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### ABSTRACT

Self-actualization is sought by all people. Experience with mental difference, both as
a patient and as a staff member in a mental hospital leads to a greater understanding
of the meaning and nature of this difference. It arises from variations in biographical
experience, social interactions, personal frame and self-choice. Providing the mentally
different with the responsibility of at least limited choice empowers them while
affirming their human dignity and worth.

During the years 1975–1978, I lived through what I consider to be a unique
experience. I became emotionally and mentally different from normal persons—
first as an outpatient and later as an inpatient in a state mental hospital. This
first episode was immediately followed by employment in a state institution for
the chronically mentally ill/mentally retarded, initially as an orderly, then as an
administrator and counselor. Thus, I experienced mental difference from "both
sides"—as patient[1] and clinician. As a Ph.D. candidate in sociology at that time,
I was able to reflect sociologically on events even as I experienced them.

I would like to share this experience in order to perhaps convey some in-
sight. Humanistic, existential, and symbolic interaction theoretical perspectives
are used to explicate mental difference as self-negation or affirmation of personal
meaning, self-labeling, institutionalization, treatment as violence, alienation, in-
visibility, journey into self, restrained choice of self, and self-actualization.

## The Experience

### Outpatient

In 1975, I was studying to become a mathematical sociologist and was about to take my last comprehensive examination. I became alienated from my wife, and we separated. On the day that we moved her belongings from our home, I experienced a deep sense of loss. I moved to a different apartment where I chose to live alone. I became very angry at sociology, blaming it for the end of my marriage. I resigned my fellowship, withdrew from graduate school, and began employment as a health planner for a state health planning agency.

I had always liked music, so I became very involved with it. I spent about $150 every two weeks on albums and would often spend evenings after work listening intently to music. Even though my stereo was modest, the music would literally leap from the album into me; I felt at one with a song.

I was filled with energy during this time. My work as a health planner was challenging and merited praise. I dated a woman, felt that I desperately needed to fall in love, and was crushed when she ended our relationship. I lost my ability to sleep for more than four consecutive hours.

After about six months, I became disillusioned with health planning, the stated goals of which were to promote equal and accessible health services for all persons while maximizing citizen input in the planning process. My analysis of organizational policy and behavior indicated that the latent, but dominant, purpose of health planning was to legitimize physician and hospital control of health services.

After a long, sleepless night, I called the director of the agency and informed him of my conclusion about the agency. He suggested that I consider resignation.

After one day, I decided to seek counseling and return to my job. A psychiatrist prescribed medication. During the next week, while sitting at home, I heard and felt a spirit enter my apartment. I was first terrified but later sensed that it meant no harm. The psychiatrist prescribed a new medication.

During the next week, again while sitting at home after work, I experienced a "thud" deep inside me. My emotions and energy fell out on the floor. I cried hysterically and felt hopelessly abandoned.

I called my work supervisor the next morning, informed him of my condition, and resigned. Counseling continued. After about eight weeks of unemployment, I regained some inner strength and moved into a new apartment with a roommate. I still felt terribly alone, but at least I was functioning more normally. I reapplied to graduate school and was awarded an assistantship. I continued to see the same psychiatrist and began to get ready for fall semester.

I then encountered deep images of my father leaving my family when I was fifteen years old. He, too, had become mentally different. The pain of my impending divorce was multiplied by the sense of loss of my father during adolescence.

I lost my ability to read. I was supposed to teach a Marriage and Family course that fall, but I could not read the text. If I could not read, I could not return to graduate school. I was seeing the psychiatrist several times a week. She verbalized concern for me but seemed to keep me at a distance. I felt that I was crying out for help but that none was forthcoming. There seemed to be no way out.

I had thought about killing myself before by jumping in front of a moving car, but it was just fantasy. I knew I could never shoot myself, but I developed a different plan: I would swallow a whole bottle of prescribed drugs, pass out, and die peacefully.

On the day of my self-execution, I visited the sociology department. Death was imminent; no need to worry. As I left the sociology building I encountered a friend. He asked me how I was doing. My lips answered "fine," but I felt completely detached from him.

I returned to my apartment, swallowed the pills, and lay on the bed, waiting to die. As the world became fuzzy, I staggered from my bedroom to the living room, where I informed my roommate of my action. He rushed me to the hospital. I awoke to a new day.

The psychiatrist arrived and apologized for not seeing the immediacy of my deterioration. I was released to my mother's care and returned to her home and began outpatient counseling. One day I heard God say to me, "I will always be with you, John." I became increasingly reclusive and, realizing my condition, asked to be taken to a state mental institution. I was admitted with a diagnosis of "schizophrenic break." I would remain hospitalized for five weeks.

Inpatient

After being admitted to the hospital, I felt relieved. Here I could be myself. I no longer had to try to pretend that I was "normal." I went to my room, put on my hospital gown, and lay on the bed. Surely these people could help me!

I soon encountered a sense of separateness from most of the patients. Even when we played pool together, we rarely talked. In one room where we gathered to smoke, many of the patients acted very weird. Some related long histories of hospitalization. I wondered if I would recover or become like them. The days drifted by in an aimless fashion.

I began to work two hours a day doing dishes. This was terrific! I was amazed and rather proud that I could actually complete dishwashing tasks. Orderlies joked with me and assured me that I would get better.

Every weekday we had "group" on my unit. The social worker would sit with us for one hour, asking us to discuss personal problems. Each patient seemed quite different from the rest. Brief conversations between individual patients and the social worker seemed disconnected from one another. My impression was that "group" was useless.

I met with the social worker for one hour twice a week. I constantly sought answers to two questions: "What is wrong with me?" and "What can *you* do to make me better?" I learned that I was depressed. I learned, not by instruction but by insight, that there was *nothing* that the social worker or the state hospital could do to help me. *I had to do it myself.* With the social worker's assistance, I formulated a plan. I would buy a car, move back to the city where my graduate program was located, continue counseling, stay with a friend, find a job, get my own apartment, and eventually go back and finish graduate school. A bold plan! I took a large risk and did it.

Technician

After moving, I applied for an orderly position at a state institution for the mentally ill and mentally retarded. As part of the job interview, I was given a tour of the living unit on which I would work. Patients were walking about singing, shouting, uttering redundant phrases, shaking their head or their arms, calling for help, and stealing from others.

I was hired as an orderly and got to know the patients. Each one had a "different" side—redundant mannerisms, shouting, clinging, stealing, an inability to talk, or violence against self or others. However, each patient also had a very human, loving side, which manifested itself as trust, a gesture of kindness, a joking manner, or expressions of liking or thanks. I found that showing kindness to these people healed my own brokenness.

One night I volunteered to escort a female patient to a movie in the recreation center. She reached for my hand during the movie, and we held hands until the movie was finished. This experience, and others like it, allowed me to realize that we, as people, are all one, and that only acts of fate separate us from one another.

The frequency of deviant behavior by patients varied inversely with their distance from the living unit. The patients' shared norms legitimated "acting out" on the living unit. Vocational training and eating occurred off the living unit but in the same building. Here a different set of norms operated. Some

"acting out" would inevitably occur, but patients would instruct each other to act appropriately. When the patients left the building to go on field trips, "acting out" was extremely rare. Patients sincerely tried to "fit in" and "act like normal people."

When a patient became physically violent (hit self or others), a buildingwide emergency would be called over the intercom. Orderlies would race to the place of violence and subdue the patient. We would place the patient in leather wrist and ankle restraints and carry him or her to a time-out room, where a nurse would administer a tranquilizer. I came to see this procedure as violence committed against the patient.

I soon noticed that many patients carried psychiatric diagnoses of "organic brain syndrome" and/or "schizophrenia," which the psychiatrist assured me caused them to behave violently and bizarrely. I realized that diagnoses of "organic brain syndrome" and "schizophrenia" were tautologies: patients who act differently have organic brain syndrome and/or schizophrenia; patients with organic brain syndrome and/or schizophrenia act differently.

I began to see the starkness of the institution—white walls, gray metal doors, and near-empty dressers—and the great dependency of the patients. Both the physical and social contexts functioned to institutionalize patients and convey to them a childlike, dependent, and irresponsible self-concept. ("Don't be a naughty boy or we'll take away your cigarettes.")

Psychological Services Assistant

I was promoted to Psychological Services Assistant and served as assistant administrator and counselor to thirty patients of one living unit. My supervisor was a psychologist.

My major job responsibility was to write comprehensive behavior modification programs for all patients. Many of these programs included consequences for multiple types of deviant behavior. The programs were known by all employees in the building so that patients could not escape the consequences of deviant acts. Patients were first verbally cued to stop a deviant behavior. If the deviant behavior continued, they were sequentially denied a reward (e.g., cigarettes), sent to their room, placed in the time-out room, placed in restraints and, finally, given a tranquilizer. If the patients behaved appropriately for a certain period of time, they were given a reward (verbal praise, candy or cigarettes, or a trip to the canteen). My most striking observation about these elaborate behavior modification programs was the patients' great abilities to resist programming and to continue their deviant acts. Through programming, hospital staff were

supposed to control patients' behaviors. In reality, however, behavior programming allowed patients to manipulate the behavior of staff. When a patient "acted out," I wrote a new program. When she again "acted out," I again wrote a new program. Staff continued to modify their responses while the patient continued to display similar deviant behavior.

One day, I tried a new intervention with a patient. Instead of placing him in restraints, I entered his room alone and talked to him for half an hour. Every time he would begin screaming and slapping his face, I would tell him to relax and assure him that he would be all right. The patient looked at me with both fear and amazement, perhaps wondering when I was going to call other orderlies and place him in restraints. After half an hour, he did calm down and was able to leave his room.

When the supervising psychologist learned of my intervention, he criticized me. I informed him that I had frequently observed that restraints produced, rather than reduced, further violence. He discredited my observation and told me never to repeat the new intervention. He explained that we simply did not have the time to use verbal assurance with all the patients. Leather restraints and tranquilizers were more efficient.

The general consensus among hospital employees was that our purpose was to modify the behaviors of patients so that they could move to less restrictive placements (group homes or apartments). However, in the year and a half that I worked at the institution, no patients from my living unit were placed. Almost all patients continued to perform the same deviant behaviors, and two people became more violent when their placement neared. I became convinced that the real, but unstated, purpose of the institution was to manage patients' deviant behavior, while keeping the patients out of public view in a secluded area near city limits.

One day a nineteen-year-old patient wandered into my office. He was unable to talk but communicated to me by urinating in my wastebasket. In the past, he had often wandered by my office while attempting to escape vocational rehabilitation class. I had then gently pushed him down the hallway and back to class. As he urinated in my wastebasket, his smile suggested that he was "repaying" me. This symbolized for me both the control that I exercised over patients and the personal abuse that I received in return. I decided to return to graduate school.

I took another risk in 1978 when I resigned my institutional position and returned to graduate school. I originally had left graduate school as a cynical positivist and grand theorist. I now returned as a person most interested in humanism, existentialism, and sociological practice.

## Theory Explication

The approach toward theory construction taken in this paper is grounded in personal experience. Theoretical concepts and propositions that sociologically organize my experience will be explicated from my story.

The traditional dichotomy between objective, empirical data and subjective, experiential information is misleading. All perceptions of data and information are filtered through the person doing the experiencing and are, therefore, subjective in nature (King, Valle, & Citrenbaum, 1978). Knowledge must be valid if it is to be scientific. To the degree that concepts and propositions are consistent with people's subjective experience, and to the degree that these concepts and propositions give order and meaning to subjective experience, the validities of these concepts and propositions are supported. These validities remain tentative, subject to new experience and new conceptual ordering. The validities of concepts and propositions introduced in this section are supported to the degree that they give order and meaning to the preceding experiential narrative.

This section will focus on the mutual influence of self and social context in ongoing interaction. The individual is constrained by social context while retaining some freedom to exercise choice (O'Brien & Sterne, 1986). The self is a real essence, not a conceptual reification. Each of us experiences a sense of self as an organizing principle in life. The self experiences feelings, learns new information, raises questions, organizes information in meaningful ways, makes decisions, and initiates action. A sense of self gives life continuity (Kotarba & Fontana, 1984).

### The Actualization Tendency

Human beings possess a tendency toward self-actualization, or becoming, but never fully realizing, the best that they can be. Humans react to a call to self-actualization from within themselves (Tageson, 1982). Genetic, biological, or sociocultural variables may encourage, shape, or constrain—but not completely suppress —this self-actualization tendency.

The mentally ill and mentally retarded patients that I came to know clearly demonstrated the actualization tendency. These people were severely hampered by genetic and biological factors, including low "intelligence" (moderately to severely retarded), seizures, short attention spans, and manic mood swings. The self-actualization of patients also was hampered by a social context that restricted interaction with persons and groups outside of the institution while encouraging compliant behavior and dependent, childlike views of self. Despite these obstacles, patients did move toward self-actualization. People who were

unable to talk developed their capacities to smile, wink, touch, or play jokes on staff, like flushing their diaper down the toilet. People who could talk would use laughter and speech to convey a sense of joy or encouragement to others. People who possessed a fair amount of inner strength would resist dependency on rewards from others, encouraged by behavior programming, and affirm their own individuality.

Abraham Maslow (1962) presents a hierarchical theory of self-actualization. Social contextual preconditions to self-actualization include freedom, justice, orderliness, and stimulation. The person first focuses on satisfaction of physiological needs. Once these physiological needs are at least partially met, the primary focus may be shifted to the satisfaction of basic needs, including safety and security, love and belongingness, and self-esteem and esteem by others. Once the person experiences at least partial satisfaction of both physiological and basic needs, some attention may be directed toward the fulfillment of growth needs. Degree of personal self-actualization becomes great when the person is able to reach significant, but never complete, satisfaction of growth needs.

My own experience supports the validity of Maslow's theory. When I separated from my wife and left the graduate program, I lost a sense of love and belongingness. As my life became increasingly more chaotic, I lost my sense of safety and security. So much of my attention was devoted to once again fulfilling these needs (new relationships, new career, new living arrangements) that I was unable to maintain my sense of esteem. By the time I became an inpatient, I believed myself to be incompetent and dependent. It was only when I was once again employed and able to construct a "normal lifestyle" (car, apartment, friends, fun) that I realized a renewed sense of safety and security, love and belongingness, and self-esteem.

Most of the mentally different patients with whom I worked were focused on the satisfaction of physiological, safety and security, and love and belongingness needs. Their lives were characterized by much chaos and little intimacy. Some patients would hide in their rooms in search of security. Others would act outrageously or steal items for the personal attention that these acts would bring. Physical abuse against self or others encouraged orderlies to respond with physical intimacy (touching, subduing, and/or wrestling). This physical intimacy from staff provided a certain sense of belongingness for patients.

The Will to Meaning

One of Maslow's growth needs, the need for existential meaning or purpose, is further articulated by Viktor Frankl (1984). Frankl transforms Maslow's affective need for meaning into a cognitive will toward meaning. He asserts that

we, as humans, are free to exercise this will, to adopt an attitude toward a situation, to realize meaning in our existence. He supports his assertion by describing his own will to meaning while imprisoned in a Nazi concentration camp.

My own experience during a time of mental difference validates Frankl's articulation of a will to meaning. In the midst of continuing personal pain, I would remind myself that if I could live and pass through this pain I would realize much self-growth and personal insight. I could then share this insight with others. I would imagine myself as a college professor, giving important lectures and writing insightful articles derived from my experience. This attitude toward my suffering introjected meaning into it. When I perceived myself as unable to return to graduate school, and therefore unable to become a college professor and share my insights, I chose to define my suffering as meaningless, and hence attempted suicide. Although past experiences and present circumstances had encouraged me to develop a very narrow focus, I could have made a different choice. I remained free to realize meaning in further suffering.

## Self-Labeling

Labeling theory often attributes the initial labeling act to someone other than the person who behaves in a deviant way. This other person invokes a stereotype to interpret the deviant act and then labels the individual as deviant. Over time the individual comes to accept the deviant label assigned by others (Scheff, 1963; Pfuhl, 1986).

My own experience with mental difference prior to hospitalization is *not* consistent with the preceding scenario. I did not experience that my supervisor, friends, family, or the psychiatrist labeled me as mentally ill. The psychiatrist carefully avoided assigning a label to my condition. Certainly my presence in the psychiatrist's office and the prescription of medication tended to validate the possibility of mental illness. But it was my own self, through the process of retrospective interpretation, that assigned a label to my mental difference (Pfuhl, 1986): "I can't sleep. Not being able to sleep is a sign of depression. I must be depressed"; or, later "It's abnormal to realize this much meaning from music, sense that a spirit lives in my home, and feel my emotions fall out on the floor. These experiences could be signs of schizophrenia. My father is schizophrenic. I must be schizophrenic."

The first significant labeling by others occurred when I entered the state hospital. I was labeled the victim of a "schizophrenic break." I was actually relieved to receive this label, because I had been labeling myself as schizophrenic for some time and now learned that schizophrenic breaks were often temporary. Given my age, it was quite possible that I would recover.

Institutionalization

Institutionalization is a social psychological process by which a mental patient and the institutional context interact to produce an increasing sense of dependency in the patient and the patient's belief that he or she cannot function outside the institution (Goffman, 1961). The consequences of institutionalization include depersonalization, segregation, self-mortification, self-labeling, and a sense of powerlessness. Institutional staff interpret the patient's behavior in terms of the label, and it becomes very difficult for the patient to escape from that label (Rosenhan, 1973).

As an inpatient, I experienced an introduction to institutionalization. When I was admitted to the state institution, my self-confidence was already very low. There was a certain comfort in the institutional routine. Not much was required of me. I could be quite passive. The presence of very long-term cases on my living unit forced me to think about the possibility that I, too, might not leave. We were very segregated from the outer world. No trips into the community were scheduled. I soon realized that the therapy was not really that therapeutic. I was terrified about returning to the outer world but also terrified about staying in the institution. When I tried to normalize my life by having a slight sexual relationship with a female patient, I was disciplined by hospital staff.

I remember wondering if I would remain within the institution for the rest of my life. There was a gentle whirlpool there that could suck you in: "Just go to group, go to therapy, do the dishes, and hang out. You'll never have to go back to that scary world again." I was fortunate in that I had an inner source of hope and good coping skills. I made a personal choice to leave the seductive privacy of the hospital; I formulated a plan and left the confines of the institution.

As a clinician, I observed both the process and human products of institutionalization. All patients were labeled with diagnoses, usually organic brain syndrome and/or schizophrenia. These diagnoses were master statuses. All patient behaviors were interpreted in terms of diagnoses. Even as staff implemented behavior programs upon their patients, these same staff expected patients to display deviant behavior. Patients were viewed as naughty children.

Treatment as Violence

Behavior programming, regarded as treatment within the institution, did violence to the selves of both patient and staff. As the severity of discipline increased, it was experienced by the patient as a threat to his safety and security and as violence against self. The patient fought violence with aggression toward staff. As staff continued to experience this escalating discipline and aggression pattern, it became difficult for them to rationalize the "treatment" as helpful to

the patient. Staff confronted their own aggression and their self-esteem declined. Hospital policy prescribed that the discipline procedure continue.

## Alienation

When I was mentally different, I experienced a great sense of alienation. This sense included feelings of loneliness, normlessness, meaninglessness, and isolation from self and others (Schact, 1984). I experienced self as an object that I could reflect on ("Am I crazy?") but not truly feel an identity with ("Is this really me?"). I experienced self not as a loving, creative person but as an object devoid of depth of feeling and adrift on an ocean of fate, without initiative or impact. Other persons were as objects in my perceptual field. I was unable to feel relationship with them or grasp their human essence.

## Invisibility

As a patient, my sense of alienation from the psychiatrist and the social worker probably had some basis in fact. I sensed that these persons related to me as a case to be processed in certain ways prescribed by their favorite psychotherapeutic approach. To the psychiatrist, I was a case to be processed in a nondirective way. To the hospital social worker, I was a case to be processed in a very rational way. In both instances, I was a case—an object. My own reality and the uniqueness of my experience were not validated by them. I felt unseen and invisible to them.

The common explanation of a patient's outbursts among hospital staff was "attention-getting behavior." This explanation holds insight. Biting, hitting, shouting, stealing, and/or throwing objects are ways for patients to proclaim their own uniqueness, to fight against the invisibility that accompanies the patient label (Ellison, 1972).

## Journey into Self

Laing (1967) describes the schizophrenic experience as inner journey. I believe Laing's observation may be expanded to include much experience labeled mental illness (including depression and various psychoses) and at least some experience labeled mental retardation.

The self most typically seeks information and stimulation outside the person, much of which involves interaction with others. However, sometimes the self will experience unbearable pain in the outer world and turn inward. Thus begins the inner journey.

Most people know little about the inner self because they focus their attention outside. Therefore, when the self turns inward, and the inner journey begins, the experience is one of isolation, loneliness, confusion, and fear.

Much of my own experience of mental difference is the journey into self: lack of meaning in school, alienation from self and others, a sense of abandonment, intense identification with music, my emotions lying on the floor, deep images of my father, a feeling of shame, a fear of duplicating my father's biography, and the courage to risk were all parts of my inner journey.

The images that I encountered during that inner journey are aspects of my adolescent experience, when my father became mentally different. These images remained as part of my self but unknown or barely recognized for years. My journey into self allowed me to reexperience these images.

Laing (1967) suggests that inner journey is a healing process when the journey is supported and allowed to continue until completion. Was my inner journey a healing process for me? Certainly it was. The healing continues as I further integrate the images of the inner journey into my present sense of self. For me, mental difference was a journey toward greater self-actualization.

In his argument, Laing places responsibility of chronic mental difference on treatments, practices, or events that prevent the patient from departing from the inner journey. However, I also believe that the self has the capacity to choose to remain in the inner journey or to return to an outer focus. I have experienced such a choice in my own life. Some people choose to remain mentally different; because for them the inner world—though often confusing—is less threatening than the outer world as they perceive it.

Mental Difference, Restrained Self-choice, and Actualization

The self exercises limited choice in the process of entering and departing from mental difference. The self chooses to seek or not to seek actualization, to experience or not to experience meaning in existence, to label or not to label self, to accept or to resist institutionalization, to accept or to resist treatment as violence, to experience or not to experience alienation, to accept or to protest invisibility, and to enter or to exit from the inner journey.

In a very dynamic fashion, past choices influence intervening experiences, present social context, and the person's frame. Frame is the self's perception of possible choices within the present social context. The self chooses in the present moment based on its frame.

An individual who has experienced the realization of many choices in the past will have a wide frame and will perceive many possible choices in the present. A person who has experienced the negation of many choices in the past

will have a narrow frame and may perceive as few as one or two choices in the present.

Each individual has a personal theory that rationalizes and justifies her frame. For instance, one person's theory may be, "I have usually been able to get what I want in the past. I have many abilities. Even if I make a wrong choice, I can change my mind." This personal theory rationalizes a wide frame, including many possible present choices. Another person's theory may be, "Few of my attempts to accomplish something ever work out. People don't respect my abilities; neither do I." This personal theory justifies a narrow frame, with very few possible present choices.

People who choose to become or to remain mentally different have a very narrow frame and a very restrictive personal theory. For instance, one person's frame may only include the options of committing suicide or becoming mentally different. Another person's frame may only include the options of remaining in a mental hospital or living all alone in a terrifying world.

Within the limitations of personal frame and personal theory, mentally different individuals display the tendency to make self-choices that they believe will lead to self-actualization. Behavior that appears to be immoral or amoral to the observer is generally the most moral option within the frame and theory of the person choosing that behavior. One person's frame and theory may suggest that she may become the best that she can be by choosing inner journey over external violence. Another person's frame and theory may suggest that he may become the best that he can be by embracing institutionalization rather than by trying to act independently, which he believes will inevitably lead to personal chaos.

Under the postulate of a universal self-actualization tendency, behavior that appears to be cruel, bizarre, or self-destructive is not an indicator of inadequate moral character or mental illness but rather indicates the limitations of personal frame and theory. As clinicians, we should seek to understand the personal frame and theory of those who are mentally different so that we may also understand the morality of their choices. We should then help such individuals to expand their personal frame and theory so that they may strive for self-actualization by choosing among a wider range of perceived behavioral options.

## Conclusions

This paper has interpreted a unique part of my biographical experience using concepts and propositions of humanism, existentialism, and symbolic interactionism. Mental difference is a social psychological process that includes self-negation or affirmation of personal meaning, self-labeling, institutionaliza-

tion, treatment as violence, alienation, invisibility, journey into restrained choice of self, and self-actualization.

All people seek self-actualization. Badness or personal defect are only labels applied by persons who express judgment without true understanding. Mental difference is the outcome of variations in biographical experience, social context, personal frame, personal theory, and self-choice. By first recognizing that all persons, including the mentally different, exercise restrained choice in determining their own fate, we may then gain a better understanding of how biographical experience, personal theory, personal frame, and social context influence a person's choice to embrace or resist mental difference. By affirming the responsibility of restrained choice among mentally different people, we are empowering them and affirming their human dignity and worth (O'Brien & Sterne, 1986).

## ACKNOWLEDGMENTS

## NOTES

1. The term "patient" is used throughout this paper. While I prefer the term "person," "patient" offers greater clarity to the reader.

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