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The Mental Hospital - Monster, Fossil or Utopia?

BY

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Mental hospitals have been in existence for a little more than five hundred years. It was on ~~the~~ a cool morning of the 24th of February, in the year 1409, in Valencia, Spain, that a monk of the Order of Our Lady of Mercy was on his way to deliver a sermon in the Cathedral, when he stopped ~~and~~ to watch~~ed~~ a group of boys ridiculing and stoning a pathetic looking man who was obviously not in his right mind. The monk was so troubled by this scene that he threw away his prepared notes for the sermon and launched into a fervent plea for the building of an asylum for the insane, so that they may be protected against the cruelty of their fellow man and may obtain shelter, food and treatment. So moving was his sermon that immediately after the service a group of citizens of Valencia approached him to declare their willingness to supply there and then the means for the foundation of such a hospital. The same year it was opened - the first asylum for the insane in the Western World.

Let us now take a long jump in history, just 30 years back, to the late 40's of our own century. At that time a cry went up across the North American continent to put an end to the unspeakably horrid conditions in the United States' mental hospitals, which were called a shame of the nation. In those days our mental hospitals were "snake pits" and huge monsters of brick and mortar. In

French Canada, at about the same time, a book was published by a former patient of a mental hospital in Montreal: Les Fous Crient Au Secours -(The Madmen Cry For Help).

These cries went not unheard, the media - press and film were alarmed, and the people rose to the need.

Many changes were ~~then~~ introduced in mental hospitals. Locked doors were opened; overcrowding was eased; the food and the physical environment in the hospitals was improved; civil rights' groups took up the cudgel, and state governments began to change and enact new legislations to give more rights to mental patients.

Then, twenty years ago, in the late 50's, a move was started in Great Britain to eliminate mental hospitals altogether. This move had been inspired by the fact that, for the first time in many years, the inmate populations of mental hospitals all over the Western World had stopped expanding and started shrinking. The massive exodus of mental patients from the hospitals over the next few years was the result of a combination of factors, but mainly of the introduction of effective pharmacotherapy for the treatment of mental illness and the awakening of a greater social conscience that created increased tolerance of the mentally ill in the community and led to improved government measures for the mentally ill. "Deinstitution-alization" became the watch-word and the dogma of the mental health movement which was rapidly developing into a mental

health establishment and industry. Mental hospitals were viewed as unnecessary, useless and often antitherapeutic fossils. To quote one recent protagonist of this philosophy, a professor of psychiatry at the University of California: "... It is quite proper for us to admit that we have evidence that the effective treatment of mental illness is best carried out in settings other than hospitals. ... Since the hospital, as a place of treatment for the severely ill psychiatric patient, is always expensive and inefficient, frequently antitherapeutic, and never the treatment of choice, we mental health professionals need to develop a strategy for our contribution to dismantling mental hospitals ..." (Mendel, 1974)

However, the same author also states that today this abolition movement has run into serious difficulties and that there is an emotional backlash resulting in renewed attempts to make a case for the therapeutic value of state hospitals.

As it is ~~Indeed~~, the fate of mental hospitals is in limbo today. Since the deinstitutionalization of mental hospital patients had been enthusiastically promoted but in no way properly prepared, patients who were dislodged from hospital wards that had often been their homes for many years, found themselves overnight in "the community" which in most cases proved to be a hostile social environment for them that posed sudden new demands on them for which they were in no way prepared and with which they were unable to cope.

Rapidly improvised foster homes soon became "community backwards". One study of this phenomenon revealed that patients in such foster homes often regressed in their social adjustment to a greater extent than control groups of patients who had continued to reside in a mental hospital. (Murphy and Engelsman, 1976) For the elderly who had been transfered by the thousands to nursing homes, these nursing homes soon became monsters in their own right which did not differ much from the old snake pits of the mental hospitals of the 30's.

A recent article in the prestigious scientific journal "Science" of the plight of the deinstitutionalized mental patient states that: "Since 1955, when psychotropic drugs began to replace straightjackets and locked wards for psychiatric patients, an estimated 1.5 million long-term residents have been released from American mental hospitals ... under the banner of "community-based care", perhaps 250,000 mentally and emotionally disabled persons are now in nursing homes, boarding houses, residential hotels, subsidized apartments, group homes, and half-way houses.

Sensible as that may sound, it hasn't been working out very well ... For most the concept of "Community care" is no more than a sad joke ... A large proportion of them have been placed in poor, crime-ridden areas that hardly qualify as "Communities". And the real communities don't want former mental patients around." (Holden, 1978)

Representative voices from Britain, where the abolition movement of mental hospitals has started, now draw attention to the fact that, at least for a number of certain categories of mental patients, mental hospitals will always be required. In the U.S., where the States of California and Massachusetts have been most active in the movement for eliminating mental hospitals, a host of new problems have arisen. Many jobs have been lost for people who had been employed in mental hospitals. Municipalities protest against the financial burden of having to take care of so many poorly adjusted citizens. A citizens association complained: "We don't like it, and we are not going to have it. People don't like having their parks taken over by patients who have nowhere else to go, or their local "McDonalds" jammed with repulsive mental patients". →pt.

Under these circumstances mental hospitals may well be headed for a comeback. Not long ago my friend and colleague Dr. Nathan Kline and I discussed plans for an article that would have been a spoof on the current situation. In a straightfaced fashion the paper would have discussed many new and "revolutionary" ideas that we, the authors, were proposing. First of all, we had the "original" idea of organizing a large architectural complex in which would be gathered all the pathetic, ill-housed and poorly nourished unstable and mentally ill people who are now forced to live out their lives on park benches and in sleezy hotels, being an easy prey for muggers and pranksters. Within this large building that would provide secure and warm shelter and

regular balanced diets for the mentally ill, we would organize facilities like large lounges, day wards and dormitories where those who wanted to socialize could do so. At the same time we would propose the "new" idea of having many isolation rooms where those patients who required privacy would be allowed to indulge in it. Nurses in this new hospital would, of course, wear uniforms, in order to promote a feeling of greater security for the patients who would then know whom to address when they needed help. The patients, too, would be encouraged to wear uniform clothing so that one might eliminate, as much as possible, any discrimination among them because of more expensive or more fashionable clothing for some but not for the others. These hospitals would be placed on attractive sites, quite far out in the countryside, where the patients could find refuge from the desultory living conditions in the dehumanizing big cities. The doors of the wards and dormitories would be locked, in order to give the patients a feeling of enhanced security - just as most normal people lock the doors in their rooms and apartments. Instead of drugging excited patients into stupor and coma, the drugless procedures of wet packs and continuous baths would be used to calm them. There would be large farms on the grounds of the hospital, in order to allow the patients to have plenty of opportunities for healthy physical workouts, much like on Dude ~~farms~~ ranches for recreational purposes.

There would, of course, be no coercion to attend group therapy or other councelling and psychotherapy sessions, that are often tedious and embarrassing to patients, nor would the patients be required to take any physical treatment unless they insisted on it.

You know, such an article, making, in fact, a case for the return to "snake pit" conditions, could almost make its points today. And that means that today we are indeed in limbo regarding the fate of mental hospitals. We seem to have thrown out the baby with the bath water, and we are in danger of having the pendulum swing back to the other extreme. Yet, the threats of becoming monsters or fossils still hover over the mental hospitals.

In 1961, Goffman, a well-known sociologist published a book- Asylums- that was the result of observations that he made as a participant observer during the years 1954 to 1957 in St. Elizabeths (Mental) Hospital in Washington. Here is what Goffman saw and concluded: a mental hospital, according to him, is a Total Institution. Goffman defines a Total Institution as "a place of residence and work where large numbers of like-situated individuals, cut off from the wider society, for an appreciable length of time, together lead an enclosed, formally administered round of life." According to him, the encompasing total character of the institution is symbolized by barriers to social intercourse with the outside which are often built

right into the physical plant, such as locked doors, high walls, etc. Goffman distinguishes five prototypes of total institutions: 1) to care for persons felt to be incapable and harmless, e.g. the aged and the blind. 2) to care for persons felt to be incapable but also a threat to the community, although unintentionally. Examples are T.B. Sanitaria; leprosaria; mental hospitals. 3) to protect the community against what is felt to be intentional dangers, e.g. jails, penitentiaries, ~~POW camps~~ and concentration camps. 4) to pursue social working tasks, e.g. army camps, boarding schools, ships, etc. 5) to serve as retreats from the world, e.g. convents and monasteries.

It is strange that the author has not given general hospitals a place in this grouping of total institutions. He mentions those that care for the incapacitated and harmless, i.e. the aged and the blind, but he does not mention institutions that undertake active treatments and assume healing functions for the temporarily ill. Goffman considers all total institutions as social hybrids - part residential community, part formal organization. A bureaucratic organization schedules all phases of daily activities for the individual and imposes them from above by a system of formal rulings and a body of officials. In a total institution the staff and the inmates find themselves invariably under adversary conditions. Staff see the inmates as bitter, secretive and untrustworthy, while the inmates see

the staff as condescending, high-handed and mean. The staff tends to feel superior and righteous; the inmates tend to feel inferior and guilty. Inmates of a total institution, such as mental hospitals, are excluded from decisions regarding their fate, for instance their length of day, their diagnosis, their treatment span. All this generates what Goffman calls antagonistic stereotypes, in that staff and inmates are "jogging alongside each other with points of official contact but little mutual penetration". In this way the inmates of a total institution undergo radical shifts in their moral career as they suffer dissolution of their social role and personal defacement. Once they have entered a total institution, the inmates suffer a series of degradations and humiliations as their selves are systematically mortified. Eventually, this must lead to a total exile from life and stigmatization. As Goffman sees it, inmates of a total institution may even live under a constant threat of loss of personal safety through beatings, shock therapy and enforced surgery (in mental hospitals).

Goffman is convinced that most mental hospitals do not exist primarily for the benefit of their patients - or, as has been claimed frequently, because psychiatrists and other staff personnel want some jobs - rather, he points out that there is a "market" for mental hospitals, and the real clients are the patients' relatives, the police and the judges who would clamor for new mental hospitals the day after they would be closed.

As for the patients, their self-conception is explicitly and consistently framed by a system which puts the patients into a special bind: if they want to get out of the hospital, then they must accept the place society and the staff, as society representatives, accord them, and they must support the occupational role of the staff who appear to force this bargain - all of which amounts to a self-alienating, moral servitude. The staff, on the other hand, has carved out for itself a role that sustains the self-conception of professionals who give a personal service according to a medical-like model. They achieve this by evoking the great tradition of the expert medical services which they try to imitate by group therapy, counselling and individual psychotherapy.

Although Goffman made his observations, and constructed his sociology of mental hospitals, during the first three years of the period when effective drug therapy entered the ~~medical~~ mental hospitals and proved the effectiveness of a true medical model in the treatment of mental illness, he chose to ignore this aspect entirely. This must be kept in mind by anyone who tries to apply Goffman's sociological model of total institutions to present-day mental hospitals.

Goffman admittedly presents a "partisan view" - from the patients perspective - but his characterization of the mental hospital as a total institution may be valid in many important aspects. If so, could

mental hospitals ever be anything but useless fossils at best, or dehumanizing monsters at worst? Were mental hospitals ever anything else? Surely, they did not start out as fossils?

Let me give you a brief, and necessarily sketchy, review of the historical stages through which the conceptions and the realities of mental hospitals have passed in the course of the last five centuries.

As we know now, the first hospital for the insane was built in Spain in the early 15th century. It was a true asylum, intended mainly for the protection of the helpless mentally ill. Although there have been - in other countries, particularly in the Arab world - houses where the insane could find refuge, these were mainly general hospitals which accepted, in a small separate section, a few mentally ill patients. The hospital in Valencia was the first that was built exclusively for patients who were mentally ill. Little treatment of any kind was attempted at that time, and the main motive for gathering these patients under one roof was to protect them.

In most other countries of the European continent one disposed of the mentally ill at that time in quite a different manner. No town and no community wanted to have mad men in their midst, and so the mentally ill had to keep wandering from village to village and from town to town, and if they stayed too long in one place the town officials would force them to move on. There was no home,

no refuge and no hospital for them. But there were in those years many houses for the lepers. France alone had more than 2,000 leprosariums in the middle of the 12th century. But leprosy began to vanish from Europe between the 13th and the 15th centuries; the leprosy houses became vacant, and the cultural scapegoats,which the lepers had been,were rapidly disappearing. The French sociologist Foucault (1961) theorizes that the stigma which had been attached to the lepers was, in the late middle ages, transfered to the mentally ill. There were still large endowments for the leper houses, but no patients in them. Then, within a very short time, at the beginning of the 17th century, laws were passed in France and other European countries that prohibited the free existence of the poor, the idle, the beggars and the madmen. They all were quarantined in large buildings, just as the lepers had been before them.

In the 18th century an attempt at social therapy was made, and the houses for the poor, the rootless and the insane became now institutions for correction, that is workhouses.

Towards the end of that period, yet another reason was discovered for keeping the mentally ill locked up in special buildings, namely the safe containment of potentially dangerous people who seemed to be more animals than humans. And now mental hospitals were no longer asylums for the protection of the mentally ill, or places where they would be quarantined, or workhouses - but what should have

been mental hospitals became warehouses of the mad where mental patients were exhibitied to the public for an entrance fee. However, we must also note that in the late 18th century some first attempts were made to treat the mentally ill medically. The treatments which were available at that time were ineffective and very exhausting. They consisted in copious blood letting, purging and the induction of vomiting.

Then, at the time of the French Revolution, at the very end of the 18th century, the great physician Pinel revolutionized the treatment of the mentally ill. He dramatically removed the chains from the patients in the Bicetré and the Salpétrière, wrote books and articles on the diagnosis and treatment of the insane and thus became the first real psychiatrist. He soon found followers among his medical colleagues in France, Britain and Germany, and it was not long before the new movement had also spread to the New World, where the first mental hospital was opened in Williamsburg, Va.

Mental hospitals were now referred to as Retreats, and a new therapeutic philosophy and practice was to reign in mental hospitals all over the Western World for most of the 19th century - the moral treatment. This treatment was very effective and even led, in the U.S., to what has been called the cult of curability. However, for all its genteel efficacy, the moral treatment did by no means represent complete liberation of the mental patients. True,

they no longer were chained in dungeons, beaten by their keepers and exposed in cages to the public. Instead, they socialized in nicely furnished rooms, they organized plays and they played chamber music in the superintendent's home. But the catch was that they had to live in this well-mannered fashion, or the hospitals authority would be severely imposed on them. They might be strapped into turning chairs - or on to finely engineered centrifuges - and twirled around until they lost consciousness, or they might unexpectedly be dropped into icy water through a hidden trap door on a bridge. For the dominant philosophy behind the moral treatment was that normal life was civilized life and that civilized behavior and well mannered sociability were the anchors of mental stability. A nasty sociologist might even have considered the famous and effective moral treatment a subtle form of brainwashing. But since it is such a nice and effective form of treatment, we have retained it to this day as one of our most important social therapies - under the name of milieu therapy. Of course, we all behave differently - and in a much more civilized manner - at, let us say, an ambassador's reception than we would in the basement playroom of our own house - but where do we feel more comfortable? And which behavior is more therapeutic? The Retreats of the 19th century were not intended to give the individual an opportunity to meditate or to come to terms with his personal problems - rather they were a kind of social finishing school, although their goals of correction were more refined than

those of the workhouse type of mental hospitals in the puritan 18th century.

However, by the end of the 19th century the Retreats had turned into huge buildings that housed many hundreds, then thousands, of mental patients who, like study objects in a museum, allowed great psychiatrists, like Kraepelin and Bleuler, to observe and classify the various types of mental disorders. It was the beginning of scientific psychiatry, and then, by the first quarter of the 20th century, mental hospitals had turned into monsters and snake pits, which had to be dismantled.

In summary, then, the problem now is this: some mental hospitals will probably always be needed, but they must not repeat the fossilized mistakes of the past, and they must certainly never again be allowed to turn into warehouses, zoos, museums or monstrous snakepits. What formula would satisfy those requirements? To start with, there is a list of things to be avoided. The motivations for admitting patients to a mental hospital should neither be quarantine, nor correction, nor just safe containment. All of these are motivations based only on society's point of view. Furthermore, those future mental hospitals should not have the character of a total institution.

From the mental patients' point of view, the principal motives for having them live in special places built for them, should be their protection, treatment and comfort. Mental patients should not have to deal with

"antagonistic stereotypes", nor should they have to suffer humiliations or loss of their personal role. No bureaucratic nor economic considerations should influence the functioning of such utopian mental hospitals.

Some places like this do in fact exist. They are the residences for mentally disturbed persons that are shaped on the model of the famous Kingsley Hall in London. Kingsley Hall flourished in the late 60's and early 70's, but it no longer exists - a victim of economic difficulties. However, eight similar residences, each housing about ten mental patients, still function in London; and one can be found on the west coast of the United States. They are non-institutions, with almost no formal structure - no regular meal hours, almost no house rules - and they provide a real asylum for their mentally ill residents. Unfortunately, these special residences do not make full use of all available medical treatment and thus do not employ their full potential as hospitals. (Wykert, 1978; Mosher, 1974).

My own imagination, regarding the mental hospital in some Utopia, visualizes a large complex of attractively built bungalows on the out-skirts of the city, but not too far from a university center. This hospital would serve three different functions. It's main part would provide a special community where the many mental patients who have recovered from their acute symptoms, but cannot adapt themselves to life in our stress-

ridden, "normal" society, would find an accepting, congenial, non-coercive, non-restrictive, non-competitive community, where little initiative would be expected from them, and where aggression would not be met with counter-aggression. Food and shelter would be available for them without having to hustle for it. Work, recreation and social activities would be provided for those who want them, but there would be only as much encouragement given to utilize them as might really be therapeutic for each individual, because there is now some evidence that psycho-social therapies, and even strong expectations of normal social functioning, may be counter-therapeutic for certain schizophrenics in remission. (Brown et al, 1972) A minimum of general rules and principles would prevail in this strange para-social setting, and patients would come and go as they please. The function of this asylum community would be secondary prevention of deterioration and of relapses in the chronically mentally ill or maladapted.

Some of the buildings would serve as clinical centers and provide active treatment for the acutely mentally ill, according to the medical or psycho-social model, as determined by the psychiatrist's judgement and the patient's choice.

And finally, some bungalows would be reserved for those, apparently normal, persons who feel the need to be - at least for a short time - in an indulgent

or better: rehabilitation. It is quite clear by now that there will always be many persons who, after having been cured of their acute psychotic symptoms, can not adapt any more to the normal social setting in which they originally broke down. And there is no other fitting place for them. Let our utopian hospital provide a custom-made, free community for them. (I hesitate to call it a therapeutic community, because that concept is too much tainted with some questionable features of the old "moral treatment", although such "therapeutic community" settings should, of course, also be available for those who require them).

The clinical center of our new hospital will provide active treatment, as indicated along the lines of the medical and psycho-social models. Finally, the acting-out section of this utopian hospital, where normal people will have the opportunity to behave temporarily as though they were not normal, if and when they feel the need for it, may be a useful addition or not. At least, it could probably do no harm as an experiment in primary prevention of psychiatric disorders, that is, in a field that so far is almost entirely unexplored.

All that remains to be done now is to persuade the government to accept the new concepts and provide funds for realizing them in Utopia which, as you will recall, translated from the Greek, means Nowhere.

environment, where they may regress to their hearts' delight without being held responsible for their behavior. * Such opportunities exist today only for people who go on fishing trips, over the weekend, but spend most of their time getting drunk, so that their regressed behavior will be acceptable. I have always thought that there should be special places where - for a limited time and an appropriate fee - any person who feels the need or desire to regress, should be allowed to do so in the fashion of his own choice. ~~They~~ nobody can certainly ~~cannot~~ do so in a psychiatrist's office. If there is any therapeutic or preventive value in such leave-taking from standardized behavior - and there well may be - this would probably be enhanced if the person, acting out in this manner, is sober rather than intoxicated to the degree of incompetence and subsequent amnesia. To that extent, special sections of my utopian mental hospital could perhaps serve some functions of primary prevention.

We have come full circle, and our utopian mental hospital resembles most the first model of a hospital for the mentally ill, built 500 years ago in Valencia - as an asylum. Protection for and tolerance of the chronically mentally ill in a special community are today the most urgent needs. Modern, active treatment of acute psychiatric symptoms is far advanced, and continuous further progress is being made in this field. But our deficiencies are great in what we call deinstitutionalization -

* needless to say that care would be taken so that no personal harm would come to anyone.

References

1. Brown, G.W., Birley, J.L.T. and Wing, J.K.: Influence of family life under course of schizophrenic disorders: A reputation. British Journal of Psychiatry, vol. 121, 241-258, 1972.

2. Foucault, M.: Histoire de la Folie. Librarie Plon, Paris, 1961.

3. Goffman, E.: Asylums. Published by Doubleday. Garden City, N.Y., 1961.

4. Holden, C.: The plight of the "deinstitutionalized" mental patient. Science, vol. 200, 1366, June 23, 1978.

5. Mendel, W.M.: Lepers, madmen - who's next? Schizophrenia Bulletin, no. 11, 5, Winter, 1974.

6. Mosher, L.R.: Psychiatric heretics and the extramedical treatment of schizophrenia. IN: Cancro, R., Fox, N. and Shapiro, L. (eds.) Strategic Intervention in Schizophrenia: Current Developments in Treatment, Behavioral Publications, New York, 279-300, 1974.

7. Murphy, H.B.M., Engelsmann, F., and Tcheng-LaRoche.: The influency of foster home care on psychiatric patients. Archives of General Psychiatry, vol. 33, 179-183, 1976.

8. Wykert, J.: R.D. Laing at 50. Psychiatric News, August 4, 1978.