Practical Alternatives to the Psychiatric Model of Mental Illness

Beyond DSM and ICD Diagnosing

Edited by

Arnoldo Cantú, Eric Maisel, and Chuck Ruby

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To Dara, my loving and unwavering rock,

who has helped keep me sane in an insane world.

-AC

Contents

Setting the Stage

The Alternatives

Editor's Introduction

Arnoldo Cantú

"Get it out of me!" This was how a bright 17-year-old male I saw for therapy described his response to be as he recounted the moment during which he, as a child, was told he had "ADHD" by his pediatrician. That story has stuck with me—the panic and fatalism he reported feeling. And in my time working as a clinician helping children, families, and adults share their stories while I, simultaneously, dictated it for them through the act of affixing a psychiatric diagnosis (primarily for billing and insurance purposes, at least here in the US), the cognitive dissonance has only amplified.

The philosopher Kwame Anthony Appiah wrote a provocative book entitled *The Lies That Bind: Rethinking Identity* in which he argued that certain notions of identity, such as those predicated on race and nationality, are built on inconsistent, unstable, and disjointed ideas.[1] I contend that "mental disorder" is an additional contemporary example of a lie that binds humanity given their intractable and questionable, at best, epistemological foundations—and the longstanding universality of human suffering they erroneously continue to mislabel.

Therefore, this volume is an attempt at helping the reader learn of and understand different ways of supporting people experiencing difficulties—conceptualizations that an individual would ordinarily be described as suffering from a "mental disorder" or "mental illness." This book recognizes and appreciates standing on the shoulders of giants; that is, those who have contributed to the abundance of literature critiquing the biomedical model of mental health and practice of psychiatric diagnosing. As such, this an attempt to move *past* that rhetoric and discourse—and,

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[1] Appiah, K. A. (2018). *The lies that bind: Rethinking identity*. Liveright Publishing Corporation.

instead, envision *practical* and *implementable* alternatives to psychiatric diagnosing.

In short, the aim of this volume is to help people walk away with ideas and novel thinking for alternative yet practical ways of working with people without having to resort to medicalizing and pathologizing their experiences—to sidestep and resist the pull of the traditional and predominant biomedical model's ritual of affixing questionable psychiatric diagnoses onto vulnerable individuals as a way to "explain" and "treat" their suffering and difficulties—lest we perpetuate the deception and oppression.

When I told the 17-year-old male that not only is "ADHD" and its concomitant menu of mental disorders controversial, but that there are other ways to help (provisionally) make sense of—and address—his difficulties, a noticeable look of relief and hopefulness appeared on his face. As I have argued elsewhere, "[T]he default setting of the human experience is to consist of challenges and suffering. Dysfunction is normal and having problems is to be expected throughout a lifetime. As such, when struggling we deserve to enter systems of care that will lift us up, rather than tell us what, at our existential core, is wrong or 'disordered' with us while we are already suffering."[2] It is my hope that this volume can provide the reader with a refreshing, newfound set of tools for going about doing that.

Disclaimer: *If you or anyone you know is taking a prescriptive psychiatric medication for any reason deemed appropriate by the prescribing physician, alteration or discontinuation of the drug(s) is not recommended by any of the information provided by the reading material found in this volume, Similarly, the content in this book should not be interpreted, directly or indirectly, as suggestions for any other current support (e.g., psychotherapy, counseling) to be abruptly discontinued without discussion with your healthcare provider.*

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[2] Cantú, A. (2023). Toward a descriptive problem-based taxonomy for mental health: A nonmedicalized way out of the biomedical model. *Journal of Humanistic Psychology*, 1–24. https://doi.org/10.1177/00221678231167612, p. 17.

Setting the Stage

The Myth of Psychiatric Diagnosis

Wayne Ramsay

Abstract: *Psychiatric diagnosis can determine who is hired for a job, who can be licensed to practice law or medicine, or pilot an airplane, or legally possess a firearm, or have custody of their children. The stigma of a psychiatric diagnosis can ruin or end careers. People who have never committed a crime are involuntarily committed to institutions for days, weeks, years, or a lifetime because of psychiatric diagnosis. People who have committed crimes are excused from responsibility as not guilty by reason of insanity because of psychiatric diagnosis. In this chapter, the author shows psychiatric diagnosis is unscientific, arbitrary, and unreliable and should never be the reason for a decision.*

In a telephone conversation with a state legislator who at the time was Speaker of her state's House of Representatives, and who had been quoted in a newspaper saying she was proud to have sponsored legislation requiring health insurance policies to pay for psychiatric treatment, I referred to people being "accused of mental illness." She disagreed with or corrected me, saying "It's not an accusation. It's a diagnosis."

People who disagree with the concept of mental illness and with the associated idea of psychiatric diagnosis call psychiatric diagnoses "labels." Such critics allege psychiatric "diagnoses" or labels are no more scientifically valid than pejorative nonscientific insults. As psychologist Jeffrey Schaler said in 2006:

> Think of how when people get angry with one another, they inevitably resort to some kind of diagnosis. They say, "You're crazy! You're mentally ill! You're paranoid!" Can you imagine somebody

> getting angry with someone and saying, "You have diabetes! You have Parkinson's Disease!"[1]

Accusing someone of mental illness is an insult. Accusing someone of having diabetes or Parkinson's Disease or any other physical illness is not. Because we do not live our lives in isolation but in a society of other people, and because a psychiatric "diagnosis" can change how other people treat a person, a psychiatric "diagnosis" can deprive a person of many of life's most important opportunities and can harm or ruin a person's life. The childhood taunt, "Sticks and stones can break my bones, but words can never hurt me" is simply not true if the words are a psychiatric "diagnosis." As was said by psychiatry professor Thomas Szasz, M.D.,

> The problem with psychiatric diagnoses is not that they are meaningless, but that they may be, and often are, swung as semantic blackjacks: cracking the subject's dignity and respectability destroys him just as effectively as cracking his skull. The difference is that the man who wields a blackjack is recognized by everyone as a thug, but the one who wields a psychiatric diagnoses is not.[2]

Psychiatric "diagnosis" can result in a person who seems normal to the average person, and who is law-abiding, spending his or her whole life imprisoned in a mental institution rather than living in freedom. Psychiatric "diagnosis" can defeat the proper functioning of the system of justice, examples being a person being found not guilty by reason of insanity and avoiding punishment for a serious crime, or a good parent losing custody of his or her child. In an interview on February 11, 2012, psychologist Paula Caplan, Ph.D. said:

> [P]sychiatric diagnosis is the fundamental building block of everything else bad that happens in the mental health system. If you don't get a label, you can't get put on drugs that might help you but are more likely to hurt you. If you don't get a label, then you can't lose your job or custody of your kids or your legal rights because of

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[1] "Jeffrey A. Schaler, Ph.D., Professor of Psychology", https://www.youtube.com/watch?v=_-iYngr6N60 at 4:05

[2] Thomas S. Szasz, M.D., *The Second Sin*, Anchor Press, 1973, p. 71

> having a label…When you hear somebody say "I lost custody of my children because I had a label that I thought was pretty mild, but you know what—it 'proved' that I'm mentally ill, and they took my children away from me."…You can't hear these stories…year after year…and not try to do something about it. People's lives have been destroyed by getting a psychiatric label.[3]

In his book *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life* (2013), psychiatrist Allen Frances, M.D. says this:

> I led the Task Force that developed *DSM-IV* [American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition] and also chaired the department of psychiatry at Duke [University], treated many patients ... *DSM* has gained a huge societal significance and determines all sorts of important things that have an enormous impact on people's lives—like...who gets to be hired for a job, can adopt a child, or pilot a plane, or qualifies for life insurance ... Done poorly, psychiatric diagnosis can be an unmitigated disaster leading to aggressive treatments with horrible complications and life-shattering impact…Psychiatric diagnosis is a serious business with major and often lifelong consequences."[4]

In Chapter 3 of *Saving Normal*, "Diagnostic Inflation," Dr. Frances includes a section quite appropriately titled "The Power to Label Is the Power to Destroy."[5] Because of the damaging, even life-ruining power of psychiatric diagnosis (or of psychiatric "labels"), the validity, accuracy, reliability, and predictability of psychiatric diagnosis is important. Investigations repeatedly reveal psychiatric diagnosis has *no* reliability or validity.

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[3] MindFreedom Live Free Web Radio: "Paula Caplan v. Psychiatric Labeling!", https://www.blogtalkradio.com/davidwoaks/2010/03/13/ mindfreedom-mad-pride-live-free-web-radio

[4] Allen Frances, M.D., *Saving Normal: An Insider's Revolt Against Out-of-Control Psychiatric Diagnosis, DSM-5, Big Pharma, and the Medicalization of Ordinary Life,* Harper Collins, 2013, pp. xi, xii, 277

[5] *Id.*, p. 109

In 1887, Nellie Bly (1867-1922), a newspaper reporter, feigned insanity to gain admission to New York's Blackwell's Island insane asylum. She described how she did it and what she saw at the asylum in a book titled *Ten Days in a Mad House*. "I had little belief in my ability to deceive the insanity experts," she wrote in Chapter 1, and in Chapter 2, "to be examined by a number of learned physicians who make insanity a specialty, and who daily come in contact with insane people! How could I hope to pass these doctors and convince them that I was crazy?" In Chapter 6 while at Bellevue Hospital, after it was apparent she had succeeded before her transfer to Blackwell's Island, she wrote:

> And so I passed my second medical expert. After this I began to have a smaller regard for the ability of doctors than I ever had before, and a greater one for myself. I felt sure now that no doctor could tell whether people were insane or not.

In chapter 7, listening to Tillie Mayard, a fellow patient at Bellevue Hospital who had just found out she was in an insane asylum after being told she was going to a "convalescent ward to be treated for nervous debility," Nellie Bly heard Ms. Mayard say to a doctor, "If you know anything at all you should be able to tell that I am perfectly sane. Why don't you test me?" Bly said the doctor "left the poor girl condemned to an insane asylum, probably for life, without giving her one feeble chance to prove her sanity." In Chapter 8, Bly describes this same Tillie Mayard pleading with a doctor after arriving at Blackwell's Island insane asylum:

> I could hear her gently but firmly pleading her case. All her remarks were as rational as any I ever heard, and I thought no good physician could help but be impressed with her story…She begged that they try all their tests for insanity, if they had any, and give her justice. Poor girl, how my heart ached for her! I determined then and there that I would try by every means to make my mission of benefit to my suffering sisters; that I would show how they are committed without ample trial.

Of herself, Bly wrote in Chapter 1:

> From the moment I entered the insane ward on the Island, I made no attempt to keep up the assumed *role* of insanity. I talked and acted just as I do in ordinary life. Yet strange to say, the more sanely I talked and acted, the crazier I was thought to be by all except one physician, whose kindness and gentle ways I shall not soon forget.

Of her own departure from Blackwell's Island, after intervention by her editor, she said:

> I left the insane ward with pleasure and regret—pleasure that I was once more able to enjoy the free breath of heaven; regret that I could not have brought with me some of the unfortunate women who lived and suffered with me, and who, I am convinced, are just as sane as I was and am now myself.

A similar experiment was done in the 1970s by Stanford University psychology professor David Rosenhan and his colleagues that was published in 1973 in *Science* magazine.[6] Dr. Rosenhan and seven of his colleagues who had no history of or evidence of mental illness (called "pseudopatients" in the study) went to 12 different psychiatric hospitals on the East and West coasts of the U.S.A. as inpatients where they remained as long as 52 days. They found that no matter how normally they behaved they were not recognized as normal by the psychiatrists and other mental health professionals they came in contact with.

Despite being normal, all were prescribed psychiatric drugs: "All told, the [eight] pseudopatients were administered nearly 2100 pills, including Elavil, Stelazine, Compazine, and Thorazine," which undermines the commonly held belief psychiatric drugs are given only to people who need them. (A more important question is whether *anybody* needs psychiatric drugs: see Peter R. Breggin, M.D., *Psychiatric Drugs: Hazards to the Brain* [1983], *Brain Disabling Treatments in Psychiatry, Second Edition* [2008], or

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[6] *Science* magazine, "On Being Sane in Insane Places", Vol. 179 (January 19, 1973), pp. 250-258; available online at https://www.canonsociaalwerk.eu/1971_stigma/1973%20Rosenhan%20Being%20sane%20in%20insane%20places%20OCR.pdf

Joanna Moncrieff, M.D., *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment* [2009]).

When the results of this experiment were revealed to the psychiatrists and other staff members of another psychiatric hospital, they "doubted that such an error could occur at their hospital." Dr. Rosenhan said "The staff was informed that at some time during the following 3 months, one or more pseudopatients would attempt to be admitted into the psychiatric hospital." During that time the hospital staff identified "Forty-one patients...with high confidence, to be pseudopatients…Twenty-three were considered suspect by at least one psychiatrist. ... Actually," said Dr. Rosenhan, "no genuine pseudopatient (at least not from my group) presented himself during this period."

Dr. Rosenhan concluded that the inability of psychiatrists and other mental health professionals to distinguish normal persons, such as himself and his colleagues, from true mental patients is "frightening." He said:

> How many people, one wonders, are sane but not recognized as such in our psychiatric institutions? How many have been needlessly stripped of their privileges of citizenship, from the right to vote and drive to that of handling their own accounts? How many have feigned insanity in order to avoid the criminal consequences of their behavior, and conversely, how many would rather stand trial than live interminably in a psychiatric hospital — but are wrongly thought to be mentally ill? How many have been stigmatized by well-intentioned, but nevertheless erroneous, diagnoses?[7]

In his book *Psychiatry: The Science of Lies*, psychiatry professor Thomas Szasz, M.D. says:

> The assertion rests on an erroneous premise, namely, that the doctors were interested in distinguishing insane inmates properly committed from sane inmates falsely detained. The whole history of psychiatry belies this assumption…each time experience was

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[7] *Id.*, canonsociaalwerk.eu, p. 184

> consulted, it showed that the experts were unable to distinguish the sane from the insane.[8]

A study titled "Suggestion Effects in Psychiatric Diagnosis" by psychologist Maurice K. Temerlin, Ph.D. published in 1968 explored "interpersonal influences which might affect psychiatric diagnosis" by having "psychiatrists, clinical psychologists and graduate students in clinical psychology" diagnose a "sound-recorded interview with a normal, healthy man."

When they heard the tape-recorded interview after introductory remarks by "a professional person of high prestige" saying the interview was with a perfectly healthy man, the "psychologists, psychiatrists, and graduate students agreed unanimously." When the tape-recording was heard by a group after introductory remarks by "a professional person of high prestige" saying the recorded interview was with a man who "looked neurotic but actually was quite psychotic…diagnoses of psychosis were made by 60 per cent of the psychiatrists, 28 per cent of the clinical psychologists, and 11 per cent of the graduate students," even though they had listened to the same tape-recording.[9] This study like others shows psychiatric diagnosis has *no* reliability and no validity.

Psychiatrist Allen Frances criticizes the lack of science and the pathologizing of normality in both his own and the current *DSM* in articles, lectures, and his book, *Saving Normal*. Lecturing at the University of Toronto on May 6, 2012, he said "We're giving too much treatment to people who don't need it."[10] In his book *Saving Normal*, Dr. Frances says overly broad psychiatric diagnostic criteria have caused "false epidemics of autistic, attention deficit, and adult bipolar disorder, and ... of several other disorders."[11] In an article on November 8, 2011 he said, "Since the DSM 5 suggestions will all broaden the definition of mental disorder, why

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[8] Thomas S. Szasz, M.D., *Psychiatry: The Science of Lies*, Syracuse University Press, 2008, pp. 67-68

[9] Maurice K. Temerlin, *The Journal of Nervous and Mental Disease* Vol. 147, No. 4, pp. 349-353

[10] "Allen J. Frances on the overdiagnosis of mental illness", https://www.youtube.com/channel/UCHCmjknv18tgygUD7d38lkQ at 29:30

[11] *Saving Normal* (see note 4, above), p. 75.

should we not worry about diagnostic inflation and the massive mislabeling of normal people as mentally ill?"[12]

Bona-fide diagnosis reveals the *cause* of a problem. A psychiatric "diagnosis" does not do that. A psychiatric "diagnosis" is merely a *description* of disliked behavior.

In his book *Psychiatry: The Science of Lies*, psychiatry professor Thomas Szasz, M.D. says "Modern psychiatry—with its *Diagnostic and Statistical Manuals* of nonexisting diseases and their coercive cures—is a monument to quackery on a scale undreamed of in the annals of medicine."[13]

According to U.S. National Institute of Mental Health (NIMH) director Thomas Insel, M.D., in an article published on the NIMH web site on April 29, 2013, "The strength of each of the editions of DSM has been 'reliability'—each edition has ensured that clinicians use the same terms in the same ways. The weakness is its lack of validity." (Validity means *truth.*) For this reason, Dr. Insel says, the "NIMH will be re-orienting its research away from DSM categories."[14] No less than America's preeminent mental health government agency has rejected American Psychiatric Association's *DSM* "diagnosis."

Dr. Insel seeks to substitute an equally invalid approach. In the same article he says "Mental disorders are biological disorders involving brain circuits" and that the NIMH will seek to create "a new nosology" that is more scientific than that of the *DSM,* one based on biological factors.[15] Because the defining characteristic of a mental "illness" or "disorder" is merely *disapproval,* and biology is no more the cause of mental illnesses or disorders

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[12] Allen Frances, M.D., "APA Responds Lamely to the Petition to Reform DSM-5", November 8, 2011, https://www.psychologytoday.com/us/blog/dsm5-in-distress/201111/apa-responds-lamely-to-the-petition-to-reform-dsm-5

[13] Thomas S. Szasz, M.D., *Psychiatry: The Science of Lies*, Syracuse University Press, 2008, pp. 18-19

[14] Thomas Insel, M.D., "Director's Blog: Transforming Diagnosis", April 29, 2013, https://web.archive.org/web/20130527220058/ http://www.nimh.nih.gov:80/about/director/index.shtml

[15] *Id.*

than electronics are the cause of bad television programs, this NIMH effort is doomed to failure.

Contrary to Dr. Insel's observation, the *DSM-5* interrater reliability results were actually poor, at least in the opinion of *DSM-IV* and *DSM-IV-TR* Task Force chairperson Allen Frances, M.D. In his book *Saving Normal,* Dr. Frances says this:

> APA [American Psychiatric Association] flunked — instead of admitting that its reliability results were unacceptable and seeking the necessary corrections that might meet historical standards, the goalposts were moved. Declaring by fiat that previous expectations were too high, *DSM-5* announced it would accept agreements among raters that were sometimes barely better than two monkeys throwing darts at a diagnostic board.[16]

In an article titled "A Response to 'How Reliable Is Reliable Enough?'" on January 18, 2012, Dr. Frances said:

> In the past, "acceptable" meant kappas of 0.6 or above…For DSM-5, "acceptable" reliability has been reduced to a startling 0.2-0.4. This barely exceeds the level of agreement you might expect to get by pure chance. ... Can "accepting" unacceptably poor agreement uphold the integrity of psychiatric diagnosis?[17]

So, actually, psychiatric diagnosis not only has no validity (truth), but also no "reliability" (agreement among observers).

Because psychiatric diagnosis has neither validity nor reliability, nor general acceptance even within psychiatry, it does not meet legal criteria for acceptance as scientific or expert evidence in courts of law under either of the standards applied by courts in the U.S.A., namely, the *"sufficiently established and accepted"*[18] standard of *Frye v. U.S.,* 293 F. 1013 (D.C. Cir.

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[16] *Saving Normal* (see above, note 4), p. 175

[17] Allen Frances, M.D., "A Response to 'How Reliable Is Reliable Enough?'", January 18, 2012, https://www.psychiatrictimes.com/view/response-how-reliable-reliable-enough

[18] As interpreted in *Diaz v. Secretary*, 2:14-cv-91-JES-MRM (M.D. Fla. Sep. 27, 2021), footnote 8, https://casetext.com/case/diaz-v-secy-doc-1

1923) that is used in some states, nor the *scientific validity* standard of *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993) that applies in federal courts and other states of the U.S.A.[19]

Courts should recognize this and stop accepting psychiatric testimony. Involuntary commitment law typically requires commitments be based on "competent psychiatric testimony." For example, Texas Constitution Article 1, Sec. 15-a provides that "No person shall be committed as a person of unsound mind except on competent medical or psychiatric testimony." However, there is no such thing as "competent psychiatric testimony" any more than there is, for example, "competent astrology testimony" or "competent palm reader testimony."

In her book *Whores of the Court: The Fraud of Psychiatric Testimony and the Rape of American Justice*, Boston University psychology professor Margaret Hagen, Ph.D., laments the fact that "we buy the accreditation of psychiatry at medical schools as if it were on the same standing as any other medical specialty" when it is not. She says, "Judges and juries, the people alone, must decide questions of insanity, competence, rehabilitation, custody, injury, and disability without the help of psychological experts and their fraudulent skills." She adds that by accepting psychiatrists and psychologists as expert witnesses in court, "Society has created its own monster".[20]

How much of a monster we have created by recognizing psychiatric and psychological diagnosis as valid (when it is not) is illustrated by Robyn M. Dawes, Ph.D., a psychology professor at Carnegie-Mellon University, former head of the psychology department at the University of Oregon, and former president of the Oregon Psychological Association, in his book *House of Cards: Psychology and Psychotherapy Built on Myth*. He tells a true story of a young woman who was determined to need involuntary commitment to a state mental hospital because of her interpretation of a single inkblot in what is known as the Rorschach inkblot test.

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[19] "Frye Standard", https://en.wikipedia.org/wiki/Frye_standard

[20] Margaret Hagen, Ph.D., *Whores of the Court: The Fraud of Psychiatric Testimony and the Rape of American Justice*, Harper Collins, 1997, pp. 303, 313 & 310

He says on the basis of her interpretation of a single inkblot (she thought it looked like a bear), the young woman was "diagnosed" as schizophrenic and (italics are Dr. Dawes'): "*The staff—over my objection—further agreed that if her parents were ever to bring her back, she should be sent directly to the nearby state hospital*…she may well have been condemned to serve time in that snake pit on the basis of a single Rorschach response."[21] Dr. Dawes says psychiatrists and psychologists lack expertise and "should be thrown out of court."[22]

The bottom line is this: Psychiatric diagnosis is nonsense and should be ignored by all. Psychiatric diagnosis serving as the basis of state and federal laws and judgments of courts is the triumph of pseudoscience over justice.

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[21] Robyn M. Dawes, Ph.D., *House of Cards: Psychology and Psychotherapy Built on Myth*, Free Press, 1994, p. 153-154

[22] *Id.*, p. 25.

The Alternatives

Restoring the Humanity in Human Services: Pathways Vermont's Relationship-First Practice

J River Helms

Abstract: *In this chapter, the author outlines the principles of Pathways Vermont's Relationship-First Practice: humanity, authenticity, collaboration, humility, curiosity, and hope. Readers will gain insight into the efficacy and sustainability of a practice that centers lived experience as expertise and conceptualizes discomfort and challenges in relationships as opportunities for growth, learning, and transformation. Our Relationship-First Practice is rooted in the disability justice, mad pride, and psychiatric survivor movements—and is inspired by various frameworks including harm reduction, the social model of disability, trauma-informed care, and person-centered care. This practice offers a practical alternative to the way services are provided under the medical model of mental illness, which has long fostered disconnection, inauthenticity, fear, coercion, and control in human services systems. Through the principles of our Relationship-First Practice, service providers and service participants co-create collaborative relationships that inspire and welcome change: roles aren't always static; experiences aren't only ever regarded as chronic or permanent; and beliefs about self, relationships, and the world shift. Utilizing this practice allows service providers to establish and build relationships that are more sustainable long-term as well as participate in transformation that extends beyond the relationship into social and systems change.*

Pathways Vermont is a social justice organization that seeks to build community, increase connection, and support autonomy, choice, and self-determination by providing housing services and innovative mental health alternatives across the state of Vermont. Many Pathways staff come to this work with their own lived experiences including psychiatric diagnoses, thoughts of suicide, extreme states, hearing voices, self-harm, substance use challenges, homelessness, institutionalization, and incarceration.

In our experience working within the human services system (as well as receiving services ourselves), we've observed that service providers are often taught to distance themselves from service participants in various ways: they're discouraged from talking about their lives outside of their work (though life and work overlap for most, if not all, of us); they're discouraged from talking about their own relevant lived experience; or they're discouraged from showing up authentically or connecting with service participants on a human-to-human level. These conditions are, in part, byproducts of the psychiatric model of mental illness.

At base, the psychiatric model asserts a "normal" or "acceptable" range of human emotion and behavior; experiences outside of this range are pathologized as mental disorders or illnesses that require treatment (nay, *correction*) with interventions such as psychiatric drugs, institutionalization, and therapy. Throughout the history of this model, its assertions of "normal" or "acceptable" have been rooted in various oppressive systems and ideologies including white supremacy, colonialism, capitalism, patriarchy, heteronormativity, cisnormativity, and ableism.

Rather than diagnose a society and its systems as oppressive and unjust, the approach has been to pathologize individual people for their identities, emotions, actions, and desires as well as their resistance to oppression, injustice, and inequity. The model has decontextualized the complex, nuanced experiences of human beings and framed a person's response to their circumstances as the problem.

We want to be clear: we do not seek to begrudge, judge, or shame individual people who find meaning in personally identifying with a mental illness or psychiatric label. We know that some feel validated by a diagnosis—that a psychiatric label can feel like an answer to a question that's previously been painfully unanswerable. We value choice, autonomy, and self-determination—and this means that we support people to make meaning in ways that work for them individually.

We also seek an alternative to the psychiatric model of mental illness which has, by and large, located social problems within individual people—precisely because we value choice, autonomy, and self-determination. The psychiatric model of mental illness has created a process of othering that's been used to justify coercion, force, restraint, isolation, abuse, sterilization, and genocide. There is no use in downplaying or tiptoeing around this history and context.

Our work at Pathways Vermont is driven by our commitment to disability justice. We are particularly informed by the social model of disability. In this model, disability is not regarded as a "problem" located within an individual person in need of "fixing" or "correcting." Instead, our focus must be on addressing and dismantling social barriers that are disabling. We're all impacted by social barriers, our nuanced experiences of the world, and the things that have happened to us, though many of us have been taught to decontextualize the suffering of others—to practice sympathy rather than empathy, to "fix" rather than to understand—and, in turn, to decontextualize our own suffering.

To do this is inherently protective, of course: to truly be with and understand someone in their suffering is hard, to truly be with and understand our own suffering is hard. If I'm disconnected from the suffering of others as well as my own suffering, then I don't have to acknowledge the ways that each of us are impacted by grief, loss, disempowerment, inaccessibility, discrimination, inequity, and injustice. This disconnect robs us from doing the profound, meaningful work of exploring possibilities, creating change, and inviting growth and transformation. The social model of disability suggests that, in order for anything to truly change, we all have to work towards change together.

Since our inception in 2010, Pathways Vermont has been trying to do something different—to put the human back in human services and create change through our Relationship-First Practice. We recognize providing services is not about an "us versus them" (service providers versus service participants) dynamic. Service providers are not "whole" and service participants are not "broken"—we believe that we are all part of the human experience, that service providers and service participants are linked together in community.

Our Relationship-First Practice necessitates that service providers reconnect with their humanity, tune into their own emotions, and show up authentically in their relationships. We recognize that there are social barriers and systems of oppression that seek to disconnect us from ourselves and each other because disconnection and disempowerment go hand in hand. Our Relationship-First Practice is meant, in part, to be an antidote to disconnection and disempowerment.

This practice also asks (nay, *requires*) service providers to tolerate and even embrace discomfort in their relationships with service participants. Discomfort is, after all, frequently a precursor to learning, growth, and transformation. And we've seen the harm that can be done when people in positions of power struggle to tolerate discomfort in relationships—discomfort becomes fear, fear leads to seeking control.

Our Relationship-First Practice serves as a reminder that even when we're afraid, even when nothing makes sense or everything feels hard or impossible in a relationship with a service participant, we're in a relationship *first*, so we always have a starting place. To illustrate our Relationship-First Practice, here's a bit about my relationship with a Pathways service participant who consented to having this story about his self-harming experience shared:

When I was a service coordinator in our Housing First program, I supported a service participant who sometimes self-harmed, cutting in particular. One afternoon we were on a hike (we often went for walks during our time together, Vermont weather permitting) and he told me he'd recently cut using an X-Acto knife. We talked about how he used self-harm as a strategy when his distress became overwhelming (in this case, his feelings about an anniversary related to a significant traumatic experience).

He reflected that the cutting was a tool he used to make his distress feel more manageable. I validated his experience and conveyed my appreciation that he had a tool that worked for him. I spoke about my own history of getting tattoos during times of intense distress—how the process of being tattooed reminded me that pain and distress can be transformative.

He noted that the wound from the cut was long and somewhat deep. My authentic response at that moment was concern that his wound may become infected if not cared for properly; I asked if I could share my concerns with him and he consented. He said that he did not want to have an infected wound. I asked if I could look at the wound with him (he was wearing long sleeves that day and his forearm, where he'd cut, was covered). He consented and lifted his sleeve to show me his wound which, as he'd described, was long and somewhat deep.

Together we talked about options for wound care and bandaging. I offered that we could stop by the store for wound care supplies on the way back to his house, though he said he didn't need that support. We continued our hike and conversation for another hour or so during which we explored the meaning of the distress he was experiencing and talked about various other unrelated topics.

I believe this experience highlights the principles of our Relationship-First Practice: *Humanity. Authenticity. Collaboration. Humility. Curiosity. Hope.* I trusted this service participant as the expert of his own experience. I acknowledged and validated that he used self-harm as a survival strategy. I shared some about my own experiences with navigating distress. With his consent, I voiced my own concerns about wound care and together we had a mutual conversation wherein I offered support that he declined. I did not try to problem solve nor change or control his experience.

My approach was to show up authentically, center our relationship, remain curious, and, above all, trust him and his capacity to know and meet his own needs. This experience changed my life. My relationship with this service participant changed my life. Together we practiced vulnerability and connected about some of our deepest pains. We talked about our needs, we made meaning together, we trusted each other, and we co-created a relationship that became a transformative space. This was all possible because we tolerated discomfort together, focused on the relationship first, and built something truly authentic and collaborative.

How do we build relationships rooted in authentic human connection?

First and foremost, we trust service participants as experts of their own experiences. At Pathways Vermont, we do not train staff to show up to relationships thinking they need to have all the answers or solve all the problems a person might be experiencing.

We train staff to show up with humility, curiosity, and a willingness to learn alongside the folks they're paid to support. We prioritize autonomy, choice, self-determination, and mutual responsibility. We understand that it's an honor to be part of someone's journey and we treat it as such, even on tough days (and sometimes there are some really tough days!).

We talk about the relationship, how things are going, what's working well, what feels challenging or difficult, and how we might try something different. We understand that relationships change over time because people change over time. We aspire to be flexible and to remember that each interaction is new—an intense disconnect last week doesn't mean that today's visit won't go well.

We utilize this practice across our programs: permanent supportive housing and rapid rehousing, a peer support warmline, a community center, and our Soteria House (a therapeutic residential program for folks experiencing extreme states often referred to as "psychosis"). We've found that this practice works well for everyone involved—service participants and service providers alike, regardless of their background and lived experience—because the focus is on collaboration and building meaningful, authentic relationships.

In our practice, traditional helper-helpee dynamics and clinical notions of expertise are left behind and relationships become co-creative spaces. Each person is understood to have valuable wisdom, insight, and knowledge. Power imbalances are directly addressed, and power is shared in relationships. When collaboration is the focus, service providers and service participants can explore opportunities for meaning-making and figure out together how to build a sustainable relationship dynamic. This practice minimizes coercion and centers the transformative power of building authentic and collaborative relationships.

Through collaborative relationships, each person has the opportunity to learn and grow because there's shared understanding and agreement about what the relationship means, how it works, each person's needs and expectations, and each person's capacity to contribute—all of which may be continuously negotiated throughout the relationship. As such, collaborative relationships inspire and welcome change: roles aren't always static, experiences aren't only ever regarded as chronic, and beliefs about self, relationships, and the world can shift.

Collaborative service relationships are rooted in the belief that all people, including service participants, have the capacity for self-defined and self-determined change and growth, that each person can build a different life for themselves if they so desire. We know a service relationship works when each person communicates openly and honestly, talks about their needs and boundaries, and gives feedback (not just positive!) to let the other person know what is/isn't working for them. We co-create service relationships via the following principles:

Humanity

We encourage service providers to show up as their **whole, human selves** in service relationships. This requires intentional ongoing self-reflection: *Who am I? What pieces of myself do I want to bring to my service relationships? How do I make meaning? How do I move through my own fear and discomfort? What dynamics do I fall into? Are there dynamics that I want to change?* This self-reflection inspires curiosity and flexibility. Relationships work well when they're dynamic and flexible (not static and rigid) because humans are dynamic.

We invite service participants to show up as their whole selves, too—to reflect on how they've made meaning out of their experiences and to share with us what they feel comfortable sharing. This practice is trauma-informed and person-centered. Trauma is fundamentally about a loss of power and identity. When a service participant is able to show up as their whole self and experience empathetic support without judgment or coercion, they're able to (re)claim their power within relationships and be authentic. When a service provider is able to show up as their whole self, they're able to build authentic, sustainable relationships.

There is much value in hiring staff with various backgrounds and lived experiences, including folks who've experienced homelessness, folks who've received psychiatric diagnoses, folks who've experienced extreme states, folks who've considered and/or attempted suicide, folks who've experienced challenges with substance use, and folks who've been institutionalized or incarcerated. Lived experience is an asset to service relationships.

Service providers can share pieces of their experiences in ways that are mutual, meaningful, and intentional in their relationships with service participants. Mutuality and intentionality are key here: service providers aren't encouraged to utilize their relationships with service participants for therapeutic benefit, though mutual relationships can certainly be therapeutic and healing! Service providers are encouraged to recognize that connecting about shared or similar experiences can be powerful and meaningful.

An example: a trans service provider who has navigated legally changing their name may offer support to a trans service participant who is navigating the name change process—this service provider is not expected to share their experience, though they're also not expected to act as if they don't have their own experience or feel like it's "crossing boundaries" or an "ethical" issue to share intentionally about their experiences.

We've found that service relationships work well when service providers don't feel pressured to fit some predetermined mold of detached expertise or hide experiences they may have in common with service participants. This principle is not about creating an us (service providers) and them (service participants) dynamic—it's about recognizing that we're all in community together. Empathy is more possible when each person shows up as their whole self and is not disconnected from their emotions and experiences.

Authenticity

We encourage service providers to be **authentic** and treat service participants as community members (because they are community members!). What does this mean? Be honest about your needs, boundaries, and limitations. Be upfront about expectations. Embrace difficult conversations—share your authentic response when a disconnect or conflict happens with a service participant and invite them to do the same.

Don't fall back on "program rules" to avoid having an uncomfortable conversation. Have honest conversations about natural consequences. Don't treat participants as if they're fragile or try to protect them from having difficult experiences.

If you're having a rough day, it's okay to say so! Service providers don't need to "turn off" their emotions and experiences at work. If a service participant or fellow service provider says or does something that stirs up some emotion for you, it's okay to acknowledge it. Moments of disconnect and conflict often take up space and energy within the relationship, so it makes sense for service providers to talk about these moments (when they're able) because the focus is on the relationship that's being co-created. When a conflict or challenge arises, each person has an opportunity to reflect on their own beliefs and needs, talk about their experience of relationship dynamics, and figure out how to move forward together.

It's important to acknowledge that the service provider-service participant relationship has an inherent power imbalance because one person is paid to provide services and one person is receiving services. It's imperative that service providers share their emotions and experiences in ways that are authentic as well as thoughtful, intentional, and mutual.

An example: you're meeting with a service participant who's feeling frustrated and yelling at you. Rather than talking about what's "appropriate" or using language that blames or shames, we suggest using "I" statements to convey your personal observations, feelings, and needs: "It seems like you're feeling strongly about this. I want to hear about what's going on for you, though it's difficult for me to stay connected when you're yelling. What if we take a five-minute break and come back to this?"