

# *Elizabeth Bott Spillius*

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## 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