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THE FAILURE OF PSYCHOTHERAPY IN MENTAL HOSPITALS

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Deductions from disease models or orthodox psychoanalytic philosophies appear to be inadequate for improving the quality of treatment in mental hospitals. The hospital culture becomes itself pathological and reenforces the patient's illness. The development of a transcendental theory of human behavior seems to offer a more fruitful alternative.

It has now been seven years since S. Weir Mitchell specifically excoriated the mental hospitals of his day:

"The cloistered lives you lead give rise, we think, to certain mental peculiarities . . . One is the superstition . . . that an asylum is in itself curative . . . Upon my word I think asylum life is deadly to the insane. Poverty, risk, fear send you many patients . . . They are placed in asylums because of the wide-spread belief you have so long, as we think, so unreasonably fostered, to the effect that there is some mysterious therapeutic influence to be found behind your walls and locked doors . . ." (Bockoven, 1963).

One popular retort was to accuse Mitchell of being a "psychiatric outsider" (Fisher, 1963). Much of the current unrest re-echoes Mitchell's clear remarks. It is only recently that the specific variables fostering institutionalization have been under study. Alternative approaches to the disease model and the psychoanalytic dyad are just coming over the horizon (Bierer, 1962; O'Connell, 1963).

The moral therapies of the small American mental hospitals of the first half of the 19th Century represent a goal we humbly and perhaps unconsciously seek to attain today (Joint Commission, 1961). In the twentieth century we are supposedly still laboring in the service of an antiquated disease model of philosophy of mental illness which has been sharply challenged by our current critic (Bockoven, 1963; Joint Commission, 1961; Rosen, 1962; Schwartz, 1958; Szasz, 1961). Yet the moral therapist of the early nineteenth century was motivated in his confrontation with the patient by the energizing attitude that the patients were well individuals: mistaken, stupid, or even sinful, but basically amenable to the unlearning and relearning of moral (social) responses. Most of the criticism of the disease model hypothesis center upon the unproductive results of treatment procedures based upon its implications. For example, avoidance of sociological and moral questions in etiology and treatment, lack of face-to-face therapeutic strategies and ignoring the undeveloped essential skills of the patient might be decidedly anti-therapeutic. Coupled with a preoccupation in therapy with the search for unconscious wishes (Lehrman, 1964) and a penchant for confusing behaviors with symptoms (Szasz, 1961), a pall of hopelessness frequently envelopes both server and serviced. Those who defend the disease model of mental illness are engaged in pointing out similarities between the diagnosis of physical and mental dys-

functions (Ausubel, 1961), but the main issues are not there. The most important consequences are concerned with how one's hypotheses influence treatment. Therefore, any philosophy of mental illness which leads to therapeutic dispair or ineffective results needs to be questioned.

For the past ten years the average mental hospital has been pictured as a huge bureaucracy, seeking to maintain symbols of competency and vested interests (Ausubel, 1956; Szasz, 1961), without criticism and research into its habitual modes of operations. The demise of overt cruelty has, at times, been followed by a pervasive double binding (Haley, 1961) detrimental to the reality orientation of both patients and personnel. This defect in communication habitually results when the sender is in conflict (e.g. told to follow tender-loving-care lines and does not believe in it) but denies awareness of such to himself and others. The alternative behavior offered patients caught in the bind is withdrawal and chronicity (or elopement for the actives) while personnel are presented with "leaving the field" or forming their own subtle means of indirect rebellion.

Examples of the double bind are easy to construct, the paradigm being the dependent person caught between two contradictory messages and not being allowed to ask for clarification. In other words, those in power may declare "you are receiving treatment" or "you are to be a therapeutic agent on a treatment team" and act otherwise.

A patient is told he is victim of an illness, hence confused and irresponsible. He is placed on a locked ward shortly after for untidy appearance. No reason is given to him.

A young psychotherapist has learned of value of psychotherapy in his training and experience but is never called upon for opinions of diagnosis and prognosis at disposition boards, even though he has participated in patient's emotional re-education for hundreds of hours. When he wants to discuss this anomaly with his supervisor, the latter begins to evaluate therapists's "clinical suitability." Patients' misdeeds and not status structure of the hospital (even though a precipitating cause of misbehaviors) are the phenomena to be investigated.

Thus, the authority figures, themselves may encourage symptoms as the response of patients, and non-therapeutic behavior as the response of personnel.

It does seem that to the extent that the treatment staffs of mental hospitals are imbued with bureaucratic thinking (people seen as interchangeable things, new ideas discouraged), the problem of isolated professional groups becomes severe. In fact, it seems easier for paramedical professions to adjust to a total disease model hypothesis than to accept that they are a priori to be therapeutic people, unless they are continually supported and encouraged in this latter view (Lefton, Dinitz, & Pasamanick, 1959).

If the "motivated patient" and transference analysis theories of orthodox psychoanalysis could result in successful pychotherapy for the chronic psychotic the effects of intra-hospital communication problems would be secondary. But relationships between patients and staff become very important when one uses a social identity model of human behavior based on Adlerian premises (low self-esteem, fantasy, compensatory sub-marginal gemeinschaftsgefühl) (O'Connell, 1961; O'Connell, 1962; O'Connell,

1963; O'Connell, 1964). If such patients suffer from low self-esteem, reject others in favor of a compensatory fantasy life and lack vitally necessary social skills, just how important is the segmented psychotherapy hour for learning and growth? Certainly the relationship and interpretations offered are important with the former assuming formidable proportions when the accent is upon constructing the patient's identity rather than analyzing the transference as is customary in orthodox psychoanalysis. In core psychotherapy (O'Connell, 1961) one can by reducing the psychological needs of the patient become a "significant one" and commence interpretations revolving around the patient's purposeful denials — not based upon a deterministic need model. But others, not sharing recent developments in psychotherapy can likewise become significant to the patient via tension reduction, reinforcing different action and goals, perhaps judging as ultimately non-therapeutic. Teams are undoubtedly wonderful but their functions are better dictated by the psychological assets of the members than fiats of guilds (Bierer, 1962).

In short, in the average mental hospital the therapist's strategies do not control the patient's attention as in the Rosen techniques (Haley, 1961; Rosen, 1962; Scheflen, 1961). In the latter's approach, the treatment monopolizes the living arrangements and non-medical therapists are aware of the goals and subgoals. As a rule, psychotherapy in the conventional mental hospital is merely *one* of the modalities offered the patient in his daily existence. He can refuse outright or deny the importance of the relationship with endless ploys (nervousness, sickness, forgetting, having other appointments, etc.). Like the neurotic symptom, the avoidance style continues through the myopic goal of postponing the tussle with disconcerting ideas and objects. If the hospital structure does not allow inter-disciplinary treatment planning and discussion and is not blessed with a "critical mood" (Fromm, 1963), what are the psychotherapist' alternatives? How does one teach beginning psychotherapists the realities of the real beyond-the-text world without adding to the discouragement the average clinical psychology student learns at universities (Zimet, 1961)?

All of this returns us to society and a belated defense of the much maligned mental hospital. These institutions are no worse than the society that spawns them. If the laws of human relations have never been of ultimate concern to such a society, and the humanism implied in our democratic and religious values have ossified into dehumanized rituals, are we not making a scapegoat of mental hospitals? At least, they do not reject patients to the extent that society does.

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