
The
SUN
ULY 2011 • ISSUE 427
U.S. $5.95, Canada $5.95

# The Voices Inside Their Heads

## Gail Hornstein's Approach To Understanding Madness

TRACY FRISCH

*As a teenager Gail Hornstein developed a fascination with first-person accounts of mental illness, and in the decades since, she has collected more than seven hundred patient memoirs, autobiographies, and witness testimonies. She likens them to survivor accounts or slave narratives, with patients struggling against the psychiatric system to make their voices heard.*

*According to the National Institute of Mental Health, approximately one in four Americans suffers from a diagnosable mental disorder. Our society has gone further than any other in classifying unwanted behaviors and emotions as diseases demanding medical — and often pharmaceutical — treatment.*

*Hornstein, now a Mount Holyoke College professor of psychology, questions whether this labeling benefits those being labeled. She also rejects the idea that psychiatric patients, however severe their symptoms, have a physical disease. Even schizophrenia and other types of psychosis, Hornstein suggests, can result from trauma, abuse, and oppression. She offers a popular course for psychology majors in which they read only books by patients, and she urges a more open-minded inquiry into what causes mental illness and how people get better.*

*The obvious place to begin looking for answers to patients' problems, Hornstein says, is with patients themselves. She's passionately dedicated to uncovering how people experience their*

*own "madness," rather than accepting what psychiatrists and psychologists tell us. From reading memoirs of those diagnosed as mentally ill, she knows that they often credit fellow patients with helping them recover, and she argues that peer support and empathetic listening can set even severely debilitated patients on the path toward recovery.*

*Hornstein's first book,* To Redeem One Person Is to Redeem the World: The Life of Frieda Fromm-Reichmann, *is a biography of a maverick psychiatrist who used psychotherapy with patients considered to be unreachable by talk therapy. (The 1960s best-selling novel* I Never Promised You a Rose Garden, *by Joanne Greenberg, includes a fictionalized version of Fromm-Reichmann.) Hornstein was in London, England, researching her second book,* Agnes's Jacket: A Psychologist's Search for the Meanings of Madness, *when she happened upon a collection of videotapes of mental patients telling their own stories. This discovery led her to the Hearing Voices Network (www.hearing-voices.org), an international organization in which empathy and nonhierarchical interactions supplant diagnostic labels and the traditional doctor-patient relationship. When Hornstein returned home to Massachusetts, she started one of the first Hearing Voices Network (HVN) support groups in the U.S. In addition to addressing professional and lay audiences as a public speaker, she now serves as cofacilitator of the group and trains people across the country in HVN's approach. She has free information and lists of resources on her website, www.gailhornstein.com.*

*On a sunny afternoon Hornstein and I sat down to talk in her book-lined office at Mount Holyoke. Several times during the interview she gently corrected me when I used a "pejorative, medicalized" word like* paranoia. *What most impressed me was her refreshing openness to real-life experience as medical evidence. She refused to be limited by the theoretical constructs of her discipline or to believe that some people are beyond hope.*

GAIL HORNSTEIN

**Frisch:** You express enormous empathy for those labeled "mentally ill," yet you avoid romanticizing their lives. How do you walk this fine line?

**Hornstein:** I try to understand people as they understand themselves. If you ask them what their experience is or read their own accounts, you'll find they can be articulate and psychologically sophisticated. Even people who lack formal education can offer highly nuanced descriptions of their emotional lives. I've adopted a phrase from my UK colleagues: "experts of their own experience." This view helps me avoid either romanticizing their experience — seeing it in a more positive way than they do — or seeing it only as a tragedy with no redemptive qualities.

Emotional distress is highly individualized, and we shouldn't come to any general conclusions about it. There are people who feel they've learned something profound from the experience of hearing voices, but there are plenty of others who are frightened and just want the voices to go away. One woman said to me, "If I could wake up tomorrow and not hear any voices, I would open up a bottle of champagne." Yet she'd discovered the strength to get through it.

**Frisch:** Why do you feel so strongly about avoiding the phrase "mental illness"?

**Hornstein:** The term "mental illness" is heavily charged, politicized, and ambiguous. I prefer to talk about "anomalous experiences," "extreme emotions," and "emotional distress." The main reason I don't use medical language is that people who are suffering often don't find it very helpful. No one experiences "schizophrenia" — that's just a technical name for a lot of complicated feelings.

People who have been taught that "mental illnesses are brain diseases" see psychiatric patients as dangerous and unlikely to recover. And those in crisis are often understandably reluctant to consult mental-health professionals, because the stigma of mental illness is so severe: it's possible to lose your job, your home, and your family as a consequence of being diagnosed with a mental illness. In cultures that take a social view of emotional distress, by contrast, people more readily seek help because they aren't as likely to be ostracized and are assumed to be capable of full recovery.

The World Health Organization did an international study comparing outcomes for patients diagnosed with schizophrenia in "developed" countries — including the U.S., the United Kingdom, Denmark, and others — and in "developing" countries such as Colombia, Nigeria, and India. To their astonishment, they found that outcomes were much better in the developing countries. As often happens when a study produces unexpected results, the findings weren't believed at first. So the study was repeated a few years later with a more stringent definition of what constituted improvement for the patients. The results were the same.

Two hypotheses have been put forward to explain these findings. One is that developing countries don't use medications over the long term because they can't afford it. Without long-term medication, patients don't become chronically disabled. The other hypothesis is that people in developing countries are more likely to be cared for at home and be a part of their community, rather than being isolated or sent away to a hospital, and this helps them recover.

**Frisch:** How does what is commonly called "mental illness" differ from physical disease?

**Hornstein:** In psychiatry mental illness is a metaphor imposed on people's behavior. There aren't any physical methods of diagnosing a mental illness: There's no blood test. There's no MRI. So-called mental illnesses are diagnosed on the basis of behavior. The "chemical-imbalance" theory was invented by the marketing departments of drug companies to try to convince doctors to prescribe their products. Some doctors say depression is just like diabetes: you have an imbalance of a neurotransmitter, the way a diabetic might need more or less insulin, and this drug will restore your balance. But with dia-

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betes it's possible to measure the amount of sugar and insulin in your blood. We know what a balanced level is. No doctor who has given anyone an antidepressant has ever measured the level of a neurotransmitter in the patient's body. There is no independent means by which to tell if someone has a "chemical imbalance."

**Frisch:** Do *any* mental illnesses have a known physiological basis?

**Hornstein:** The initial symptoms of Huntington's disease resemble the symptoms of mental illness. When folk singer Woody Guthrie first manifested Huntington's disease, he was sent to a psychiatric hospital. Similarly people in the early stages of brain cancer may behave in anomalous ways. If you don't know they have cancer, you might think they're having a psychiatric breakdown. But once they get a CAT scan, you can see the brain tumor. You can't see schizophrenia.

**Frisch:** I have always taken it for granted that only mystics or crazy people hear voices, but you suggest that it's more common than we think.

**Hornstein:** Many people who hear voices never attract the attention of the psychiatric system. Estimates are that 4 percent of the UK population hears voices — approximately the same percent that has asthma. In Western society we most often associate hearing voices with illness. If we lived in a part of the world that was given to greater religiosity, unusual psychological experiences might be labeled as divine gifts. All the major religions of the world include figures who heard voices or had other anomalous psychological experiences. If the pastor in an Evangelical Christian church tells the congregation, "God spoke to me last night," no one in that church thinks he has lost his mind.

Whether a phenomenon is considered "abnormal" or not depends on the circumstances, the person's suffering, the reactions of others, and many more factors. One of the main goals of my book *Agnes's Jacket* is to give readers the opportunity to learn about people who have unusual experiences and to encourage them to tolerate a wider range of behavior in themselves and others.

**Frisch:** Of your first visit to a Hearing Voices Network meeting in the UK, you write, "People whose doctors had dismissed them as chronic schizophrenics or treatment-resistant cases were sipping tea and thoughtfully analyzing each other's actions and feelings." How could this be?

**Hornstein:** One of the biggest myths about people who are "out of touch with reality" is that they don't have any insight into their own experience. Another myth, which unfortunately comes straight from psychiatric textbooks, is that a person who has a psychotic experience can't empathize with others, that such people are narcissistic and egocentric.

On the basis of my experiences with support groups, I find that's just wrong. Many people who come to meetings have been in the mental-health system a long time. They might be heavily medicated and shuffling and stumbling from the side effects of prolonged medication. Frankly they don't immediately strike you as people who could make insightful, empathic comments. But I have learned that when these people, who perhaps have been written off by everyone else, feel supported by the group, they are likely to be extremely helpful, to listen intently, and to share enlightening observations.

We shouldn't make assumptions about the capabilities of a person diagnosed with schizophrenia or bipolar illness or major depression. Someone who is in a distressed state might be incapable at that moment of being empathic to others, but he or she might be perfectly capable an hour later. When anyone is in a rage or overwhelmed or terrified, he or she is not going to be able to listen or make helpful suggestions. But these feelings don't last forever. That's how we should start to think about psychotic states. They vary in intensity and duration.

**Frisch:** What is hearing voices like?

**Hornstein:** It is not the "inner speech" most of us are familiar with, where we tell ourselves to do something, or admonish ourselves. True voice hearing is a different phenomenon. Many of those who suffer from it hear these voices through their ears, the way you are hearing my voice. Most people find it highly distressing. The experience often becomes overwhelming, especially if they don't tell anyone, which is common. Imagine if I started screaming obscenities at you and accusing you of things that only you would know you were potentially guilty of. It would be terrifying.

Of course, the voices are different for each person. But it is possible for us to describe them to one another and thus identify similarities. I am often amazed at how people in peer support groups grasp the subtleties of each other's experiences. It's rare for them to have anyone else listen attentively to what they are going through.

**Frisch:** I was surprised to hear that the group members' psychiatrists had never inquired about what their voices were saying.

**Hornstein:** Psychiatrists typically don't ask people about the content of their voices because they believe that it will cause patients to further "lose touch with reality." In their view delving into the content of such experiences might push a patient into isolation and withdrawal. Psychiatrists sometimes call this "colluding with the illness."

I don't agree with that theory. Twenty years of research by the Hearing Voices Network has shown that, however ter-

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rifying it is for the person to talk about what the voices are saying, doing so seems to diminish the voices' intensity. So we know now that it's sensible to talk to people about what their voices say. Unfortunately the overwhelming majority of people diagnosed as "psychotic" do not see psychotherapists, who might help them articulate these experiences. Instead they see people in the public mental-health system and are treated with medication.

When people are able to analyze what their voices are saying, they can respond to them more appropriately. Ignoring them only makes it worse, just as someone who is trying to attract our attention will start yelling louder if we ignore them.

Last week, at the Hearing Voices Network group that I helped start in Holyoke, Massachusetts, someone came for the first time. She was tormented by the voices she heard. They were driving her away from her family and causing her to consider suicide, she said. She was very suspicious of the group and went around the room and asked each of us if we heard voices, too. When she found out that I didn't, she seemed even more reluctant to talk. But after listening to the other members for a while, she began to tell us about her voices. By the end of the meeting she was thanking people profusely and saying she would come back next week.

**Frisch:** In other words, people want to know they aren't alone in their experience.

**Hornstein:** Yes. No matter how accepting family and friends are, people find it easier to talk about hearing voices with people who have also heard them.

**Frisch:** Do you have any hypotheses about why people hear voices?

**Hornstein:** I think the most common reason is that they have experienced some kind of trauma that is too unbearable to remember directly. So it comes back to them in this form. Take childhood sexual abuse, for example: Besides the actual abuse, the abuser often tells the child, "Don't ever tell anyone about this, or I'll kill you," or, "I'll kill your family." The experience was already terrifying, and now the victim is afraid to talk about it. The younger the abused is and the more brutal the experience, the less likely she or he is to be able to integrate it. Part of our mind can split off and turn against us and scream accusations. It's not necessarily the abuser's voice, but it might use his or her tone.

Sometimes multiple voices talk to each other about the person. One voice might say, "She's so stupid, isn't she?" And another voice will say, "Yeah, she doesn't even know how to do this." The person is a mute witness to the conversation. This, too, might mirror a traumatic experience from the past.

The unconscious operates autonomously, the way digestion does: we don't have control over it. If you have an experience that you can't assimilate into the rest of your personality, it can take on a life of its own.

People often do everything possible to try to keep from hearing the voices. They wear earplugs or play loud music. Some hear a noise that's not quite a voice. It sounds like mumbling or static or animals or a machine. So calling it "hearing voices" isn't precisely accurate for everyone. I prefer that term, though, rather than "auditory hallucinations," because it's closer to most people's actual experience.

**Frisch:** Do people ever hear voices that say supportive things?

**Hornstein:** Absolutely. The Hearing Voices Network tries to help people marshal a positive voice that can stand up to the more negative ones. Carl Jung had this advice about a recurring dream where a figure is chasing you: try to get yourself to stop, turn around, and say, "What do you want? You don't have to chase me to get my attention. I'm listening." Sometimes, with help from the group, people who hear voices can do something similar — just as in real life, if someone were chasing you, you might be more likely to stand up to your pursuer if you felt you had support.

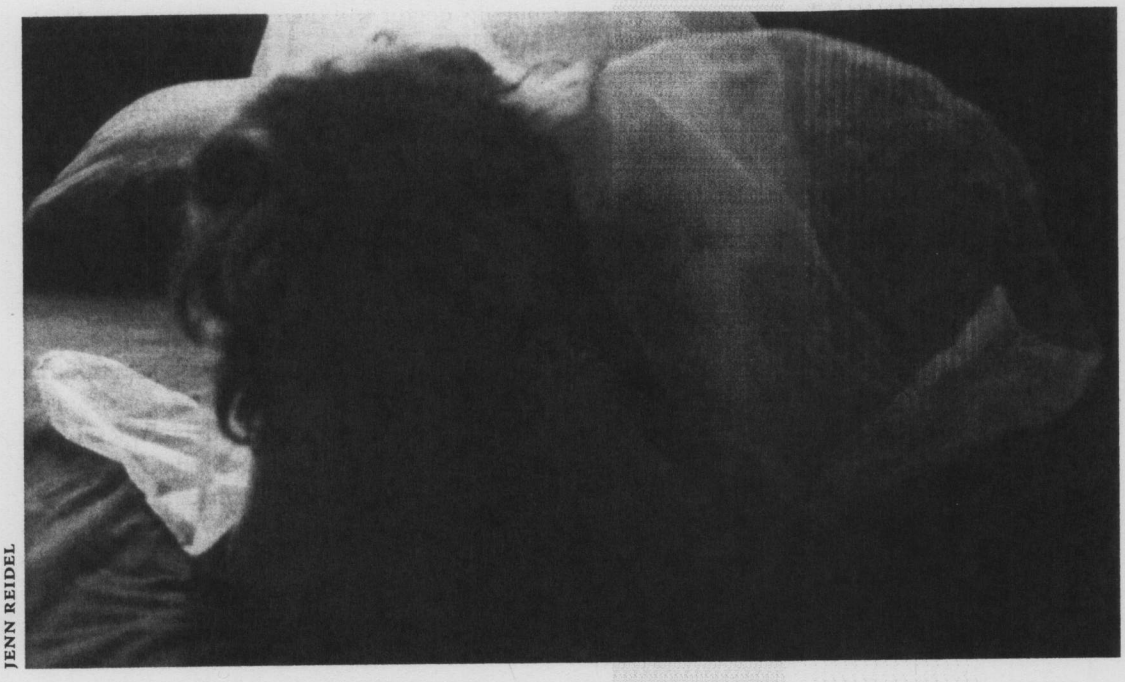
**Frisch:** Is there ever a role for psychiatric drugs in treatment?

**Hornstein:** Psychiatry is a very politicized field. People who raise questions about drug treatment are often dismissed as knee-jerk critics, and people who see something positive about it are often considered apologists. Both those extremes are wrong. The challenge is to understand medication in a much more complex way, not oversimplifying people's experiences and cramming them all into one box or another.

I take seriously the people who find drugs helpful. If a person says, "I was unable to get out of bed until I began taking this antidepressant," I think we should applaud that. The number of people who experience such results, however, is far smaller than drug-company advertisements or ardent proponents of biological psychiatry make it seem.

Psychiatric drugs are helpful to roughly a third of the people who take them. Another third find that the medications don't work for them. Often this group does not learn other techniques for coping with their psychological difficulties. When they stop taking the medications, they have no other resources to fall back on.

The third group consists of people who experience some effect from the medicine, but it doesn't help them with the symptoms that they themselves find problematic. The medication might knock the person out so that he or she can't do much else. Some people might want that kind of feeling briefly.



JENN REIDEL

If you've been in a manic state and haven't slept for a long period of time, being knocked out can feel fabulous. But after a week or so it becomes detrimental. You can't go to work. You can't go to school. You can't talk to your family. You can't even read because the print dances around on the page.

**Frisch:** Do you see peer support groups as supplementary to other forms of treatment or as an alternative to them?

**Hornstein:** It depends on the person. Every approach that has ever been developed in the history of psychiatry — medication, shock treatment, hospitalization, surgery, psychotherapy, peer support groups — has worked for some people and not for others. The problem is, it's impossible to predict in advance which remedy will be effective for a particular person. What we need is more flexibility and more options.

**Frisch:** What happens in these peer support groups that doesn't occur in the mental-health system?

**Hornstein:** What's most important about these groups is that they're peer led. Group therapy, to which they are often compared, is not peer led. It's a method of treatment in which a professional therapist sees a number of patients together.

**Frisch:** Don't the people in group therapy provide insight and support to one another?

**Hornstein:** Yes, but in traditional group therapy the therapist has a hierarchical relationship with the patients. In peer support groups no one is in charge. The facilitators simply make sure that the rules the group has agreed upon are followed. In our group, for example, we try to start and end on time, but people can come and go when they want. We provide a confidential environment: nothing anyone says leaves the room. We provide support and encouragement for one another. We agree on basic rules of respect: nobody insults anyone else. And we clean up our snacks before we leave.

People think that in a peer-led group one distressed person will take up all the time, because there's no authority to stop him or her, but even people who come to the group in the middle of a crisis will typically talk for ten or fifteen minutes and then suggest that someone else take a turn.

**Frisch:** People often aren't that courteous in regular social situations.

**Hornstein:** The group members are very respectful of each other, because they know what it's like not to be respected. They don't want to do to each other what has often been done to them.

There's also no pressure to speak. No one will say, "Gee, Bob, you haven't said much. Are you feeling resistant?" the way they might in traditional group therapy. I know people who went to peer-led groups for weeks without saying anything. What finally allowed them to feel comfortable enough to talk was that no one made them do it.

The other big difference is that people go into therapy in order to heal in some way. Peer-led groups are there just to provide support. People often do heal, but that isn't the goal of going to the group. The Hearing Voices Network does not aim to stop people from hearing voices. It aims to support them and help them learn better ways to cope. Many people continue to hear voices even after they've been in the group

awhile, but most feel less terrorized by them.

**Frisch:** Why is paranoia so prevalent among people who hear voices?

**Hornstein:** I don't know that it is. Like many psychological terms, *paranoia* has seeped into the general culture, and we use it in an offhand, inaccurate way. I prefer to use a word like *suspicion*.

Some people who hear voices believe they cannot trust anyone. According to the mental-health system, such people would never open up to a group of strangers. But, paradoxically, it's often a relief for them to be in a group with other people who have similar feelings of suspicion.

**Frisch:** As a condition for attending the hearing-voices groups, you had to agree to participate, rather than come only as an academic researcher or observer.

**Hornstein:** Yes, they'd been observed enough. In psychiatric hospitals they've had cameras watching them or been viewed from behind one-way mirrors. When patients started their own groups, they decided that no one who isn't a part of the group should attend. The last thing I wanted to do was violate their rules, so I agreed not to take notes, and to talk about my own experiences just as other people in the group do. Though I don't hear voices, I have certainly had experiences of vulnerability or isolation. I find that being a member frees me from any professional obligation to help people. I answer questions in the group, because I know a lot about psychology; last week people were asking how a certain medication worked, and I told them. But I am not an authority or leader. In HVN's view each person is an expert on his or her own experience.

**Frisch:** Are people with milder symptoms more likely to attend and benefit from peer support groups, while those with more-serious symptoms are prone to isolate themselves?

**Hornstein:** No, the overwhelming majority of people I have met at peer support groups are long-term psychiatric patients who have been in the mental-health system for many years, sometimes for decades. Most have been given every possible kind of treatment and still have severe symptoms.

Some people with serious symptoms do isolate themselves from society but make an exception for peer support groups. A member of our hearing-voices group in Massachusetts walks three miles each way to be at the meetings; he says it is often his only weekly contact with others.

**Frisch:** Why do people find it hard to believe that a diagnosed schizophrenic might be able to recover through mutual support?

**Hornstein:** First of all there's skepticism that people who have been labeled "mentally ill" can get better using any method. This is one of the great tragedies of psychiatry. Psychiatrists themselves, partly because they have yet to come up with highly effective methods of treatment, are easily overwhelmed by the intensity of their patients' problems. They can end up feeling despair. A doctor who feels that his or her patient is never going to get any better will convey that in one way or another to the patient. Dr. Andrew Weil calls this "medical hexing." It's a destructive, self-fulfilling prophecy.

I actually find it quite puzzling that we don't think psychiatric patients are treatable through peer support, since Americans invented the self-help group. We accept it as a treatment for alcoholism. Maybe you need medical assistance to detox, but any doctor will then tell you to go to Alcoholics Anonymous. If peer support will help alcoholics, why not people who hear voices or have other forms of emotional distress?

**Frisch:** Have your ideas put you at odds with the mainstream?

**Hornstein:** My belief that I've learned more about psychology from mental patients than from anyone else is certainly an unpopular position for someone with a PhD in psychology to take. Academics think that information about these phenomena should be learned from abnormal-psychology textbooks. That is the bias of all professions: that the knowledge you acquire during professional training is superior to that from any other source.

I'm particularly at odds with biological psychiatry, which is the dominant point of view in the U.S., though not in other countries. Mental patients are made helpless by the assumption that there is something wrong with their brains. We wouldn't understand how to treat brain tumors by talking to people who have them, the thinking goes, so why talk to mental patients?

**Frisch:** In a January 2010 article in *The New York Times Magazine* — and in his new book *Crazy Like Us: The Globalization of the American Psyche* — Ethan Watters argues that the United States has exported the notion of mental illness. He says that "mental illness" is not an objective condition, and that what might be considered quite odd in one time or place might be perfectly acceptable in another. His case studies of anorexia in Hong Kong and post-traumatic stress disorder in Sri Lanka show that what we think of as objective "diseases" manifest differently in different cultural contexts.

**Hornstein:** Many people, including me, have made similar arguments. There is a vast amount of literature critiquing the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or DSM. (The rest of the world doesn't use the DSM, by the way.) Not only do diagnoses vary widely across cultures, but patients within the U.S. are often given different labels by different doctors.

**Frisch:** You've criticized the influence of pharmaceutical corporations on how we understand and treat emotional problems in our society. How has the drug industry shaped the "mental-illness" paradigm?

**Hornstein:** Pharmaceutical companies have enormous influence, both directly and indirectly, on defining mental disorders. The American Psychiatric Association has to keep revising the DSM in part because drug companies are always seeking new markets. There are three times as many mental disorders in the fourth edition of the DSM as there were in the first. In two years we're going to have a DSM V, which will have even more. The way that mental illnesses multiply is deeply related to the economics of healthcare.

For example, attention-deficit hyperactivity disorder (ADHD) was invented with the help of the pharmaceutical industry. Fifty years ago out-of-control children were described

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as "naughty," not as having a mental illness. But even though today thousands of children (primarily middle-class boys in the U.S.) are diagnosed with ADHD, this is still a finite population. So drug companies pushed the American Psychiatric Association to create a new category called "adult ADHD." To use a metaphor like "the cart pulling the horse" is not strong enough. The treatment led to the creation of the illness.

In the mid-1990s the pharmaceutical industry convinced the Food and Drug Administration to allow direct-to-consumer advertising. This is legal only in the U.S. and New Zealand. In the rest of the world no patient ever sees a drug ad; only doctors do. So patients in other countries do not come to their doctors and request a prescription for Paxil because they saw it on TV. The drug companies are pressuring other countries to allow the commercials, but so far their efforts have been blocked.

In the U.S. we don't rely as much on social explanations for people's problems. For example, many Americans don't think that, as a society, we should take care of people when they fall on hard times, because they don't think that poverty has anything to do with the social structure. Rather they think you're poor because you didn't work hard enough or you have a lower IQ. Americans tend to see everything in terms of individuals, and biological explanations fit well with that perspective.

A psychiatrist in the Netherlands, where there is a strong community-support system, is more likely to think that a psychiatric breakdown is related to poverty, racism, or another social ill that the patient can't cope with. Here it's just a chemical imbalance in the brain, treatable only with a prescription.

**Frisch:** When people try to get off these drugs, their symptoms can actually get worse.

**Hornstein:** Patients and their families aren't told how physically addictive these drugs are. After you've taken them for a while, your biochemistry is changed. No one should ever come off a psychiatric medication cold turkey, especially if you have been on a high dose of it for a long time. The Freedom Center (www.freedom-center.org) has a helpful publication called the *Harm Reduction Guide to Coming Off Psychiatric Drugs* that's available as a free download.

Patients also aren't told enough about the side effects of medications. People who take a strong antipsychotic drug, for example, may find it impossible to work. They're put in the position of choosing between being distressed and being able to keep their job.

Many tranquilizing medications cause weight gain. One of the few generalizations I can make about psychiatric patients is that they're more likely to be overweight than the general population. The antipsychotic Zyprexa has been shown to cause an increased risk of diabetes. So you can get a new physical illness to struggle with alongside your psychiatric problems.

From the point of view of the drug companies, side effects are not a problem. If drug X causes a side effect, they'll sell you drug Y to counteract it. A patient might take seven or eight different psychiatric medications at the same time. This is called "polypharmacy." There are no data on the effect of taking that many medications at once or how they might interact with one another. A psychiatrist will rarely take you off a medicine that another doctor has put you on, but he or she will still give you something else.

**Frisch:** In the mid-twentieth century doctors invented the lobotomy, insulin-shock, and electroshock "therapies." Drugs to control depression, anxiety, and mania went on the market. And psychiatric hospitals were emptied out. What was the effect of these developments?

**Hornstein:** It's a common misconception that the mental hospitals closed because the medications were invented. While those two events did occur at roughly the same time, the real reasons the hospitals closed were that the states ran out of money and the federal government changed Medicare and disability rules, making it possible for a person to receive benefits for mental difficulties without being in a locked institution.

The great conundrum in psychiatry is that every single method that has been invented works for some people but doesn't work for others. That's true for lobotomy, shock treatment, medication, psychotherapy, and peer support. If there were a magic bullet, it would long ago have been discovered, and everyone would be using it. But every psychiatric method has been oversold in a burst of enthusiasm by its inventors. I say this for methods that I support as well as for methods that I don't.

Forced treatment, however, is always a problem. That's true as much for psychotherapy as it is for shock treatment. No forced treatment is going to work. The people who say they've been cured by shock treatment are the ones who sought it voluntarily. I've read many narratives by people who had forced shock treatment; they are often terrorized by the experience.

In general I think that we should err on the conservative side and not use treatments that have permanent side effects. Science journalist Robert Whitaker has written an important new book on this topic, *Anatomy of an Epidemic: Magic Bullets,*

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*Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, which has more detail on this issue.

**Frisch:** The emptying of mental institutions led to the growing problem of imprisoning people with psychiatric problems.

**Hornstein:** This is referred to as "transinstitutionalization." Patients got moved from one kind of institution — a mental hospital — to another kind: a prison. Clearly prisons are horrible places for people who are experiencing any kind of emotional distress. If you are hearing voices, your symptoms often intensify in a prison. The question is why our society doesn't have any alternatives to prison for people who are distressed.

**Frisch:** So what are the answers for people suffering from intense emotional distress?

**Hornstein:** They need empathic listeners who are able to sit with them, hear them out, understand what's causing their problems, and try to help them make positive changes in their lives. It could be a nurse, a priest, a family member, or all of them together. Psychiatrists could be a part of such a team.

People who are in the middle of a psychiatric crisis feel overwhelmed. They can't come up with a solution alone. They want help, but they don't want anyone deciding on treatment without their participation. And they can find support among their peers. The hearing-voices group in Holyoke is one of the first in the country, but starting last year we have begun to train facilitators for many more such groups in the Northeast. Our goal is eventually to expand the network across the U.S. We've got a long way to go. The UK, with 60 million people, has 180 groups, whereas in our country of 300 million there are just a handful.

We must remember that no matter how serious someone's emotional difficulties have been, they *can* completely recover. It's crucial for them and their friends and family to know that. No expert knows enough about mental illness to say that you can't improve. You might not know how to get better at this moment, but you have to start by knowing that it's possible.

**Frisch:** So how do people get better?

**Hornstein:** One way is by building up their tolerance for stress and their ability to cope with trauma. They become more resilient. It's analogous to the way we can build up our immune systems.

Patients might take up yoga or change their diet to reduce stress. Or they could avoid situations that are likely to cause stress, the way you or I might avoid a visit with relatives we know will upset us. People who've had psychotic experiences can learn to identify the triggers that set them off, and some can get to the point that they're less likely to fall apart in stressful situations.

**Frisch:** What will it take to create supportive environments in the U.S.?

**Hornstein:** A first step is to listen to people who have had these experiences themselves. They have an enormous amount of wisdom and insight, and ignoring them doesn't help us at all. And society should have a much broader definition of what constitutes acceptable behavior. That's something that each of us can change in ourselves. We would have far fewer people in the mental-health system if we didn't include all the kids who are fidgeting in their chairs because they need more recess or more-challenging reading material or smaller classrooms. And we would have far fewer people labeled "mentally ill" if we didn't include all the young adults who don't have enough guidance to move forward in their lives, who feel so overwhelmed by others' expectations that they can't cope and fall apart.

We need to give a person having a mental-health crisis other options besides going to an emergency room. That's often the worst possible choice. It's likely to make them more frightened and their behavior more out of control, which leads doctors to give them an involuntary injection of a fast-acting tranquilizer to knock them out. The experience can be more frightening than whatever the patient was experiencing in his or her mind.

We need to give people in crisis places to go other than a psychiatric ward or an institution. The Berlin Runaway-House, which isn't just for runaways, is one such place. It's a big house in a quiet part of Berlin where people in crisis can live for a couple of months. They will have a roof over their head and food if they want it. They will be able to walk around outdoors. They can sleep or not sleep. They can talk to other people, or they can be alone. They can do whatever it is they need to do without causing any violence to themselves or anyone else. Hopefully this will allow them to calm down and figure out long-term solutions to their problems. And when they leave, they won't have a stigmatizing psychiatric diagnosis. If we had places like that all over the U.S., I think it would lessen the likelihood that people would go on to become chronic mental patients. ■