organization once a year when it was imperative to document its work.

I was struck by Father Ben's knowledge of what needed to be documented since neither he, nor any members of the clinical staff, had formal clinical training. I wondered how they learned to do this. After talking to clinical staff and state agencies, it became evident that they had learned over the years with the assistance of the state agencies that wanted to contract with them. Since Menar was cheaper than other providers and there was a dearth of beds in the state, it was in the various bureaucracies' best interest to teach them how to do appropriate record keeping. Father Ben had leaned precisely what the medical model demanded of Menar and taught two of the other clinical staff members in turn.

When it came to the critical elements of funding there was no room for any type of experimentation or liberties, what was required was a perfect replication of the mechanisms of the medical model. This included clinical vocabulary, detailed treatment plans, recommendations of psychiatrists and nurses, observations made by the clinical staff, communication with families of patients, and the authorial voice of clinical distance and authority. Although creating these documents was stressful and laborious, every time the STF's requisites were delivered, it allowed for the community to continue to exist.

**Patient rights and patient advocates**

Society realizes that mental patients are a vulnerable population because they must trust others for their health and safety and their caretakers do not always live up to their responsibilities or treat them kindly. Thus, a legal and social system of extensive patient rights and patient advocates has been created. Legally, Menar is required to post information about patient rights and the name of their rights advocate in all patient residences. Additionally, when patients arrive at Menar they are supposed to receive a

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[1] One of the things that felt bizarre was that the members of the community that were not involved with patients tended to ignore the fact that that the financial viability of the community depended on the patients.

booklet explaining these rights along with the name of their rights advisor and information about contacting him should a rights violation occur.

But, nowhere in the main residential treatment building or any of the other patient residences was this information posted. When I asked a few the patients if they had received their rights booklets, they responded that they had no idea they even existed. I randomly discovered the booklet while assisting in moving some boxes out of the clinical office during remodeling.

The booklet is produced by Menar and outlines the federal and state regulations pertaining to patient rights and responsibilities. It lists the name of the patients rights advisor as Father Ben. This is highly unusual; generally the rights advisor acts as a neutral, third party investigator/advocate and does not have a clinical or administrative role within the same institution.

In the "complaint process" section of the booklet it says that a patient has the right to complain about rights violations and details how to do so. First, a patient should explain the complaint to a staff member or a rights advisor. Second, if the patient is not satisfied with the results, the patient should write or ask a staff member to write the problem up on a "rights complaint form" (which to my knowledge did not exist at Menar). Once the form is completed, the complaint is to be investigated by the rights advisor within 30 days. Finally, if the answer the patient is given, or other action taken as a result of the complaint is not satisfactory, the patient may appeal in writing to the state Office of Advocacy and Rights Protection. The mailing address of the Office is given without a specific contact name or telephone number.

The fact that this information was not publicly posted or distributed to the patients made the option of complaining about rights violations to someone external to Menar quite remote. Even if this information were posted, for the majority of patients at Menar

the possibility of composing a written complaint, obtaining the paper, envelope, postage, and correctly addressing the correspondence, without the assistance of the staff or rights advisor, would be unworkable.

The problem with the Menar system of having Father Ben as the patients rights advisor was that there were conflicts of interest stemming from his other roles as clinical director and general director of Menar. It was in the community's best interest not to have any rights violations reported externally since it made the community look bad. Particularly since Father Ben had a reputation to live up to as a religious leader, his status could be damaged by patient complaints to external people or Offices. Father Ben had to uphold his standing in order for the general public to continue contributing money, attending his church, and feeling confident about the patients' care. He also wanted the state to continue contracting with Menar for services, giving them grants for expansion, and promoting Menar as an excellent facility.

The staff was under pressure to comply with this informal agreement to internally contain patient complaints. They had a vested interest in enhancing Father Ben's and the community's image because to do otherwise might jeopardize their status or cause them to receive punitive measures from Father Ben or other community members.

I witnessed two events where the mechanics of dealing with patient complaints were revealed. The first revolved around Dennis, a patient who was dissatisfied with the staff's inability to make other patients in the dorm abide by the dorm rules. Dennis was kept up at night by other patients noise, was scared of the other patients using drugs, and was upset by the stream of extraneous people visiting the dorm at night. Since he had an obsessive compulsive disorder, he kept detailed, written data on the infractions, the names of the patients who committed them, the date, time, and staff response. He had been complaining about the staff's lack of attention to his complaints for 6 months and was very

angry, so he requested to come and read a statement and review his data at a clinical staff meeting. I was present at the meeting where Father Ben allowed him to address the staff.

As one of the higher functioning patients, he presented a very articulate series of well-reasoned complaints about the living conditions and rules in the dorm. He detailed how his complaints were never taken seriously by the staff and how on several occasions when he asked other patients to abide by the rules they became violent with him. He had had his rights abused and was dissatisfied with the staff and Father Ben's handling of his complaints. Several times while he read his written statement, staff members interrupted him to tell him that he was being unreasonable. When Dennis concluded, Father Ben began to explain to him that his obsessive compulsive illness was making him inflexible with the staff and other patients. He was also told that he was being selfish by not concentrating on the numerous things that Father Ben and Menar had done for him. Two other staff members told him that they were tired of his paging them during the night and were not going to protect him from other patients any more. The suggestion was that he had better start being less assertive with the other patients' rule violations, or he was going to face more violence.

A similar denial of the patient rights complaint process unfolded when Fred was punched in the face by Greg after refusing to turn his stereo down. Fred had a permanent shunt in his neck and a history of head injuries, so soon after the incident when he reported that he felt did not feel well, a staff member took him to the county hospital nearby to be checked out. It turned out that he had suffered a minor concussion from being hit. A few days later when he recovered, he told Father Ben that he wanted to call the police and file a report about the incident. Fred reported to me that Father Ben told him not to do that because it was not good for the spirit of the community. He was told that he should not have antagonized Greg and that this was precisely an example of his psychological

problem of blowing things out of proportion and not taking responsibility for his own actions. As one of the longest-term patients, Fred had come to see Father Ben as his father and Menar as his family and had an intense sense of loyalty to them. Father Ben easily capitalized on this, turning the incident into an issue of Fred's allegiance.

This system of blaming the patient's complaints on their illness and questioning patient's gratefulness and loyalty was effective in dissipating patient complaints. The message was clear; the staff was not going to take responsibility for the problem: If there was a problem, it was with the patient and it was caused by or associated with his or her psychiatric illness.

In the same way that the organizational chart symbolized an undisputed reality, the fact that a patients rights booklet had once been created and a few copies existed in an office, served as the ultimate reality concerning patients' rights, even in the face of all the evidence to the contrary. The patients did not know the regulations mandating that rights be posted and county or state officials who came through the patient residences mentioned the absence of the posting of the rights.

Patients were not well protected by their family members either. While family members are often seen as the protectors of mentally ill patients, showing up, calling and checking up on patients, most of the patients' families did not live near Menar, were not interested in visiting routinely if they did live nearby and were motivated to believe that their mentally ill family member was enjoying the beauty and benevolent helpers at Menar. They trusted the caregivers, particularly Father Ben, and they wanted to trust them since many of them felt helpless and guilty about their mentally ill family member.

I was disturbed by the fact that Menar represented itself as a place that took patient care seriously and knew how to care for the mentally ill. I thought it was dishonest to create, only on paper, a treatment plan for a patient and say that it was developed with the patient. Menar did not have the resources or commitment to make these plans real. Additionally, the idea that the patients did not know what was in their charts and that Menar portrayed them as involved in creating their treatment plans strained my ethics.

Furthermore, making charts look like patients' progress was documented in a timely way depicted the patients as being central at the Community, which was untrue. At an uncharitable moment, I wrote the following about Menar in my fieldnotes:

June 29, 1996
This is a group of marginalized people who wanted to live on the land and be separated from the rest of the world and be alternative so they found a bunch of crazy people to subsidize their lifestyle. They invited people even more marginalized than themselves to join them in a community together.

I had come to Menar thinking of the traditional, bio-medical version of the patient/professional relationship as unequal in power, judgmental, and disempowering for patients. I perceived clinicians as often not truly caring about patients and unable to see them as whole people who were more than their mental illness. I was attempting to be open to the notion that patient/staff relationships at Menar were non-traditional, familial. I wanted Menar to do a better job than the medical model at giving patients what they needed as people and patients. I struggled endlessly with the pros, cons, and uncategorizable aspects of patient care at Menar versus what I had experienced and researched in my social work training.

For the first time, I saw the advantages of my clinical training: a professional code of ethics, a set of boundaries, practices, regulations all grounded in standardized training and education about mental illness seemed appealing. Although there were violations of the code of ethic and mistakes being made all the time in biomedicine, there was knowledge about mental illness and patient care. What I did not know was how invested I was in that knowledge. I struggled to remain unbiased and tolerant of the way Menar cared for patients and wanted to maintain my original openness to the idea that no formal clinical training could potentially mean better patient care. However, I became uncertain of the morality of Menar not being informed of basic knowledge that could assist patients.

For example, from my clinical training, I knew that it was standard procedure in the medical model to enforce patients with severe depression to get out of bed, do activities, monitor their sleep closely and encourage them to take anti-depressants. This behavioral intervention was seen as necessary as the drugs for depression. At Menar this

was not the case. For most patients drugs and a few outings a month was what treatment consisted of. It was precisely those patients who were the most isolated, low-functioning, and unsavory whom clinical staff did not seek contact with. Although there was an ideal of family inclusiveness, some patients did not have routine contact, which from my clinical perspective was psychiatrically contraindicated.

I tried to determine whether this was due to a different perspective on patient self-determination, neglect, ignorance, a different value system or some combination of factors. It appeared to be a combination; clinical staff did not know that it was helpful to do things other than give patients medications and interact with them. In addition, sometimes there was neglect in this regard since the STF was understaffed and clinical staff were busy attending to other parts of their lives. My research on the state's mental health services confirmed the familiar pattern of inferior services in areas where rural poverty is widespread. The state had been sued twice by the Federal Government for its neglecting to provide adequate mental health services, which meant that the standards for Menar were low. I often reminded myself that without Menar several of the patients might be in hospitals, on the streets, or in far worse situations.

Prior to the beginning of my fieldwork I knew that the fact that I was a trained clinical social worker was going to be hard to navigate in a therapeutic community for the mentally ill. During my stay at Menar, I spent a lot of time dissecting my ethics and responsibilities and considering my social service background and anthropologist/student role. My professional background, clinical knowledge and expertise felt like a persistent ethical dilemma in this situation and eventually became the reason why I left Menar after 3 months. As I have mentioned and continue to describe throughout this account, there were many incidents of negligence or inappropriate care for patients. I went back and forth criticizing myself for being too structured, overly mainstream in my perspective and constructs. Then I would ask myself why I was willing to bend over backwards to try to see value in poor care for patients. My anthropologist voice would get in there and say that this is what fieldwork is all about, that I need to collect data here for a year, and better get used to the ethical dilemmas.

Patients regularly spent their money on drugs and alcohol, brought them back to Menar, and consumed them on site. Sometimes they drank or did drugs alone, sometimes they shared their purchases with other patients. The official rule at Menar was no drugs or alcohol on the premises. However, I never saw this rule enforced. Rather, I witnessed a great deal of tolerance of this behavior. In fact, when I casually asked Father Ben about this he said that they would have no patients if they really enforced the rule.

I was often upset by what I saw and concerned about patient welfare. The breaking point of these conversations and negotiations with myself came about with a patient who was suicidal. One Friday afternoon Tom, a patient with severe depression, called the suicide hotline from Menar several times. After being contacted by this hotline, the police suicide prevention unit showed up at Menar and determined it was necessary to take him to the hospital in order to keep him from harming himself. He returned to Menar on Sunday in a more stable, less suicidal state of mind.

On Monday, Father Ben called a clinical staff meeting to discuss the incident. He began the meeting by outlining his dissatisfaction with the way things had been handled with Tom over the weekend while he was away. Menar's goal is to contain costs for insurance companies and an emergency hospital stay was costly, violating this objective. Additionally, when the police come to Menar (which happens approximately twice a week for different reasons) it reflects poorly on the Community's ability to deal with its patients. He was also concerned that Tom had used outside resources, the hotline, instead of working with the Menar staff. The following dialogue is an excerpt from this clinical meeting:

**Father Ben:** From what I understand his [Tom's] doctor was gone and the secretary told him to call the crisis line. They came out and took him to the hospital.

**Larry**: I was on duty on Friday night when the police came. The communication wasn't there (meaning Larry did not know that Tom was suicidal). Tom told him [Don] the only reason to live was his marriage, that's ending and his family is moving on without him... Don told me that he went over and talked to him on Friday and told him to let it all out, not to keep it bottled up. He [Don] said everything was under control... I was involved in my own stuff and I wasn't going to be involved with this in any way, shape, or form.

**Don**: He could really use counseling and a support group for people going through divorce... We need to walk around and tell him how much we love him and don't want him to die. [We should] visit him a lot so he knows we're checking on him.

After this conversation I found myself asking a question that I often pondered. What is the difference between a lack of formal education and training and a lack of common sense or accountability? For example, I recall asking Hans one day how he felt about bringing his children, age 2 and 6, up in a community where there was a patient who was a recovering sex offender. He told me that he and his wife look out for the children and that he trusts Andrew not to prey on them. This answer resulted in a struggle that plagued me. Where is the line between compassion and benevolence and ignorance and negligence? At first I saw the clinical staff's lack of formal education as interesting, full of possibility; they were not constrained by labels, theories, and definitions. There was room for creativity in interactions and authenticity in trying to understand patients as individuals, not members of illness categories. But, there was a certain sense of going back in time, rediscovering the wheel at every turn. Often I thought about the effects this had on the patients and the staff. How would formal education change the relationships? Would clinically trained people who had spent the time and effort on their training be willing to come to Menar?

When Tom returned I paid close attention to him because I was concerned about the lack of employment of standard clinical techniques to deal with suicidal patients. In some sense it was an opportunity for me, the anthropologist, to see how Menar would handle an acute situation. In another sense I began to think that if this patient killed himself and I could have prevented it, I would be unable to live with myself.
I went back and forth on what the appropriate thing to do was and decided that it was important for me to talk with Father Ben about the care of this patient.

In this moment I came to represent the clinical gaze. I knew that I had definitely gone from anthropologist to clinician and that the ensuing conversation was a high stakes one in terms of my relationship with Father Ben and Menar. He wanted to hear my suggestions, wanted to implement them, and thanked me. But in the following days it became clear that his thinking about me had shifted; he saw me now as part of the outside

clinical gaze, a person with privileged knowledge/power about patients, who was potentially able to function as an outside monitor of Menar. He was fearful that I was more knowledgeable than he about clinical matters and seemed concerned that I was going to disclose what had gone on with Tom to people outside Menar. I had also done something that I had repeatedly said that I was unwilling to do, be a clinician. I had violated my own rule and told them what to do with a suicidal patient.

This situation with Tom combined with the increasing intensity of conflict within the Community made Father Ben concerned that too much dirty laundry was being exposed (I think there was also a sense of "who knows what the anthropologist is going to do next?"). Father Ben started to see me, and my clinical knowledge, as surveillance rather than the intellectual and political ally he had hoped for. He started to watch me very closely, coming by the rectory and asking me about how long I was planning on staying, and describing how there was a shortage of housing for patients and community members. I decided that it was a good idea for me to go away for a few days and let things settle down, so I went away for the weekend. When I got back on Sunday night, many of my belongings had been put in boxes. The message was clear. I was no longer welcome. That night, I had two staff members come by and visit me individually. They knew that my stuff had been packed up and wanted to say that they were sorry and hoped that I would not leave. They told me that Father Ben would calm down and that this was a manifestation of the tensions that had been going on in the Community. The next morning I talked to some other staff members and decided that I would leave Menar at the end of the week. I spent the next few days conducting interviews with patients and staff almost non-stop. Patients and staff were saddened to hear that I was departing and voiced the hope that I would be back when things at Menar settled down.

I was relieved that I was leaving since I would not have to be in a situation where I was scared for patients and feel ambiguous about my moral duties and role. However, I was concerned about leaving a few of the patients in Menar's hands and unsure of what my obligation was to them. I did not want to leave on a bad note in case other researchers wanted to go come to Menar so I did what I could to depart on friendly terms.

From the beginning of my research I have been concerned about how to write up my experience fairly and accurately. It is challenging to write a balanced account that includes a critical perspective as well as an appreciation for the things Menar does well, particularly given the political and economic landscape in which they operate.

**Anthropology and ethical dilemmas**

Initially, when I returned from Menar I was devastated that I had failed as an anthropologist. I felt I should have stuck it out and figured out a way to make the situation work. At other moments I was proud of myself for doing the right thing for me. I still often reflect on what I would do differently- from choosing this site, to my stay there, to my departure. Now, it is several years later and I think I sleep better at night because I did the right thing for me. At times this experience still seems like an anthropological failure; I was supposed to collect a year's worth of data, not three months' worth. In discussing my experience with other anthropologists I get varied responses; some say three months of my experience is more than enough to write about while others are concerned that there may not be enough data. Perhaps, more confusing is that some anthropologists value data so much that they reprimand me for not staying in the field and collecting data in such an intense situation. These conversations have lead me to think that many anthropologists do not speak or write openly or genuinely about mishaps and serious ethical dilemmas in the field because it is taboo to admit mistakes and vulnerabilities. Instead of interpreting this experience as inadequate or shameful, I've come to see it as something important to write about, not only for me, but so that other people have an honest perspective on ethical dilemmas in fieldwork, a challenge to the canon that dissertation fieldwork must be one year in length, and access to the extraordinary richness of the data that I collected while in the field.

## Chapter IV: Through Foucault's lens

Foucault is one of the foremost theorists of the relationships among power, knowledge, surveillance, and discipline. It is through the lens of his work that I analyze the events at Menar. We will begin our discussion by reviewing Foucault's overarching concept of power relations. Then we will define several of the core constructs involved in power relations: dividing practices, the gaze, the power/knowledge loop, and power and resistance. Finally, we will use these constructs to analyze my observations about power relations at Menar.

Foucault did not want to create a theory of power, instead he wanted to train our minds to observe power practices. Dreyfus and Rabinow help to illuminate this when they explain Foucault's message: "one must analyze institutions from the standpoint of power relations, rather than vice versa..."(1982:222) Foucault thought these relations were best identified and analyzed in "spaces" such as clinics, hospitals, and prisons, since they are confined areas. Not only were these spaces confined, small societies, which made for readily analyzable units, they were also confining. Menar meets all of Foucault's criteria for an ideal site for analyzing power relations.

Foucault's concept of power relations is an unusual one because it disturbs traditional notions of how power works. Generally the analysis of power proceeds by observing who has power over whom. Foucault complicates the analysis: "Power operates from the top down and the bottom up." (1965:185) He sees all individuals as existing in a network of relationships where each individual is subjected to power over them as well as dominating other individuals. Traditional notions view power as a hierarchy of differentials where individuals at the bottom of the rungs appear as completely dominated and powerless within the structure. Foucault says this is not the

way power works. Indeed, there are differentials in power, but there are neither powerless individuals nor all-powerful ones. This concept is crystallized in his statement that "power is exercised upon the dominant as well as the dominated." (1965:186)

One of the mechanisms of this network of power relations is dividing practices. Dividing practices start with the structure of a category and then arrange individuals in a hierarchy that categorizes and classifies them along a spectrum contained within that particular category. For example, if we took the category "health," individuals could be examined and then arranged along a continuum of healthy to terminally ill. We would be able to see the range of possible behavior, count how many individuals were in each sub-class. Then, as a short hand to represent the difference among those being categorized, we could create the dichotomy healthy/sick.

A dividing practice then is the act of comparing individuals, dividing them based upon their differences, and then arranging them in a hierarchy, which is generally reduced to a dichotomy. All individuals participate both in placing themselves in categories and classifying others. Therefore, dividing practices make an object of the subject. (Foucault 1965) Although all individuals participate in this, power differentials magnify the ability of any one individual to reify categories, systems of classification, and determinations about where other individuals are placed within the category.

Foucault argues that dividing practices emerged at the beginning of the modern era. (1965) At this point in time a dramatic shift towards democracy occurred; the King's absolute top down power ceased and the exercise of power became far more diffuse. This created a major social change in the dynamics of power, resistance, self-control, and punishment. When the King had absolute power, he would choose certain deviants to torture publicly. Their punishment was an example of his power and his ability to maintain order. In the modern era where power was diffuse, new democracies created a situation where social order was maintained by self-surveillance, surveillance of fellow citizens, and institutional punishment. Individual cases of public punishment were not sufficient to maintain order and deter deviants. Deviants needed to be kept from the

collective and punished, thus institutions were constructed. Once all the deviants were rounded up, it could be determined who they were, what was wrong with them, and what to do with them. The collective's first task was to separate the deviants from the rest of the society; its next task was to teach deviants how to survive/comply in the new self-contained, self-restrained order. Those that could not master themselves needed to remain in the institution for modeling and the safety of the collective.

Dividing practices were used to separate and categorize deviants once they were rounded up and taken to an institution. One of the most significant divisions was distinguishing those deviants who were able to participate in the workforce from those who could not. Whereas the poor, the criminal, and some physically ill individuals could participate in the labor force, mentally ill people were often too out of control to work and be productive. This was a serious problem since labor, industrialization, and urbanization were quickly becoming the European standard. Deviant individuals who were able to use self- control, self-discipline, and self-restraint may have been "bad," but they were still useful, unlike mentally ill people. Separate institutions and separate social categories were created to house this form of deviant. These dividing practices comprise the underpinnings of the categories of mental illness, institutions, and even therapeutic options at the present. We divide and separate the poor, insane, criminally insane, chronically mentally ill, acutely mentally ill, and then develop a prognosis of eventual normalcy based on these divisions. The etiology of particular types of mental illness are heavily influenced by these dividing practices. The social imagination and lay conception of the difference between depression vs. manic depression or obsessive compulsive disorder vs. schizophrenia demonstrates how these practices have seeped into folk ethnopsychology.

In his analysis of this history, Foucault calls attention to the fact that conceptualizations and meanings of mental illness change over time. (1965) He asks the question why does the "Truth" about mental illness keep changing if it is "The Truth?" He answers by demonstrating that truth is based on knowledge and meaning reconstructed anew by powerful forces that are invested with the legitimacy to create

authoritative knowledge. Since power is constantly shifting, truth is also constantly shifting. This is the power/knowledge loop, where the power to create knowledge reinforces claims to power based on existing knowledge. The correlation between the power/knowledge loop and dividing practices is one of mutual influence. Authoritative knowledge is used to buttress dividing practices and dividing practices reify knowledge and meaning, which invests further legitimacy in power.

Another component of Foucault's network of power relations is the notion of surveillance and "the gaze," which originated in the panopticon. (1979) The panopticon is a type of prison architecture where guards observe prisoners from a centrally located tower with a panoramic view of all inmates. Prisoners are not able to tell if a guard is watching them from the tower or not, thus they must assume that they are always being watched and should monitor themselves. This ability to watch prisoners without their knowledge of when you are and are not actually watching creates a disciplinary space- regardless of the guards' actual location, inmates think that they are being watched and, thus, self-discipline themselves.

The gaze is the power to, and the act of, creating and watching subjects. The gaze, much like dividing practices, is not reserved for the power elite, instead all individuals in some way are both gazed at, as subjects, and gaze upon, as observers. The gaze, or surveillance, influences the power/knowledge loop and dividing practices by providing evidence of indiscretions and transgressions, which are then integrated as supporting data for dividing practices and authoritative knowledge. One way of thinking about this interrelationship is to ask, "What determines who gets to be in the tower of the panopticon?" Dividing practices have helped determine who should be inmates and who should be jailers and those dividing practices are built upon knowledge developed by dominant forces.

Not many individuals have access to the tower, a most powerful, advantageous location for surveillance, but there are valuable aspects of other locations. Foucault described a relationship between people in dominant power positions and their subordinates as a demonstration of power by the first group and resistance to that power

by the latter. Subordinates regularly challenge the dominant ideological structure by using a variety of techniques ranging from subtle opposition to outright defiance. This game of resisting without being detected or punished by authorities is a complex labyrinth. Since dominant forces are concerned about maintaining the upper hand in the power hierarchy, they employ surveillance techniques to closely monitor subordinates' actions. But, subordinates study the weaknesses in surveillance and learn to exploit blind spots. Dissecting this relationship, Foucault posits that although subordinates are able to express resistance, dominators actually control the way resistance is expressed. (1979) Therefore, power regimes are able to anticipate the actions of resistors. Furthermore, resistors may have the sense that they are one step ahead of those in power; this is merely an illusion fabricated by dominators which allows dissent to be performed to a degree controlled by them. If we borrow the metaphor of chess, the way the game is structured, the rules, and the strategy are generated and maintained by forces of domination. In this chess game, resistors are motivated to re-think ways to outmaneuver the opponent within the structure of the game.

**Dividing practices: qualities of insanity, a spectrum of taboos at Menar**

Using this Foucauldian framework, we will look at the ways in which the core constructs of power relations are expressed at Menar. During my first few days at Menar one of my tasks was to figure out who were the patients and who were the staff. I would always try to guess before I was told. For the most part I was able to guess correctly based on visual cues or after talking to people for a few minutes. I became interested in what exactly these cues were and how I was able to make this classification so quickly. I started making notations about what made patients seem "different" or elicit positive and negative responses from myself, staff, or other patients. I wanted to pinpoint the physical indiscretions, speech, behavior, and thinking that made people seem "Other".

I started by recording what patients did that provoked my own responses of humor, disgust, discomfort, anger, pity, concern, fear, shame, or empathy and those of community members, and other patients. Several observations emerged from this process:

First, we, meaning myself, patients and community members, were all disturbed by the same things. Second, there were themes to the offenses committed (see breakdown of categories below). Third, there was a spectrum of tolerance and intolerance, where emotional transgressions, like crying fits, were less problematic than physical ones, like urinating on oneself. Sometimes the combination of several lesser offenses stacked up over a day or so, like three accumulated strikes, would get a patient thrown out of the social ballpark. This could mean that other patients or staff would shun the patient or he or she would lose privileges for a period of time. Other times one profound transgression, particularly one that was interpreted as willful, like stealing someone's teddy bear and taunting him/her, would constitute sufficient reason to be struck out immediately.

Upon reviewing my notes about patients' offenses and the responses they elicited, I saw that some patients make mistakes without being condemned. Why? One explanation is that "normal" people may violate these rules but they do not betray these standards frequently enough or severely enough to be labeled insane. Another rationale for why some people can get away with infractions is that they have enough social and/or fiscal capital to manipulate cultural norms. A sub-category of this group are people exempt from receiving the insane label by way of having outstanding talents, such as painting, singing, finance, mathematics, etc. As a culture we deem these talents to be so awesome that they overshadow, excuse, and may indeed justify social infractions. Members of this category are labeled "eccentric" rather than insane; acceptably insane because insanity is the price to pay for being an artist/genius.

When I first got to Menar I started writing down staff and patients' dividing practices. I summarized my findings by developing the following chart of classifications of infractions and taboos committed by patients.

**Category I: Out of control of self/not able to take individual responsibility for self**

**Reasoning and mind:**

1. Has not enough insight/too much insight into self
2. Has no judgment or poor judgment

3. Has no sense of cause and effect

4. Speech and action have surplus meaning: paranoia, conspiracy theories, unification theories

1. Speech has lack of meaning
2. Speaks to self, speaks to people who cannot be seen, speaks to inanimate objects
3. Cannot distinguish reality from fantasy

**Category II: Social skills:**

1. Reveals too much personal information in conversations
2. Has no social graces: interrupts, does not respond when spoken to
3. Laughs out loud without appropriate stimulus
4. Uses words that do not make any sense
5. Lies

**Category III: Body/social body**

1. Stares off
2. Is disheveled: shows signs of bodily functions or fluids
3. Has inappropriate affect, bad affect
4. Is too energetic/no energy
5. Is violent towards self, others, things
6. Wanders aimlessly, paces
6. Touches self, others, or objects inappropriately or too frequently
7. Gets too close when talking/will not get near other people
8. Speaks quickly/speaks slowly

From a meta perspective, the three categories outlined above make up a sub-classification of deviants; the "mentally ill". The hallmark of this sub-classification is that members do not share the perceptions that are the building blocks of social interchange. As Sass puts it, there is something special about madness that marks it as distinct from other types of deviants. What is that "specialness" that I traced at Menar? Sass sees it as the

convergence of several dynamics: lack of rational thought; meaninglessness; absurdity; paradox; lack of ability to 'see' mental illness; its rupture of social order; and it's likeness to death. Patient charts embody these manifestations of disorder and specialness by describing them in clinical language such as, "lack of insight into self", "attending to internal stimulus", "poor reality testing", "attends to internal stimulus", "cries frequently". This clinical language is also used by clinical staff to describe patients, which reinforces their membership in a different category that requires its own language.

**Deviants, categories, and types of violations**

At Menar it is easy to see that certain forms of "deviant behavior" are acceptable and sometimes even rewarded and other types are not tolerated and are punished. Menar official policy is that all deviants are treated equally in treatment and punishment. However, a closer inspection of interaction calls this into question. In fact, upon close inspection it becomes evident that our general cultural prejudices, tolerances, and intolerances are replicated in our interactions and classifications of mentally ill persons. It is not that there is one classification of mentally ill people, all of whom are thought of and treated the same. Rather there are sub-classifications that serve to reify social values that are pervasive in numerous other areas. In observing the interactions among patients and among patients and staff, it is clear that these divisions between disgusting and despised patients and creative and loved patients has quite a bit to do with the ways in which they demonstrate their deviance or illness.

Mentally ill people regularly perform behaviors that are seen as disgusting, shameful, and bizarre. It is unpredictable when and where they will demonstrate these behaviors. By observing mentally ill people it becomes clear that they participate in behaviors and have ideas that are directly in contrast to the most culturally significant values and mores: they dismantle the building blocks of the cultural or consensual reality. It is not easy to determine if insane people are considered insane precisely because they do not participate in consensual reality or if the reason they are so disturbing and bring up such intense reaction is precisely because they violate the primary rules and guidelines of

consensual reality. Do they participate in this alternate reality and are therefore called insane or are they taught to manifest their insanity in particular ways?

After a while categories of behaviors that were distressing to the staff and patients began to emerge; There was a particular set of unspoken rules, invested with such cultural depth and meaning that when broken, transgressors were treated as violators of some ultimate yet undeniable taboo. These rules were invisible until they were broken and I could only begin to classify the offending behaviors after inspecting the causes that led to the fearful, disgusted, angry, and punishing reactions.

After paying close attention, I began to see patterns. Behaviors that were the most offensive were based in bodily rule-breaking: looking disheveled, not dealing appropriately with bodily fluids, or not respecting the bodily boundaries between self and others. Foucault saw "The body as a place where the most minute and local social practices are linked with the large-scale organization of power." (1965:111) In other words, patients' bodies were outward manifestations of the project of generalized normalization. When patients' bodies looked and acted "appropriately" this signified the successful management of self and the adoption of discipline. Conversely, when bodies were "inappropriate" they signified defiance and lack of discipline. If we think about Foucault's concern with the use of space generally, we can see that the body is a microcosm of architecture, management, and discipline. When bodily rules are broken, it is the most personal and social expression of disobedience.

In the category of thinking/mind there were also several characteristic problems: lack of insight; assigning surplus meaning to events or objects; being paranoid, believing in conspiracy or unification theories; having no judgment or poor judgment; having no sense of cause and effect. The typical problems in the social skills category were being out of control of oneself and/or not being responsible for one's self; lying; and not following appropriate social protocol for conversation, for example, revealing too much personal information.

The remaining behaviors spanned more than one category. In the social/bodily category the main problem was either having too much energy or not enough energy.

Speaking to people who cannot be seen, speaking to oneself, or speaking to inanimate objects involved both the thinking/mind category and the social category. Similarly, the inability to distinguish reality from fantasy and not following the ground rules of time and space were simultaneously problems in the thinking/mind category and the social category.

Strong reactions came from violations that took place across the thinking/mind, social, and bodily categories. These included: being violent, attending to internal stimulus, laughing out loud, swatting at things, inappropriate affect such as laughing at inappropriate times, crying too often, and wandering aimlessly. Public violations of the social order and bodily categories, no matter how clever, were never viewed as clever and were perceived only as evidence of sickness- lack of self-control, lack of respect for oneself or the community. Patients who engaged in such violations had nothing to lose and had the upper hand in manipulating the staff and other patients' revulsion, fear, and anxiety about what they might do next.

Creative, clever, or humorous public violations in the category of mind or thought organization could place a patient in the staff's elite patient category of "hero/creative genius". This was an area where a patient could transcend a taboo by creating a performance that was so cunning in its absurdity, irony, ambiguity, and manipulation that it was recognized by the staff as an alternative way of experiencing something. There was a small group of patients whose insight into "reality", spirituality, or metaphysics was so profound that it could only signify the brilliant aspect of madness. These patients were well liked and handsomely rewarded by the staff. They were also well liked by the other patients because they were equally cunning, creative, humorous, and entertaining in trashing the establishment when in private. They also had the spectacular performance commodity that other patients respected and when in trouble could ask them for favors or public representation.

The best example I saw of this type of taboo-transcending performance was when a patient named Kurt made a costume in the art studio at Menar and then wore it to lunch. The costume was a replica of Father Ben's Sunday Mass outfit complete with a high,

Papal-looking hat, a large cross around his neck, and a sash around his waist. He then proceeded to wander around the dining hall blessing the patients and staff and imitating Father Ben. However, instead of quoting scripture, he was pretending to hypnotize people with the cross around his neck. It was a brilliant inversion of the social order, deeply insulting on many levels, slightly dangerous, and highly calculated. The response from everyone was laughter. Father Ben, who looked upset at first, was forced into laughing it off, so as not to appear unable to take a joke. Kurt's performance was praised by patients and staff for days.

Another group of patients was made up of "do gooders" who infrequently violated norms, helped with maintenance of the grounds and thus symbolically the maintenance of the social order, obeyed the rules, followed directions, gave lip service to Father Ben's authority, and spoke highly of Menar. These patients qualified for the big rewards from Father Ben and the other staff members. Big rewards included being taken for trips to the city, lunches at McDonalds, rides in the Menar van, and trips to the beach, receiving allowances early, borrowing money, and having Menar going to bat for the patient if legal or medical issues came up where the Menar administration could have a positive influence on things. Interestingly, while these patients were well liked and rewarded by the staff, they were disliked and disrespected by the other patients.

Patients that were neither troublesome nor heroes were seen as "good patients" and did not require much energy on the part of the staff. They were seen as neutral by the staff- cooperative but not helpful in the maintenance of Menar as an organization- and therefore they did not qualify for special privileges or rewards. There really was not a group of seriously troublesome patients because Menar did not accept them. If they did happen to make it through the screening process, came to Menar, and proved too hard to handle, they were referred out to a different facility, a process which I observed with a patient.

**Patients' views on mental illness: the trickle down of dividing practices**

Dividing practices are not the sole province of clinical staff; patients reenact their own experiences of being categorized and apply the same classificatory system to themselves and their fellow patients. This reinforcement of categories is reflected in the answers that I received when I asked ten of the thirteen patients about their ideas on mental illness. I did not ask three patients who I thought were likely to become agitated or confused by this question. Of the ten patients I did query, five of them were not able to concentrate or grasp what I was asking them. Thus the answers I got from them were unintelligible. There were five lucid responses that I thought were meaningful and perceptive.

*Andrew: Everybody is mentally ill in some way or another. Some people are just crazier than others.*

Andrew's comment normalizes mental illness as universal: nobody escapes it. The only difference among people is their degree of mental illness. I commonly heard this sentiment from patients.

*Fred: I'm not here to please people. People think that just because I'm mentally ill I shouldn't have a gun... It [mental illness] doesn't exist. It's something people who want control say about other people. We all have problems, the point is to look past that and look at somebody's heart. I'm labeled because I have problems and take drugs [psychopharmacological] and people judge me and think they know me based on that. But they don't.*

The theme of feeling judged for being seen as different is something Fred conveyed to me in many conversations. He often lamented the fact that people did not want to get to know the person behind the illness. The comment, "It's something people who want control say about other people," reflects his distrust of Father Ben, who has been both his advocate and his adversary.

*Greg: [The mentally ill are] people who can't learn from consequences or punishment. They're just stuck.*

He is repeating a construct frequently heard at the Community: the notion of being "stuck" is Menar's expression of the idea that we all have the same type of emotions or experiences as mentally ill people. The division is that mentally ill people get trapped in these situations or feelings, whereas non-mentally ill people are able to "move through" them. The genesis of "being stuck" is psychodynamic processes, such as emotional and relationship-based difficulties that were not "worked through." This lack of resolution in turn creates spiritual consequences that are akin to the Eastern sense of energy becoming blocked and thus unbalanced. Clearly, he has internalized the label of being stuck and is a member of that category of permanently stuck people (patients). He also resists that classification when he says, "they're stuck", which suggests he is not a part of the patient group.

*Tom: I don't know. Maybe in one hundred years or so there will be doctors that will help people like me die with dignity... They [the other patients] are in their own worlds a lot, but they're not that different from me or you.*

Tom, as described previously, has suffered from severe depression for almost all of his life. He was undergoing shock therapy as a treatment of last resort while I was at the community. I was fond of him and had developed a solid friendship with him, which is why I believe he gave me such an honest answer to my question. Here he is describing the indignity of living as a mentally ill person, particularly the indignity of his short-term memory being disrupted for a few days each time he went to the hospital for shock therapy. I think he is also saying that he wishes a doctor would assist him with dying, rather than continue trying different treatments that don't have any impact on him other than dehumanization. He also comments on the fact that depression, a mood disorder, is

very different from schizophrenia, a thought disorder, when he says that other patients are "in their own worlds a lot." Yet, he adds, " they're not that different from me or you," by which he means that to think of them as "other" removes their dignity.

*Gloria: It's not that I'm abnormal. It's that I'm super normal. That's considered mentally ill.*

Gloria is playing with the social hierarchies and notions of mental illness, abnormal, and normal at Menar. She states that she is not abnormal, nor normal, but "super normal," meaning superior. She was letting me in on the secret that at Menar, where everybody is either normal or abnormal, she is considered mentally ill because she is superior.

Patients' internalization of these divisions re-creates these distinctions and perpetuates these categories as useful, neutral tools rather than judgments about status, membership, and standing. The fact that patients participate in dividing practices speaks to the ubiquitous nature of these rituals of power.

**Power relations in institutions**

Erving Goffman (1961) describes "total institutions" as places where patients or inmates lose any connection to their prior identities and are demoralized as a means of simultaneous treatment and punishment. He characterizes the total institution as a social and organizational structure with five essential elements: 1. inmates/patients conduct all of their activities in the same place under one authority; 2. all inmates are required to do the same activities together and receive identical treatment; 3. officials coordinate a highly regulated and routinized schedule that organizes all activities; 4. all activities are synthesized to appear essential to the stated purposes of the institution. These institutions are places where patients learn how to play the power/resistance game if they can withstand the impact of demoralization. It is the acquisition of this skill that assists in

normalizing patients by teaching them how to both resist strategically and comply strategically.

Elizabeth Lunbeck's "The Psychiatric Persuasion," (1994) is a detailed account of the development and practices of a total institution. She explores the ways in which the Boston Psychopathic Hospital's opening in 1912 created an opportunity for psychiatrists to develop a disciplinary vision and model of disciplinary space. Psychiatrist's examinations of patients became a forum for creating subjects to scrutinize mentally and physically, often multiple times in a single day. This system of examination placed patients under the scientific lens of the developing field of psychiatric medicine while producing "ceremonies of power." Examinations allowed psychiatrists to determine the degree of normalcy and abnormalities embodied by each patient in the hospital and then compare and classify them based on their impartial scientific knowledge. Examinations were neatly integrated into the "principle of visibility" in the hospital, which kept patients under surveillance.

> Discipline, as both a mode of power and a congeries of procedures for producing knowledge, figures centrally into my account, for the psychiatric program I construct gravitated less toward social control than toward the point at which knowledge and power fostered the conditions conducive to the realization of both... Disciplinary power, as conceived by Foucault, is not fixed and easily identified, but is spread throughout the social body... (1994:5)

Her description of the Hospital reinforces Goffman and Foucault's observations that disciplinary power is not concentrated in one place, but is diffuse. The Hospital is a place where patients' clothes and personal effects are taken from them, they have no privacy, their actions are recorded in massive charts, they are examined up to five times daily, and their abnormalities are discussed publicly. Patients cannot pinpoint the one place where the authority or power over them is located.

Menar is both similar to and different from the Boston Psychopathic Hospital. Menar, unlike the Hospital, is not a highly regulated environment; there are no formal psychiatric examinations, the schedule is very loose, patients come and go as they please, phone calls and letters are not monitored, they have their own rooms with doors, they

have their own belongings and clothes. They are similar in that patients' problems are discussed publicly, their medications are distributed publicly, and charts are maintained (though not constantly). Most importantly, power is diffuse. In the case of the Hospital, the direction of surveillance is uni-directional, downward from the psychiatrists and social workers to the patients and examinations are rationalized as necessary practices based in existing medical and scientific knowledge. Correspondingly, examinations allow for further development of knowledge that confirms the grounding of mental illness in medical/scientific knowledge. The authority to perform these examinations reinforces that they have the power to perform them. Lunbeck, in fact, explains that patients fear that if they do not submit to examinations and answer questions appropriately, they will be condemned to more examinations.

Menar and other therapeutic communities have tried to move as far away as possible from the total institution. In comparison to Goffman's "total institution" Menar had some of the "otherizing" aspects of total institutions such as patient charts, diagnosis and illness labels, patient living quarters, medication distribution, public discussion of patients' psychiatric issues, and lack of privacy. However, patients' independence and decision making, community involvement and participation, shared public space, various relationships, and the lack of constant monitoring and scheduling made Menar tremendously different from total institutions.

**The panopticon, Foucault's gaze, and the coyote trickster**

Foucault describes the panopticon as the site where diffusion of an important dynamic of power, the gaze, occurs and entities become both the observer and the observed. Sass notes that "...the significance of this panoptic system has less to do with the synoptic knowledge it offers to those in the tower than with the effect it has on those observed, who are brought to internalize, and act in accordance with, the standards and expectations of the system in which they are caught." (1992:252) At Menar this is evidenced in the interactions and feedback loops between the state, Menar as a community and a Special Treatment Facility, patients, Father Ben, clinical staff, and

other members of the Menar community. All of these groups are "caught" in each others' web of gazing as subjects and objects, managing expectations, acting appropriately, leveraging strong suits, and conforming. But, the most important aspect of this is that each party seems to know precisely how and when to obey, and they do it cleverly and politically.

At Menar there are multiple directions of surveillance, which creates a dual role of observer/observed. The state observes Menar and the state is observed by the public and federal government. Menar observes the patients and simultaneously the patients observe Menar. Patients, community members, and staff all observe and are observed by each other.

Menar as an organization was constantly negotiating its ability to operate beyond the gaze of the state or directly in front of it without the state either seeing or caring about what it was doing. Often the state gazed with one eye open and one eye closed, and Menar was skilled at identifying these spaces for freedom and compliance. Father Ben knew that the state was looking for particular things and once those requirements were fulfilled they became uninterested in looking or seeing anything farther.

Often times I experienced the gaze as being similar to the coyote or trickster found in numerous Native American stories. In these stories, things are never what they seem and the coyote plays tricks on an individual to make a point. Generally, the point is a lesson about the values or ethics of the particular culture. The individual is usually trying to get away with something or is humanly flawed or vulnerable and the coyote appears as an ally or an opportunity. The individual, being human and vulnerable and trusting, decides to engage with the coyote. The coyote can appear as many seductive things. Once it has seduced the individual, the person is trapped and eaten or tricked. The story is meant to be a lesson about cultural values, the ordering of the cosmos, that things are not the way they appear, that humans are vulnerable, and that there is a need for humility since human perception is flawed and can be easily outwitted. Often these stories are referred to as "dances with the coyote." When the individual engages with the trickster it is called "dancing with the coyote."

Many of the patients were experts at playing the role of the coyote. They were "shape shifters", experts at changing their appearance and the responses they elicited in different situations and capable of tricking "the powers that be." When it came to responsibility, insight into their illness, and navigating the landscape of being a mentally ill person, patients were masterful at teaching lessons, foiling plans, and derailing expectations. They did this with staff and other patients at Menar, the state, and mental health professionals. It was most fascinating to see patients trick people at Menar, particularly because some of them were aware of the rewards for spiritual content or particularly insightful comments. Erving Goffman (1961) would argue that these patients had come to understand how to succeed in this institution. The trick was that they were onto Menar's notion that there was something spiritual and important in mental illness and were able to exploit that for more privileges.

Originally I thought of the dance with the coyote as being unidirectional; patients were tricking Menar and the state for their benefit. However, I came to view Menar and Father Ben as tricksters as well, able to dance successfully in a battle of tricksters. Menar deployed its shape shifting abilities with patients and with bureaucracies. The state was also a trickster, sometimes appearing benevolent with the patients' best interest at heart, other times appearing interested in saving money and cutting back on paperwork. There were multiple tricksters, multiple layers of things seeming one way and being another and at any given moment roles could change and tricks could be reversed. One could say this is simply an elaboration of manipulations and competition for power. However, that would miss the spiritual and theoretical context of this set of practices. Menar always presented itself to the state and other bureaucracies as a Christian facility with solid, typical Christian values in caring for mentally ill people. Since Father Ben was a priest, there was a church on the grounds and Christianity permeated their public literature, this facade was convincing. What was not shown was the New Age philosophies occurring at Menar. The state also believed that the sprawling land, clean air, and back to the land therapy was good treatment for patients.

In this hierarchy the state was at the top, Menar in the middle, and patients at the bottom. Although there was no actual rearrangement of that structure, there were constant challenges and movement within it. Although Father Ben had a sense of control and was masterful at dealing with the state, he feared it and respected its position as the entity that licensed them and paid them for services. And, the state was also tricky; laws and mandates could change, personnel changed, state bureaucracies controlled the money and flow of patients, and had to be appeased.

The dance between Father Ben and the state bureaucracy was complex. In my fieldnotes from 7/21/96 I wrote, "If Father Ben had a slogan it would be 'I'll be whatever I need you to think that I am.' This is a perpetual con job- from both sides." I was beginning to formulate the game being played between Menar and the state. Menar cons the state into thinking patient care is their primary concern and that they are a sophisticated patient care facility. The state is willing to be conned because it makes their job easier. The state cons the public into thinking they are fastidious and demanding about making sure that patients receive top quality care. The state maintains this show despite the fact that they are repeatedly reprimanded by the Federal Government for not providing adequate services and care facilities to mentally ill people in the state. Menar delights in trumping the corruption and power of the state bureaucracy by outwitting or out- masquerading them. But the game revolves around never exposing that a game is being played, the corruption exists, and believability is more valuable than truth.

**The micropolitics of power: the state, biomedicine, and Menar**

Menar's dealings with the state around patient care provides optimal terrain for understanding the tensions between the power and authority of Menar, the biomedical and legal establishments, and the state.

The highly charged arena of how to deal with patients and the state's involvement was exemplified by the love/hate relationship between Father Ben and Leah. Leah represented the medical model at Menar and Father Ben the anti-medical model. Leah had formal education in geriatric health, a background in health care administration, and

joined the community a few months before I arrived. Father Ben hired her as a clinical staff member precisely for her ability to work with the state, her organizational abilities, and familiarity with rules and regulations. In this role, she was supposed to make sure that Menar adhered to all the state mandated rules so that they would pass the licensure requirements in order to continue contracting with the state for their services. She was constantly pointing out the pragmatic boundaries of Menar's ability to operate in an anti-medical model given the constraints of the medical model that Menar had to exist within. Although Father Ben saw the value and necessity of having Leah, she was always a source of tension and conflict. Even though she was by no means pro-medical model or an advocate of conventionality, she was cast in the role of being anti-Menar and wanting them to change. Father Ben simultaneously saw her as an ally since he could leverage her education and experience, but he resented her for having that knowledge and background. The resistance to her suggestions made it virtually impossible for her to perform her intended role. The animosity that Father Ben and others had for her was about what she represented, not her personally since philosophically she was aligned with Menar culture.

The following conversation I had with Leah about the Special Treatment Facility and her role as a clinical staff member illustrates the connections between power, authoritative knowledge, and multiple directions of surveillance:

*Liz: What is your feeling about clinical staff education?*

*Leah: Staff are uneducated and untrained, but devoted. I believe love is therapy. That's compassionate and humanistic. The question I have is are we [a] custodial or a therapeutic center? Father Ben sees us as both. If we want to be therapeutic, then we have to have some trained staff. We need to learn how to be therapeutic. I mean we have some arts and some of the patients do work... meeting the therapeutic needs of the different people would take a lot more than that. The day treatment program here exists on paper. We need case management, psychotherapy, groups, individual, activities... For*

*some patients what we offer is perfect. Certain people do better in this place than others. We need to deal with the uniqueness of each patient.*

*Liz: Take Greg, (a manic depressive patient) is Menar the right place for him?*

*Leah: Exactly, no. He sleeps all day. He needs to get up, be shown what to do with himself. It's not good for him to be in his room sleeping all day.*

*Liz: Do you ever make suggestions about that type of thing to Father Ben?*

*Leah: Father Ben has an allergic reaction to my ideas. He calls anything I say the hospital model and is against it. He wants me to make Menar work in terms of paperwork and regulations without changing anything. And that wasn't our agreement when I came here. When I signed on we were supposed to have weekly meetings about the STF, patients, staff, evaluation, improvement. I'm lucky if I can talk to him for five minutes a week... My problem is that this place runs from crisis to crisis. There are things that could be different, [that] could prevent that. Nobody wants to listen to me because I'm the hospital model... The fact is that I don't like the hospital-institutional model. Its rules and regs, I'm not for that. I appreciate what they do here. I always operate within the nature of Menar... it could be better for the patients. They [Menar] learn through daily demands, flying by the seat of their pants.*

*Liz: A few days ago you mentioned to me you were involved in writing the state guidelines for STFs in the eighties...*

*Leah: Yeah, when I was a health services planner for the state... I worked on populations and planning services. To give you an idea of what was going on, we [the state] didn't even have a comprehensive 911 system at that time. I was working improving the services*

*to elderly adults. This part about mentally ill adults came up. It was in bad shape so I wrote down some suggestions. I thought there should be some therapeutic care besides custodial care. There were care homes, nursing homes, custodial places. Nothing therapeutic. I said let's add a category that has a therapeutic part. The STFs... I had no idea they would just adopt it entirely. I mean it was a first draft, some thoughts I jotted down that I thought we'd talk about.*

*Liz: And now it's the official guidelines... it seems like not a lot of qualifications for staff and administors.*

*Leah: Yeah, I agree. That was supposed to be rough ideas that other people would add to. See, Father Ben hasn't been trained and the director of the STF.... I think it's good that there's a focus on the psychiatric drugs here. The other non-traditional stuff is too unfocused to work. The other day I made Father Ben sit down with me for a few minutes. I said I was concerned that we have the crisis of the day, that that takes away from patients. He said, "I know. Sometimes we do everything but the STF." That's the problem, there's always something going on in the community and the patients suffer.*

*Liz: That seems like it would be really hard for you to be in that position.*

*Leah: I have my ideas of what my professional code of ethics is. I [have] problems with that. I've thought about leaving but what would I do? I don't want to live alone and my parents both died last year. I wanted to come here and be part of a community and work with patients. That's harder than I thought. The community thinks I'm un-Menar, too demanding too hospital. Every time I suggest we change something, Father Ben says, 'At least they're [the patients] not at the state hospital.' I can't argue with that. But when the inspectors come he wants me to have it all worked out. Like I told him before, if the progress notes aren't there for the patients then I can't do anything about that. You need to instruct the staff. But they [the case notes] are still missing.*

*Liz: That's something I'm curious about... that the inspectors would overlook something [the case notes] like that. How does that happen?*

*Leah: At Menar the inspectors were taken by the place, the Father Ben talk... I used to do inspections in elderly care homes. You know, in a state this size you either know the people from school, or you know their brother, or their mother is your mother's best friend. You overlook things because you know you're going to need them. One way or another, you're going see them, deal with them again. What you do with them will come back to you... If there's something that can't slide, take them aside and mention it, politely. [You] don't write it up.*

*Liz: Do you know if the staff has any training in suicide prevention?*

*Leah: I don't think so. How hard would that be? I mean, we could do that in an in-service. I'm in charge of doing staff education, maybe you could give a presentation on dealing with suicidal clients?*

*Liz: That's interesting that there hasn't been any problem with this before.*

*Leah: It's pure luck... really scary. You know when Larry said that he didn't know about Tom's suicidal ideas because the 'communication wasn't there'? That's not good at all.*

This conversation demonstrates the competing networks and nuances of power, authority, and knowledge both within and connected to Menar. Politically it is fascinating to see the negotiations of who has the power(s) to determine the meaning of the community, construct its history, and define, sabotage, and/or resist Menar's internal power structure.

The micropolitics of power negotiations were best examined at community meetings since this is where Father Ben consistently publicly reinforced his authority. These meetings took place weekly and many of the same issues were discussed at every meeting: the need to continue to find ways to work together, what the center of the community is based on, and how news gets communicated in the community. However, this was also the public forum for discussing disputes. At one community meeting, Father Ben was very angry with members of the staff who were "circulating conspiracy theories and paranoia in the Community" about his capacity to make staff members leave Menar. He accused them of being part of the "Menar underground," eroding the efforts of the entire community by questioning his motives and gossiping.

One of Father Ben's strategies for maintaining his authority and power was by outrightly denying his power. He did this by jokingly posing questions to the staff such as, "You can't really think that I run the whole show here?" He followed up by asking, "Really, if I ran this place don't you think the church would be bigger?" This made believing that he was all-powerful in the community seem preposterous and laughable. By telling the community that he was not endowed with absolute power and arguing that the postulate that he had the power they attributed to him was absurd, that it could not possibly be true, he was well defended against most community members. If that strategy failed, he used shame and guilt, charging that staff members were not truly "team players" as was evidenced by their questioning his motives.

Particularly at the beginning of my stay at Menar, Father Ben confided in me that he thought most of the staff and all of the clinical staff would not be able to make it outside of Menar. This was a mixed bag for him. On one hand it was a burden, since he felt he had to take care of them. It also seemed that he was lonely as the only highly functioning person. This loneliness is partly why I think he let me come to Menar and confided in me. He saw me as a comrade, someone who could see that he really had two sets of patients; the staff and the patients. On the other hand, he seemed glad that the staff members had found Menar and took pride in the fact that he and Menar had helped several staff members become "better adjusted."

He described the staff as being only slightly better off or mentally healthier than the patients. Frequently he used clinical vocabulary to describe the staff, "She is borderline... He derails and is volatile...." Father Ben's power and authority gave him the legitimacy to label patients and staff with psychiatric terminology and conversely, his ability to classify patients and staff invested him with more power and authority. Edelman's (1984) insight into the use of psychiatric terminology helps to illuminate this process.

> The chief function of any political term is to marshal support or opposition. Some terms do so overtly, but the more potent ones, including those used by professionals, do so covertly, portraying a power relationship as a helping one. When the power of professionals over other people is at stake, the language employed implies that the professional has ways to ascertain who are dangerous, sick, or inadequate; that he knows how to render them harmless, rehabilitate them, or both; and that his procedures for diagnosis and treatment are too specialized for the lay public to understand or judge them... When there is an allegation of mental illness, delinquency, or intellectual incapacity, neither the diagnosis or the scope of authority is readily checked or limited, but its legitimacy is linguistically created and reinforced. (1984:298)

**Power, resistance, and the power/knowledge loop**

Menar is a site where hegemony is reproduced via adoption of and resistance to hegemonic forces. Foucault theorized that resistance to hegemonic forces appears to oppose dominant forces, but in actuality, it does not. Instead, governing powers subtly control resistance by carefully drawing the parameters for potential change and experimentation. By allowing slight, cosmetic transformations of original patterns a perception that resistance creates change is maintained. This tactic remains cloaked and thus successfully sustains power relations and the status quo.

This cycle is demonstrated at Menar through its relationship with the biomedical model. Denizens of Menar are permitted to have a variety of notions regarding what mental illness is and how to treat it. However, if the Community wants to contract with the state for mental health services, it is forced to adopt the biomedical model's treatment of mental illness. This is an example of how the legal and medical establishments have succeeded in advancing the diffusion of the biomedical model into mental health services.

In Menar's case the realm of opportunity for resistance is the arena of explanatory models of mental illness where heterodoxy exists. Correspondingly, the sphere of treatment of mental illness restricts heterodoxy; there is no possibility of taking patients off of their psychiatric medications. Clinical staff has internalized the notion that it is best to keep patients on their medications because it is advantageous for the patients. But, they do not mention that there is no possibility of experimentation or control in that domain. It may or may not be advantageous, but the community is constrained by the fact that they cannot take away medications. Foucault discusses the ways in which power leverages the ability to create authoritative knowledge, which in turn reinforces the power to create additional authoritative knowledge. This power/knowledge loop is evident at Menar in the way that biomedical knowledge about mental illness and its treatment is taken as neutral and natural "Truth."

*The power/knowledge loop: The clinical staff's views on mental illness*

The clinical staff's views on mental illness are an example of how Foucault's power/knowledge loop operates in the realm of biomedical psychiatry. We begin investigating this loop by examining clinical staff's conceptualizations of and approaches to treating mental illness. The clinical staff's beliefs about the genesis and meaning of mental illness reveal an arena where the biomedical model is simultaneously resisted and internalized. Clinical staff's views on mental illness resist biomedical hegemony since their beliefs are informed by a complex combination of New Age ideologies, Theosophy, utopianism, pop-psychology, and Eastern Orthodox Catholicism, and biomedicine. These jointly held beliefs about mental illness reflect several explanatory models of mental illness and its treatment, rather than solely biomedicine. What is critical to extract from their answers is the ways in which they weave together various beliefs and thoughts about spiritual, biomedical, and psychodynamic models of mental illness.

The following transcript is from a clinical meeting that I attended where I asked clinical staff about their thoughts on mental illness:

*Don: It's a chemical disorder in their brains. They get an out of control, overly heightened spiritual awareness... See in the West it's a problem if you see something unusual and in the east it's just a spiritual process that went awry. I've been there. The key is to watch it, kick back, observe it, but not follow it and get lost. It's easy to get stuck, get fixated. I used to follow garbage bags around because I thought they told me things. [Your] senses are heightened, you're psychic, totally confused... It takes time to heal and progress. Some people never heal from their initial wound. The trick is to make old wounds make sense. But, once they make sense you shouldn't go off your medicine. That's what I learned.*

Don, who originally came to Menar as a patient, is now a member of the clinical staff and is able to function well so long as he takes his psychiatric medication regularly. He supplies the unique perspective of an ex-patient, providing insight into the struggles and 'realities' of being mentally ill. His thoughts mirror the mainstream medical model of mental illness as well as the psycho-spiritual camp, but it is important to call attention to the fact that he sees these processes as influencing each other. He says, "It's a chemical disorder in their brains...They get an out of control, overly heightened spiritual awareness." It is uncertain whether the spiritual awareness is created by the chemical disorder in the brain or the chemical disorder's genesis is in the heightened spiritual awareness. Clearly, he sees them as related. Additionally he mentions the Menar conception of mental illness as being stuck, which is basically a psychodynamic explanatory model of mental illness discussed previously.

*Father Ben: It's an internal justification of a bio-chemical process. We need to give them compassion, their process is similar to the process mystics undergo with God. A spiritual process and a chemical structure in the physical body. The human ego has been torn down and the spark of divinity is at the bottom. They need compassion and a safe environment. They need activities and a healthy diet... Everything is profoundly meaningful to them, [their] heightened sense of awareness is sometimes a blessing,*

*sometimes hell. Something in their soul has gone wrong, their thinking, feeling, and willing is malfunctioning... It is very close to the artistic process but they can't tell the difference between fantasy and reality.*

This is similar to Don's response in that the medical model, the psychodynamic model, and the psycho-spiritual model are all understood as components of the complex picture of mental illness. I do not think that it is coincidental that Father Ben's answer spans the mind, body, and spirit, rather, this trinity is a core element of his understanding of personhood and what mental illness affects. He also reproduces some of the core notions of what a traditional, Christian therapeutic community for the mentally ill is and what it offers to patients, "The human ego has been torn down and the spark of divinity is at the bottom. They need compassion and a safe environment. They need activities and a healthy diet."

*Leah: Mental disease is dis-ease, without ease. It's mental, emotional, behavioral.*

Leah has a master's degree in geriatric services and is the only person on the clinical staff who has formal education in human services. From extensive conversations with Leah, I found that her perspective on mental health is a quasi-medical model, consisting of bio-psycho-social and person-in-environment components. Here she uses the language of the medical model, "Mental disease is dis-ease," while inserting what the clinical term means to her, "without ease."

*Steve: It's both chemical and spiritual. I'm glad I'm not them. I'm happy that I deal with the medical side, charting, giving meds- the practical, physical side. I wouldn't be good at dealing with the spiritual side.*

Although Steve thinks that mental illness is "both chemical and spiritual," he is more comfortable with the chemical, medical aspects of providing patient services. His candor

about the fact that he is "glad I'm not them" is significant because it marks his view that there is an us and a them, and that they, the patients, are Other. This is very different from another position often heard at Menar; the mentally ill are not Other, essentially they are just like us since mental health and mental illness is a matter of degree because we are all on a shared continuum. Viewing one's self as similar to patients generates empathy towards them. In contrast, Steve's perspective makes it difficult for him to relate to them because they are so different. The distance that is created by viewing patients as Other is comfortable for Steve and allows him to contribute to patient services in a more detached way that others on the clinical staff would find unrewarding.

*Gwen: It seems like a lot of mentally ill people come from the military. Maybe they are exposed to chemicals or something happens to their bodies. A lot of the clients here were once normal and then something happened. They were once like me. I could be them. They're in their own worlds a lot but they're not that difficult.*

When Gwen says, "...the clients here were once normal. They were once like me. I could be them," she demonstrates her understanding of patients as akin to her. Being able to put one's self in the position of a patient and see them in us and us in them, influences the idea that "they're not that difficult."

*Betty: They [patients] need love that they never got. They need to have their inner child re-parented. [They are] Some of the specialest, most important people on the planet. We need to listen to them. Listen to their suffering and figure out their message. They know things about God, spirituality. They make us stop and look at our selves, what we're doing. They are the best teachers I've ever had... As the student, we have to figure out what they're teaching us.*

Betty's ideas reflect a psycho-spiritual position where mentally ill people are thought of as conduits to higher consciousness, brave heroes that have spiritual insights as a result of

their illness. She interprets mental illness as a spiritual message being sent to us in the perplexing language of suffering. From her perspective, the message may be cryptic, but it is meaningful and worthwhile decoding since they "know things about God."

*Hans: I don't know what's wrong with them. They are unmotivated and over indulged. [They are] people who want the rest of us to take care of them. They are the most manipulative, lazy people, don't want to take any responsibility. [They] drift off into their own reality, check out expecting us to take care of them. It's the easy way out. We all could do that. Somebody has to be responsible, do the work... Being crazy is selfish. They take the easy way out, we can't help them unless they do it for themselves.*

Hans, in great contrast to Betty, thinks that patients are lazy and selfish people who chose to take " the easy way out." His comments suggest the notion that we allow mentally ill people to take on a sick role, which relieves them of many responsibilities in exchange for being thought of as sick and 'other'. It is interesting that he says they are "unmotivated and overindulged," in light of the fact that he is German and invoking a Freudian construct. In Freudian terms, overindulged refers to mothers who did not appropriately control the amount of milk they were offering suckling babies, which allowed offspring to be greedy at the nipple. Overfeeding babies at the nipple produces adults that come to expect access to whatever they desire and have excessive expectations. Although I don't think Hans literally meant that the patients had been overindulged at the nipple, I do believe he was implying that Menar was the nipple that was manipulated into endlessly providing for them. Whether he thought that patients had learned this behavior from their mothers early in life is unclear. It is clear that he views patients as responsible for their illness and their behavior when he says, "we can't help them unless they do it for themselves."

*Larry: [A mentally ill person is] a person out of balance. We need to always be in motion like in the Eastern sense. Their teeter-totter got stuck and isn't moving. They know the*

*spiritual realm is there but they can't move past the mirror to find it... We all experience it, but they get stuck in it and can't find their way out. Something quite profound is coming out of it; how we use it as a society is another thing... I definitely think schizophrenia is a neurochemical thing.*

This is another example of the blending of the bio-medical model of mental illness and the psycho-spiritual model. He understands mental illness as being out of balance, both in the chemical sense and the Eastern spiritual sense of movement and balance. Larry says mental illness is a "neurochemical thing" and "Something quite profound is coming out of it; how we use it as a society is another thing." This indicates that mental illness is meaningful and we, as a society, are challenged by the puzzle of interpreting and making use of their suffering. Larry, like other clinical staff, believes we are all alike, the only difference is that the patients just got stuck in one place.

This tapestry of explanatory models is unlike psychiatry or social work, where it is paramount to choose one set of assumptions about the nature of mental illness and a corresponding way of treating it. Clinical staff at Menar are not compelled to align themselves with one explanatory model that dominates their beliefs and practices because the models are not conceptualized as competing with each other.

Although mainstream clinicians may see interactions between models, such as the bio-psycho-social model, during their training they are urged to make a choice among these competing approaches. Furthermore, in mainstream treatment locations, pressures exist not only to make a clear choice between models, but specifically to adopt a biomedical explanatory model and treatment modality. In Luhrmann's book, "Of Two Minds: The Growing Disorder in American Psychiatry," (2000) she discusses the forces behind the pressure to embrace of a biomedical explanation of mental illness in psychiatry and social work. She traces the rivalry between the psychodynamic and biomedical camps in psychiatry throughout the 20$^{th}$ century in the US and the reasons why the biomedical model has become the dominant paradigm. Demonstrating how economic forces like deinstitutionalization and managed care converged with legal and

medical elements, such as liabilities stemming from medical standards of care guidelines, she illustrates how the biomedical model of mental illness became the prevailing model.

Upon closer inspection, this general trend towards privileging the biomedical model is also expressed at Menar. One expression of this is the fact that a biomedical explanatory model is mentioned in six of the eight responses above. Another way biomedical hegemony is evidenced is via the reliance on medication for treating patients, which is indispensable for contracting as a mental health service provider. Although these hegemonic forces are resisted by a diversity of jointly held understandings of mental illness, biomedical supremacy forces Menar to treat mental illness with psychiatric medication.

Further evidence of biomedical penetration is seen in the way in which clinical staff has come to think of biopsychiatry and neurochemistry as natural and in unison with spiritual explanatory models of mental illness. This aspect of staffs' knowledge about mental illness seems neutral. However, if we follow Foucault's lead and dissect this knowledge and review its history, we see that it is heavily influenced by power relations. Recall earlier when we saw that since the early 1970s, biopsychiatry has steadily gained in its ability to dominate the arena of treatment of mental illness. At this point, it is no longer legally possible for a therapeutic community to treat mental illness without incorporating psychiatric drugs. The compacted realm of possibilities for treating mental illness is depicted in the way clinical staff has come to think about mental illness. Since Menar must maintain patients on psychiatric drugs, their explanatory models incorporate this political, medical, and legal reality. This is the process of naturalization and normalization of the biomedical explanatory model and the way in which power and knowledge reinforce each other.

Earlier we discussed Menar's mandatory compliance with biomedical standards of psychiatric care such as spatial regulations, charting, and psychiatric medication in order to be a licensed residential therapeutic institution and receive state money. Through my conversations with staff at Menar, I witnessed their ability to comply with regulations while manipulating them to achieve their goals. Since Menar's start in 1974, they have

perfected the art of the hide-and-seek relationship between power and resistance. They have become experts at determining where they can take liberties and where they must stick closely to the rules in order to accomplish their mission. They realize that they are expected to watch the patients and that they are also being watched. They also know that those who are watching them are being watched as well. They are well practiced at the game of being both an object and a subject. They understand what they are allowed to do and what they must conform to in order to run their therapeutic community.

The answer to the question "to what degree is Menar resisting biomedical hegemony?" is best understood in the context of Menar's integration of biomedical and spiritual aspects of mental illness. This interrupts the late twentieth century Western notion that biomedicine is modern and spirituality is traditional. This notion is rooted in viewing "the traditional" as the opposite of modern and nature as the opposite of culture. Customarily, each opposite in the dyad is thought of as a distinct category connoting a meta-narrative about difference. However, at Menar instead of choosing one meta-narrative, there are multiple meta-narratives. This is because conventional thinking about these opposites has been destabilized. Menar is a prototypical postmodern institution precisely because it is multifaceted and does not fit neatly into any one of the dichotomies, instead it represents strands of diverse lineages that often appear contradictory. It has porous boundaries, flexible ideologies, and is itself hard to categorize. In "Religion, Modernity, and Postmodernity", Heelas describes the difficulty of pinning down exactly what and where places like Menar fit into these frames:

> Postmodernity, together with postmodern religion, has been variously conceived. For some, the disintegration of the certainties of modernity has left a situation in which postmodern religion- Gnostic or New Age spirituality- can develop. For others, the distressing certainties of modernity have resulted in the valorization of a premodern past. For yet others, postmodern religion belongs to that great counter-current of modernity, namely the Romantic movement. And then there are those who associate postmodern religion with changes taking place within the mainstream of capitalistic modernity. (1998:1)

Initially, I framed my task as an ethnographer as having to answer the question is Menar Modern, Postmodern, Utopian, or to use Heelas' term "detraditionalized"?

However, given the complexities that Heelas details, I no longer think that asking or searching for an answer to that question is particularly helpful. The greatest transformation in my thinking is that my task is to understand and describe Menar, not explain where it "fits" into these frayed divisions. One of the most helpful tools for framing Menar on its own terms is Robert Bellah's concept of "utilitarian individualism". In a chapter titled "New Religious Consciousness and the Crisis in Modernity"(1976) he describes the cultural upheaval of the 1960s in the US and the changes that occurred on social and religious dimensions. He attributes much of this transformation to the rejection of the core American value of utilitarian individualism, "a neutral state in which individuals would be allowed to pursue the maximization of their self-interest, and the product would be public and private prosperity."(335) An array of critiques of this sentiment came from multiple points, but there was a unifying theme:

> the question whether the quality of life was a simple function of wealth and power, or whether the endless accumulation of wealth and power was not destroying the quality and meaning of life, ecologically, and sociologically. (339)

These elements of the cultural backlash of the 1960s are part of Menar's core; it is deeply concerned with modernity, nature, and meaning and is profoundly anti-utilitarian individualism. Bellah explains that during this period "There was a turn away not only from utilitarian individualism but from the whole apparatus of industrial society. The new ethos preferred handicrafts and farming to business and industry, and small face-to-face communities to impersonal bureaucracy and the isolated nuclear family." (341) Clearly these values are embedded in Menar's culture and are important to recognize as having roots in 1960s counter-culture. And in order to fully situate and understand Menar in terms of traditionalism, modernism, nature, culture, reason and unreason, it is critical to keep the influence of this period in mind.

I am not implying that Menar is a relic from the 1960s or a throwback, rather, I am illustrating the ways in which the dichotomies we have been discussing can seem misleadingly neat. Part of the reason for this image is that concepts such as nature and culture change. They are always theorized as contrasting each other, but are not actuality two distinct things so much as points on a common spectrum. Where these points lie on

the spectrum and how the spectrum is constructed and reconstructed shifts at different times and places. At Menar, this may appear as paradoxical and contradictory dichotomies, but this shifting and reconstructing is how Menar, as a community makes sense of itself.

By looking at this problem in a different context we can gain insight into this issue. In Sharon Kaufman's article "Death with Dignity" (2000) she discusses biomedicine's current ability to technologically maintain the breathing of individuals who are in persistent vegetative states via mechanical ventilators. This practice, she asserts, is at the intersection of moral reasoning, technology, and medicine, which are heavily influenced by wider social and economic forces. The mechanical ventilator has become standard, it has changed our conceptualization of death and the naturalness of it, and now influences medical choices. But its influence on this process is invisible. She examines how this practice has become routine and transformed our cultural understanding of death, life, nature, and technology. Through her examination of thinking about life and death before and after the advent of mechanical ventilators, she illustrates how belief and meaning have changed.

Her conclusion is that the categories of nature, culture/technology and the differences between them, have changed over history and they continue to change. Thus, although nature may be thought of as "truth" because it is organic and natural, it in not a fixed idea or category. This problematizing of the dichotomy of nature and culture is key to understanding Menar's conception of these categories. Kaufman notes, "The cultural construction of nature is perhaps most vividly revealed at sites where medical practice and technology converge." (2000:78) This is precisely the case with Menar and its production of the meaning of "natural" and "technological". The same process shapes the adoption of the mechanical ventilator and Menar's use of psychiatric drugs. Likewise, the decision making surrounding the application of the technology is embedded in the same understanding that it reduces patient suffering, therefore it is immoral to withhold the technological intervention.

# Chapter V: Analysis of Care-giving

By paying close attention to care-giving practices at Menar, I was able to learn about the Community's approach to treating patients. This chapter examines care-giving philosophies and practices as well as the influences that shaped what I observed. We begin by seeing how Christian traditions of caring for the sick underpin care-giving practices there. Specifically, we will see how philosophies of benevolence and compassion shape ideas about help-giving and inform beliefs about mental illness and its treatment. Next, we explore how Menar's focus on family-like relationships with patients and the physical setting of the community mirrors conventional care-giving practices at therapeutic communities for the mentally ill. Included in this is a discussion of caregivers' and patients' views on care-giving and care-receiving. We subsequently review Menar's requirement to incorporate psychopharmacological treatment of patients and the impact this has had on care-giving practices. Then we analyze how these treatments and care-giving modalities express themselves in the role of care-givers and their explanatory models of mental illness. Finally, we situate Menar's blending of "modern" and "traditional" care-giving practices in the Community's larger understanding of its own identity as a therapeutic site.

## Care-giving and benevolence

Reviewing Menar's core care-giving mandate, benevolence, helps us to contextualize underlying attitudes and beliefs about mental illness and help-giving. Webster's Dictionary defines the word benevolent as, "having a disposition to do good; kind; charitable." If there was a unifying mission statement or treatment philosophy among all of the members of the Community who were involved with patient care,

benevolence was it. Not only was benevolence a desirable personality trait, but often it was described as a mandate from God (or some other spiritual equivalent) in dealing with patients. Generally the benevolent helper ideal seemed to have its roots in the biblical precept, "Love your neighbor as yourself." This golden rule was the guiding principle for clinical practice at Menar; it was their version of the Hippocratic Oath. So long as caregivers treated patients the way they would want to be treated if they were in need of help and were acting from a place of benevolence, it was assumed that they could do no harm to the patients. All clinical staff members saw themselves as benevolent helpers; people who were interested in making a positive difference in patients' lives by acting kindly toward them.

There are two major considerations pertaining to this clinical directive based on the golden rule. First, relying on the golden rule and assuming benevolence on the part of caregivers is a slippery slope. While the golden rule seems like an easy rule to follow, even with the best intentions, it is not. How does one actually go about loving one's neighbor as one's self? How can one put one's self in somebody else's place and presume to know how that person would want to be treated? The essential problem in carrying out the golden rule is that your neighbor is not in fact you, and you are not your neighbor. What you like may not be what they like. It is not possible then to put yourself into another person's place and behave toward them the way you think you would like to be treated in their position.

All of this is even more daunting when people are different from you in some major way, such as being mentally ill. One solution to the dilemma of trying to discern your neighbors' preferences, asking your neighbors how they would like to be treated, is not effective when one's neighbors are mentally ill. Could mentally ill people comprehend what they were being asked in such a situation? Could they answer in a

meaningful manner? And how would caregivers proceed once this information was gathered? How would they interpret the answers given? What would happen if patients' answers to this question were in direct opposition to the protective, benevolent, custodial duties of the helping profession? If a patient answered for example, "I want you to kill me so I don't have to suffer anymore", how would the helper respond?

In our society mentally ill adults have been judged either incapable (legally mentally incompetent) or in need of assistance (legally mentally competent, but mentally ill) in deciding what is best for themselves. They are presumed to need the guidance of other, non-mentally ill, people in making decisions ranging from what type of treatment they should participate in to how much medication they should be taking, to how to spend their money. Mentally ill people must participate in numerous relationships where, based on the judgment that they are not in a position to make decisions for themselves, they enter into uneven power relationships and rely on people who are supposed to have their best interest in mind.

Some of the most significant relationships for mentally ill people, in terms of impact on their day to day lives, are those with caregivers. In these relationships, mental health workers constantly determine what weight the expressed desires of the patient should be given in making both major and minor decisions. Despite the difficulties I have noted, our society trusts members of the mental health system, such as the staff at Menar, to analyze patient's desires and consider them when making decisions in their best interest.

**The ideal of the benevolent staff (parent) and the innocent patient (child)**

The second consideration pertaining to the golden rule as a clinical directive is that constant benevolence in dealing with mentally ill patients is an impossible goal; it

ignores the vexing, tiresome, endless, thankless tasks of caring for mentally ill people. Thus, a trap is laid where caregivers can only fall short of attaining an ideal that is in fact unattainable. Human beings, unlike God, are doomed to fail at the task of undeviating kindness. Chronically mentally ill people are a very difficult group of people to "help." Generally, their conditions do not improve markedly, some play out the same day after day with sometimes disturbing or disgusting behavior, and it is often hard to see any improvements in their condition as a result of one's care for them. Moreover, often they are not aware of the care they are receiving, so that little if any thankfulness is gleaned from them. Caregivers would like to live up to the goal of always acting compassionately toward patients, but they constantly disappoint themselves.

Parents, in order to rise to the task of caring for their children, idealize the care-giving relationship in the same way staff motivate themselves by idealizing their role with patients. With children, too, it is hard to practice the golden rule in every instance and like mental health caregivers; parents constantly fall short of their aim to be flawlessly kind to their charges. It is therefore interesting that combined with the concept of ever-benevolent care-giving, Menar weaves the concept of the parent/child relationship into both its social fabric as well as its treatment ideology. Shortly after I arrived at Menar and sat down for one of my first chats with Father Ben, he said:

> Healing crazy people is a matter of giving them the love they never got. They are children who are ill. They need some sort of order so they don't go over the limits... Normal people are self-directing, mentally ill people have lost their ability to self-direct. Ultimately they are a threat to themselves or others. We try to provide benign parental managed care. We have personal relationships with clients. We are related, but not related, family but not family. We do parenting. A good parent knows when to let go and when to let them blossom and take risks.

It is not just Menar that fosters this family/parental dynamic; it is discussed often in the therapeutic community literature. In "On Being Good Enough, Bad Enough, and

Never Getting It Right- A Comparison of Motherhood and the Experience of Working in a Therapeutic Community, " Penelope Campling talks about the similarities between motherhood and being a staff member at a therapeutic community in England:

> It's something about doing a job so undervalued by society that many don't consider it a job at all; something about the repetitiveness, the lack of clear goals, the absence of any sense of achievement or even the satisfaction of starting and finishing a job; something about continuously responding to someone else's needs, the strength of the bond, the claustrophobia, the lack of space for one's self... Change, if it happens, seems to occur during long hard days in the wilderness rather than in a flash on the road to Damascus. Life in a Therapeutic Community for staff and residents alike can be boring, repetitive, slow, frustrating, and at times feel like drudgery. (1992:77)

This quote not only exemplifies the prevalence of the parent/child model throughout therapeutic communities, it also portrays the feeling that the work with patients is thankless and never ending, a phenomenon discussed by staff members at Menar.

But it is precisely on the dimension of endlessness that the parent/child analogy breaks down in understanding the therapeutic community. The vast majority of parents make a time-limited investment. Children grow up and become adults, the relationship between parent and child changes, and eventually children become individuals capable of being on their own. Parents may feel afraid of their children growing up and losing their dependence on them. However, mental health workers need not have similar concerns. Mentally ill patients are often endlessly dependent; the relationship between staff and patients does not mature into a relationship between two independent adults.

In the context of Menar, and its religious mission, an additional problem with the clinical golden rule surfaces. Even though caregivers feel called by God to do their work, they see that God does not give them the endless patience and fortitude it would actually take to carry out the golden rule. Why, they might wonder, did God allow for such imperfect humans, mentally ill people, to be created and then make equally imperfect caregivers? Like all humans, caregivers get tired, angry, callous, selfish, and fail as

fountains of kindness. When caregivers want to be like angels but act like humans they become guilty, angry, and may themselves feel desperate and depressed. This in turn reduces the caregivers' ability to be sympathetic and gentle with patients, which creates additional guilt.

When caregivers demonstrate their fallibility and patients feel they have been treated with less than unconditional benevolence, patients may attempt to punish and manipulate their caregivers. It was clear that one such patient, Paula, was expert at this. On one occasion Don had promised to take her to get a hamburger at McDonald's as a reward for not waking staff up during the middle of the night. But Don had to cancel their trip at the last moment, when, unexpectedly, he had to take another patient to the doctor. When he explained this to her she began yelling at him about breaking his promise. He responded by getting angry with her and saying that he would never take her to McDonald's if she did not respect his obligations to other patients. Paula began to cry and ran away from him. Feeling guilty about breaking his promise to her and then getting angry, he ran after her and apologized. While he was out with the other patient, Paula put rocks in a communal toilet bowl in his building and flooded it.

On another occasion, Paula repeated for several hours, "My stomach hurts, I'm dying. I'm seeing dots. I feel anxious." She demanded that Father Ben take her to the hospital. This type of behavior was standard for her, and so he denied her request, reassured her that she was not dying, and suggested that she try deep breathing. That night she filled a large trash can, on her porch, full of paper and threw her lit cigarette in it making sure it ignited. When the fire trucks arrived and found the site of the blaze, there she was standing near the smoke and flames watching the commotion she had caused with a slight smile on her face.

Paula's actions demonstrated a response to the frustrating fact that even when she felt she had been treated poorly by a caregiver, she had to rely on him to survive. Like mentally ill patients in other institutions, patients at Menar are in a situation where they are forced to trust caregivers. They are dependent on them to administer their medication, allocate their state money, drive them to doctors' appointments, feed them, protect them, and help them when they are scared, angry, or troubled. They must trust people who are not always kind to them. This predicament contributes to feelings of vulnerability, depression, and anger.

A few days after the incident described above, Paula's state-sponsored social worker arrived for their weekly meeting and they were walking on the grounds together. Father Ben approached them and recounted the incident to the social worker. He described the incident as her "acting out again" and they agreed that it was evidence of her worsening lack of self-control. When patients respond to their situation by retaliating or withdrawing, the mental health system sees this as evidence that they have become sicker. James C. Scott refers to this process as marginalizing resistance in the name of science, a concept based on the Foucauldian notion that diffuse authority, power, and knowledge coalesce to form the basis of medicalization and the rationalization of discipline. Having had what patients may feel is their legitimate response to less than benevolent care-giving labeled as being "more sick" and uncooperative, they feel powerless. In a place like Menar where the caregivers act on behalf of God, or because God instructed them to do so, patients might begin to ask, "If I can't trust God, whom can I trust?"

**The social politics of benevolent helpers**

Because the majority of people in our society do not want to interact with mentally ill people, we authorize mental health caregivers to make decisions in the patient's best interest. Society acknowledges mentally ill patients as a class of people who are unable fully to make their own decisions. We also acknowledge that they are at risk for a myriad of abuses by the agents whom we have assigned to care for them. That is where fear and collective social guilt enters the picture.

Like physically ill people, mentally ill people often evoke a broad range of social fears from people outside of these categories. These fears include dread of having to trust others for one's well-being, concern over losing one's connection to reality, terror of not being in control of oneself, fear of the suffering and isolation that might befall any one of us, etc. But unlike most physically ill people, mentally ill people are to a large extent not perceived by the general public as demonstrably ill, thus the degree to which mental dysfunction is voluntary and willful is still hotly debated. Most of the population can easily relate to physical illness- perhaps they have had a sore throat, a broken bone, or a toothache and have experienced the non-voluntary origin of their pain. However, comparatively few people have had the experience of disruptions in their own mental functioning. Since mental illness is outside of most people's direct experience and it does not have the same external, technical confirmations as other illnesses (i.e. as a thermometer corroborates a high temperature), it is more complicated to determine whether it is fabricated and controllable.

When physically ill people break taboos we assume that they are not capable of controlling themselves and therefore not accountable for their behavior. However, when mentally ill people break taboos questions about their volition and degree of responsibility are routinely asked. Furthermore, mentally ill people break taboos with

such frequency that it seems bizarre to not punish them and let them "get away with" making transgressions against social order.

Our mixed responses of fear/denial, guilt/avoidance, and compassion/blame are evidence that we are in the process of negotiating the nature of mental illness and the treatment of the mentally ill. Society is indeed concerned about the welfare of the mentally ill, yet not to the extent that we want to them to be incorporated into our social sphere or deal with the direct day to day details of their care. We are concerned about these unfortunate people, but they are not trustworthy in terms of controlling themselves, playing by the rules, or mastering their own illness. We are also unsure about the extent to which this category of people is responsible for their illness and their actions. In sum, we feel mixed about them. In order to reduce this discord we conclude that mentally ill people should be out of our sight and mind, somewhere where they are safe and society is safe. We succeed at this by investing the mental health system with the power, legitimacy, and authority to determine when and how to punish, control, contain, treat, and/or rehabilitate mentally ill people as they see fit. We empower them to do this via the resources of specialized mind/body technologies (psychopharmacological interventions with the potential for suffering reduction and repression), professional deference, and a highly specialized language.

In "The Political Language of the Healing Professions," Edelman discusses the mechanics of the language of the healing profession, "Though the linguistic evocation of the political system is subtle, that very fact frees the participants to act out their political roles blatantly for they see themselves as helping, not as repressing." (1974:297) This special language is essential in assisting the mental health profession to transform our distasteful collective desire for mentally ill people to be removed from society into the palatable righteous thing for us to do for them.

Menar is a space where mentally ill people live and staff members care for them while concealing all elements of this socio-political deal. Menar invokes an additional layer of mystification to assist them with this process: God and the golden rule. But, as discussed above, the golden rule gives us very murky guidelines for clinical practice with mentally ill people. By evoking the mandate of God via the golden rule, we are all obligated to assume that staff members are doing their best to take care of mentally ill people (and as shown above since we personally do not want to take care of them, we want to assume this to comfort ourselves).

At Menar there is rarely any questioning of staff, at any level of the clinical organization, about their actions in carrying out their clinical work and God's mandate. If a staff member is questioned about her actions toward a patient she can always assert that the behavior in question was within her interpretation of the golden rule and therefore benevolent. Should patients have difficulty seeing or understanding the benevolence behind a caregiver's approach, it behooves them to interpret her acts as benevolent and be grateful for the care they are receiving. If patients feel they are not receiving benevolent care, they should feel guilty for questioning the integrity of those that care for them. After all they are mentally ill and they should question their ability to distinguish benevolent care from other types of care. As Edelman points out, "It is no accident that governments intent on repression of liberties and lives are constantly puritanical, just as helping professionals exhibit few qualms about exterminating resistance to their therapies in people they have labeled dangerous and in need of help." (1974:303)

**Work life and private life**

As described in earlier chapters, one of the ways in which Menar did not reflect the medical model of care-giving was its blend of work and private domains. At Menar, patients and staff play multiple roles. Clinical staff members also work on-site as artists,

cooks, construction workers, spouses, parents, and priest. Several patients work as on-site construction workers, landscapers, and gardeners. The community's atmosphere is very much like a large family since members of the community live and work together.

One problem resulting from this flow of public and private space is that clinical staff feel intense burnout since there is little separation between work, care-giving duties, and other aspects of one's life. The fact that the STF is often understaffed by clinical staff contributes to "always being on call." Due to time constraints, geographical distances on the farm, and clinical staff playing multiple roles, discussions about patients take place at any time and any place.

Most clinical staff spoke with me about feeling "burned out." Some discussed their dissatisfaction with their role, treatment, and pay at Menar. Clinical staff were sometimes depressed themselves, unable to take care of patients, and looked to patients for support. In one instance Steve was on-call and received a page from the STF at dinner. He asked a patient to go see what was wrong and to get him only if he couldn't handle it. Involving some of the higher functioning patients in the care of lower functioning patients was one way clinical staff were able to get moments of peace.

This family-like atmosphere created several layers, or therapeutic communities within a therapeutic community. One of Hill and Pullen's subjects reports a similar parallel process at EBC, a therapeutic community in England:

> We have described how working on the EBC is intolerable whilst I said people are queuing up to join us! The solution to this paradox, I believe, lies with our use of the therapeutic community... I suggested that there were 'two parallel and inter-relating therapeutic communities, one made up of the staff and one made up of the residents. (1988:113)

At Menar there were several directions of "therapy" and therapeutic communities: from the clinical staff to the patients, from patients to staff, among patients, and among staff.

This lack of separation between work and private space contributed to one of Menar's major strengths: its approach to patient care focused on relationships that are not bound by time, space, or roles. Patients were not treated with a clinical recipe, instead they were treated as whole individuals, who were more than just their mental illness. At

Menar several staff members believed that all people have "gifts", including, if not particularly, mentally ill people. These staff members thought that patients' gifts were in the spiritual or artistic realm. They also felt that patients had the gift of teaching staff to reflect on themselves and what they were doing or had to be thankful for.

As discussed earlier, one of Menar's main spiritual themes was "the oneness of humanity," which appears as a tag line on their brochures. This idea manifested itself in patient care; clinical staff endeavored to behave like everyone mattered equally. Staff members were, as Father Ben often said, "seeking the humanity in others to connect with," in the patients. The idea was that the patients at Menar could be me, my friend, a family member, my lover.

**Clinical staffs' reflections on care-giving**

I wanted to know how these notions of care-giving coalesced in the role of clinical staff members, who have the primary responsibility for patients at the Community. I wondered how they thought about their role as caregivers within the context of a therapeutic community. Particularly, I was interested in what they thought Menar offered to patients in terms of care. I had the opportunity to ask the clinical staff about these issues at a staff meeting. Below are their responses:

*Don: Managed care. We give direction to people who are lost. We deal with people with problems so severe that we have to turn them around and send them onto a new path. We explain why they need their meds. Remind them what not to do. Attempt to give them a better way of life... a secure environment where they get the love they need. We help people not to vegetate on things by drawing them out of their darkness. When I take them on excursions I want them to accomplish something, to smile, have a good time. It's nice to see them almost whole.*

Don's view is that Menar mainly plays a custodial role in patients' lives and that the milieu of the Community is essentially what patients are offered.

*Larry: We provide a safe environment where the stimulus can be controlled. We become their families and they become ours.*

Although Larry also sees Menar as custodial, he adds that becoming part of a family is what is significant for him and the patients.

*Leah: [We] give them less institutional care and more individual care than the hospital or group homes.*

Leah perceives Menar as offering surroundings with more humane care than other treatment options.

*Father Ben: A normal person is self-directing, mentally ill people have lost their ability to self-direct... Dora (a co-founder of Menar) said that we should have an attitude of hospitality for the patients. We do. What's our basic philosophy of mental illness? We have a mood of soul that pervades the community, not a corporate mood of soul. We offer safety, love, respect, and a personal relationship with clients. Like children, they need some sort of order and limits. That's what we give them. They need benign parental managed care. They need good parenting and a family. We are family, but not related... We could do a lot more with adequate funds. If we didn't have to worry about money so much we could spend more energy on individual needs of the clients, be more professional. The insurance companies want to move the clients out before we can make a difference. Menar doesn't have a vested interest in keeping patients here, we want them to be here long enough to have a positive influence in their lives.*

Father Ben mentions Menar's hallmarks, the notion that family-type, personal relationships with patients is what they offer to patients. Notice that it is not an equal familial relationship, rather patients are seen as children being provided with good

parenting performed by adults/parents. Clearly, he is not entirely happy with what Menar offers and cites insurance companies and capital as limiting factors.

The themes that emerged from these responses are that the staff perceive care-giving as providing patients with protection, family, love, individual care, and an alternative to cold, uncaring institutions. These perceptions were consistent with my overall observations and conversations with clinical staff and general staff and reflect many of Menar's strengths as a place for mentally ill people. Providing family-type relationships in an atmosphere of openness on spacious farmland are prototypical constructs of care-giving in therapeutic communities for the mentally ill.

A significant part of what enables this type of relationship with patients at Menar is the fact that the clinical staff is not formally trained as mental health clinicians. This circumvented the typical use of diagnosis and the therapeutic relationship to create clinical distance from patients. The clinical distance expected of clinical professionals does not generally allow for true interaction with patients, only observation. Although the therapeutic alliance, the relationship between a clinician and a patient, is supposed to have healing properties, often the relationship is greatly constrained by the clinician's dictum of avoidance of intimacy (I don't mean sexual intimacy here, but rather authenticity). In a therapeutic community, relationships with patients take place at all times and in all circumstances and hence interactions are more genuine. Additionally, the concept of clinical boundaries and distance is non-existent and would not be valued. This of course, as I have described in other places, has its downsides when caretakers are angry, tired, busy, vulnerable, uncertain, afraid, etc. Authenticity in relationships is also a great strength because it creates a level of trust and caring that motivated caretakers to do very generous and kind things for patients.

The absence of formal clinical training meant that clinical staff and other community members were not involved in medical prophecy, that is, knowing a patient's diagnosis and then having expectations about prognosis and course of illness. These anticipated prognoses and outcomes deeply influence clinician-patient relationships, which in turn influence treatment and expectations in the environment. Clinical

expectations color clinical perceptions: biomedical psychiatric knowledge teaches practitioners to anticipate and act upon a priori expectations about disease categories and members of those categories. Clinicians then perceive the mentally ill according to these expectations with corresponding treatments and outcomes. These are the mechanics of creating a self-fulfilling medical prophecy.

Father Ben and the clinical staff had ongoing interactions with patients' psychiatrists, psychiatric nurses and social workers, all of whom had biomedical training and shared knowledge and suggestions about patients with them. Menar staff also realized that there were similarities in behavior between patients with the same diagnosis. But those influences did not create biomedical, clinical expectations of patients. For the most part Menar, as a whole, chose to remain unfamiliar with biomedical psychiatric knowledge and thus the cycle of clinical anticipation, perception, and corresponding beliefs about outcomes, course of illness, and treatment. This meant that patients at Menar were treated as individuals, not as a schizophrenic or a manic-depressive.

Treating patients as individuals and creating a true "home" where they are cared about and not pushed to leave was the essence of treatment for mental illness in this community. This is the intersection where Menar's overall conceptualization of mental illness and ritual healing through a community meet. It is also the point where I had the most consternation and confusion about Menar. As an anthropologist who has biomedical psychiatric knowledge, and a critical perspective about that knowledge, I am ambiguous about the pros and cons of Menar's approach to patient care. I observed demonstrations of genuine caring and love for patients that clinical education would not have allowed. My thinking and feelings about Menar are as nuanced and complicated as Menar itself, but the Community's unique ability to demonstrate love and concern for patients was precisely what I saw as missing in the clinicians and settings I had practiced within. Some of the very elements that troubled me the most about the Community were exactly the things that allowed for these humane interactions with patients.

**The patients' views on care-giving and caregivers**

I wanted to get a sense of patients' perspectives on Menar as a care-giving setting, so I asked ten of them what Menar is like compared to other places where they had received care. Here are thoughts on care-giving issues collected from nine patients who were able to articulate their views:

*Fred: The group homes don't care about you. Here they care about you. I like to be involved and have people around. They don't treat you like something is wrong with you.*

He represents many outgoing patients' experience at Menar when he remarks that he feels cared about. The feeling of being cared about is linked to his last comment: "They don't treat you like something is wrong with you." There is a genuine feeling of mutual caring between patients and the rest of the community, which is generally not found in treatment settings.

*Tom: I need more activities. More challenges... They have all these things going on here? Where? That's not true. I need my mind to be stimulated otherwise I get depressed.*

For Tom, an isolated, depressed patient, Menar was not what he needed and he knew it. Like several other patients, Tom was unhappy that there was a major difference between the supposed Menar with its activities and customized treatment and the actual Menar.

*Elsa: The food is good. I can take the bus from here to town... They look after me here. They are nice to me at this place.*

Elsa's perspective represents a handful of patients that have spent a lot of time in the state hospital and experience Menar as a great improvement over the hospital, particularly in regards to feeling cared about.

*Andrew: I get into trouble and start thinking about bad things if I don't work a lot. Here I work all the time. I mow the lawn, do construction, odds and ends. The really crazy people here do annoy me though, they get on my nerves.*

By working on the buildings and grounds, Andrew contributes to the community and keeps himself occupied. He exemplifies the traditional notion that the essence of what is "therapeutic" in a therapeutic community is patients working, interacting, and giving back to the community. The reference to "The really crazy people here" is a marker he uses to distinguish himself from psychotic patients that cannot, or chose not to, participate in manual labor projects. He is demonstrating that he is in a different, higher-functioning category of patient.

*Gloria: I can do art all the time here and write my poetry. I don't have to do anything else. I like that.*

Gloria is the type of patient who does not do well at Menar precisely because she is allowed to withdraw and "do art all the time here and write my poetry." She is appreciative of the fact that Menar does not interfere with her by making her "do anything else." Unfortunately, social skills and daily living skills would likely be beneficial to her in terms of getting her out of her room.

*Gary: Sometimes there are trips, I like that... [There's] not a lot to do here. They don't care what you do. They want you to go to meals, go to art class. There's no schedule. I get into trouble with no schedule.*

Gary is not served well by the loose structure of Menar. He is an example of the type of patient who has a great deal of insight into what does and does not work for him in terms of improving his mental illness. Therefore, he could be involved in his own treatment planning and management if that had been available at Menar.

*Greg: When I get depressed, I'll sleep all day and won't do anything. They'll [the staff] come by and knock on my door... but they leave me alone.*

This is another example of a patient being satisfied by the staff's agreement to "leave him alone." However, allowing depressed patients to continue sleeping and isolating themselves is not what would be considered helpful treatment for the illness.

*Paula: They take good care of me here.*

Paula is a distinctive, colorful patient that has been at Menar for many years and is part of the fabric of the community. Menar has done an incredible job caring for her, particularly in terms of providing a safe, custom-built shack for her where she can stockpile her trinkets without bothering other patients. Her sense of belonging showed in the way she walked around the community stopping to chat with everybody, something she did not do at all when she first came to Menar.

*Dennis: If they want my money they should treat me well. But they don't... People should follow the rules, they don't because they're mentally ill. Father Ben says I should be more tolerant, for a priest, he should treat me nicer... It needs more organization.*

Dennis was one of the patients who paid for Menar with his family's private money. He was endlessly complaining to Father Ben and the staff about the infractions committed by other patients, but did not get the response he wanted. He felt that given the amount of money he paid, they should be doing more to accommodate his needs, which provoked Father Ben. Because of this, Dennis and Father Ben had a most contentious relationship. Having spent time visiting with patients in the main patient housing facility where he lived, I sympathized with the unpleasantness he endured living with some of the other patients.

Unlike most other facilities for the mentally ill offering psychiatric beds, Menar was not under the economic and institutional pressure to get patients stable and send them back into the community rapidly. Since patients stayed at Menar for long periods, deep, extended, family-type relationships were formed. All Community members attempted to treat patients as people first and their biology and diagnosis as secondary to their importance as human beings. These hallmarks of care at a therapeutic community were reviewed optimistically by six patients: Three patients mentioned feeling cared about or taken care. An additional three patients made positive comments regarding Menar as a care-giving facility that meets their needs. However, the three remaining patients communicated negatively about Menar's ability to care for them appropriately. The core aspects of the therapeutic community, relationships and community did not provide the care-giving they wanted. The patients that sited lack of structure and organization as their main critique of Menar demonstrated insight into the fact that they would be better served in an environment with more structure.

**Clinical staff's views on psychiatric medication**

I was interested in the clinical staff's thinking about the role psychiatric medication played in care-giving. Although there was a diversity of views on the relative importance of psychiatric drugs, and how and why they work, all staff members were supportive of the patients using psychiatric drugs. At a weekly staff meeting attended by five clinical staff members, I asked for their views on psychiatric medication. Below are their responses:

*Larry: They work! It's an honor to see people who were way deep make their way out.*

Larry's experience is that patients improve when they are taking psychopharmacological drugs.

*Leah: What they need is drugs, unconditional love, firm kindness, consistency with the staff. It doesn't matter what we believe about drugs, they help them. First the behavioral approach was in vogue now it's drugs, chemicals in the brain. I think it needs to be a combination of all of them.*

Leah's remarks reflect a belief that love and kindness are as important as drugs. She sees these drugs work for patients and that is the bottom line; it does not matter how or why they help them. However, she thinks that drugs and brain chemicals are a fad in the same way that behavioral medicine once was promoted as the new best thing in treating the mentally ill.

*Father Ben: Menar has always had a tension between meds and no meds. When we founded [Menar] we thought a natural, healthy diet would work and patients wouldn't need drugs. But the illness cycles when patients get off drugs, we've got to have them.*

He begins by saying that the therapeutic community originally did not want to use drugs with patients. But, reflecting on his lengthy experience living with and caring for patients, he has concluded that drugs are essential. It is important to highlight the fact that the phrase "the illness cycles when patients get off drugs" is traditionally heard in clinical settings and used by mental health professionals. The phrase implies a common cycle in which patients become very ill and are motivated to take medications, however, once their illness improves they stop taking their drugs and the illness deteriorates. The subtext here is that when patients stop taking their medication they become very difficult to manage and live with.

*Steve: Taking patients off their meds and living with them twenty four hours a day? I wouldn't do that.*

Steve shows his own self-interest by very bluntly commenting that the idea of living in a community with patients while they are not taking their medications would make him abandon the community. This type of honesty about personal limitations in dealing with patients was quite acceptable during clinical staff meetings at Menar.

*Don: Meds are important because they are inhibitors. They stop too many things from going on at a time. Let's you function without being overwhelmed. It's too exhausting to see meaning in everything.*

Having been a former patient and now a clinical staff member, Don straddles both perspectives. When he says drugs "are inhibitors" he means that they inhibit patient behavior, thus making his duties as a clinical staff member tolerable. We also get the other side of the coin when he says "it's too exhausting to see meaning in everything." Here he is describing his own personal experience as a patient and the relief that medication provided for him.

**Traditional/modern, nature/culture, and madness at Menar**

One of the things I found most fascinating about care-giving practices at Menar is the fact that both "traditional" (therapeutic community) and "modern" (psychopharmacological) aspects of care-giving were practiced together. Usually, the treatment of mental illness falls into the category of traditional or modern since they are thought of as opposites. In order to understand this joining of seemingly distinct sets of practices, it is necessary to examine three elements: First, the relationship between care-giving practices and their grounding in notions of mental illness. Second, the history of the conceptualization of mental illness and its treatment follows the trajectory of wider social and technological changes. As changes in thinking about mental illness and its treatment occur, notions about the role society plays in creating and treating it also shift. Third, ideas about mental illness and appropriate care-giving practices have competed,

and continue to compete, for dominance in the arena of explanatory models of mental illness.

In order to understand the presence of both traditional and modern care-giving practices at Menar we must first situate the dichotomy of traditional/modern. The dichotomy of traditionalism/modernism, corresponds to the European Enlightenment period marking a cultural shift from the age of unreason to rationalism. This shift created "...the vision of tradition as modernity's devalued opposite," (Collier 1997:10) where tradition is typically seen as less advanced and less rational. Menar reworked this notion and was critical of the idea that modernism is superior to traditionalism. At Menar, tradition was translated into living close to the land, spiritual connectedness, community, and knowledge of a "real" existence. Modernity, on the other hand, was marked by artificial relationships with oneself, with others, and a move away from God, and spiritual and the workings of nature. There was a prevalent belief that there was something more real about the past, that the way people lived in ancient times was how humans were supposed to live. Development, although convenient and attractive was seen as a disservice; the current, modern state of being was unnatural, and synthetic, and it was important to rediscover the authentic aspects of being human. This was a rejection of the scientism and rationalism of modernity, a questioning of technology and its impact on human relationships, the environment, and mental health.

This intense romanticizing of "the past" and distrust of the present was exemplified when community members spoke of "needing to heal" and "healing". These phrases were used in many different contexts, for example: "He needs to heal that"; "I want to heal that in myself"; "Until that's healed, it won't change." At first, I thought this was a New Age idiom for communicating distress. Upon closer analysis I realized that "healing" here referred to the genesis of distress or disharmony being in artificiality, and alienation of the self, the hallmark of modernity. The healing process meant analyzing where the inauthenticity or disconnect in the self was and employing the appropriate strategies to make repairs by getting in touch with the self. The mechanisms for making this repair were self-reflection, spiritual connection, evaluating one's relationships, or

spending time "in nature." This concept of healing was reproduced in the physical setting of the community, the literature Menar produced for public consumption, day to day interactions among community members, and in caring for patients.

By thinking of illness and healing as social metaphor, we can learn several things about the notions of cause, effect, and healing mental illness at Menar. Recall that at Menar society is seen as disordered since it is out of touch with nature, spirituality, and the authentic self and that mentally ill people represent the need for a re-balancing of the social order. Cure, in this case, means altering the social fabric in which the problem developed. If one thinks of the world outside Menar as being disordered and mental illness as a mirror of that disorder, it is healing to bring mentally ill people to a community where collectivism, rather than individualism, is central and spirituality and nature is accessible. This reflects an us vs. them mentality that defined Menar. There was a sense that the social causes that made people sick outside Menar could make anybody sick. It was important to treat the cause of mental illness, which was modern society, as well as its victims. Thus, treatment of mental illness happened at the symbolic level in terms of Menar's rejection of outside society and its embrace of the balanced society it had created. The Community is seen as an improvement, a healthier place than the outside social environment for all community members, especially mentally ill people. It is this social balance and improved environment that is curative for mental illness.

If we take this construct of mental illness as a social metaphor and then apply a comparative perspective on healing, Menar is a system of correspondences that is based on balance. The dis-ease of mental illness is an excess of modernity (inauthenticity, individuality) needing to be balanced with traditionalism (nature, spirituality, collective). Patients' mental illness represented the most extreme cases of disharmony caused by modernity and the best way to treat or heal them was to re-familiarize them with the genuine, traditional modes of being a human being, such as interdependence with nature. This had a direct influence on the way community members thought about blame and responsibility for being mentally ill. Since community members saw the outside world as sick and therefore capable of making anybody sick, mentally ill people were innocent

victims of a sick society. They were also messengers illustrating the need to re-balance society and not individually responsible for their illness. I often mused that Menar symbolically thought of the mentally ill as canaries in a coalmine, where the coalmine represented the toxicity of modernism.

**The dialectic: madness and modernism**

Questions about the interaction between capitalism, modernism, and mental illness are at the intersection of multiple layers of psychopolitics involving political, moral, and religious dimensions. In order to understand the current debates about capitalism and mental illness, it is necessary to situate them within their larger epistemology by historically tracing the ancestry of these debates and their related systems of belief.

In order to understand the debate about what role modernism plays in mental illness, we must trace the history of the debate about traditionalism and modernism and their correspondence to insanity and sanity. In Sass's "Madness and Modernism" (1992), he reviews the tensions, parallels, resuscitations, and transformations of beliefs about madness from Plato, Romanticism, the Enlightenment, and modernity, to post-modernity. The majority of the book is dedicated to dissecting the dialectic of madness and modernism, which is helpful for understanding Menar's perspective on mental illness and patient care.

Beginning with the Greeks and Plato, sanity was thought to be the result of reason triumphing over passion. Conversely, insanity was the consequence of passion overpowering reason. Insanity marked the inability to control passion and desire, an incapacity to manage primitive drives. Simultaneously, it was captivating because it represented the penultimate expression of human passion and vital energy. During this period, reason was seen as distinguishing us as human, thus madness became a symbol of death because it represented darkness, sleep, a departure from reason, and dissolution of reality. In Europe during the Enlightenment, madness was seen as a defect, anti-consensus, and asylums burgeoned as the appropriate place to house the mentally ill.

For the majority of the 1800s the same thinking existed, however, later in the century an evolutionist perspective was incorporated, correlating madness with primitive societies and reason with evolved societies. Then, at the end of the 1800s and into the 1900s, a resurgence of interest in Romanticism's glorification of nature and unreason surfaced along with a critique of faith in reason and technology. Much of this social critique came in the form of avant-garde literature and theater championing the madman as hero, espousing that modern civilization was the cause of madness.

This was an interrogation of the underlying assumptions of cultural evolution, particularly the idea that the industrial revolution's legacy of time schedules, regulation of workers, interaction with machinery, alienation, and division of labor represents progress away from the primitive age of pre-industrial disorder to a modern age of order and reason. The equation of capitalism and its institutions providing order and stability, hence decreasing madness, was problematized. This discourse of resistance to the ideals of cultural evolution and modernity is represented in the anti-psychiatry movement's opposition to the notion that mental illness is diminished by the progression toward modernity. Sass postulates that at the core of modernity's fertile ground for the production of madness is a hyper-rational, hyper-consciousness that leads to a form of destructive self-reflexivity. He goes on to say that modernity resembles the hyper-reflexivity that is characteristic of schizophrenia.

Sass reminds us that this tension regarding the role of nature, culture, traditionalism, and modernity in mental health and illness has been part of Western culture for a very long time. This tension and its lineage is in evidence at Menar. By examining how it is played out in this particular therapeutic community we can better understand where we are in this historical arc currently.

**The noble savage**

The evolutionist perspective tended to categorize mentally ill people as savages. Over time, this concept transformed into the notion that they are a particular type of savage: the noble savage. As noble savages they were seen as living in an ideal state of

grace, depicting the true essence of humanity, nature, and Godliness. They are seen as candid, spontaneous, childlike, simple, naive and unsocialized. They represent what we, "modern people", have lost in our development from simpler times to overly complicated times. Nostalgia is a core element of this equation since the hallmarks of modern times are the loss of our connection to nature, God, our true essence as humans, and our innocence. Madmen cum noble savages require protection because there are forces that want to civilize them and remodel them as moderns. It is also important to guard them because they symbolize what we have lost.

This formulation was demonstrated by members of Menar in the belief that patients can teach us about our mistakes and possibly save our civilization from environmental and spiritual self-destruction. Patients were a hybrid of noble savages, shamans trapped in their own healing crises, and teachers with healing capabilities. Members of Menar thought that if we do not listen to them, and attempt to comprehend their madness, then we have lost an opportunity to regain some of the knowledge we lost in our journey out of the wilderness (literally).

Levi-Strauss (1967) critiqued the idea of the noble savage, that members of simple societies are primitive and irrational, and members of complex societies are civilized and rational. In "Tristes Tropiques" he discusses the false dichotomy between "the primitive" and "the modern" in his writings about travel books and argues that the savages described by travel writers are described as purely primitive, with no intrusions of modernity, cast this way because modern French authors need a "noble savage." In "The Savage Mind" (1967), Levi-Strauss again confronts the boundary between primitive and modern, critiquing the analogy between stages of development of the mind and social evolution. By presenting evidence of "modern thought" among primitives and "primitive thought" among those in modern societies, he questions the idea that modern thinking evolved out of primitive thinking, and that the two are distinct.

Levi-Strauss explains that these false descriptions of primitives by French writers helps to obscure the hand that "moderns" have in destroying "primitives" via

imperialism. This is a commentary on the paradox of destroying them and creating nostalgia for them simultaneously. Similarly, Menar treated patients as noble savages by romanticizing insanity as a realm of pure traditionalism where chaos, God, and nature existed. This romanticism extended into a hope that mentally ill people could teach "moderns" about God and reality. In a sense, Menar's mission was to protect these savages and create a Garden of Eden where the natural state of being could be accessed and harmony created between people(culture) and nature. However, the noble savage/patients' state of "naturalness" was seriously curtailed by biochemical treatment of mental illness, embedded in modern ideals of the self, where structure, control, and reason are essentially dictated by the State. The paradox at Menar is the goal of reconnecting with nature, simplicity, celebrating the mentally ill's "natural" state, and advocating psychiatric medication. Given Menar's landscape of values and beliefs, particularly seeing the mentally ill as noble savages and heroes, the case could be made that Menar reflects both Romantic and Modernist constructs. However, a discontinuity occurs when one asks, "Why did they embrace psychopharmacological treatment for patients?" I have several interpretations of this based on participant-observation. Cultural regression to a child-like, primitive state is valued on the spiritual and theoretical level as a utopian ideal. However, the realm of ideology is hampered by the actual day to day care of mentally ill people because treating them as heroes is very challenging. Consistently responding to patients from a place of honoring them is impossible when they don't make sense, refuse to participate or cooperate, can be manipulative, and destructive. Additionally, although aspects of mental illness represented healing and spiritual possibilities, the intrigue was overshadowed by the intimate experience of the undeniable suffering seen in patients' disorder and psychosis; people at Menar experienced first-hand the role these drugs played in reducing suffering among patients. Perhaps most significantly, as a business and community involved with the State, they had to demonstrate their fitness to care for mentally ill people, which meant they had no option other than adopting psychiatric drug treatment. We will return to this point shortly.

**Moral and technological imperatives**

The theme of nature, farming, and simplicity being helpful in the treatment of mental illness is abundant in the psycho-spiritual/alternative mental health literature and dates back to the earliest philosophies of therapeutic communities for the mentally ill. The idea is simply that the connectedness provided by a rural existence is helpful for the mentally ill, God is in the beauty of nature, and being in a beautiful place is curative. Menar had incorporated the 1960s "back to the land" ideal by living a rural, agrarian existence, but the Community did not rejected technology fully as the Amish have, for example. They have phones, TVs, a few computers, washing machines, and machinery for building.

The intersection of the community's ideologies and practices spawned many questions in my mind regarding its simultaneous rejection and adoption of technology and biomedicine. I often found myself wondering, "How can it be that a community that devalues modernism in favor of tradition trusts and depends on up to the minute psychopharmacology for the care of patients?" I was particularly interested in the use of psychiatric drugs at Menar since in the literature on psycho-spiritual interpretations of "mental illness", pharmacological intervention is seen as impeding spiritual processes. I was surprised that I never heard that position advocated. Clinical staff members advocated for making sure that patients were not overly medicated, but they were not for taking patients off drugs. One could make the case that the clinical staff's embrace of psychiatric medication demonstrates the Community's movement and fluidity between traditional and modern, nature and culture. This would suggest that these categories are more complex, permeable boundaries than rigid dichotomies.

But more importantly, it is impossible, given the legal and medical climate, to experiment with taking patients off drugs and remain a contractor with the State. Since this is not a possibility, it is never discussed, which is a core device the State employs to achieve its authority while mystifying its power. One of the methods for maintaining this cloak, and not calling attention to the relationship between ideology and practice, is the technological imperative: This is the drive to apply or engage technologies, such as

psychiatric drugs, based on the idea that because we have technology, it is essential that we use it. James Scott refers to the technological imperative as the conquest of nature and space, a celebration of technological achievements.

The technological imperative can be generated by, or itself produces, a moral imperative, the motivation to do something because it is viewed as ethically necessary or ethically "right." (Koenig 1988) At Menar this is a complex relationship, a loop, of reinforcing imperatives. It takes the shape of the technological imperative, psychiatric drugs, giving rise to the often heard moral imperative at Menar that it is inhumane to keep drugs from patients when it reduces their suffering. Going back to Foucault's theories about the power/knowledge loop, Menar's ability to exit its loop is limited by its economic viability without the state. Further reinforcing the loop, ethical reasoning supports Menar's culture of benevolent caregivers, which discourages questioning biomedical domination in the form of psychopharmacology. Consequently, biomedicine's hegemony via economic and legal enforcement is concealed by the adoption of psychiatric medication as a moral and technological imperative compatible with Menar's goal of benevolent caregivers. In Menar's case, the power/knowledge loop continues to revolve because hegemony naturalizes itself as part of Menar's culture while silencing the possibility of challenging it.

In tracing the history of conceptualizing and treating mental illness we see that moral reasoning, available technology, religious beliefs, knowledge, and power all shape notions about what mental illness is and how best to deal with it. One could say that this is a history of the relationship between the moral and technological imperatives as it applies to mental illness. If we add Foucault to this formula, we see how the drive to incorporate new biomedical knowledge about mental illness and its treatment is fortified by seemingly neutral moral and technological imperatives. In the case of Menar, it is important to notice the way in which its knowledge about spirituality and mental illness is made inconsequential due to its location on the margin of the power structure/competitive arena of meaning-making and authoritative knowledge about mental illness and its

treatment. Yet, as we have seen, it is precisely this marginal location that affords it some ability to enact "alternative" practices with patients.

In thinking about the moral and technological imperatives at Menar, it is necessary to review the Community's analysis of technology; it should be evaluated carefully and deserves critique, but not necessarily avoided since it offers positive things, mainly convenience. When I came to Menar I was puzzled by the clinical staff's embrace of drugs. I anticipated them advocating for psychotherapy without drugs since they are supportive of patients talking about their problems. But they were not interested in patients receiving formal therapy and it surprised me that Menar was accepting of allopathic medicine's mechanistic view that manifested itself through psychiatric pharmacology. I realized that I thought of biomedical science, particularly psychiatry, as part of the social nature of medicine and deeply embedded in a power hierarchy. Whereas the anthropological perspective sees psychiatry and psychiatric knowledge as socially constructed, they see science, and by extension psychiatry, as grounded in the natural world and therefore objective and neutral.

# Chapter VI: Conclusion

This ethnography contributes to the sub-field of psychiatric anthropology by exploring an example of an alternative method of caring for the mentally ill and documenting its accomplishments and limitations as a model for treatment. It also records the current environment of legal, medical, and moral barriers that curb this community's ability to experiment with alternative approaches to mainstream biomedical psychiatry. By looking at Menar through the lenses of power relations, the political economy of mental health services in a local context, and the history of conceptualizations of mental illness, we develop a better understanding of care-giving practices at Menar.

In this account of my time at Menar, I have attempted to achieve what Geertz describes as a major goal of fieldwork, "To discover who people think they are, what they think they are doing, and to what end they think they are doing it, it is necessary to gain a working familiarity with the frames of meaning within which they enact their lives. This does not involve feeling anyone else's feelings or thinking anyone else's thoughts, simple impossibilities"(1999:14). I hope to have come close to this mark by exploring Menar's core ideologies, organization, and practices. Through this "thick description", Menar can provide insight into our larger cultural debates about mental illness, culture, nature, and technology in the late 20th and early 21st centuries.

Menar can be used as a tool to examine issues affecting alternatives to mainstream treatment of mental illness generally, and therapeutic communities specifically. I am also motivated to use my experience at Menar to illuminate important changes that need to be made in the way residential treatment facilities are certified to care for mentally ill people. I will take these points up below with the understanding that Menar, similar to any culture, is likely to have changed since I did my fieldwork and will continue to change over time.

### Could power dynamics have been different at Menar?

Power and dividing practices do not disappear in Menar's model of caring for the mentally ill. Rather, they are transformed into a mode where power is naturalized via the rhetorical strategy of insisting that there are no hierarchies or power differentials at Menar. This strategy recreated the biomedical version of expert-driven, top-down hierarchies of power and knowledge and transformed it with Menar's ideology and practices around healing.

Community members at Menar thought of themselves as an independent community that was able to operate as an alternative to mainstream society. And in some ways this ideal was achieved. One area in which this independence was not achieved was in its provision of mental health services. Since Menar depended on the state for revenues through contracting for their services it was tied into state regulations that greatly determined the treatment they could deliver to patients. Although I have discussed the ways in which Menar resisted and ignored some aspects of the fact that state regulations and state bureaucrats did not enforce all regulations, even so, Menar's independence and creativity in patient care was deeply constrained by the forces of state administration of medical and professional knowledge and power.

Although there are troubling dynamics of patient care at Menar, it is important to appreciate the spirit, intention, and achievements of this social experiment. One of Menar's greatest successes is in humanizing interactions with mentally ill people. It is easy to see this ideal, germinated at Geel and retained throughout the history of therapeutic communities, reflected in Menar. The actualization of this ideal is best understood in opposition to Goffman's description of the total institution:

> In total institutions there is a basic split between a large group conveniently called inmates, and a small supervisory staff. Inmates typically live in the institution and have restricted contact with the world outside the walls; staff often operate in an eight-hour day and are socially integrated into the outside world... Social mobility between the two strata is grossly restricted; social distance is great and often formally prescribed. (1961:7)

Menar's goal is to be the antithesis of this description. Though it does fall short of this ideal in some places, overall it succeeds in disrupting this type of power arrangement based on dehumanization and difference. One could say that Menar excessively minimized

the pathology of mental illness because they did not want to reinforce difference by overly regulating the patients. I still struggle with the core question, is unfamiliarity with conventional knowledge about the course and treatment of mental illness unethical? Is it possible to have clinical knowledge about mental illness as background information, used to inform, but not necessarily structure patient care? How would power relations change at Menar with the introduction of this type of knowledge?

**Is it possible to have the best of several treatment models?**

Several of the humanizing elements of Menar's patient care would be worth replicating in mainstream clinical practice. Unfortunately, there is a lack of discourse between mainstream clinicians and non-traditionalists. Instead of a cross-pollination of ideas from therapeutic communities and other groups treating mental illness, there is little communication or respect between these two groups, which is unfortunate for providers of patient care and patients. As a clinical social work student I was motivated to learn about the history of the conceptualization of mental illness and study non-conventional ways of treating mental illness. On my own I discovered the alternatives to hospitalization and most importantly the therapeutic community movement.

Information about therapeutic communities was not included in the curriculum because, clinical social work students like others learning about mental illness, encounter mainstream psychiatry's resistance to therapeutic communities. Rohn Friedman (1985) attributes this to several intertwining forces. First, there are economic considerations such as the fact that hospitals make money when beds are filled and lose money on outpatient care. Furthermore, "Insurers including the government, despite the official policy of deinstitutionalization, have favored inpatient treatment over alternatives"(473). Part of this preference for in-hospital based treatment is due to the difficulty in calculating the direct cost savings of alternative treatments, since most of the cost savings and benefits are indirect.

Second, psychiatry's attitudes about inpatient hospitalization as the appropriate location and treatment for mental illness is driven by economic and social rewards within the larger arena of biomedicine:

... there is a status consideration in the resistance to nonhospitalization The renewed ascendancy of the of the medical model in psychiatry has influenced the entrenchment of hospital-based treatment. Psychiatry has increasingly sought to underline its role as a medical field, for the medical health care delivery system (and its training and research investment in the hospital) is perceived as a more credible and prestigious one than a community-based mental health system. 'Putting on a white coat' offers the promise of more secure research money, program grants, and insurance reimbursements.(Ibid. 477-478)

Friedman outlines the tension between the decades old agenda of deinstitutionalization with its community-based mental health care and the social, political, and economic forces producing and reinforcing medicalization and professionalization in the realm of psychiatry. Finally, he notes that psychiatrists in training obtain their clinical experience in hospitals with established psychiatrists who act as agents transmitting the aforementioned forces. Perhaps most significantly, he says, "Where hospitals are the central medium for training, it is not surprising that they become the central medium for treatment."(477)

The result of this bias is the separation and contempt between the mainstream clinical camp, that advocates for a hospital-centric view of mental illness and its treatment, and its marginalized alternatives that functions outside of the hospital. The unfortunate result of this is a lack of cooperation and a climate of mistrust and fear. My hope is that there may be more openness to exchange of ideas in the future, which would allow a place like Menar to preserve the spirit of innovation and humanity in their patient care while adding mainstream clinical information. The problem of attracting a clinician with formal education in patient care to a place like Menar is also difficult to overcome. Menar would not be able to pay a professional the same salary they would get at a mainstream setting. It would also take Menar wanting to change not just for economic or regulatory incentives but because they believed this was beneficial to patients. However, the clinician could always choose to live outside of Menar.

**Quality of patient care: Family involvement and improved monitoring**

As discussed earlier, Menar worked well for some patients and was dangerous for others. Menar's criteria for accepting patients were non-violent, fairly high functioning individuals. This patient profile is key to maintaining Menar's community, however, not necessarily a good match in terms of the kind of care patients need. One way of improving this situation would be to investigate the profile of potential patients, particularly attending to their tendency toward isolation. Menar was a pitfall for patients who were depressed or not interested in interacting with others. For these patients, the lack of structure and involvement in daily activities allowed them to withdraw to their rooms, becoming further withdrawn and isolated, which was unsafe and ethically questionable. For patients with the ability to structure their own time and interact successfully on their own, Menar offered an environment infused with freedom and independence. These patients thrived in this less regulated format and appreciated the autonomy compared to other treatment environments that were too highly organized.

Two courses of action could potentially improve the quality of care for patients who were not well served by the Menar system. One avenue to pursue, for patients with known family members, is increased family involvement so that they would be able to monitor the patient's interests more closely. Many patients were in touch with their families via telephone often, but there were only a handful of families that visited patients at Menar regularly. Most family members were located in other parts of the state or in other states, which made regular visits to Menar difficult. Those families that were not near by relied on Father Ben to be the liaison between them and patients; I frequently heard him fielding phone calls from family members inquiring about the well-being, psychiatric status, and financial welfare of their relatives.

Relatives trusted Father Ben's appraisals of the situation and acted accordingly, sometimes by increasing allowances for patients or calling the patients more frequently to support them during rough patches. Between Father Ben, phone conversations with their

relative, and the fact that it was a licensed facility, families believed that their relative was in good hands and that they did not need to be deeply involved with their care. This desire to believe that one's relative is being treated well at a facility is understandable and widespread. However, the desire to maintain this belief does not replace the actual need to regularly confirm it through visiting the patient at the facility regularly. It is widely known as "clinical wisdom" among social workers that patients who have families that routinely visit them receive better care and more attention than patients whose families do not visit them. This is because there is an immediate feedback loop between the facility, patients, and families when families visit patients; there is interaction, communication, and perhaps most significantly, an opportunity for families to inspect the situation for themselves.

There are, of course, flaws with the notion of family involvement as being important in improving patient care. First, when announced in advance, facilities can prepare patients and staff for the upcoming visit. Second, families may be biased toward believing that the care their relative is receiving is of good quality because it makes them feel assured. Third, there is no guarantee that families know what to look for when critically evaluating the care their relative is receiving. A recounting of flaws in the system for monitoring, licensing, and inspecting mental health care facilities is presented in "Care for the Seriously Mentally Ill: A Rating Guide of State Programs" (Torrey and Wolfe 1988). The following are excerpts that are particular relevant to Menar:

1. Quality of records is not quality of care. Medical records do not necessarily reflect patient care, "...it is possible for hospital personnel to cite treatment activities in treatment plans which are purely fictional."
2. Surveys are predictable and it is known weeks in advance when surveys will occur. "Furthermore the surveyors themselves are predictable, and once the identity of the team is known (as it is weeks in advance), a few telephone calls to other institutions will reveal kinds of possible problems those particular surveyors are inclined to pay attention to."

3. Surveyors do not communicate directly with patients, "...surveyors make no effort to contact families of patients or consumer groups, and, in fact, have virtually no contact with patients themselves." (21-22)

In order to combat these shortcomings in the process of certifying care facilities, they suggest performing unannounced visits to facilities with surveyors who are knowledgeable mental health professionals independent from the mental health system. I would add that interviewing current patients, and potentially their families, would improve the authenticity of the data gathered about a place like Menar. Speaking with ex-patients about their experiences would assist in obtaining accurate information about the care patients receive. I would suggest surveyors make several visits, each of which would be lengthier than the current standard of a few hours. Additionally, a representative from the state's Office of Mental Health and the Office of Patient Rights should visit facilities regularly so patients could form an understanding of their rights education and advocacy. It is too difficult to make the leap from a pamphlet on patient rights, which contains a person's name and phone number (which at Menar was not posted or distributed) and extrapolate their rights and an advocate's role.

Perhaps one of the most significant cultural reflections to be gleaned from Menar and the system of monitoring residential treatment facilities for the mentally ill, is that their care, and the conditions in which they live, are not a high priority. Although patient rights and advocacy on behalf of mentally people have improved in the US, we have a long way to go in terms of actualizing the true ideals of moral therapy. Too often patients' welfare is not monitored within a system of checks and balances to ensure that patients are not taken advantage of. Furthermore, responsibility for their well-being is diffuse. Too often we want to believe in, or have confidence in, a benevolent system made up of benevolent individuals. And worse, nobody wants to find out that mentally ill people, who deserve our protection, are not being treated well. This is a potent and dangerous force; it is important to not allow optimism or fear to cloud our judgment about the actualities of mentally ill peoples' care. These dynamics are important to keep in mind regardless of whether or not

a facility is conventional or an alternative to mainstream care. As we have seen, the abuses of power at mainstream psychiatric institutions reported by Rosenhan (1973) and Laing (1967) are also present at Menar.

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1968 The Electric Kool-aid Acid Test. NY: Bantam Books.

# Elizabeth A. Strober

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**(206)679-4681**


***WORK HISTORY***

**Director of Qualitative Research and Program Evaluation** *October 1999-present*

Family Centered Care Project, Packard Children's Hospital at Stanford University, California

- Design and execute qualitative research strategy and plan.
- Manage program evaluation.
- Create and manage qualitative research database.
- Coordinate consultants and researchers.
- Interview study participants.

**Interim Program Coordinator** *January-August '99*

Declare Program, Seattle Central Community College

- Presented workshops for minority students on careers and education.
- Advised students about the process of declaring a major.
- Managed work-study students.
- Wrote educational material for students about transferring to four-year colleges.

**Instructor** *January '99-April '99*

Social Sciences and Humanities Division, Seattle Central Community College

- Taught Survey of Sociology course.
- Developed syllabus.
- Designed course.

**Teaching Assistant** *September '95-April '96*

Department of Anthropology/UWired Program, University of Washington, Seattle

- Instructed three sections of an undergraduate anthropology course.
- Developed a syllabus that integrated traditional anthropology curriculum with computer/Internet skills.

**Researcher/Interviewer** *January-March '95*

University of Washington Breast Cancer Risk Perception Study, Seattle

- Designed surveys and interview protocols appropriate for Native American women.
- Interviewed women about their health and illness beliefs.

***FOUNDATION/NOT-FOR-PROFIT EXPERIENCE***

**Member of the Board of Directors** *1997-present*

Foothill-DeAnza Community Colleges Foundation, Los Altos Hills, California

- Participate in institutional advancement.
- Member of financial committee.

**Vice President** *1990-1998*

The Kaider Foundation, a family foundation based in Mountain View, California

- Developed guidelines for awarding grants.
- Made decisions about grant applicants and grant amounts.
- Analyzed and made recommendations about the Foundation's financial investments.

• Analyzed and made recommendations about the Foundation's financial investments.

**Member of the Board of Advisors** *1993-1996*
University of Washington Women's Center, Seattle
• Graduate student representative.
• Member of the development committee.

**Consultant** *1993-1995*
Multi-Cultural Affairs Committee of the Art Institute of Seattle
• Analyzed and evaluated student services in an effort to improve utilization rates.
• Designed and implemented culturally congruent student service programs.

**Social Work Intern** *July-December 1992*
Jewish Family Service, Seattle
• Evaluated social service programs for refugees and immigrants
• Developed guidelines for culturally competent social services.
• Provided psychotherapy to individuals, couples, and families.

**Social Work Intern** *January-June 1992*
The Art Institute of Seattle
• Analyzed the service needs of minority students and presented findings to management.
• Counseled students with drug and alcohol problems.

*EDUCATION*

**Ph.D.** *2001*
Cultural/Medical Anthropology. University of Washington, Seattle

**Master of Arts in Cultural Anthropology** *1995*
University of Washington, Seattle

**Master of Clinical Social Work** *1992*
University of Washington, Seattle

**Bachelor of Arts in Psychology** *1991*
Pitzer College, Claremont, California