

Elizabeth Bott Spillius

Asylum and Society*

Introduction

Since first publishing this paper (Bott, 1976) I have changed my view of what its central theme should be. The original research was a study of a typical large British mental hospital carried out between 1957 and 1972. It had two main themes: the persistence of chronic hospitalization and the presence of endemic conflict in the hospital. I devoted a great deal of discussion to the first theme because it was assumed in the 1960s that the number of long-stay “chronic” patients was rapidly declining. The big old hospitals in the country were to be closed down and replaced by psychiatric wards in general hospitals for short-stay “acute” patients. The remaining chronics would be housed in a reduced number of the old country hospitals or, better, in some sort of facility provided by local government authorities. “Community care” was a fashionable idea, though little real effort was made either by the National Health Service or local government authorities to make concrete plans for it.

Now, 30 years after the study began and 12 years after its first publication, it is generally accepted that long-stay patients, including young long-stay patients, are still accumulating and that providing care for them will be a continuing social problem. Interest in mental health circles is no longer focused on whether services for the chronically mentally ill will be needed but on what form these services should take, specifically on whether and how chronically ill patients can be cared for in the community near to their homes (Wing and Furlong, 1986; Clifford, 1988; Griffiths, 1988).

In keeping with this new attitude, my own focus of interest has shifted to the second theme—the presence of an inherent conflict in the hospital. This theme is important because it is likely to occur in any institution, whatever its form, that provides services for the mentally ill. The basic conflict occurs between the mental patient and his or her society. This means immediate relatives along with neighbors, the police and courts; beyond them, it means the structure of the health services and of the wider society itself. The hospital provides

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services in the form of treatment and care intended to benefit but also to “manage” the individual patient—i.e., to control the patient on behalf of society. The chief reason for admission to a mental hospital is that relatives and society cannot manage the patient, so that the hospital is expected to carry out this task on their behalf.

Since patient and society are in conflict and the hospital serves both, the hospital has an intrinsic conflict within itself. In the hospital I studied this conflict was not explicitly recognized; it was often evaded or obscured by social defenses. It is intrinsic in all institutions that treat and care for mental patients; it can be handled well or handled badly, but it cannot be eliminated.

By British standards the hospital was large, its mean annual size between 1905 and 1972 having been 1840 patients. It was situated on the outskirts of a village, which it dominated, and near an industrial town where many of its patients worked, though neither the village nor the town belonged to its catchment area, which was some 20 miles away in north London. The catchment area had varied in size from a population of 427,000 to 1,076,000. It included two local government authorities, which added to the difficulty of joint planning by community and hospital.

The hospital was divided into two main buildings, one composed of 24 long-stay wards for patients of all ages, including admission wards for patients over 65 years of age, and a second of 8 short- and medium-stay active treatment wards for patients under 65 years of age. At the beginning of the study about three-quarters of the patients were long stay; later this proportion decreased to about two-thirds. The grounds were particularly beautiful, a strange contrast to the grim Edwardian buildings. There were 18 medical staff members: 4 consultants, one of whom also acted as medical superintendent, 4 other relatively senior doctors and 10 junior staff members in various stages of training. In 1957 there were 174 trained nursing staff (of whom 100 were men) and 173 unqualified nursing assistants (of whom only 42 were men). There was a high turnover among the nurses, particularly among unqualified nurses. There were a handful of psychologists and social workers and 20–30 occupational and industrial therapists. In the 1960s the number of clerical and administrative staff varied between 250 and 350.

A general practitioner and/or a community social worker were usually involved in securing a patient’s admission to the hospital. The duty doctor of the hospital made the decision of whether to admit the patient or not, often with very little knowledge of family circumstances. In 1972 80 percent of patients were admitted “informally,” meaning that legally they could leave the hospital whenever they liked. Of those admitted compulsorily, half were reclassified as informal within a few days of admission.

As early as 1930 the hospital had a reputation for being unusually humane

and kindly. In this respect it presented a considerable contrast to accounts of state hospitals in the United States (Belknap, 1956; Dunham and Weinberg, 1960; Salisbury, 1962; Goffman, 1961; Bucher and Schatzman, 1962). Various forms of physical treatment were introduced in the 1940s. Since the early 1950s the medical superintendent and senior medical staff had been widely recognized as having a "psychodynamic" as distinct from an exclusively "organic" orientation and the hospital was considered in psychiatric circles to be favorably disposed towards psychoanalysis and the psychoanalytic training of its staff. In the 1950s and 1960s various forms of social therapy were adopted. In 1972 the hospital was "regionalized," meaning that it was rearranged so that each medical unit, which consisted of a number of wards responsible to a particular consultant, would take all the patients from a particular geographical sector of the catchment area, the objective being to improve continuity of care and allow the development of an effective domiciliary service. This change was the end result of a long and painful process begun by the consultant whose wards I was studying.

My initial study was based on interviews, group discussions and observations of the wards of Dr. Dennis Scott, one of the four consultants. For various reasons I had to abandon the study periodically, and whenever I returned the hospital had somewhat changed. In the process of trying to understand why certain changes had occurred but others had not, I examined the adoption of various new methods of physical and social treatment and related them to trends of change in admission and discharge rates. The lack of fit that soon became apparent led me to conclude that I had been paying too much attention to what was going on inside the hospital and too little to the hospital's connections with its environment.

The changes that occurred in the hospital and the use made of it by its public were a function of changes in the environment as well as in policies and treatment methods inside the hospital. Between 1934 and 1955 an increasing number of people started to use the hospital for short stays, the increase being especially marked among older people. Changes in family structure and social network formation (Bott, 1951; 1971) during and after the war made families more willing to seek professional help for personal difficulties and perhaps less able to care for disturbed relatives at home. Such receptiveness was met by the provision of new physical and social treatments that aroused hope that mental illness would become as treatable—and therefore as ordinary—as physical illness.

Yet the hospital continued to provide long-term custodial care. Among older people the demand for such care increased, as one would expect from the increased number of older people in the general population. Among people under 65 there was only a slight trend of decline in the rate of chronic hospitalization from 1934 until the late 1960s. Although the decline was

statistically significant, it was not so marked as one would have expected from the usual assumption in psychiatric circles at the time that long-stay patients were no longer being created in sizable numbers.

The finding that chronic hospitalization among patients under 65 had decreased less than expected is of special importance. It indicates a comparatively stable aspect of the relationship between the hospital and its environment, a relationship that had not been much affected by changes of psychiatric fashion, redefinition of madness as illness, or by such environmental changes as alterations in family and network structure. It may indicate an unchanging core of mental illness, but it is more likely that chronic hospitalization is not a reliable indicator of such illness, but a result of the pattern of relationships between the patient, his or her significant others and the hospital. Whether a patient eventually ends up inside or outside the hospital depends on which offers a more viable social place.

The Admission Process

It is now common to speak of the use society makes of mental hospitals and of the function such hospitals perform for society. Admission is the crucial transaction in which the nature of this use becomes manifest. There are two types of admission, temporary and permanent, though no-one knows when a patient is admitted for the first time which sort he or she will turn out to be.

I did not study either process directly. My discussion is therefore based on the work of others, particularly that of Dennis Scott and his colleagues (Scott, 1973, 1974; Scott and Ashworth, 1965, 1967, 1969; Scott et al., 1967, 1970). All his papers deal with the process of admission and the part it plays in the relation between the patient and his or her significant others. I have also been much influenced by Erving Goffman's (1969) paper "The Insanity of Place," which describes with painful acuteness the destruction of one's sense of self by the madness in another whom one cares about. His paper is unique in describing the process before hospitalization—a corrective to retrospective accounts from inside hospitals, but a corrective also to facile assertions that the typical situation is one in which an innocent deviant is victimized by persecutory relatives and over-conventional society.

Although in 1972 90 percent of patients at the hospital had informal legal status, they did not come in of their own accord; typically patients are admitted in a crisis in which someone—usually a relative—decides that their behavior is abnormal. It is a rare patient indeed who comes to the hospital explicitly seeking treatment for self-acknowledged difficulties. People who want treatment go elsewhere, for all the treatments that are offered at a mental hospital are available outside it (Tonnesmann, 1968). Patients come to a mental hospital

because someone thinks they cannot be held responsible for their behavior and need to be controlled and removed from their customary social place.

The behavior called mental illness is a form of social deviance. Like other forms of deviance—genius, crime, rebellion—it arouses strong reactions, usually negative, because implicitly it attacks the norms people live by. It differs from other forms of deviance in that it is not supposed to be the patient's fault. In this respect attitudes towards mental and physical illness are similar, for in neither is the patient blamed or held responsible for the state. But in physical illness the disability is restricted to the body, whereas mental illness affects the person's sense of self. Further, as Goffman so poignantly describes in the paper mentioned earlier, the person behaves in a way that destroys the sense of self of the people close by. As well as feeling guilt and a terrible sense of failure, they begin to feel that something absolutely crucial in themselves is being attacked. It is for this reason that the relatives of the disturbed person get so wildly distressed, sometimes over things that seem trivial to an outsider. The interactional framework that has defined the relative's sense of self is being destroyed. Scott puts it in slightly different language: "Physical illness is a role but mental illness is an identity." One *has* a physical illness; one *is* a mental illness. And between the person who will become a patient and the relatives there is what he calls "identity warfare"—a battle for psychic survival (Scott, 1974).

Usually it is a relative who makes the first crucial decision in which the patient's behavior is redefined as "ill." Such redefinition, distressing though it is, takes some of the pain out of patients' behavior, for it makes it unintended; they do not mean it; they are not responsible for themselves. But it is this very redefinition that makes it terrible. It annihilates a person's identity as a responsible adult and, for the relatives, is fraught with often unacknowledged anxiety and fear of revenge. The fault is defined as residing in the illness, not the person. The person is "not oneself." This is the process that Scott describes as "closure" (Scott and Ashworth, 1967). So long as the closure is maintained, what used to be a relationship is dismembered into illness in the patient and health in the relative, a process to which a patient may obligingly and even cunningly contribute.

Calling madness "mental illness" is a comparatively recent phenomenon, part of a humane attempt by the medical profession and mental health propagandists to take away its stigma and accord it the same dignity and respectability as physical illness. The definition assumes that the illness is a concrete disease inside an individual which is, or one day will be, treatable and curable in the same way as many physical illnesses are. Sociologists and many psychiatrists have been critical of this definition of madness as a concrete disease entity inside the individual. (See especially Goffman, 1961, 1969; Szasz, 1961; Laing and Esterson, 1964; Cooper, 1967; and Scott's various papers,

especially Scott and Ashworth, 1967, 1969; Scott, 1973, 1974). Their criticism is based on the fact that behavior that is labelled mentally ill is crucially involved in and defined by interaction with other people. On the matter of causes as distinct from effects of the disturbed behavior, the various authors disagree. Laing and Cooper regard mental illness as a form of social deviance created by families and society. My view (which is also Scott's and Goffman's) is that, whatever the cause, the view that madness is only deviance from conventional norms fails to appreciate the destruction the mad person, or, more accurately, the mad part of the person, wreaks not only on conventional society but on *any* form of society. The view that the patient is an innocent victim ignores the extent to which he or she controls and manipulates both associates and self to destroy the basis of thinking and gratification for both.

Whatever the cause of the behavior that is defined as mentally ill, once a patient has been removed to a mental hospital the distinctive feature of his situation is that, rightly or wrongly, someone thinks that control of his interpersonal behavior is required. This fact puts the disturbance in interpersonal and social behavior into the center of the picture, whatever the state of affairs inside the patient may be.

When relatives seek hospital admission for their potential patient, they are not merely seeking relief from an excruciatingly painful conflict. They are rarely satisfied if a doctor promises to admit the patient because the behavior in question is intolerable. Typically they want a clear statement that the patient is *ill*, and that it is because of this illness that the patient is being admitted. Only then can they feel at least partially absolved of responsibility. If need be they can tell the patient (and themselves) that they did not want to get rid of the patient; it was the doctor's decision; it was "because of the illness." They can assure themselves that the madness is in the patient, not in themselves, for relatives are tacitly pronounced "well" by the same act that pronounces the patient "ill." Henceforth responsibility for the care, control and treatment of the patient is placed squarely on the shoulders of the doctor and the hospital for as long as the patient remains in hospital. It has become a medical not an interpersonal problem.

Thus relatives say and usually also feel that they want help for their patient, but act as if the help had to take the form of removal, control and care. They will accept treatment easily only if it does not threaten their own status as "sane" and if it avoids making explicit the hatred of and dependence on the patient that the relatives have secured his admission to get relief from.

Having an illness absolves the patients of responsibility and entitles them to care. But the stigma is enormous, and admission to the hospital, especially for the first time, is a catastrophe. It alters one's sense of self irrevocably, a fact that people who work constantly in mental hospitals tend to become almost unaware of. Accepting the labelling of oneself as ill, even as a person with

difficulties or disturbance is usually impossible; patients are unwilling to say how the hospital might help or that they need help in any case, or even why and how they come to be in the hospital. But they usually do not leave the hospital. Thus they act as if they find it a relief to be away from their relatives: they use the hospital as a refuge but cannot say so.

However, refusal to accept the ill status does not mean that one fails to perceive in oneself, or to see that others perceive in one, the sort of attributes that are generally considered to indicate mental illness. Scott and Ashworth (1965) developed a test, which they call the Family Relationship Test, in which patients and their relatives are asked to ascribe various adjectives to themselves and to each other; the patient is also asked to predict how the relatives would see him or her. Virtually all patients who took this test used ill adjectives to describe themselves; they also thought that their relatives would see them as ill. Accepting ill attributes and acknowledging a socially perceived and defined ill status are thus entirely different things.

In spite of its degradation, the status of mental patient gives one considerable power. Every act, however mad, that challenges the former *status quo* in one's relation with relatives still lacerates their sense of identity, even when the patient is in the hospital. The patient can continue to use supposed mindlessness to attack not only relatives' sanity but also his or her own. And every self-damaging act hurts the relatives yet again. The patient has an advantage in the identity warfare. A growing body of work in the United States in the 1960s established that mental patients, including chronic patients, are able to modify their behavior to secure the ends they desire (Braginsky et al., 1966); Fontana et al., 1968; Ludwig and Farrelly, 1966; Towbin, 1966). Patients who want to stay in the hospital know how to behave as if they were more ill, and patients who want to leave know how to behave so as to seem less ill.

In his relations with nursing and medical staff, the patient has a similar advantage. One of the important elements of what Talcott Parsons (1951) has described as the "sick role" is that patients, though not held responsible for being ill, *are* held responsible for cooperating with the doctors who are trying to help them get better. In the case of patients in mental hospitals these two expectations lead to a built-in contradiction: the patient is expected to cooperate with doctors and nurses, but, cannot be expected to cooperate since the ill state involves the whole identity. One is assumed not to have enough mind to cooperate with. (Erikson, 1957 makes the same point in a slightly different form.) Certain patients make the fullest use of the opportunities for evasion and confusion that these contradictory expectations allow.

To the ordinary citizen, the propaganda attempt to make mental illness respectable has not had much effect. Anything that involves destruction of predictable behavior and capacity to think is not regarded as similar to physical illness. Studies of public attitudes to mental illness show that people in general,

like relatives, are reluctant to label people as mentally ill and will tolerate behavior deviations as "eccentricities" for some considerable time, but once the label of "mental illness" has been assigned the impulse to reject the person so labelled becomes intense (Sarbin and Mancuso, 1970). The term mental illness has thus suffered the fate of most euphemisms; it has come to mean the same thing as the term "madness" it was intended to replace. Stigma still attaches to mental illness and to the hospitals and people that deal with it. Public attitudes towards mental hospitals fluctuate between a wish not to know they exist and sudden concern over the welfare of their inmates, with occasional bouts of fear that dangerous madmen are being irresponsibly released into the community.

For the doctor and the hospital, the basis on which admission is conducted is crucial to the definition of the setting in which the work of the hospital goes on. Before a patient can be put into the hospital someone, usually a relative with the support of a general practitioner or social worker, has to get a hospital doctor to agree to the admission. What general practitioners and hospital doctors are asked to do is give the sanction of expert medical opinion to a lay decision by relatives, a decision that has already been made. By agreeing to admission, they confirm the relatives' view that the patient is incapable of accepting responsibility for behavior and that the hospital doctor and staff should accept responsibility for care and control. Further, the admitting doctor tacitly confirms the relatives' belief and hope that the trouble is a medical matter, that it consists of a concrete disease entity inside the patient as an individual. An admitting doctor also undertakes, tacitly or explicitly, to provide treatment and to try to cure the patient. For the doctor and the hospital, all these aspects combine to form a fateful decision which leads inevitably to conflict within the hospital, a conflict which is often as unacknowledged as the conflict between relatives and patient or within the patient's own self.

The admission situation would be much more straightforward if the relatives could make it clear to the patient that it was they themselves who wanted the patient sent to the hospital because they found the patient's behavior temporarily impossible, perhaps also with acknowledgement that the patient also found the situation intolerable. But such direct acknowledgement of conflict and hatred contravenes the implicit rules of social interaction, as well as being especially intolerable to people who are frightened of madness in themselves and each other. If a doctor refuses to grant admission except on the basis of such acknowledgement of need for mutual respite, the relatives are likely to feel very persecuted, especially if there is no other hospital they can send their patient to.

There is thus a dishonest element in the work expected of doctors and mental hospitals, though hospitals and their doctors usually comply without protest, even without realizing the contradictoriness of what they are being

expected to do, which is to treat the patient's illness in order to help the patient but also to control the patient on behalf of the people with whom the patient has an untenable relationship.

There is a consistent thread of feeling running through all the social and personal attitudes towards mental illness, mental patients and mental hospitals. All concerned act as if they agreed, without having to reflect on it, that madness cannot be contained and accommodated as part of ordinary personal and social life. It is beyond the pale. If it is kept inside it will destroy: destroy the individual, the family, the fabric of society. At all costs it must be separated off and sent somewhere else, and the main task of the mental hospital is to be that "somewhere else."

Lack of Social Place: Chronic Hospitalization

Most patients come into the hospital in crisis, calm down, and go home—"on the conveyor belt," as one doctor put it. But some get stuck in the hospital. Dennis Scott has been particularly concerned, both clinically and in research, to find out what sorts of patient get stuck in the hospital and why (Scott et al., 1967; Scott, 1973). His studies indicate that in spite of the early discharge policy and the increasing frequency of readmissions, mental hospital patients can still be divided into two distinct sets, which he calls "community centered" and "hospital centered." Community centered patients are those who, regardless of the number of times they go in and out of the hospital, eventually end up spending most of their time outside. Hospital centered patients, regardless of number of discharges and readmissions, eventually spend most of their time (defined as over 80 percent of the two-year period after first admission) in the hospital. Among first-admitted patients of all diagnoses in 1964, 15 percent became hospital centered. Among first admitted schizophrenics in 1964 20 percent became hospital centered.

Scott and a psychologist (Casson) carried out a statistical examination of first admitted patients who became community centered and of first admitted patients who became hospital centered (Scott et al., 1970). Scott then revised the clinical approach of his team to detect and concentrate therapeutic effort on patients likely to get stuck in hospital (Scott, 1973, 1974). He expanded the plan to include a domiciliary service to give help outside the hospital and to prevent unnecessary hospitalization. The development of this service in the catchment area made essential the regionalization of Scott's clinical unit.

According to Scott, patients who become chronically hospitalized have no viable place in society. There are two main causes of such lack of social place: violent, permanent discordance with close relatives, especially parents; and social isolation, often following the withdrawal or death of parents. All pa-

tients admitted to a mental hospital are in a state of discordance and distress in their personal world; such discordance is the crucial feature of admission. But in most cases it is temporary, whereas the distinctive feature of patients who get stuck is that it is permanent.

Scott identified several types of patient likely to get stuck in the hospital, but the type he studied most were young adults, usually diagnosed as schizophrenic, in what he calls "untenable" situations with their parents, the nature of the untenability being that the patients do not support their parents' view of themselves (the parents) as healthy and well. The parents think they themselves are well, meaning sane; the parents think the patient thinks they are well; the patient does not confirm this expectation, but thinks the parents are ill, too (Scott et al., 1970; Scott, 1973, 1974). None of these discordant expectations is openly recognized or discussible by parents or patients; the feelings of hatred and dependence are so painful that they are wrapped in confusion and assertions of illness and helplessness. When such patients are discharged they are soon readmitted in crisis. Such relatives and patients manage to agree tacitly on two issues: that there shall be no clarification of the state of relationship between parents and patient, and that the doctor and the hospital staff should accept all responsibility for dealing with the patient's state. This set of patients alerted Scott and his team to what he calls the "treatment barrier," that is, the unwillingness of both patient and relative to be helped in any fashion that threatens the status quo. The relatives are opposed to any shift that threatens the safe location of madness in the patient and of the patient in the hospital. In Scott's experience such relatives do not sever physical contact with their patient; typically they make conscientious visitors. The parents are painfully dependent on the patient to confirm their identity, their sense of self; once disaster has struck, the patient's being in the hospital fulfills the function of making him or her the identifiable vessel of what the relatives often feel, with varying degrees of awareness, to be a family taint (Scott and Ashworth, 1969).

Sometimes such patients are very skillful in enlisting the doctor's aid in the identity war. The doctor is almost sure to be more sympathetic to the patient than to the relatives, for the doctor sees the patient more often, and is likely to think that the patient is more obviously in need of help, less able to cope with life, more victimized. And the patient is usually young, which is appealing and makes the state of mind seem particularly tragic. Hence the temptation for the doctor to see the patient as a helpless victim of family and social pathology. It is easy to overlook the fact that victims so readily use their capacity to control the feelings of relatives so as to collude with the victimization, to attack their own sanity by getting others to do it for them. But this process, although deliberate, is not necessarily conscious; and even when it is, or is partially so, patients are adept at confusing themselves and others so that the destructiveness of their attack on their own sanity and on that of others becomes difficult to perceive.

Relatives are likely to get wild with rage and distress if they feel that the doctor is too sympathetic to the patient and is therefore accusing the relatives of making the patient ill; the doctor, the relative feels, is threatening the location of sanity and madness in their rightful places, and, like the patient, the doctor is threatening the relative's identity.

The doctor, not surprisingly, is likely to feel attacked from all quarters. In such circumstances thinking straight is more than usually difficult, and the solution of keeping the patient in the hospital seems not unreasonable. But even this decision is usually not taken very deliberately. Patients get transferred to a long-stay ward after failing to improve for some time, and the doctor loses sight of them.

Socially isolated patients also tend to become long-stay hospital residents. There are several types of isolation. Patients who have been incapacitated but kept and supported at home by parents are likely to become hospital centered when the parents die. Middle-aged women whose children have left home and who are not emotionally attached to their husbands or to meaningful work run considerable risk of becoming chronically hospitalized, depression being the typical complaint. Elderly patients without relatives willing or able to care for them are another well-defined set, some degree of senile dementia being the typical complaint. The size of this set of chronically hospitalized patients has increased considerably since the 1930s, which is not the case among the other types of isolated patient. Patients suffering from psychoses of organic or toxic origin were also present among the chronically hospitalized group, but here too the crucial factor was the patient/relative relationship rather than the degree of disability in itself.

Although neither Scott nor I made a systematic comparison according to psychiatric criteria of the severity of symptoms among hospital and community centered patients, it was clear from ordinary clinical practice, both inside the hospital and in out-patient clinics, that some patients who got stuck in the hospital were not especially severely disturbed, whereas some of those who went home to their families were too incapacitated to work and lead independent lives. It is difficult to know how prevalent such disability is since ordinary clinical practice does not provide accurate information about what happens to patients once they go home (cf. Brown et al., 1966). I believe that whether patients end up inside or outside the hospital does not depend primarily on the severity of the psychiatric disorder. It depends on the type and severity of discordance between patient and society, and thus on whether home or hospital offers the patient a more viable social place.

Organically oriented psychiatrists consider that chronic hospitalization occurs because the disease process involved in madness incapacitates patients and prevents them from occupying their social places outside hospital. In the 1950s and 1960s the popular psychiatric view was that mental hospitals "in-