Dr. Osmond's Memos

MODEL MUDDLE IN A UNIVERSITY HOSPITAL, A SPLENDID EXAMPLE

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Bette Howland W3
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Ms. Howland's book is one which, I would like to think, would be read with assiduity by all those who run psychiatric wards, but especially by those who run university hospitals. For it is in a university hospital, unless I am mistaken a very famous one, that Ms. Howland had the opportunity to make incisive and brilliant observations following her fortunately unsuccessful suicide attempt. I might add that I very much doubt whether those who run university hospitals have even heard of Ms. Howland and her excellent book. Doctors are, on the whole, notably incurious about the patient's view of illness, so perhaps it would not be out of place to suggest that those many lay committees associated with university and other hospitals present copies of this book to their medical employees and urge them to read, mark, learn, and inwardly digest it. I realize that this may sound a drastic move, but sometimes these moves are required.

The author's description of coming around from her suicide attempt is admirable. I was much impressed by the extraordinary technical cleverness of the hospital, combined with an equally extraordinary clumsiness in the human aspects of the catastrophe which had enveloped and nearly destroyed her. About the only human contact she appears to have had during these crucial hours of recovering from being very close to death was her nurse Henrietta, whose daughter had the surprising ambition of wanting to go to morticians school. Henrietta was not wholly happy about this decision, but seemed resigned to it, saying, "She may not be all that bright, but is she stubborn!" Adding, "I won't stand in her way."

Henrietta decided that Ms. Howland's aphonia, probably the result of her being intubated, was a hysterical manifestation . Apparently no one had bothered to explain either to the patient or the nurse that this is not unusual. Henrietta's splendid efforts were therefore wasted. In addition to Henrietta, Ms. Howland's mother came to help. At first her efforts seemed to have been resented, but as we will see later on, she soon became incorporated, at least into the nurses' view of the community, when she

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reached the psychiatric ward.

On her first morning after arriving in the ward, there were what are called community rounds, for this particular ward was being run as a community, since this is now a fashionable thing to do. At these community rounds, patients were called upon to introduce themselves to the group. This morning, however, there was considerable surprise when Iris, describing herself as "a manic depressive of 27 years standing," proceeded to hold the floor. The author describes this unexpected event in these terms (Page 27):

This was not the customary response, this was a power play. Iris was claiming seniority, like a bird in a barnyard . . . Iris was not taken in by all this community stuff, the illusion—successfully maintained with a good many of us—that it was our relationship with other patients that was important to us, that was going to help us. She had been around long enough to know that her survival in a mental ward depended upon her status with the doctors. They were the ones who dealt out the pills, the passes, and finally the discharges. She knew the score and she was letting them know. Ms. Howland gives us a brilliant account of her induction into this therapeutic community. Apparently, these community rounds occurred with about 50 people present. And before long she was asked to introduce herself. She says (Page 31):

/ didn't feel like telling this bunch of strangers how greedily I had wolfed down a whole bottle of sleeping pills, or about the considerable time I had spent in livid imagination, laying my cheek to the greasy doors of gas ovens. I didn't feel like telling them anything. I could explain all right, but it would take too long. It would take my whole life. I could sense it behind me, cold submerged like an iceberg. I declined to speak on account of my voice. "WHAT'S THE MATTER WITH HER VOICE, CAN'T SHE SPEAK UP?" The doctor in charge of the ward then said, "IS THAT WHY YOU'RE HERE, YOU CAN'T TALK WITH SOMETHING WRONG WITH YOUR VOICE?"

Ms. Howland's inability to speak caused a considerable amount of discussion and argument. However, the community was put out by Iris' holding forth with such skill and knowledge (Pp. 33-34).

But one thing was clear, Iris was creating no tension, no interaction. Our "community" was suffering a collapse. Night and day we were a community, the fact was relentless. THIS UNIT IS NOT TO BE USED AS A THOROUGHFARE, the sign on the glass door spelled out. Though the ward was locked, our doors must be, at all times, open. Patients must have roommates, except for those in isolation (and they were envied for it and for their locked doors). We were not to be alone. The little rooms with their dormitory bunks, colored bedspreads, plastic desk lamps, were not to be a refuge. We were expected to be out in the communal areas of the ward, Rec Room, lounge, Occupational Therapy, gathered around the piano, pool, or ping pong tables [the eternal triumvirate of psychiatric wards). Active participation colliding with life— life which was to be found somewhere out there and not in ourselves, demonstrably not. The places of our meeting were lifeless enough, faces present and accounted for. We were faces, not bodies and souls.

However, while keen about these community matters, the hospital seems to have been much less helpful about practical matters such as getting toothbrushes, combs, clothes, etc.

All the patients were heavily drugged. One wonders whether this constant emphasis on community had made it necessary for them to be given these large quantities of tranquilizers.

Because she wasn't drugged, due to the condition of her lungs, Ms. Howland astounded the nurses by filling in a psychological questionnaire, presumably the MMPI, on the same day that she was given it (Page 43).

When I handed the test in later the same day, the nurse seemed to be taken aback. It occurred to me that I hadn't been expected to finish it right away—ever maybe,—and that my confusion was a

more widespread general condition. She never received, as far as I can make out, any feedback regarding this test, which just disappeared. In the evening, they had the Patients' Meeting, where patients presided (Page 54).

These Patients' meetings after dinner were sparsely populated. Cone were the stiff white coats, which strode in and out so rapidly during the day. Now there would be only the nurses, at most two or three [there was a constant reduction in numbers, a sense of attrition as the day wore on, shrank toward night), sitting about like peaceful chaperones, their heads bowed over the hooked rugs in their laps. Hooking rugs was all the rage on the ward, though it was mostly the nurses who had such projects; they spent more time in Occupational Therapy than we did. The patients felt that the main idea of the Patients' Meeting was to get on to passes and privileges, which was what they were all waiting for. These were discussed at considerable length; however, we then discover on Page 64: *And so on. Each request duly discussed, then voted on with a show of hands. Yes! Yes! Yes! But it makes no difference if we always vote yes. This is a mock tribunal. We have no power to grant Passes—only to ask, like Flora. So what are we doing then? Why are we sitting here? Making our requests, voting? We are behaving—like Doris—mocking ourselves, playing the game.*

Trudy was right. This meeting sucks. Interestingly enough, the doctors apparently never explained to anyone what the object of this, to me quite absurd, exercise was. It has a Kafka-like flavor. What it was supposed to do for the patients is a matter which requires some explaining.

There was one exception to the rule about doors being shut. One day Ms. Howland found that her door was shut (Page 65).

/ found the door closed. This was highly irregular; inmates were never permitted to shut their doors. A nurse came tiptoeing up to me in the hall, her finger to her lips and pulling a long face:

"SHHHH! she warned. "YOUR MOTHER IS RESTING!" What is it? What's the matter? What's happened? "IT'S ALL RIGHT. SHE'S FEELING BETTER NOW." Her mother then later says: *"The nurses have been so sweet to me. They gave me aspirin and brought me tea ..." She held the empty cup aloft in the crook of her finger.* Ms. Howland adds: / was *fit to be tied. I couldn't get aspirin—it was not on my chart. Under no circumstances could I shut my door. And as for the nurses fetching and carrying, bringing tea, whispering and bobbing their heads and going on tiptoe—that was really the limit. Unheard of. Nurses were not very indulgent on W3. How did she do it?* The answer was very simple; the nurses, at last, had someone who was unequivocally in the sick role. Not a member of the "community." And like the well-trained creatures they were, they hastened to care for mother. They were only too delighted to be carrying out their proper functions. Unfortunately, Ms. Howland does not yet have information of this kind, which makes good sense, of this apparently irrational occurrence.

Shortly after this, her mother took her two grandsons back to Florida and there is a pathetic account of Ms. Howland trying to say goodbye to them. For some idiotic reason they were not allowed to come and see her or she to see them. Apparently, all this baloney about the community, etc., maintaining relationships with the real world, and all that, quickly came to an end where it might have been helpful. Hospital rules must be upheld, though they may be inhumane, untherapeutic, and plainly silly. Ms. Howland tried to get the little boys' attention from a high window and they peered up mystified, unable to see her, but encouraged to wave by their grandmother. Here, as elsewhere, Ms. Howland is remarkably good humored in spite of the obvious inconveniences to which she was clearly subjected.

On Page 70 there is a well-observed description of Fran, who entered the hospital in a depressive episode, and she

seems to have been severely retarded. She refused all efforts to make her accept office in the "community" and seemed quite unmoved by social pressure, until, after a few weeks, she suddenly began to perform her tasks. Ms. Howland notes (Page 70):

To outward appearances anyway, there seemed to be almost no interim: the transition was abrupt, total; once it got started, Fran's progress was not to be denied. She moved from being very depressed and retarded to being a bossy, active, outgoing organizer. Ms. Howland comments on Page 80:

Fran's recovery wowed the other inmates who witnessed it, wowed all the doctors. {For the hospital was a teaching hospital, and our doctors were new to it themselves, in training, here to observe.) A patient like this vindicated all the theories about the therapeutic effects of showers, combs, lipstick, and social activities. It was a victory for the public spirit of our "community." Fran's behavior could be accounted for by all these textbook equations—yes, yes, as the visible motions of the fixed planets could be explained by the epicycles of Ptolemy.

Oddly enough Ms. Howland does not apparently know and no one apparently informed the patients or "community" members that recurrent endogenous depressions of this kind do behave exactly like this, whether the patient is treated in the community or not. These patients also respond rather well to antidepressant drugs, but we don't know whether Fran was being given these. In this university hospital everything was ascribed to the wonders of the "community."

A little later on Ms. Howland discusses the social cohesiveness of the narcotics ward as compared with the general psychiatric ward. On Page 83 she writes:

There was no pool table on the narcoward. No piano, ping pong, lounge, T. V.

They held no Meeting, had no Passes and Privileges, they were not expected, not even permitted to weir "clothes." And yet they stuck together; they were truly a

body, a group, in the sense that we on W3 could never be. And maybe the "clothes", the "community", all the social emphasis of W3 was really meant to prevent this from happening—precisely this; to prevent us from ganging up, closing ranks in the most instinctive, elementary way: We against Them. Ms. Howland's slightly paranoid explanation is unfortunately not true. What is true is that there is little or no evidence that "communities" of this artificial kind benefit mentally ill people very much one way or the other. It is hardly surprising that therapeutic communities are found to be more useful for psychopaths and sociopaths, who are often to be found on narcotics wards, than they are to other psychiatric patients: after all, that is how they began with Maxwell Jones in Belmont, England. The "community" which annoyed her so much was not evidence of Machiavellian cunning but, I believe, simply imitative incompetence combined with an unimaginative zeal for following the inspiring Dr. Maxwell Jones who is, understandably enough, very happy about the apparent success of his inspiration and its widespread, if inept, use.

Throughout the book she refers to herself and other patients as inmates: very curious inmates living in medical surroundings without apparently being patients. I think, with her usual perceptiveness, she is quite correct. They were not patients. They did not have the sick role with its manifold rights and duties; instead, they were apparently members of this allegedly therapeutic community, and for them "inmate" is as good a term as any other. It is difficult to guess why this expensive farce was maintained. I suppose that it was originally justified on an economic basis, as a way, perhaps, of saving psychiatrists. However, at this university hospital there were lots of consultants arid residents, but the patients seldom saw them. One patient hadn't seen her doctor for more than a month. Ms. Howland says (Page 127):

These private conferences with our

doctors seem to be the payoff, the big bout, the main event. We believed that this business of seeing a psychiatrist was a chief business of life. Its most significant feature and we spent all the rest of our time waiting for it to happen—this was what we were in the hospital for . . . We spent all the rest of our time being a "community.'" Talking about the "community," conceding to its claims. When would we get a chance to talk about ourselves? To be ourselves? Whoever that might be.

On Page 135, she says very perceptive-ly:

The thing that was never made clear to us on W3 was the fact that the patients existed for the sake of the hospital, not the other way around. It was a conventional sort of mistake, and maybe the staff didn't quite understand it themselves.

And indeed this is true, for the "community" which they had established had nothing to do with patient needs. There was no evidence whatever that depressive or schizophrenic illnesses require "communities" of this kind. There is a good deal of evidence that they don't. Ms. Howland recognizes this and describes it very well, even though she has no suitable technical terms with which to describe the deception which she and others endured.

As a matter of fact, things were peculiarly indifferent. The nurses worked hard but they were not solicitous, not here to fetch water. The astronomical fees did not include much that resembled usual hospital nursing services. Not what you anticipated. ($20.00 a day for psychiatric consultation and $11.00 a day for Occupational Therapy fees—our yarns and beads.) This last Cerda pointed out with particular bitterness, she was much preoccupied with what it was costing. "Do it yourself, or go to Hell" was the way Elke gently characterized the ideology. In brief, because no one had any clear grasp of the model being used, it was both a muddle and a fraud, even though I am sure doctors and nurses believed that they were treating patients. Unluckily neither patients nor their families could overcome their medical piety sufficiently to question this dubious arrangement, because they had no suitable language with which to challenge that which the doctors in their omniscience had decreed.

Shortly after this, Mark was admitted, apparently with a toxic confusional state resulting from pneumonia. He appears to have been treated just like any other member of the community and was not even given breakfast in bed. Ms. Howland says (Page 146):

He didn't know us, didn't speak to other inmates; he coughed all night, he raved with thirst. In the delirium of his high fever he found himself in a madhouse— what else could it be? Where, in his condition, he was expected to get up and come to meals, appear at meetings, attend to his own needs. His own consciousness was sporadic; as soon as he lay on his back, it wandered off and we all became his passing phantoms. "Hey! Water Lady! Nurse!" and yet now he spoke to these phantoms, delivered himself of his opinions . . . I don't know if anyone else found these outbursts of logic strange—these bubbles of lucidity. I was looking forward to Mark's recovery—the time when he would come to himself less intermittently—so I could start asking him questions. I was curious.

The fever broke, the delirium lifted—and Mark departed, leaving me mystified.

This is a classic description of a delirium and is a formidable indictment of the "community." While the medical and nursing staffs' devotioa to the "community" was so great that a patient with pneumonia couldn't be treated there in an ordinary medical way, when members from the real community, that is the society outside the hospital, came in to visit patients, the nurses kept shouting, "COME ON AND EAT, YOUR DINNER IS GETTING COLD." And eventually the visitors were driven away by this persistence.

Ms. Howland is very much a child of

her era for on Page 199 she tells us: *Cerda clung to the hope that there was some neurological, physical, even chemical basis for her illness—the thing I would have dreaded most in the world.* Apparently, she doesn't see herself in the sick role, but she ends the book by saying (Page 206): *One day some months after I had left W3 for good, it all of a sudden occurred to me, I had had what is called a breakdown, that is what had happened, but I didn't know. That is, I believe, one of the characteristics of the condition, by then I had moved on into other regions and the word held no special terrors for me. In other words, it might also be called a place.*

But in fact, what had happened was that the "community" so-called had prevented her from getting the sick role, so that she left the hospital following her recovery with no more knowledge of her illness than when she went in. At least so this book suggests. She does not tell us of her diagnosis, she tells us very little of her treatment. Unless of course, one is to assume that the "community" was the treatment. Indeed, that is exactly the assumption that is made.

In **Hospital and Community Psychiatry,** January 1975, there is a review of a book called **Patient Power, The Development of a Therapeutic Community in a Psychiatric Unit of a General Hospital,** by Philip Margolis, M.D., Thomas, Springfield, Illinois, 1973. This book describes a psychiatric inpatient service at the University of Chicago Hospital and Clinics. I can only suppose that it is another account of VV3. There is an extraordinary contrast between the glowing account in this review of W3 and what Ms. Howland herself says towards the end of her book. Ms. Howland could not have been there when the unit was visited by Maxwell Jones whose questions, it is said, provided a. powerful impetus towards accelerating the process of change. This apparently helped the ward to reach its goal, though what that goal was is never stated clearly. The reviewer writes that Dr. Margolis' book is a descriptive account of a psychiatric ward's development from a traditional authoritarian medical model to a more democratically oriented one, in which the dominant theme is "Patient Power." It may have looked that way to Dr. Margolis and to the ebullient Dr. Maxwell Jones. It certainly did not look that way to Ms. Howland, and she was the customer, the patient, the inmate, as she calls herself, "that article there," upon which the whole enterprise was founded. This is what she says (Page 172):

The staff never seemed to realize that they were also under observation. People feel this sort of immunity with mental patients, children. I think this must be why I've had so *little to say about the staff: because they had so little to do with it. They did not share our lot. In the end, it really was the inmates who mattered to one another, who made the only difference.*

There were many moments that reminded me of childhood. What else could you expect? We *behaved as children, we were treated as children, the offenses committed against children—the same petty deceits. (Why did people keep talking to me as if I couldn't hear them?) And it was understood that our very condition had something to do with childhood—the seething cauldron of all our woes. For our sins, we had been returned. We were as children. And our childishness was so much taken for granted, a shameful fact of our shameful lives, that it was a long time before I understood what it was really all about. That all these children within us were just our own lost selves.* What then are we to make of these two totally different views of the same series of events? Is there any particular reason why a medical ward should be democratically oriented in a political way? Has illness really anything to do with politics? What kind of community could possibly be formed in a few brief weeks by gravely ill people, who should surely leave as soon as they are in good shape for politics? Most of us, when we are ill, have no ambition whatever to undertake

leadership roles. When our leaders become ill, we do our very best to get them to depart from leadership and to undertake the sick role. Yet in VV3 as Ms. Howland shows, when people become ill, we believe the remedy is to force them into an unwanted leadership, even though there is little evidence that this benefits them..And even though as a shrewd participant observer, Ms. How-land doesn't believe for one moment that they were benefited.

Her book should surely be compulsory reading for those who, like Dr. Margolis, are concerned with developing "therapeutic communities" in general hospitals or anywhere else.

I worked for some years close to the original therapeutic community which Dr. Maxwell Jones had in Sutton, England. It was developed specifically for sociopaths,* and Dr. Jones strenuously resisted our sending him any seriously ill patients. There was always some debate as to whether his sociopaths were helped, but we gave him the benefit of the doubt. He was carrying out a useful function for no one was anxious to care for sociopaths, who, as their name suggests, are great nuisances. Is there any justification for extending this still dubious treatment to people as seriously ill as Ms. Howland undoubtedly was, and going even further to treat people with pneumonia this way? These patients were deprived of the sick role and, under the guise of being given "patient power," appear to have been deprived of everything except drugs, which were handed out in large quantities. Patients were not deceived. They did not believe in this bogus "community" and I doubt whether they ever do. They participate in it, not because they think it is democracy, but because they think they won't see the doctors otherwise.

I would like to think that some benevolent person will buy copies of Ms. Howland's book and send it to all those who run therapeutic communities,

*** The diagnostic category then in use for those most favored by Dr. Maxwell Jones was "inadequate psychopaths," a label now out of favor.**

urging them to read it with the greatest seriousness. I would hope too that nurses, social workers, and others will study Ms. Howland's excellent account. All those who work in mental health should read this book. We may believe that pious frauds of this kind benefit patients, even though patients themselves are very doubtful. In my opinion, it is wrong to deceive patients. That is clearly what Ms. Howland thinks. But it is even worse to deceive ourselves. And for what reason? Here was a welr-staffed hospital, which had sufficient people to insure that every patient there had the full benefit of an up-to-date version of the medical model. What they got instead was this travesty of a community and what sounds like very poor treatment at enormous expense. I would have thought that a medical audit might have been the best way to rid the university hospital of this wasteful and costly experiment, carried on, it seems, for no better reason than to be in fashion.

Read Ms. Howland's book, get others to read it, so that even if professional good sense does not reassert itself, then public displeasure may encourage us to give up idiocies of this kind, which discredit psychiatry without, so far as I know, benefiting patients. POSTSCRIPT, January 10, 1975

Lest it be thought that I have used Ms. Howland's book to justify personal prejudices, which is always possible, and in this case partly true, it is interesting to note that in the issue of the **American Journal of Psychiatry,** 1321, January, 1975, there is a paper by Louis H. Reich and Brian L. Weiss, called "The Clinical Research Ward as a Therapeutic Community: Incompatibilities." This paper shows that running a research ward as a therapeutic community appears to be harmful for both research and patients. The experience of trying to do this made Reich and Weiss have grave doubts whether therapeutic communities are therapeutic communities at all. They suggest that the stressful nature of the ward may have produced some of the biochemical changes which they found

occurred. They write:

As described the milieu setting, with its emphasis on forced social interaction and participation in various group meetings, provides complex and intense stimulus input for the disorganized schizophrenic patient. The seclusiveness and isolation of the schizophrenic patient represent not mere pathology, but also defense that should be respected until the patient can contend with increased stimulation. The environments of schizophrenic patients should be simplified and non-ambiguous; patients should be given cues in clear concrete language. That archetypal milieu phrase, "talk about it," serves no such function for the disorganized schizophrenic patient. It is for these reasons that others have warned of the deleterious effect of an intense milieu on schizophrenic patients and have recommended reduction of arousal and removal of stress.

They then give two cases, one a schizophrenic and the other suffering from an endogenous depression, and show that both patients were damaged by the community. They note, referring to these two cases:

Unfortunately the remedy for countering such regressive, dependent behavior, i.e., cohesive and united staff action is actually a difficult and unlikely accomplishment in a heavily staffed, team oriented non-authoritarian milieu. It is of interest that these patients can quickly recover their aggressive behavior in a custodial, authoritarian, unpleasant environment.

It shows that even in their iconoclastic posture these observant authors still remain piously apologetic. There is no reason why an authoritarian environment should be custodial or unpleasant. The disordered chaos and muddle of W3 was nightmarish for Ms. Howland and would be distressing to most of its inhabitants. What is needed in a psychiatric ward is a social setting which helps rather than harms its occupants. This is not in principle any different from other hospital wards, which are or ought to be designed to benefit those who are in the sick role, to ease their suffering and speed their recovery. I know of no evidence that these so-called therapeutic communities fulfill any of these necessary functions.

Although this paper is concerned with research wards, in my opinion these findings apply to all those gravely ill with psychotic conditions.

Reich and Weiss say that "no self-respecting hospital psychiatrist could ever confess to not running a therapeutic community." And since it appears that they are inefficient and damaging to the illest people, it is surely time that we took stock and asked ourselves whether this extrapolation from Maxwell Jones' early work is justified. The first rule of medicine is *nil nisi bonum***,** nothing unless good. The first principle of a hospital, as Florence Nightingale said, was "to do the sick no harm." Here, as so often before in medicine, we have allowed a fad which for many patients is therapeutically unsound, to become so much of a sacred cow that criticism is forbidden. Perhaps the time has come to send this particular cow to the butchers.

Neither Ms. Howland's book nor Reich's and Weiss' paper throw any light upon just how and why Maxwell Jones' small center restricted to psychopaths has become so swollen and inclusive that now "no self-respecting hospital psychiatrist could ever confess to not running a therapeutic community."

In his original work, Maxwell Jones did not suggest that this was a universal remedy, but as he himself emphasizes, enthusiasm is an essential ingredient of leadership and presumably his enthusiasm communicated something to others which they then returned to him. This has caused him to reverse his earlier views, though not, I think, to reassess his original judgment about the limited nature of therapeutic communities. This is an old medical habit. We have many examples in the past of extending treatments, useful for some limited problem, until they become considered a panacea or cure-all. Maxwell Jones' therapeutic community is one of these

errors of medicine, which was probably made possible by the development of tranquilizers.

Unlike bleeding, which is an earlier example of this kind of error, generaJized by the efforts of another enthusiast, the lively Dr. Broussais, therapeutic communities are seldom fatal, but they do seem likely to damage the illest patients and there is still no evidence that they do much good to anyone except psychopaths and character disorders. As Ms. Howland herself noted as regards the narcotics ward in the university hospital, it does not call for very much energy or zeal to produce a community among this particular group of patients or for that matter among alcoholics. Whether such communities are therapeutic or not depends upon the skill with which they are run. No amount of skill seems to be capable of making severely schizophenic or deeply depressed people participate in a community. Just how and why doctors of presumably sound mind get swept up in these fads is one of those strange aspects of medicine requiring our careful and respectful attention. This propensity also calls for the attention of those who become recipients of these enthusiasms, our patients.

I do not know that we have ever succeeded in butchering any sacred cow of medicine—they usually die of advanced old age. Perhaps with the therapeutic community our patients will initiate a new phase in doctor-patient relationships and help us to end a very ineffective and expensive medical fad. Few things would be more indicative of patient participation, and Ms. Howland in her fine narrative has given us all an excellent place to start from.

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