Reprinted from *Diseases of the Nervous System,* Vol. XXII, No. 9, September 1961.

Do Our Hospitals Help Make Acute Schizophrenia Chronic?

NATHANIEL S. LEHRMAN, M.D.

This paper offers the hypothesis that at times some of our psychiatric hospitals may inadvertently have an antitherapeutic effect on patients, thereby tending to make some acute schizophrenic reactions chronic. It will attempt to indicate how this process may take place, and will suggest certain procedural and attitudinal changes to prevent or correct it.

The Susceptibility of the Acute Schizophrenic

Acute schizophrenia is usually characterized by symptomatology which is both florid and fluid. Relatively small stimuli during periods of acute illness and intense agitation tend to elicit large responses. While every human being is constantly responding to the circumstances in which he finds himself, the acute schizophrenic, by virtue of his lability and instability, seems particularly sensitive to the influences impinging on him at any given moment.

Dollard and Miller[1] have suggested that in mental illness, "the progression from an initial profusion of variable symptoms to fewer constant ones is the result of differential reinforcement." Similarly, it appears that the progression from acute to chronic schizophrenia in our hospitals may also be the result of unconscious differential reinforcement of chronic schizophrenic responses by the total hospital environment. For each patient this environment can be seen as having a specific medical and a general social aspect.

The Role of the Physician

The physician plays a significant role in facilitating certain responses from his patients and inhibiting others. While this is true in all branches of medicine, it is perhaps most significant in the psychiatry of functional mental illness, where no independent organic processes have been demonstrated whose presence alone might be responsible for symptoms.

Balint[2] has described clearly the physician's role in the reinforcement of the symptoms of "nervous" patients. He points out how such troubled patients come to their family doctors "offering" a particular symptom or response. This tends to be retained if the doctor considers it important, but tends to be dropped, with another symptom sometimes offered instead, if the doctor is unresponsive. Balint writes:

> "Some people, who, for some reason or other, find it difficult to cope with the problems of their lives resort to becoming ill. If the doctor has the opportunity of seeing them in the first phase of their becoming ill, i.e. before they settle down to a definite 'organized' illness, he may observe that these patients, so to speak, *offer or propose various illnesses,* and that they have to go on offering new illnesses until between doctor and patient an agreement can be reached, resulting in the acceptance by both of them of one of the illnesses as 'justified.' In some people, this 'unorganized' state is of short duration, and they quickly settle down to 'organize' their illness; others seem to persevere in it, and although they have partly organized their illness, they go on offering new ones to their doctors. The variety of illnesses available to any one individual is limited by his constitution, upbringing, social position . . . etc."

If we substitute the words "symptom" or "behavior" for the word "illness" in the above discussion, we have a reasonably accurate picture of what occurs between an acute, hospitalized schizophrenic and his doctor. The patient presents a welter of troubling thoughts and feelings to his doctor, who tends to select out only some of them for more detailed investigation. If the

physician's primary orientation is diagnostic, he will tend to be more concerned with those responses which have a bizarre flavor, such as hallucinations or delusions. The fact that the doctor selects these particular responses for scrutiny will underline their significance to the patient. The latter may then tend to become more anxious, as well as more aware of, and disturbed by, what might have been relatively minor incorrect thoughts or feelings. If the doctor does not explain to the patient that symptomatology of this kind can be understood—e.g. by suggesting that these incorrect, pathological responses may be the panic-produced responses to unresolved conflictual stimuli—the patient, knowing this symptomatology is "crazy," will easily become even more frightened by the greater attention being paid to it.

Several years ago, this author attempted an experiment at a large municipal psychiatric hospital. There was little active treatment at the hospital then; primary emphasis was placed on diagnostic labeling. Although it was not clearly appreciated at the time, the diagnosis of "psychosis" seems to have been made by the *fact* of the patient's admission to the ward; the "diagnostic problem" of the physicians was primarily to decide *which* psychotic diagnosis was to be given the patient to justify his transfer to a state hospital.

The purpose of the experiment was to determine the effect on the patients of a consciously harsher attitude taken by the doctor. Not surprisingly, it was found that a stern, cross-examining attitude made it far easier to elicit psychopathology, and thus to justify a diagnosis of psychosis. If, for example, patients admitted "strange experiences," they were repeatedly prodded, beetle-browed, as to their absolute certainty that they had not been having hallucinations. If an affirmative reply was elicited by such inquisitorial tactics, a rather shame-faced sense of victory was sometimes experienced by the physician at having clinched the diagnosis.

This approach, quite different from the examiner's usual manner, was attempted with about half a dozen patients. Although it was noted that psychopathology could be elicited far more quickly, it was also found that the patients seemed far more disturbed after such interviews than they had been before, or than they had been after interviews conducted in the examiner's usual friendly fashion. It seemed apparent that this grilling method of questioning was harmful to the patients and it was abandoned.

Yet, this same kind of inquisitional procedure may still go on unknowingly between some harried state hospital doctors, pressed to get a diagnosis down on paper, and their patients. A patient looks for help from a physician, and expects to comply with his wishes in order to get it. If the doctor implicitly suggests, as in the experiment described, that the patient is "insane," and this suggestion is accompanied by considerable psychological pressure, the patient will be under strong pressure to respond in the apparently-expected fashion. But if the patient's response is a self-belittling one, as it would be in this case, considerable inner turmoil can be the result.

The Role of the Hospital Milieu

In large state hospitals, the role of the hospital milieu may be even more important in reinforcing schizophrenic responses than the unconscious anti-therapeutic activities of physicians. The most important anti-therapeutic effect of the hospital atmosphere may result from its reinforcement of passive, "troublelessness" responses. While such passive responses are far easier for overworked hospital staffs to handle in the short run, they tend to sap the patient of his self-esteem and his self-assertiveness at the very time that he needs them most: immediately after a panic-produced emotional disorientation, i.e., an acute schizophrenic episode.

Awareness is growing of the extent and the manner in which inconsiderate hospital routines may aggravate mental illness. Macmillan[3] has stated:

"Many of the symptoms which we had formerly regarded as due to the psychosis were in fact due to the restrictions which we had imposed on the

patients, and disappeared with the removal of these restrictions. . . . The resentment and feeling of injustice which certification causes in the mind of the patient is intense, and it lasts for many years. When patients are in a state of emotional upset, when their self-confidence is already seriously undermined and disturbed, to deprive them of civil rights depletes that stock of self-confidence even more at this critical phase of their life. One can hardly imagine anything more likely to upset them. The depressed patient becomes more depressed. The delusional become more fixed in their reactions and consider that they have justification for them. Withdrawal symptoms become more pronounced."

Hunt[4] summarizes the viewpoint that hospitals sometimes tend to augment pathology.

"Much disability in mental illness is (considered by some to be) artificially superimposed . . . treatable and . . . preventable. Disability is in large part artifact of extrinsic origin. . . . Much disability associated with psychotic illness is not part of the illness as such . . . (certain social) attitudes (may) lead to rejection and extrusion of the deviant individual. This extrusion cuts off the individual from opportunities to develop skills and results in atrophy of skills already possessed. This loss of potential skills for living constitutes an artificially produced disability. . . . Macmillan and Rees . . . have shown beyond question that much of the aggressive, disturbed, suicidal and regressive behavior of the mentally ill is not necessarily or inherently part of the illness as such, but is very largely an artificial by-product of the way of life imposed upon them. . . . Our modern standard practices may be almost as brutalizing and degrading as those which Pinel abolished."

These modern standard practices, and the details of their impact upon the patient, are the subject of Goffman's distinguished researches.[5] He has written:

"Once (the patient) begins to settle down (in the hospital) the main outlines of his fate tend to follow those of a whole class of segregated establishments—jails, concentration camps, monasteries, work camps and so on—in which the inmate spends the whole round of life on the grounds, and marches through his regimented day in the immediate company of a group of persons of his own institutional status. Like the neophyte in many of these 'total institutions,' the new inpatient finds himself cleanly stripped of his accustomed affirmations, satisfactions and defenses, and subjected to a rather full set of mortifying experiences: restricting of free movement, communal living, diffuse authority of a whole echelon of people, and so on. Here one begins to learn about the limited extent to which one's conception of one's self can be sustained when the usual setting of support for it are suddenly removed.

"While undergoing these humbling moral experiences, the inpatient learns to orient himself in terms of the 'ward system.' In public mental hospitals this usually consists of a series of graded living arrangements built around wards, administrative units called services, and parole status. . . . For disobeying the pervasive house rules, the inmate will receive stringent punishments expressed in terms of loss of privileges; for obedience he will eventually be allowed to reacquire some of the minor satisfactions he took for granted on the outside. . . . The ward system, then, is an extreme instance of how the physical facts of an establishment can be explicitly employed to frame the conception a person takes of himself. . . .

"Each moral career, and behind this, each self, occurs within the confines of an institutional system, whether a social establishment such as a mental hospital or a complex of personal and professional relationships. *The self, then, can be seen as something that resides in the arrangements prevailing in a social system for its members.*" (Perhaps "role" would be a better term than self—NSL.) "The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him. *This special kind of institutional arrangement does not so much support the self as constitute it.*" (Italics mine—NSL.)

Psychiatric or Democratic Institutions

It is rather noteworthy how apathetic this submissive, institutional schizophrenic "self" is. Mental health involves "the continuation of constructive activity and organismic growth," writes Menninger,[6] and this requires that an individual have the courage of his own convictions. Too often, the mental hospital may undermine this courage by making the psychiatrist the unquestioned expert on the moral value of everything.

Such a fundamental conflict between his American democratic heritage and the autocratic institutional realities thus imposes an additional stress on the acute schizophrenic patient at a time when he is least able to cope with it. Are his physicians healers or jailors? Sometimes they speak like the former and act like the latter. The lack of clarity resulting from this conflict serves only to make patients increasingly confused, and to foster the apathetic "troublelessness" responses of chronic schizophrenia.

Patients sense the inconsistencies in the hospital atmosphere, and at times rebel blindly against them. Such rebellion, although incorrect overall, may indicate the presence of a spark of healthy self-esteem in the patient. But in hospitals, such rebellion is usually treated far more punitively than is the apathy of the back-ward hebephrenic. Since there is usually insufficient staff to help the patient to see the healthy aspect of his incorrect rebellious behavior, he begins increasingly to see life as presenting a choice only between punishable defiance and relatively painless apathy. The latter response tends often, in consequence, to be chosen.

The fluidity of the acute schizophrenic response, and the great sensitivity of the acute schizophrenic patient to external stimuli have been mentioned. Once a response is established, however, it is harder to eliminate. As Dollard and Miller[1] point out:

> ". . . if the progression from an initial profusion of variable symptoms to fewer constant ones is the result of differential reinforcement . . . then we would expect these later symptoms to be harder to eliminate because they had received more rewarded practice. This is apparently exactly what happens: Grinker and Spiegel report that 'treatment of war neuroses becomes more difficult as time goes on,' and this is indeed the general clinical experience. . . . If the symptom is learned by reinforcement, we would expect any additional reinforcements that are received to increase its strength and make it harder to eliminate. This expectation is confirmed by the well-known fact that secondary gains, such as pensions, that are dependent upon a symptom make it harder to get rid of that symptom."

Are Schizophrenics a Biological Subspecies?

It may be suggested that the autocratic quality of some psychiatric hospitals exists because the patients are so sick. It may be contended that schizophrenic human beings differ in some unknown essential way from other human beings. Perhaps this difference lies in some still-undefined biological or genetic factor which makes the schizophrenic less capable than the rest of us in handling stresses. A logical end-point of this position, which is usually not stated, is that the schizophrenic should be considered some kind of slightly subhuman subspecies. This viewpoint is strongly disagreed with by Menninger.[6]

Whichever viewpoint is taken, however, it seems clear that all humans, whether or not they are schizophrenic, learn from experience and are affected by their environments. Irrespective of one's personal position on the "essential nature" of schizophrenia, it seems likely that patients suffering with it can be harmed by hospital treatment which promotes "troubleless" reorganizations of the personality.

Certain changes which would improve situations such as those just described are worthy of consideration. The first would involve a conscious attempt to shorten the duration of psychiatric hospitalization and hence the exposure of the patient to the authoritarian atmosphere of the hospital. A second might be a fuller recognition of the extent to which the therapeutic atmosphere of an institution is determined at its very top. A third might be a re-evaluation of the role and function of the patient's family, and of the methods hospitals have evolved of dealing with them. Each of these suggestions will be discussed briefly.

The longer patients remain in the hospital, no matter how comfortable or psychotherapeutic that hospital may be, the poorer do their chances appear to be for ever returning to useful functioning. This has been suggested statistically for several differently diagnosed groups,[7] although it has not been demonstrated statistically with schizophrenics. Consideration of the sociological interactions described above, however, suggest that conscious attempts to reduce the duration of hospitalization should be made. Perhaps a period of a few weeks should be considered the optimal period for psychiatric hospitalization, and patients who remain beyond this time should be considered as treatment failures, warranting the same detailed investigation as accidental deaths.

A second area for possible change in some hospitals lies in recognizing more fully that the therapeutic atmosphere of a hospital, like the morale of a military establishment,

is determined primarily at its very top. Almost all top administrators are already aware of this fact, although sometimes this awareness may be intuitive rather than explicit. A superintendent's courage, honesty and humanity, his recognition that his patients are really his brothers, can percolate down to every ward attendant. A superintendent with a deep sense of worth in himself, and pride at being able to help his fellow man, can be a noble example to his entire staff.

A third area for possible change lies in reevaluating the relationship of the hospital to the patient's family. Sometimes a hospital's rigid exclusion of the patient's entire family, his main source of interpersonal support, may tend to widen the gap between them. The patient is made to feel deserted at the time he believes he needs their help most. While temporary physical separation of a patient from his family is often necessary, an emotional chasm between them should, in general, not be allowed to develop. But such chasms do sometimes appear. One cause is that some busy physicians tend to see relatives as rather annoying nuisances. Another is the practice of having a different individual, e.g. a social worker, see the family while the doctor deals only with the patient. This may tend to further the divisive, and therefore anti-therapeutic, effect on the people concerned.

Direct responsibility for the entire family unit, one of whose members is ill, might well be vested in one individual—the physician. Macmillan[3] points out that in his experience, "the interpersonal relationship between the patient and the members of the family was a most important factor which required treatment. That is to say adjustment of the attitude of the relative was often as important as treatment of the patient." It seems relatively elementary to suggest that this mutual adjustment process can be handled far more efficiently by one person than by several. However, dividing each family among psychiatrists, social workers and other professionals still seems to be the rule rather than the exception. Some aspects of treating the entire family have been discussed by Ackerman[8] and by the present author.[9]

Conclusion

Hypersensitive acute schizophrenics may be unconsciously led in an anti-therapeutic direction by authoritarian practices in some psychiatric hospitals. A number of the factors tending to produce this effect are discussed, and some specific recommendations for their improvement are offered.

REFERENCES

1. Dollard, J., and Miller, N. E.: "Personality and Psychotherapy." *McGraw-Hill,* New York, 1950. p. 195.
2. Balint, M.: "The Doctor, His Patient and the Illness. *International Universities Press,* New York, 1957, pp. 18, 32.
3. Macmillan, D.: Hospital-Community Relationships, in "An Approach to the Prevention of Disability from Chronic Psychoses." Milbank Memorial Fund, New York, 1958, p. 29.
4. Hunt, R. C.: Ingredients of a Rehabilitation Program, in "An Approach," etc., op. cit. (3) supra.
5. Goffman, E.: The Moral Career of the Mental Patient. *Psychiatry,* 22, 123, 1959.
6. Menninger, K.: The Unitary Concept of Mental Illness. *Bull. Menninger Clinic,* 22, 4, 1958.
7. Lehrman, N. S.: The Uselessness of Prolonged Psychiatric Hospitalization. Paper read before the Annual Meeting of the American Psychiatric Association, May 1960, Atlantic City, N. J. *Comprehensive Psychiatry,* in press.
8. Ackerman, N. W.: "Psychodynamics of Family Life." *Basic Books,* New York, 1958.
9. Lehrman, N. S.: The Family, a Biosocial Hierarchy; How Democracy Begins at Home, paper read before Section K, Social and Economic Science, American Association for the Advancement of Science, December 30, 1959, Chicago. Ill. *Psychiatry,* submitted for publication.