

ATTENDANT-PATIENT COMMONALITY AS A PSYCHOTHERAPEUTIC FACTOR

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What would be the theory underlying the observed phenomenon that the professionally untrained mental hospital attendant can be an effective psychotherapeutic agent? It was Adler who stated that the factor which all psychotherapies have in common and which is the prerequisite for all, is that they establish for the patient a good human relationship, possibly for the first time in his life (1, p. 343).

This concept although similar to Freud's notion of transference differs from it importantly. Transference is defined as "the phenomenon of projection of feelings, thoughts, and wishes onto the analyst, who has come to represent an object from the patient's past" (11, p. 751). Adler meant the more basic concrete human relationship in the present situation, without which the debatable phenomenon of transference would not even be possible.

According to Adler, the good human relationship requires first of all social interest on the part of the therapist. By the demonstration of social interest to the patient, his potentiality for this, it is assumed, will be awakened. While the patient's awakened social interest will at first be directed toward the therapist, the goal of therapy is to spread it toward other people in general, eventually toward all of mankind.

At this point it becomes necessary to examine Adler's original term for social interest, for which there is no single adequate translation. The term is *Gemeinschaftsgefuehl*, the most literal translation of which might be considered to be "community feeling." Regarding mental patients, one thing is certain, which is that they live in a world of their own. For one reason or another, they have lost the feeling that they are part of the human community. This may go so far that a patient may act like an animal or, in catatonia, even like an inanimate object. Or, he may consider himself particularly close to God, again by-passing the human community. The old-type custodial institution gave strong support to this separation from the community on the part of the patient, which certainly was one of the important pathogenic factors in the first place. Thus the back-ward patients have notoriously shown further deterioration rather than improve-

ment, and the question was justly raised: "Do our hospitals help make acute schizophrenics chronic" (16)?

The entire endeavor of the Vermont Project (4), with which the principle author is associated, and of similar innovations in mental hospitals (13), has been to bring the patient back into the human community. This has been attempted through tearing down the hierarchy within the hospital which left the patient in his isolated position, and also the barrier between the ward and the community. An extensive system of graded privileges, educational opportunities, limited outside employment, visiting, etc. (3) has been developed, all for the purpose of bridging the separation of the patient from the community.

The implicit theory behind it is to restore in the patient the community feeling, which according to Adler is the criterion of mental health (1, p. 154). "As soon as the patient can connect himself with his fellow men on an equal and cooperative footing, he is cured" (1, p. 347).

In order to awaken this community feeling, all those who come in contact with the patient must, of course, demonstrate to him by their own actions that a community of man does indeed exist, that it is the living reality on which all of our lives are based. They must themselves "act out" community feeling. This is not something which those with professional training can do better than others. On the contrary, the professionally untrained attendant is in a better position to establish a community with the patient because he spends more time with him, knows his ways more intimately, and in our observations has been found to have a greater community of language, values, and certain other background factors.

To examine the nature of the commonality between patient and attendant and how this important therapeutic potential which rests in the attendant can be mobilized and utilized, is the purpose of the present paper.

NATURE OF ATTENDANT-PATIENT COMMONALITY

We at Vermont State Hospital have long maintained that the basic relationship in our work should center around the patient-attendant nucleus. We have maintained this because we have been aware that quantitatively and qualitatively patient and attendant are more linked together than are patients and other staff members. Everyone knows that patients see more of attendants than of anyone

else in the average state hospital, and that this being so, more problems will be solved and decisions made between patient and attendant than between patient and other staff members. Yet, in some settings higher-ranking staff members who see patients only infrequently assume that their roles outweigh those of the attendants in relationship to patients.

Hollingshead and Redlich (12) have pointed out that there is a distinct correlation between mental illness (most especially schizophrenia) and social factors. This fact coupled with the role they assign to cultural values in psychotherapy suggests that effective therapy can only be maintained when and if the basic values of patient and therapist concur in an effective way. Thus, to argue that the basic relationship ought to be between patient and professional staff seems to ignore basic problems in values and communication. In our work, we have observed that many times the professional staff is more unaware of the patients' values and problems than any other group. We are therefore convinced that the most natural and therapeutic relationship should be between patient and attendant in the majority of cases, and particularly in the majority of cases of chronic schizophrenic reactions.

Common backgrounds. In our setting we have observed that by and large the backgrounds of the chronic schizophrenic patient and the attendant are very close (7), in terms of level of education, degree of rurality, and potentiality of occupation, i.e., if attendants and patients all left the hospital and went to work outside, the types of jobs and range of income each group would attain would probably be comparable.

Most staff members in most state hospitals are aware of these things and may frequently demean the attendants as a result, suggesting that "they are little better than the patient." However, rather than being a demeaning factor this similarity should be recognized as a therapeutic blessing on the grounds that at our present level of understanding, comparability of background facilitates understanding and interaction among people.

We have some data to bear out this contention. In a questionnaire study (2) we asked released patients what had helped them most to recover (as well as other questions). When individuals were mentioned, they were more likely to be attendants or work supervisors than doctors or other professionals. This we felt to be especially significant because this questionnaire was administered by a psy-

chiatrist, and some patients may have been tempted to "fudge" a bit by naming the psychiatrist or one of his professional associates as the greatest source of help. On the other hand, we know that schizophrenics are especially truthful (15).

When these former patients did note that an attendant or someone comparable had been the source of greatest help, this was in one of two ways. (a) The attendant had performed some act or series of acts of straightforward kindness which helped the patient at the time, e.g. giving him his own clothes or some cigarettes. (b) The attendant had "talked straight," e.g., "If you don't stop talking that crazy talk you will never get out of here." When higher echelon staff were mentioned, the same things might be said, but more often than not, the patient would explain their help in more vague and indirect terms.

Acts of kindness. At the level of doing for and with patients, attendants are more in a position to perform a straightforward act of kindness for a patient than anyone else and are more inclined than anyone else to do so anyway. This is true because attendants' relationships with patients are functionally diffuse whereas the relationships between patients and other staff members are more functionally specific. Psychiatrists and doctors, for example, interview patients but do not traditionally do things with and for them. Nurses relate to patients through attendants rather than to patients directly. Research workers study patients and worry about interacting with them for fear of losing objectivity or contaminating research design. Some of the above specifications of duty, or social distance between patient and other staff members are a function of the bureaucratic structure of the state hospital in which prestige can in general be measured by decreased interaction rates with patients (14).

Talking the same language. But, in addition we would allege that the attendant is able to help the patient through a straightforward deed not altogether because he inherits this role by default, but because he is most likely to understand the patient's needs, being culturally closest to him.

It is logical to suppose that two people can talk together more meaningfully when they are culturally similar rather than dissimilar. Hollingshead and Redlich (12) point out that middle and upper class psychotherapists quickly become impatient with lower class patients because they do not understand the value system of the therapist, in other words, "don't talk the same language." We assume conversely

that patients and attendants do talk the same language more readily than do patients and other staff.

Lay approach to communication. But, we are not only concerned with talking the same language in the sense of content of speech and idiosyncratic speech similarities; we feel that the attendant handles the disturbed communication of the schizophrenic patient in a more therapeutic way than is generally true of other staff.

Haley (10) has pointed out that the schizophrenic frequently refuses to acknowledge the presence in a social setting of another person and uses a variety of devices to accomplish this. The professional when confronted with this problem often takes the "what do you mean when you say" approach. The general result, except in the hands of a very skilled expert, is for the professional to be "led down the primrose path" of delusion.

The average attendant would perhaps realize more clearly that the patient is trying to deny a relationship, and instead of playing the patient's game would conclude either "if he doesn't want to talk to me then I'll leave him alone," or insist "if you are going to talk to me then talk so that I can understand you." The first approach permits the patient to deny the relationship, but prevents the therapist from getting lost in the patient's fantasy. The second approach forces the patient eventually to give ground and to communicate realistically. In our experience, success in talking with disturbed patients has proceeded only on this lay basis.

Yet, on the other hand, it must be acknowledged that professional prestige is based on the supposed knack of understanding the patient's symbolic speech and participating in it with him. Now it may be that occasionally one can challenge the patient in his terms so to speak, and Haley and others (9, 10) have given some instances where this has been productive. However, in our experience the lay approach works better, and we feel that when professional staff is successful in communicating with patients, this is accomplished by using the attendant's straightforward approach. Coupled with this is the further corollary typical of a lay approach: if the patient does or says something that can be interpreted in terms of patient culture in the hospital, then accept this explanation rather than look for evidences of complicated psychodynamics at work.

Absence of commonality. It is equally true, on the other side of the coin, that if patients should differ markedly from attendants, then the

intimate relationship between them will be harmful rather than beneficial. We have been notably unsuccessful with patients of college education, or in "private" status. Indeed, the patient-attendant relationship has been marked by severe conflict in many of these situations. Therefore, it may be necessary in private mental hospitals characterized by either highly educated or wealthy patients for top professionals to maintain the closest relationships with patients rather than for attendants to do this. However, it may still be true in these situations that the "lay" approach would serve better than any other.

IMPLEMENTING THE ATTENDANT-PATIENT COMMONALITY

All that has been said can be invalidated if the hospital hierarchy denies the attendant his realistic opportunity to be a therapeutic agent. On the other hand, supporting the attendant in his therapeutic effort with patients involves basically that he be included in all policy-making decisions concerning patients either directly or indirectly. Of course, this ideal is one of the cornerstones of the therapeutic community, and many descriptions of the process of bilateral or cross-hierarchical decision making and working together have been given (4, 6, 13). The model for this has perhaps most clearly been set forth by Jones (13) whose work has given much of the tone to therapeutically oriented rehabilitation programs.

We feel that we have begun to approach the ideal. There is no greater proof of this than a decision in which the wishes of the attendants have been honored over those of higher echelon personnel. In our experience we have a number of instances in which this has happened. Again, nothing conceived by higher ranking staff for rehabilitation patients can be acted upon unless such programs are first cleared with the attendants, and their cooperation is gained. Our patients do not usually see the psychiatrist without the attendant's permission and presence. This policy gives the attendant the right to communicate with the patient in the presence of the psychiatrist and in many ways reduces the "mystique" associated with the so-called "psychiatric interview."

It must be realized that steps such as the above produce hostility and anxiety on the part of both attendants and professional staff. Most reports, including our own (4), do not develop these points of friction sufficiently, and the reader is justified in being suspicious when reports are made concerning the therapeutic use of the attendant which stress only cooperation and progress.

In our work, higher-echelon staff have often felt that the attendant had taken over the hospital. On the other hand, the attendant is frequently very anxious in his new status and frequently has to be pushed into utilizing the prestige and equal voice he has acquired. Some attendants seem for a time to become less autonomous than in the past. They seem paralyzed in a changed situation. Certain others may overstep bounds in the sense of utilizing new-found authority for manipulative purposes and the expression of pent-up hostility against the institution's former rigidity. There is then a constant problem involving the attendant's reluctance to assume a higher place and his tendency to utilize this higher station in a manipulative way.

This point has been developed at some length because the transition from a custodial to a therapeutic institution cannot be made without considerable stress and strain even when principles of gradualism are utilized, and when realistic attempts are made to integrate programs functionally. It is easier, of course, to see how trouble develops when rehabilitation and therapeutic principles are imposed by fiat (17).

Using attendant's verbal and thought patterns. In order to have basic communication with attendants, higher staff personnel must utilize the attendant's verbal patterns and to some extent his thought patterns in the communication process. This must be done not in a demeaning, condescending, and political fashion which has overtones of talking down to, and destroys communication, but rather in a natural fashion on the understanding that this is the only way that effective communication is possible. Most attendants are naive as regards the lexicons of medicine, psychiatry, and social science. Most professionals are naive about the lay language of attendants. However, it is probably more possible for the professional to talk and think like the attendant, then for the reverse to be true. The point is not that the professional oversimplify and distort his ideas and his values, but rather that he couch these in common-day speech. If he cannot do this, he cannot effectively communicate with attendants and cannot utilize their therapeutic potential. After all, it is true that people have been talking about things psychiatric and social for centuries and doing it well, whereas professional labels are very new and the province of but a few.

At Vermont State Hospital we have witnessed an increased ability for effective communication, due in large measure to the professional's ability to understand and utilize the language and ideas of the lay-

man. Perhaps in our setting this is not as great a problem as it would be in other settings having a higher ratio of professionals (8). The point is that formal structure and channels for communication only insure the opportunity for people to talk and decide together. These do not guarantee that people will understand what is getting said.

Using attendant's knowledge about hospital and patient. The second way that the therapeutic potential of the attendant may be used is in terms of applying, and helping him to apply, the fund of knowledge he has about the hospital and the patient to the best therapeutic purposes. Here the professional must recognize that it is the attendant who really knows what's going on apropos of the patient. In fact, the attendant may be the only person having any accurate idea about the daily life of the hospital at the ward level. However, to draw this information out and to apply it, requires awareness of it and respect for the attendant's place in the scheme of things. All too often higher staff refuse to recognize that the attendant knows anything, and would feel it humiliating to ask for much information.

Even if we assume that the attitude is such as to permit freedom in getting and using the knowledge of attendants, there is the further question of the model, i.e. the view higher staff planners have which conditions what kind of information will be sought.

In another context (3) we developed the model that the attendant serves in a pseudoparental capacity. We drew analogies between ward life and family life. Within this frame of reference we sought information which would bear on this model. Were one interested in establishing a more "custodial" frame of reference, one would seek information along altogether different lines. In a sense we are all captives of our concepts and models and, to paraphrase an expression, "Truth is in the eye of the beholder." This problem of model cannot be separated from the attitude which one has toward the attendant, the effectiveness of the mode of communication with him, or the influence one has on him.

Educating the attendant. While we have adopted much of the language and techniques of the attendant, and have used these as the bases of communication with attendant and patient, the attendant has to some extent been "professionalized." Group activity leaders (who include attendants and others) work together in weekly instructional meetings (which constitute an "in-service" form of training, i.e. learning while doing), to collect information bearing on such

topics as "how patients in groups handle problems which arise," "what the leaders are able to learn from patients," and so on. The leaders are asked to direct themselves to these questions, and to conduct group activities with a view to amassing information for discussion.

The above suggests a fairly profound educational venture at a reasonable level of sophistication. There is, however, this important point to be noted: No technical terms of any kind are used.

In most places, the basic direction is to teach the non-professional staff the rudiments of psychiatric terminology, and to strive to get them to think in terms of psychic mechanisms, psychodynamics, and so on. But, thereby, only a language and a series of abstractions are taught. And, what develops may well be the substitution of a pseudo-analytic interpretation of behavior for direct "encounter-type" interactions between attendant and therapist. This sort of superficial training often turns a good attendant into a reasonable facsimile of an undergraduate psychology major. Drives and symptoms become substituted for human behavior. The attendants may be overwhelmed by concepts, with resulting detriment to their work.

But, if the language and ideals of the attendant are permitted to stand, he can learn a great deal about interpersonal relations in rather profound dimensions and end up doing his job in a more mature fashion. Our attitude on this point could be considered anti-intellectual. We choose to think of it as actually pro-intellectual, with regard to common sense, although anti-terminological. We hold here with Adler in his abhorrence of technical jargon. Of him it is said that after one of his lectures a physician remarked to him that he spoke only common sense. Adler's reply was, "Why do you not also?" (5).

Maintaining personal contact with the attendant. We try to break down the older traditional system which substituted chains of command, memos, telephone calls, and so on for direct face-to-face contact. Personal relations based on concrete problems to be worked out and solved take the place of maintaining stability by minimizing problems through bureaucratic structure and impersonal contacts. The very virginity of the work makes it dynamic, unstable and problem-centered. In contrast, the more custodially oriented hospital is oriented toward "the uneventful day" (14). Firm structure and lack of change become goals in themselves.

The danger which confronts our program, and others like it which have been going on for some time, is that they will become

institutionalized, with structure becoming an end in itself. One of the guarantees against this is to keep all groups working together on tangible problems. We feel that nothing is ever permanently solved and that disintegration threatens if personal contacts diminish. Involved in keeping this spirit are certain administrative techniques and policies which are, however, beyond the scope of this paper.

In conclusion a word should be said about two terms much employed to describe therapeutic efforts for rehabilitation: "team" and "consensus." Both are overused and tend to convey a false impression. "Team" implies a coordinated and well-planned effort based on high specificity of performance, with clear-cut, rational ends and objectives clear to all. This term is borrowed from a game analogy and makes one think of the high skill and coordination, e.g., of the double play and the forward pass. "Consensus" implies neat agreement, harmonious working together, and the existence of no marked differences of opinion. These terms are too static, too rational, and too structured to convey what this work is really like. They can suggest a lack of dynamism and sense if faceless groupism to this work, which does not exist. They refer more to the static impersonal bureaucracies from which we are trying to get away. We would do better to find a vocabulary that suggests the real nature of interpersonal relations. We run some danger of using certain terms so constantly that we will eventually impute to them properties which were not meant to apply in the first place.

Rather than "team" and "consensus" true rehabilitation work involves varied people working together constantly in a face-to-face way, reaching essential agreement based on a broad interchange of ideas, with the understanding that there will be disagreement, but that everyone will work with the will of the majority whether he really agrees or not.

SUMMARY

The attendant has the best opportunities of any member of the state hospital staff for communicating and relating with the patient. This is by reason of his commonality of background and language, and his close association in doing things with the patient. Further, his lay approach has been found more effective than the "deeper" interpretations of the professional. The attendant's role should therefore be implemented by intercommunication with the rest of the staff in lay terminology, and by giving him a greater part in decisions

affecting the patients. His therapeutic usefulness is understood in the light of Adlerian theory which sees therapy as the process of developing the patient's community feeling.

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