

IDENTIFICATION AND CURABILITY OF THE MENTAL HOSPITAL PATIENT

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The mental hospital microcosm is now passing through an age of what we fervently hope is a burgeoning maturity. Not so many years ago we had no doubts, no anxieties, and were blithely turning to oracular authorities for assuring answers. We learned the dogmas all too well: The high priest was the medical man and the psychologist an insecure acolyte; or, in more modern sophisticated analogy, the psychiatric team of psychiatrist, psychologist, and social worker was the personification of authoritarian father, rebellious son, and doting mother (18). Psychoanalysis was the treatment of choice "for all God's chill'un;" and the "incurability myth" (4) was an inviolate truth. Furthermore, psychotherapeutic ceremonials were only valid when practiced by those with proper and respectable degrees. The couch, the one-to-one encounter, and other manifestations of "one-upmanship" (10) were prized. Group methods had their secondary places of honor in the therapeutic armamentarium, depending for their appraisal upon whether the acknowledged leader was medical—or psychological, social, or a mere aide. In the latter cases, the appellation "psychotherapy" was never uttered. The quest was for insight and, like the mythical unicorn, it was only hunted by certain people at appropriate times.

Now all this has been seriously questioned, and the mental hospital ethos is experiencing the "strain and stress" of inquiries into those premises upon which so much time and energy has been based. It is the writer's hope and belief that mental hospitals will profit from such experiences by responding with increased anecdotal and experimental research, rather than regressing to their old stultifying "incestuous fixations" (8) and concomitant multiple hostilities. The purpose of this paper is to point in one hopefully fruitful direction.

THE PASSING MENTAL HOSPITAL SCENE

The domain of medicine. Psychological treatments, predicated upon neurotic problems, have never deeply impressed the decision makers in the small world of the disenfranchized schizophrenic. The

biological substratum has been paramount in mental hospital mentation. Obviously it offers a more palpable and somewhat more measurable approach than the psychological. The millennium seemed to have arrived with the tranquilizer. The medical man's image was enhanced, and he was able to spend his time indulging in medical matters: searching endless combinations of drugs, and combating their side effects. The "ancillary" personnel's role seemed even more futile, drone-like, and unrewarding than before (13). But the surcease and pleasant hopes proved only temporary.

The failure of psychoanalysis. The psychoanalytic mode of thought is second only to the organic frame of reference as the favorite hypothetical and deductive system of professionals in the mental hospital field. Studies of defense mechanisms and id-derivatives may have been of assistance to the eventual understanding of human problems, but unfortunately as far as treatment of the schizophrenic is concerned, there is little or nothing to be gained from following the psychoanalytic model. Certainly one can translate phenomena of treatment into psychoanalytic terms by a Procrustean squeeze, but these terms have been based on "uncommon sense" observations in the first place. Many psychoanalytic deductions contribute to the pall of hopelessness which has been one aspect of the "style of life" of neuropsychiatric institutions: the basic unfavorable view of psychoanalytic treatment for schizophrenics; too much attention to biological, energetic concepts at the expense of observing the therapeutic effect of people, especially in the formation of primary and secondary narcissism (3, 8); a narrow view of love as debilitating rather than enriching the ego (3,8); an insistence upon a kabbalistic relationship (2); esoteric jargon as a necessity for a real cure; and the injunction that patients' problems are never to be discussed outside the therapy hour by patients, for this constitutes wanton defensiveness and dissipation of the optimal therapeutic tension.

When we grasped at the straws of somatogenesis and psychoanalysis, and refused to let go, the treatment aspects of mental hospitalization were forthwith temporarily doomed. Although the organic and psychoanalytic theories seem incompatible to the novice, they are both essentially constitutional, biological viewpoints sentencing the schizophrenic to poor prognosis and eventual chronicity.

The "incurability" of schizophrenia. When one incorporates the incurability myth into his attitudes, he becomes a living example of

R. K. Merton's uniquely human "self-fulfilling prophecy" (11). Physical laws operate beyond our thought control, but the laws of behavioral sciences must allow for the operation of the individual's universe of attitudes upon resultant behaviors. In other words, if I believe the incurability myth, I will act toward patients "as if" they were really impossible cases or objects, and, if this reaction is mirrored in many others, the patient *becomes* essentially incurable. The patient has been deprived of the interest of others, and is made to believe also by rejection that he is incurable. The phenomenon of chronicity as man-made rather than the end result of an endogenous disease process, has been ably reported by discerning psychiatrists (4, 5, 6, 13, 14).

To the hospital's error of incurability one might add the process of infantilizing "understanding" and the inculcating and reinforcing of the "sick role" and all its conditioned responses, e.g., enhancing somatizations and passive waiting for cures.

Incipient dissatisfactions with custodial care and psychoanalytic methodology as ways of solving the mental-health problem have brought back a host of ancient concepts and frames of reference. Values, sin and responsibility, free will and determinism have been resuscitated. Some value may be realized in time from their re-examination, yet it is difficult to judge what, if anything, has accrued from all this to benefit treatment of schizophrenics.

The existential trend has certainly highlighted the defects of psychoanalytic dogma. But it encourages another error in the neglect of etiological determinants. That is, responsibility, free will, and the like do not just grow like Topsy but have laws which govern their appearance. There is determinism—although Mazer (15) reports that psychiatrists subscribe to this law only during their office appointments—and the psychotherapist's task remains that of contributing something positive to the determiners.

IDENTIFICATION, A WAY OUT

The process of identification enters here. It can be conceived as just such a positive determiner, and the application of this concept may make our mental hospitals worthwhile institutions for re-socialization. But first its value must be recognized, its operation carefully reported, and eventually its experimental variables manipulated.

There have been a number of serious psychological studies on identification (7, 12, 16), but these have been far removed from the

psychotherapy of schizophrenics. Despite his brilliant research and incisive thought on identification, Mowrer (16) seems to have compartmentalized this work as he tackles the problem of schizophrenia. His thought here commences where we leave off: the ability of a patient to confess and take responsibility for transgressions. It is hoped that as Mowrer deals with more regressed patients, he will take into account his enlightening views on the identification process as a learning relationship based upon tension-reduction premises.

Some attention is paid to the concept of identification in psychotherapy at the present time. But this is mostly according to psychoanalytic thought, limited to the value which accrues from identification with a shadowy withholding authority, and amounts to lip service only.

Schizophrenics need much more than that. A first premise will be that the schizophrenic does suffer from a lack of adequate identification models. In his life he has had a paucity of significant others to aid in the development of a consistent sense of identity. He has never been helped to achieve the firm belief that he is a worthwhile unique person, with roots in the past, and a future in which he can make an important contribution to the lives of others. The schizophrenic feels that he does not really exist. He feels like a confused, unworthy appendage of someone powerful, or like nothing at all—a microscopic bit of plankton on an infinite stormy sea. He cannot assert himself normally because of fear of imminent cataclysm; so he talks and aggresses in a circuitous manner which he fears might be decoded by a potentially overpowering person.

In other words, the schizophrenic is one who suffers from extremely low self-esteem, the core theory of schizophrenia (17), and from lack of social relatedness. Thus the appropriate therapy is one of encouragement and socialization. If the patient cannot learn to socialize in the hospital, he has no alternative but to become a chronic patient. Before the icing of insight can be added, a stable bilateral relationship must be formed between the patient and the therapist.

Within the framework of such a view, identification implies the slow development of Adlerian social interest, an "evaluative attitude toward life (*Lebensform*)," actively encouraged by the therapist.

The ability to identify must be trained, and it can be trained only if one grows up in relation to others and feels a part of the whole. One must sense that not only the comforts of life belong to one, but also the discomforts. One must feel at home on this earth with all its advantages and disadvantages . . . The capacity for identification, which alone makes us capable of friendship, love of mankind,

sympathy, occupation, and love, is the basis of social interest and can be practiced and exercised only in conjunction with others. In this intended assimilation to another person or a situation lies the whole meaning of comprehension (1, p. 136).

IDENTIFICATION IN HOSPITAL THERAPY

Regarding the place of identification in therapy, perhaps it would be well to distinguish between the social interest of process schizophrenics and of reactive schizophrenics.

The hallmark of the process schizophrenic, who is highlighted here, is a preoccupation with personal panics to the exclusion of a positive interest in others—others who are in his eyes uniformly withholding, tantalizing, and tempting. There is no place for nondirectiveness here; such a patient must be taught social skills from the ground up and be rewarded for his essential humanness which he does not see.

This throws a tremendous burden of responsibility upon the therapist, from which he is sheltered by the organic and the “50 minute hour toward insight” approaches. He must be a *real* person with strong feelings of worth, hope, and unburdened by residual hatred. The therapist must be active and consistent in rewarding courage and in blocking generalized self-disparagement. For how can a patient incorporate attitudes which are seldom or only subtly and ambiguously expressed? The therapist must be able to venture into self-disclosure as a model for identification and to counteract the schizophrenics' perception of him as an omnipotent authority.

Double binding (17) must be minimized. Again this requires an active therapist who must be certain that the patient is not misinterpreting in silence. The act of double binding presupposes a dependent “victim” and authorities who communicate incongruous messages and will not allow discussion of the contradictions. Repeated exposure to such treatment is one method of inculcating low self-esteem in people, and is sometimes a sickness of the hospital itself. An example of institutional double binding is seen in cases where the patient learns to communicate more openly in group psychotherapy, yet at the same time his awkwardness is not tolerated by ward personnel, and he is restrained by physical or chemical means.

In the reactive schizophrenic there may be partial identification with others, and high self-esteem for a particular infantile image which the world outside of the primary group will not accept or reward. Social skills are more developed but without a mature attitude of mutuality. The role of the therapist here requires less “mothering” but more flexible “fathering” (8).

Identification with any real people, regardless of professional status, is the essential process of psychotherapy. Lack of acceptance of this is partly responsible for the dilemmas of co-professionalism and social intrusion, even in progressive humane hospitals (9). In fact, not only boundaries of the hierarchy of the professions but also the patient-professional boundary are here often still inviolate, and identification goes on in the one-up-and-one-down relationship of the circumscribed hour. When the therapist feels threatened by the patient, he believes that academic degrees and information necessarily keep an iron curtain operating between himself and the patient; the therapist seems to feel that growth and maturity in the patient will cost him so much libido as to leave him vulnerable. Actually, the therapist should know that the true differentiation between himself and the patient is his capacity for humanistic identification and his self-esteem, which the patient cannot take from him.

AN EXAMPLE

There is no doubt that being a real person, in the above sense, involved in ordering the confused world of another, is more taxing for the therapist than other models of therapy available. The difficulties with patient CC will illustrate what happens when the defensive social barrier goes down.

CC had been a member of group psychotherapy for over a year. He is a typical process schizophrenic with all the social gaucheries implied. His mother has been a mental patient for over 20 years, and his father is probably a paranoid schizophrenic uneasily tolerated by the community. CC was humorless, dogmatic, and handicapped by a borderline IQ. In the group he glowered silently at the members and appeared on the verge of fights many times. He later became very tremulous in psychodrama and started to derogate authorities and females indiscriminantly. These displays resulted in the application of many chemical restraints. When he went on initial group-therapy outings, he started to learn the value of some of the social niceties and received increased attention and reward for such. Shortly afterward he began to discuss sexual prowess in the group but wanted a pill to relieve these sins. Then a therapeutic dilemma reared its ugly head. The patient began to punch the therapist lightly and push him around whenever they met.

The typical attitude expressed by psychologically-oriented personnel was that the patient could not help such behavior and was expressing sexual and hostile bullying impulses. Such interpretations did not halt the patient's behavior. But when the therapist drew the line, the patient noted the anger easily, blamed the behavior on the

result of past ECT ("made me like a child"), then loudly threatened suicide. The therapist's approach was to admit his anger and state emphatically that the patient was capable of acting differently and not destroying himself. He pointed out that his anger was a sign of interest in the patient, and there was to be no rescinding of the patient's privileges. This elicited many expressions of hope and fear from the patient, which he had not expressed previously. The punching by the patient ceased, but his lack of social skills still kept him in close contact with chemical restraints.

CC's behavior is an excellent illustration not only of the difficulties precipitated by social contact, but also of the necessity of blending "objective" and phenomenal interpretations of the patient's behavior. Whereas the observers believed this to be the eruption of hostile and sexual responses, the patient stated that he was being friendly, "like the boys on the ward taught me." The latter pictures infantile expression more vividly.

REWARD AND PUNISHMENT

More active, identification-based psychotherapy undoubtedly requires more setting of limits, without double binding. Such tactics might sound spuriously like punishment, but are they? There is no taking away of privileges, no threat of lowering the self-esteem. This is not to say that all punishment is out of order, for it is a device in socializing the child and the schizophrenic. There are times when noncorporeal punishment is required in the raising of a child and his emotional counterpart, the regressed schizophrenic. The patient, like the child, is not allowed to harm physically either partner in a relationship, and harmful solutions are negatively reinforced. Punishment is frequently necessary in the daily routine of the ward. Personnel are chronically puzzled over the manipulations of rewards, especially the non-material interpersonal varieties. What to reward and with what? At times tension must be fostered in the patient to insure tension reduction, learning, and a creation of significance for the therapist, who schools the patient in the art of reducing tension and anxiety in the most efficacious style.

Failure to realize the potential incentive and reward value of the therapist as a real person, has encouraged us to continue glibly with an encapsulated abstract need-system philosophy. This awesome view of determinism has led to the cul-de-sac of subtly neglecting the patient ("he needs to be that way"), until personnel frustration ex-

plodes in arbitrary acts of mechanical restraint and withholding of privileges, leaving the patient no chance for queries. That is, we temporarily tolerate the patient's behavior as an expression of inexorable needs, without examining two important points: (a) Is the patient's behavior really need inspired, or simply habitual and therefore more amenable to change if someone encourages him without embarking upon emotional strangulation? (b) What influence can we bring to bear to alter the acceptance of such destructive determinism in favor of a more personally satisfying determinism?

A remark by SC, paraphrased by many other schizophrenics, will serve as an abrupt close. "I hated my mother because she'd say, 'Do what you want, dear,' but she'd never assist me to develop any skills except listen quietly as she read fairy tales to me. But at times when I thought I knew what to do, she said, 'Do what I say and don't talk about it!'" Are we in the mental hospital perpetuating the traumata?

SUMMARY

Psychotherapy with hospitalized schizophrenic patients has been tethered by treating it as the medical man's domain exclusively, by the tacit incorporation of psychoanalytic frames of thought, and by assuming the incurability of schizophrenia. If there is any truth in the premise that regressed schizophrenics are unsocialized and childlike, more active, extensive approaches must be employed in therapy, working toward the growth of humanistic identification on the part of the patients, in Adler's sense of identification as "intended assimilation to another person." Such proposed treatment would highlight the development of social interest in patients through the active support and understanding of therapeutic personnel who are skilled in "mothering" and "fathering," rather than simply observing and reporting symptoms. Difficulties involved in this approach would represent a necessary stage in the growth of mental hospitals and must be faced maturely if such institutions are to become treatment-oriented rather than remain custodial in nature.

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