This chapter explains my position on the current state of the mental health delivery system. In the forty-five years I’ve been in psychiatric practice, I have counseled in every area of psychiatry except with small children. Regardless of their symptoms, all who came or were sent to me for counseling had the same basic problem: They were unhappy. Their lives were not going the way they desired them to go, and in almost all instances it was because they were not getting along with the important people in their lives to the extent they wanted. They were not mentally ill. There was no pathology in their brains or brain chemistry. The term mental illness should not be applied to these unhappy people. That diagnosis should be reserved for people who have pathology in their brains, such as people who suffer from Parkinson’s or Alzheimer’s diseases. These long-established mental illnesses are treated by neurologists, not psychiatrists.

The most accurate way to describe these unhappy people is that although they are not mentally ill, they are not nearly as mentally healthy as they would like to be. Currently, the best way to help them is through counseling. However, I would like to offer an alternative. I believe that unhappy people can be taught to improve their own
mental health through Choice Theory, a new form of psychology I created to help people improve their relationships (Glasser, 1998). When they do, they will be both happier and mentally healthier than they are now. Better relationships are the key to mental health and happiness. The Choice Theory approach provides a way for huge numbers of unhappy people to help themselves to better mental health when they can’t afford or won’t accept counseling. And they can do so at little or no cost to themselves or anyone else.

By the year 1990, mental health—never a strong component of psychiatry—had almost disappeared from the profession. What the vast majority of psychiatrists (whom I refer to as the psychiatric establishment) do today is diagnose unhappy people as mentally ill and prescribe psychiatric drugs to treat them. These psychiatrists call themselves biological psychiatrists. They do little or no counseling. Some who prescribe brain drugs exclusively call themselves psychopharmacologists. For reasons I explain shortly, none of them seems to have any concern for mental health. In all my years in practice, I have counseled unhappy people successfully and never prescribed a psychiatric drug (Glasser, 2000). I counsel without drugs by teaching people in layman’s terms to apply Choice Theory to the way we choose to live our lives.

There is no longer a concerted effort from the psychiatric establishment to create a counselor–patient relationship and talk about the problems of those who suffer from psychiatric symptoms, such as those described in detail in the DSM-IV (a compilation of psychological symptoms, many of which are put together as syndromes and called mental illness). The biological psychiatrist will maintain that a patient’s symptoms are part of a “mental illness” caused by a brain chemistry imbalance that can only be corrected with drugs. Most of the few psychiatrists who still counsel almost always combine this effort with psychiatric drugs, and many imply that the drugs are the most important component of their treatment.

What the current psychiatric establishment is doing that harms the mental health of those treated extends far beyond the psychiatrist’s office. Almost all health professionals seem to be caught in this neurochemical “web” (Black, 2003). Psychiatric drugs that can harm the brain dominate the entire “mental health” landscape. To give an example of the magnitude of this domination, in 2001, 111 million prescriptions were written for just one class of drugs: serotonin reuptake inhibitors (SSRIs) such as Paxil, Prozac, and Zoloft. This represents a fourteen percent increase over the year 2000, and the numbers are still climbing (Los Angeles Times, 2002). Recent studies show that this class
of drugs may be no more effective than placebos for depression (Kirsch, Moore, Scoboria, & Nicholls, 2002).

General practitioners, as much or more than psychiatrists, have begun diagnosing mental illnesses and prescribing Prozac and other similar brain drugs. Pediatricians are diagnosing attention deficits (ADD or ADHD) in children and prescribing Ritalin, a strong synthetic cocaine that acts on the child’s brain in ways that are not yet known and may never be known. Psychologists, social workers, and counselors are diagnosing mental illnesses and teaming with general medical practitioners and psychiatrists to get drug prescriptions for their clients. Often this is done without the prescribing doctor examining in any depth the people for whom they prescribe.

These psychotropic drugs are not harmless. There is a large body of scientifically sound psychiatric research that lays out in detail the harm these drugs can do both to mental health and to the brain itself. At the same time this research points out that these drugs are nowhere near as effective as claimed by the companies that make them (Antonuccio, Danton, & DeNelsky, 1999; Fisher & Greenberg, 1997; Zito, Safer, dos-Resi, Gerdner, Boles, & Lynch, 2000). In February, March, and April of 2004, the FDA issued several warnings directly to physicians regarding serious side effects of antidepressants, including the increased risk of suicide, especially in adolescents. This is the dark side of biological psychiatry that is rarely discussed.

Still, it might be argued that it is worthwhile risking the damage these drugs may do to one’s brain if there are no safe effective alternatives to them. But there are. Quick effective counseling without brain drugs has advanced beyond what it was twenty-five years ago. The problem is that most unhappy people who could benefit from counseling cannot afford the costs of talking to a counselor, much less a psychiatrist. Their health insurance will cover brain drugs for years on end, but rarely more than a few counseling sessions will be reimbursed.

Damaging as this practice may be, the real horror of this system is the harm it does to our innate desire to try to take care of ourselves. The message that now comes through loud and clear from biological psychiatry is that when you are diagnosed with a mental illness there is nothing you can do to help yourself. The message I am striving to convey is that no matter what “mental illness” a person may be diagnosed with there is no pathology in the brain. The correct diagnosis is unhappiness, and there is a great deal that patients can do to help themselves or family members become happier or mentally healthier.
The media went “gaga” when John Forbes Nash, Jr. recovered from schizophrenia, a supposedly incurable mental illness that even with the best psychiatric care separates its sufferers permanently from reality. But as you saw in the movie *A Beautiful Mind* this is not the case at all. Many psychiatrists, including myself, don’t believe schizophrenia is a mental illness. Schizophrenia is only one of the hundreds of ways that unhappy people like Nash deal with their unhappiness. One of the first psychiatrists to deny the existence of mental illness was Thomas Szasz (1961), who warned that such diagnosis is a mistake. No psychiatrist did much for John Nash. What he did to recover, he eventually did for himself, together with the help of his loyal wife and the tolerance of the Princeton Math Department, which let him wander its halls for years.

Unfortunately, near the end of the movie, a blatant untruth stated that his unanticipated recovery was greatly furthered by the use of modern brain drugs. Written in Nash’s biography (Nasar, 1998), and shown somewhat in the movie, is that he did not take his brain drugs regularly before 1970 and after that year took none at all. I think it is more accurate to say his much later recovery was aided by the happiness of being awarded the 1994 Nobel Prize for economics, which earned him much respect from his colleagues. His wife divorced him but always provided him with the safety and comfort of a home. He may have wandered around Princeton during the day but he was never homeless. His recovery occurred despite his psychiatric care, not because of it.

**THE DIFFERENCE BETWEEN PHYSICAL HEALTH AND MENTAL HEALTH**

Most people know a lot about physical health but very little about mental health. When health is discussed in the media, the focus is almost always on curing and preventing physical illness, as if our population is either physically ill or physically healthy. This focus is extremely misleading; the vast majority of us are neither physically ill nor physically healthy. Only a very small percentage of people are so physically ill that they carry a medical diagnosis such as cancer, heart disease, or diabetes. Even a smaller percentage is so physically healthy they are fit to run a marathon. This leaves millions of us who are neither physically ill nor in top physical condition. We are somewhere in the middle between illness and good health.
Therefore, the best way to describe the physical health of the whole population is to use a continuum, shown below, with relatively few of us at either end and most of us somewhere in the middle.

**Physically Ill ——— Out of Shape ——— Physically Healthy**

Physical illness, always based on pathology, is shown at the left, and physical health at the right. The vast majority of us who occupy the middle can best be described as out of shape. In the affluent, indolent, well-nourished society we live in, I still think it is fair to say that most of us in the middle would like to be more physically fit. And almost all of us are well aware of what we need to do to get there: exercise more and eat less. However, from experience, we are also painfully aware that knowing what to do is far easier than doing it. To get encouragement, attention, and instruction we may enroll in a fitness class or employ a personal trainer. But whether we do it alone or with help, we still have to do it. No one or no medication can do it for us.

With that in mind, I’d like to offer a mental health continuum that is analogous to the physical health continuum:

**Mentally Ill ——— Unhappy ——— Mentally Healthy**

On the left are the relatively few mentally ill people who suffer from brain pathology. Their mental illnesses correspond to physical illnesses such as cancer, heart disease, and diabetes. Examples of these mental illnesses are Alzheimer’s disease, Parkinson’s disease, epilepsy, brain tumors, or multiple sclerosis. Any neurology text will list these and many more. Pathology in the brain can lead to much unhappiness, but these diseases are not how we express unhappiness. They are diagnosed and treated by neurologists, not psychiatrists.

The “mental illnesses” that establishment psychiatrists diagnose, treat, and list in the DSM-IV should not be labeled illnesses because none of them is associated with any brain pathology (Glasser, 2002). These “illnesses” are the many ways in which unhappy people express their unhappiness. As you can see in the physical and mental health continuums shown above, the mental equivalent of out of shape is unhappy. If those in the middle of each continuum—out of shape or unhappy—know what to do and are willing to do it, they can move toward the healthy end of the continuum.

The difference between the continuums is that those who are out of shape know what to do. They must exercise and lose weight. Information that teaches how to do this is available in hundreds of reliable books. Those who worry that they may be too out of shape to risk exercising can go to a doctor for a physical examination. If there is no
pathology, the doctor will suggest a gradual increase in exercise and decrease in food intake.

On the other hand, it is unlikely that those with symptoms of unhappiness such as anxiety or depression know what to do to improve their mental health. They may look for a self-help book, but these are rare. As far as I can ascertain, there was no book that specifically taught how to improve mental health until I wrote *Psychiatry Can Be Hazardous to Your Mental Health* (Glasser, 2003). You were on your own if you wanted to move toward the healthy end of the mental health continuum.

Those persons in the middle of the mental health continuum are in a more hazardous place than those in the middle of the physical health continuum. They not only don’t know what to do, but if they seek help from an establishment psychiatrist they may end up worse off than before. Instead of receiving assurances that they are not ill, which a medical doctor provides to those who are out of shape, they will be diagnosed as suffering from a mental illness caused by pathology in their brains or brain chemistry. They will be told that they need brain drugs to treat the “pathology” they do not have. They will also be told that they might benefit from counseling. However, the emphasis will be that psychotropic drugs are the important part of the treatment. Current psychiatric thinking is blind to the fact that if the brain is not diseased, then the problem is that the patient is unhappy and the symptoms are a way of expressing this unhappiness.

As difficult as it is for doctors to accept the concept of a mental health continuum, they easily understand the concept of a physical health continuum. Very likely they use it to improve their own physical health. When they’re out of shape, they know they’re not ill and have no need for drugs. They will diet and exercise like anyone else.

By diagnosing mental illness that does not exist, psychiatry is a hazard to mental health. Prescribing drugs that interfere with the brain’s normal functioning is a further hazard to mental health and to the integrity of the brain itself. But by far the greatest hazard to mental health is being given the message that we can do nothing to help ourselves. I attempt to teach that by learning Choice Theory there is a lot that we can do for ourselves or to help an unhappy family member toward better mental health, at no risk and little cost. When establishment psychiatrists make a diagnosis, especially based on symptoms of anxiety or depression, they tell patients that a neurochemical imbalance in the brain is causing these symptoms. The fact that there is not a shred of valid evidence to support this claim doesn’t seem to
bother them. An unshaken belief in mental illness has convinced these psychiatrists that it is impossible for anyone to suffer from the symptoms described in the DSM-IV and still have a physically and chemically normal brain.

In making the case for mental illness, the psychiatric establishment has replaced science with “common sense.” If a patient has symptoms, something must be wrong with the brain. Because no reputable scientist has ever found anything pathological in the brain structure or chemistry of anxious or depressed patients, biological psychiatrists focus on what is fleeting, rapidly changeable, and can’t be seen under a microscope: abnormal brain chemistry. Because brain chemistry changes continually as behavior changes, one does not have the same brain chemistry when happy as when fearful, angry, or depressed. But because brain chemistry changes does not make it abnormal.

To prove what they claim is true about brain chemistry, establishment psychiatrists employ pseudoscience and say abnormal brain chemistry is shown by brain activity. They scan the brain and show that parts are either more or less active when one is depressed, fearful, or angry. They then make a huge leap of intuition and claim that the scanned change in brain activity represents ever-changing brain chemistry. A further leap leads them to conclude that it is the change in brain chemistry that is causing fear, anger, or depression. That conclusion is about as scientific as my taking a patient’s heart rate when he is calm, then pointing a gun at him, shooting a few bullets past his ears, taking his heart rate again and telling him that he has heart disease because it is now beating abnormally fast. In this scenario it would be abnormal if it remained the same.

There is another huge difference between being physically ill and mentally ill. If a person has a physical illness such as clogged coronary arteries, the doctor can offer a specific diagnosis and an effective surgical treatment. He may also offer a statin to lower cholesterol. But in no instance will he try to force this treatment on a patient. However, when a psychiatrist diagnoses a patient as mentally ill—most often when the diagnosis is schizophrenic—he is almost certain to tell the patient that pathology in the brain supports his diagnosis and then prescribe drugs to treat it. If the patient disagrees or resists, the psychiatrist may do something no other doctor will do: try to force the patient to take the medication he believes is needed, even if the patient has to be locked up in order to be watched. Siebert (2003) provides a first-hand account of how a patient’s freedom is threatened whenever an establishment psychiatrist gives a diagnosis of schizophrenia. To get a patient locked up,
the psychiatrist has to declare that the patient is a danger to himself or others in the community. Some people diagnosed with schizophrenia may indeed be dangerous, but in the vast majority of cases these symptoms are not associated with harmful behavior directed at oneself or others.

By far the most dangerous persons in any community are unhappy young men between the ages of eighteen and thirty. They are especially dangerous when they drink, but no one suggests locking them up or even restricting their access to alcohol. Given care, support, and protection or just avoiding psychiatric care, as John Nash managed to do, they can learn to help themselves. Few people—no matter what their “mental illness” diagnosis is—can be accurately assessed as dangerous enough to themselves or others that they have to be forcibly medicated or locked up.

Psychiatrists who tell a patient or the patient’s family that these restrictions are necessary are not avoiding the truth as they see it. They are insistent because they believe they are telling the truth: the patient is mentally ill and needs psychiatric drugs, incarceration, or both. If these psychiatrists are shown evidence that supports what I claim about mental illness and medication (Glasser, 2003), they will insist that this research is wrong. They may claim that there is better or more recent brain research to back up their stance. But I advise caution. There is overwhelming evidence to show that the research they cite is funded by the companies that make the drugs they are prescribing. This is about as valid as the research funded for years by the tobacco companies that concluded “scientifically” that cigarettes were neither addicting nor harmful.

If this were just an academic argument about the validity of the diagnosis of mental illness, I would not be writing this. But what’s at stake is not academic. It is the mental health of our population and, on a more personal level, the mental health of a family member or a good friend. Still, I do not advise patients to stop taking a drug if they or their families are convinced this drug is helping. Even if they do stop taking it, they should do so slowly because an abrupt withdrawal from these strong brain-altering drugs may also be harmful to the functioning of their brain.

**Why Psychiatry Maintains the Fiction of Mental Illness and Disregards Mental Health**

When a patient is diagnosed with a mental illness such as depression, schizophrenia, bipolar disease, or obsessive compulsive disorder and
treated with a brain drug, he or she becomes one of the millions of geese who lay golden eggs for the multibillion-dollar brain drug industry. This industry masquerades as mental health's best friend, generously funding a variety of groups and activities that promote mental illness and the use of their drugs to treat it. Examples of this funding are lucrative research grants to psychiatrists who come up with supportive research, plush psychiatric conferences, liberal grants to mental health associations that vigorously support mental illness and brain drugs, enticing grants to patient advocacy groups that do the same, and millions of dollars to high-powered public relations and advertising firms to promote the "new drugs" that treat "mental illness" and persuade the media to support the value of brain drugs. The last thing the psychiatric establishment and the drug companies want is for people to get the idea that they can improve their own mental health or help loved ones improve theirs at little or no expense.

MOVING TOWARD MENTAL HEALTH

It may be easier to help oneself move from unhappiness to mental health than it is to move from being out of shape to physically fit. Those persons in the out-of-shape, middle range of the physical health continuum are not in pain. They enjoy eating and sitting around. It feels good to remain in the middle. Most find that making the effort to diet and exercise is difficult and painful. We know we'll feel guilty if we start to diet and exercise, then give it up. So most of us are content to live a sedentary life, top off our bellies, and hope for the best.

In contrast, those in the middle of the mental health continuum are unhappy and often suffer from painful symptoms such as depression and anxiety. Once they accept that they are not mentally ill and that there are easy-to-understand ways to move toward being mentally healthy, they have an incentive to begin improving their lives. This effort is not painful; it feels good. Each step they take in the direction of mental health increases their incentive to go further.

Being mentally healthy means enjoying the company of the people you know, especially family and friends. Mentally healthy people like people in general and are more than willing to help an unhappy family member, friend, or colleague feel better. To a great degree, they lead a tension-free life, laugh a lot, and rarely suffer from the aches and pains that many people accept as an unavoidable part of living. They enjoy life and have no trouble accepting that other people are different from them. They don't criticize or try to change anyone. They are creative in
their endeavors and usually fulfill more of their potential than those who are mentally unhealthy. Even in difficult situations when they are unhappy, they know why they are unhappy and will attempt to do something about it. Being physically healthy is not a prerequisite for mental health. A person may be physically handicapped like Christopher Reeve and still fit this criterion.

My mission is to encourage people to be more aggressive in protecting themselves from wrong diagnoses and harmful brain drugs by learning how they can help themselves to be happier and more mentally healthy. Patients and their families should ask any doctor who diagnoses them as mentally ill and advises drugs to explain the basis behind the diagnosis and treatment. Are there alternatives to what is being suggested that don’t involve drugs? Remember, there is no pill for unhappiness. Any pill that makes one feel better can be addicting. It would be most helpful for patients to sit down and read a few of the books that seek to help people move toward being mentally healthy. Personally, I strongly recommend Beyond Prozac: Healing Mental Health Suffering Without Drugs by Terry Lynch, M.D. (2001). If I ever get seriously unhappy, I plan to camp on his doorstep.

Preparing Patients to Help Themselves

In the last twenty-five years, the psychiatric establishment has almost completely reversed direction. It no longer supports the belief, commonly held for centuries and as sensible today as ever, that a person who is unhappy and capable of carrying on a conversation should seek counseling. I take this belief a step further. If a person is capable of reading and talking about what they’ve read, there is a good chance they can learn to help themselves by reading books that offer step-by-step support and talking to others about how they can implement the ideas they glean. There are millions of unhappy people who will never seek counseling but could easily and pleasurably join a low-cost or cost-free Choice Theory Focus Group and learn to help themselves.

The current psychiatric belief is that even those who are in contact with reality and could be counseled are still mentally ill and better treated with psychiatric drugs. Some of the establishment psychiatrists that patients are almost sure to see if they belong to an HMO may be interested in counseling but rarely are given permission to provide it. After doing little more than compiling a brief checklist of symptoms, they will tell the patient and/or the patient’s family that he or she is mentally ill or suffers from a mental disorder.
This now-dominant psychiatric practice, supported by a multimillion-dollar media blitz paid for by the drug industry, has been so successful that it has been accepted not only by most psychiatrists but by almost all medical doctors, many psychologists, social workers, and counselors. It is the way that the current mental health system makes money from unhappiness and is embraced by a general public that has no easy access to the truth.

We have learned to go for the quick fix. Our society has become accustomed to the concept of medicating discomfort with over-the-counter pills, syrups, and potions. The public likes the simplicity of the argument: a person with psychological problems is ill, and all that’s necessary to make life better is to take a pill. The public has no awareness that the price of this pill is to blind patients to the concept that they can pursue happiness and mental health on their own. There is a further price to be paid, however, by taking strong brain drugs. Many of them harm the brain and, in so doing, cause the symptoms that are at the far left of the mental health continuum.

This harm may be called side effects by physicians, but once these chemicals are in your brain there is nothing “side” about them. In his book, Prozac Backlash, Joseph Glenmullen, M.D. (2000) points out many of these side effects and also explains that some of them start when the drug is discontinued. Thus, even getting off the drug is not always safe. The worst side effect he discusses is called tardive dyskinesia, which causes a person to lose control over many muscles, including facial muscles, resulting in uncontrollable writhing and grimacing. In many cases, it appears incurable. It is very hard to predict who will get this disease and what drug dose is safe.

At this time no one knows specifically what causes the symptoms described as illnesses in the DSM-IV. There are a lot of inferences such as lowered serotonin, a brain chemical found to be lower than normal in stressed rats who “appear” to the researchers to be depressed. They use rats because the only accurate way to determine serotonin levels is to grind up the brain and assay the ground-up material. But even if the inference in the comparison of rats to humans is correct, no one yet knows whether the depression lowered the serotonin or the lowered serotonin caused the depression. Psychiatrists who use brain scans to diagnose depression are guessing it’s the latter and trying to persuade physicians and their patients to go along with this guess.

I’d like to offer a plausible explanation for the cause of many of the hard-to-understand psychological symptoms such as hallucinations, delusions, and mania. I believe they stem from a person’s creativity,
much as dreams do. A better understanding of this creativity may help us deal more effectively with its unwanted aspects.

When medical doctors tell patients that their symptoms are caused by a disease, disorder, or an illness such as heart disease, they have explicit pathological proof for their diagnosis from one or more of the following: physical pathology found on examination; pathology found from x-ray, Cat-Scan, or MRI procedures; microscopic pathology seen on slides; and/or chemical pathology derived from testing blood or other body fluids. When psychiatrists say that symptoms are caused by a mental illness, they haven’t a shred of similar evidence. To label a person mentally ill, which now translates in almost everyone’s mind as some sort of brain pathology, is to stigmatize millions of people who should not be subjected to the rejection, ostracism, harmful drugs, and brutal electric shocks to the brain that can and often do accompany this erroneous label.

Unusual, crazy, or frightening as these symptoms may be, they are no more caused by mental illness than was Timothy McVeigh’s act of blowing up the federal building in Oklahoma City in 1995. He turned out to be the most dangerous American who ever walked the streets of our country but no one called him mentally ill. What unhappy people have in common is their unpredictable behavior. People who knew McVeigh before and after he committed the crime were well aware that McVeigh was unhappy. What they didn’t know was what he was planning to do. There is no limit to the illogical destructiveness of unhappy people, just as there is no limit to the kindness, caring, and self-sacrifice of mentally healthy people. In both cases, their brains are normal; it is how they choose to use them, and the reasoning behind this choice, that differentiates mental health from mental illness (Glasser, 2003). For example, when your computer fails to work the way you want it to, it is a thousand times more likely that the trouble will be in the way you are using it or in the software than in the computer itself. You need to use it more accurately or find better software. You don’t need to fix the computer any more than you need to “fix” a normal brain with drugs or electric shocks.

Dealing with Depression

In the treatment of depression, the placebo effect of sugar pills is strong evidence that unhappiness, not mental illness, is the cause of the symptoms. If depression were caused by a chemical imbalance in the brain, then it should not be relieved by a sugar pill. Yet evidence is mounting that given with care, conviction, and time with the doctor who gives it,
the sugar pill works better than antidepressant drugs such as Prozac, Paxil, and Zoloft (Vedantam, 2002). It is also interesting that brain activity scans are used to confirm the “positive effect” of these drugs on the brain. The PET scans of people on sugar pills show equal or even greater brain activity in the same areas than those of people on the real drugs. Placebos also can be more effective because they do not have the adverse side effects of real medication.

For example, patients who are depressed because they are unhappy with a relationship might go to their doctor, who prescribes a medication that she says with some conviction (because she believes she is telling you the truth) is the latest medication for depression. “It has helped many of my patients. I think it has a good chance of helping you. It takes a while to work but please call me in a week and tell me how you are doing.” With this much attention, patients, most of whom want to please an attentive doctor, will report improvement. What is interesting is that after Vedantam’s 2002 research was finished, some of the patients who reported strong positive placebo effects were told that they, indeed, had received a sugar pill. They relapsed immediately. The placebo effect had been shattered by this revelation.

Studies such as this on the effectiveness of placebos have been going on for centuries and nearly always turn out the same. What is vastly different with psychotropic drugs is the huge media support for their effectiveness, almost all of it financed by drug companies, with the complete cooperation of the psychiatric establishment. There are billions to be made with these drugs. On the other hand, there are no corporate profits in counseling or programs to improve mental health. Like a psychiatric cancer, the false belief in mental illness that only a drug can cure has invaded our entire society, reducing the use of counseling, and standing directly between a patient and mental health by convincing the patient he is mentally ill. What is so ironic is that the HMOs, who mostly control access to psychiatric care, have climbed on the mental illness/brain drug bandwagon because they see counseling as more expensive than drugs, although the drugs are not cheap. To put a patient on Paxil for a year, 365 pills at $3.00 each, costs more than a thousand dollars and carries little certainty that the patient’s “disease” will be improved to where he has no need for further drugs. On the contrary, once the drugs are started, their use tends to escalate, especially because many of them are addictive. The Choice Theory Focus Groups I advocate (Glasser, 2003) teach patients how to live their lives more effectively and cost them little or nothing. Because they can continue using what they have learned, the results can be much longer
lasting than those from drugs. This would appear to be a win–win opportunity for both patients and HMOs.

HMOs interested in the mental health program I suggest—that is, offering unhappy symptomatic people the option of enrolling in a Choice Theory Focus Group—could easily have one or two of the psychiatrists who work for them devote a few hours a week to setting up and supporting this program. Considering how many HMOs there are, the impact could be astounding. This is an interesting challenge for HMOs that would cost them next to nothing to put into place.

A further benefit to the HMO’s mental health program is that it would provide medical doctors with another option for the many unhappy patients they see every day who complain of pain or discomfort for which no physical cause can be found. Even after the expensive MRIs and CAT scans are done and a lot of doctor time invested, patients suffering chronic pain from fibromyalgia and other problems keep returning to their doctors. I recognize that these patients will be highly skeptical of any mental health program, protesting that what they need is more physical care and better medication and that their mental health is fine.

Yet for the nine years that I was the psychiatrist for the Los Angeles Orthopedic Hospital, I worked with more than fifty patients with chronic pain. No cause for their pain had been established, and I found them remarkably open to the idea that the pain might not be medically treatable. I spent time with them and created a relationship with them. The results in many cases were very good. The Choice Theory Focus Group program was not in place then. But I can see now that a program giving these patients usable mental health information plus time and attention could have been quite effective. Such group programs should be active and incorporate a great deal of give and take, not just lecturing and listening. A friendly, we’d-like-to-see-you-again approach would encourage attendance. There would be none of the long waiting times followed by the hurried encounters patients run into now when they finally see a doctor.

**Encouraging Mental Health Associations to Get Involved**

The natural place to begin reforming the mental health field is in the many mental health associations that span our country. Mental health associations could begin doing what their name implies: improve the mental health of the community by offering access to ongoing Choice Theory Focus Groups at no cost to participants. These are not therapy groups. Anyone who has read my book (Glasser, 2003), in which I
describe such a group in action, and who has some teaching skills, can get a group started. (There is also a demonstration video available, showing a Choice Theory Focus Group in progress. Information on this tape can be found on the Internet at www.wglasser.com.) Once initiated, these groups can continue on their own without leaders. This is what Alcoholics Anonymous has been doing since the 1920s with staff members and trained volunteers.

**Unsatisfying Relationships Are the Main Cause of Unhappiness**

Unhappiness is best described as a time and place when our life is not the way we’d like it to be. We can be in this unhappy place for a moment or many years, but as soon as we realize we are in it, we want to do whatever we can to get out of it. However, most of the time we don’t know what to do. If our unhappiness continues for weeks, symptoms such as depression, anxiety, mania, panic, headaches, chronic pain, and even symptoms associated with what is called schizophrenia can appear. Because we are creative, there is always the possibility that a new symptom will present itself. This is one of the reasons that the DSM-IV volume has grown so large.

Assuming that we are physically healthy and have sufficient food and shelter, we experience more unhappiness in unsatisfying relationships than in any other situation, with marriage leading the list. The initial symptoms are commonly anger and depression. The depression will persist if we don’t do anything to improve our mental health. If it continues, additional symptoms such as fatigue, headache, listlessness, difficulty sleeping, and loss or gain of appetite may add to or replace depression. It is virtually impossible to be unhappy for longer than a few months and remain symptom free.

It is safe to say that no one can avoid unhappiness. All we can do is try to understand what is wrong and from this understanding try to figure out how to get along better than we do now with the important people in our lives. If we can improve our relationships, we will improve our mental health and our symptoms will disappear. The idea behind the Choice Theory Group program is to help people who don’t need psychiatric care or psychiatric drugs—the vast majority of us—learn coping and awareness skills that will help them improve their relationships and carry over their new-found contentment into every aspect of their lives.

This is my vision for the future of the mental health field.
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OTHER BOOKS ON CHOICE THEORY


