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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

\*A new paper based on “Hospital and Society”—*British Journal of Medical Psychology*, 49:97–140, 1976.

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-

stitutionalized" patients and thus incapacitated them for life outside hospital. Scott's work and to some extent that of Goffman, Szasz, Laing and others suggests that the crucial factor in chronic hospitalization is the nature of the relationship between the patient and society, especially the relatives. If the patient and relatives are in a violently discordant but mutually dependent relationship, the patient is likely to end up permanently in the hospital. For the patient the hospital is an asylum; for the relatives it acts as a place that contains and controls the madness and its destruction of their own sense of their identity as sane. In cases in which a patient is socially isolated, particularly if the relatives die or withdraw themselves from contact, the patient may use the hospital as a substitute for a world in which he or she feels they cannot make a place. In brief, chronic hospitalization occurs when a hospital place is accessible and appears to the patient to offer a more viable social place than could be found outside.

It seems extremely unlikely that society or its health services can eliminate either the mad aspects of familial relationships or madness in individuals. But finding the best place to contain and care for it poses considerable problems.

### *Control, Care and Treatment*

My thesis is that the admission process, combined with the way the hospital is connected to its environment, leads to the development inside the hospital of conflicts ultimately deriving from the basic conflict between madness and sanity, between patient and society. When my study began there was no open controversy or awareness of conflict over this issue, only an occasional voicing of an ill-defined feeling that something confusing was going on that made staff, especially doctors, uneasy and dissatisfied without knowing why. "This is a marvellous place to work because of the permissive atmosphere, but there is something odd about it. I don't know how to describe it," said a young doctor who had recently come from a much more authoritarian hospital. "The hospital is like schizophrenia itself," said another, "split up in bits, projections all over the place, parts not communicating with other parts. Things are always getting lost in this place—people, ideas, decisions. There is an overpowering sense of inertia." Or another, in 1961: "Do you want a chunk of my private paranoia? Trying to change anything here is like falling into an animal trap. Once you get outside your own ward everything is chaos. Each misunderstanding is understandable, but there are just too many. It couldn't be chance. But I stay here, don't I?" More recent studies indicate that these feelings of discomfort, even demoralization, have not altered much in the past thirty years (Hinshelwood, 1979, 1986; Donati, in press).

Being wise after the event, it is now my view that what was making these

doctors uncomfortable was an unarticulated sense that something the hospital was doing was not straightforward. There is a sort of dishonesty in unknowingly allowing the hospital to be used to treat and house individuals who are acting as the receptacles of the madness that their relatives cannot bear to face as part of their family or as part of themselves. Malaise was aggravated by certain organizational features peculiar to the research hospital, but the basic dilemma is built into the organization of all mental hospitals that use the traditional definitions of why and how patients are admitted, because these definitions land the hospital in a situation of trying to help an individual on behalf of a society which does not recognize its wish to get rid of the individual as well as to help him.

In the formal medical-nursing model the functions of control, care and treatment are supposed to act simultaneously in the interests of patient and society. Yet it is usually thought that control and care operate in the interests of society and that only treatment operates in the interests of the patient. It is, however, widely recognized that patients, relatives and staff sometimes regard treatment as punishment meted out by the hospital on behalf of society—hardly surprising in view of the ferocity of the early physical treatments—whereas custodial care is sometimes regarded as a refuge from society. Further, many doctors have come to regard ward regimes and nursing care as a major component of treatment—the only treatment in some programs.

The *control* component of hospital activities consists of a set of regulations and restrictions designed to prevent patients escaping or hurting themselves or causing offenses to others. The regulations and rules are usually thought to be carried out for the benefit of society rather than to help the patient, except in the sense that preventing suicide can be considered helpful to the patient.

The general public has different views of the need for control from the views of people who are closely acquainted with mental patients in mental hospitals. The cultural stereotype still is that mental patients are dangerous and would all try to escape if they were not locked up, whereas to patients, relatives and hospital staff it is inertia rather than violence that is the typical problem. The difficult issue is to get patients to leave the hospital, not to keep them in.

Doctors carry overall responsibility for the control function, but it is the nursing staff who immediately exercise it and, unless the doctor is particularly active in defining the way he or she wants the nursing staff to exercise control, they regard themselves as being responsible for the control function to the senior nursing staff and the medical superintendent; ultimately, though more tacitly, they regard themselves as responsible to the external society. Generally speaking, nurses accept the control function as their rightful task whereas doctors would like to get rid of it.

Standards of control used to be much more stringent than they were even in 1957 when my study began. Preventing suicides and escapes was no longer a

major preoccupation of the nursing staff, and standards of cleanliness and order were less exacting than they were during the 1930s. But even at that time nursing staff regarded themselves as—and felt they were regarded by others as—responsible for maintaining something close to the usual standards of control and care. Sometimes nurses made the social basis of their anxiety about patients' freedom very clear, as when a former nursing officer complained that the medical staff were allowing certain wards to run riot with permissiveness; he was worried that it would end with the nursing staff in court if there was a suicide. Another nurse complained about a medical program of doing nothing for patients, saying he knew it was designed to make the patients take responsibility for themselves but thought it damaging to the ward nursing staff to see the ward and the patients get into a filthy, disorderly state. Again, adherence to the control function showed itself in the content of the rumors that usually circulated when a ward was starting a new program. The typical content of such rumors was that patients were being allowed to indulge themselves sexually or to be violent—the two instinctual urges that it is traditionally the task of society to keep under control.

Although hospital doctors are ultimately responsible for the control function, most of them do not like it. Many try to avoid it because they feel it interferes with treatment. But, in the hospital situation, control and authority were always a crucial part of the treatment setting: it is a doctor who decides whether a patient can come into the hospital; a doctor decides, or is at least in charge of the team who decide, on a patient's general ward program, work regime and treatment; it was a doctor who used to determine a patient's "privileges" and "passes"; and it is a doctor, or a team headed by a doctor, who usually decides when a patient leaves the hospital. In law, in the eyes of the general public, in the opinion of relatives and of patients, the doctor is the ultimate authority, and holds this authority on behalf of society. Control is an integral part of the job.

If a hospital doctor denies this social and administrative authority or avoids its implications, he or she is sure to run into trouble. Some doctors at the research hospital tried to get their nursing staff not only to exercise the control function but also to take responsibility for it in the eyes of the patients, so that the doctor could be devoted entirely to psychotherapy; this procedure led to conflict between nurses and doctors. In some hospitals the responsibility for the control function may be assigned to administrative doctors and the treatment function to clinical doctors, which leads to conflicts between the two, as at Chestnut Lodge (Stanton and Schwartz, 1954). In group or community therapy a doctor may allow the group to exercise control, which leads to experiments by patients to discover what sort of violence they need to perpetrate in order to force doctors to show their hand (Rapoport and Rapoport, 1957; Rapoport, 1960). A doctor may collude with patients in idealizing the

therapeutic endeavor of his or her own unit while locating the control function in the parent hospital or the parent society (Cooper, 1967). Doctors may differ in how they express their responsibility for the control function, but they cannot get rid of it.

The hospital provides *care* as well as control—shelter, food, work, recreation, a social round of sorts—the framework of a life that would normally be provided by patients themselves or by their relatives and society. It is the nursing staff who provide the care, though other staff and patients may help. Everyone agrees that care is provided in the interests of the patients though opinions differ sharply on what their interests are. Although nursing staff are expected to provide the care in the interests of the patient, they are kept very much aware by frequent contacts with relatives that it is the relatives and society to whom they are responsible for providing the care. If the desires of patients and the desires of relatives differ, the nursing staff are caught in the middle. There is likely to be a marked element of competitiveness in the relationship between relatives and nurses because the nurses carry out functions that relatives would be executing if the patient were at home. Relatives often feel guilty about not looking after their patient, though without admitting it to themselves; hence they sometimes accuse the nursing staff of the neglect and other faults in providing care of which they themselves feel guilty. Sometimes, of course, nurses are neglectful.

To chronic patients the hospital becomes home. They resist being banished from it. This is the “institutionalization” so much criticized in the 1950s. In the research hospital many nursing staff on chronic wards thought it would be cruel to send patients outside. They felt that the young doctors who were trying to clear out the chronic wards were only trying to enhance their own reputations and to save the Health Service money, not to help the patients. The young doctors thought the nursing staff were trying to hold on to their ward workers. Most relatives wanted their chronic patients to stay in the hospital; a few were willing to try having them at home; some had lost contact. Patients wanted things to stay as they were, with the provision of more recreational facilities. One patient who had lived in the hospital for many years caused much amusement by saying, “There are so many changes and upsets here now that I might as well go home.”

*Treatment* is usually thought of as the special province of the doctor though nurses, psychologists, social workers, occupational therapists and industrial therapists may help. In theory treatment is supposed to benefit the patient, relatives and society. Often it pleases none. It depends on the situation and the type of treatment. No conflict arises if the doctor sticks to forms of physical treatment and ward management that require only a minimum of cooperation from patients and relatives, though even in the case of the gentlest physical treatment patients may avoid treatment by not taking it, as in the case of pills.

If the rift between patient and relatives is not deep, a traditional program of admission ward activities combined with drugs will usually repair the damaged relationship sufficiently for the patient to return home. Even before the use of physical treatments, "cures" were frequently achieved merely by the refuge and cooling off provided by the process of admission. "Patients come in raving," said an admission ward doctor in 1958, "and then get better, I really don't know why. I feel that all I'm doing is superintending a process of spontaneous remission. Anyway I haven't time to do anything else."

When the relationship between patient and relatives is untenable the doctor is caught in conflicts of loyalty to the patient and to society, and treatment in hospital becomes virtually impossible. "We know you have your methods," is a not uncommon remark by a relative, meaning that he thinks the doctor ought to use treatment to punish the patient and make him conform. It is not surprising that patients do not want such treatment, or that many sociologists, adopting the patient's point of view, hold that doctors delude patients into thinking they are ill instead of only socially nonconforming. If, on the other hand, a doctor provides a form of treatment that the patient accepts but the relative does not, the relative may attack the doctor and appeal to higher authority to try to obstruct the process. A doctor who uses a form of treatment that requires the cooperation of both patient and relative, when the relative and the patient have a deeply untenable relationship, will be opposed by both. Whatever their differences with each other, neither relatives nor patient want to face the painful issues they are trying to use hospitalization to avoid. One might think it reasonable that such relatives and patients should agree to lead separate and independent lives but this, too, is often unthinkable to them, for their mutual dependence is as intense as their unacknowledged hatred. Thus, in cases of acute discordance between patient and relatives, no method of treatment that ignores the discordance can have much effect, but treatments that take the discordance into account are likely to arouse strong resistance, certainly from relatives and usually from patients as well.

### *Organizational Arrangements*

At the time of my research the senior medical staff found it convenient to have a division of labor between themselves and the medical superintendent in which they were freed of what they regarded as tiresome administration, because they wanted to get on with therapeutic work on their admission wards. The hospital was divided into four medical units on the basis of age, sex and diagnosis, not on the basis of where the patients lived. The hospital staff provided out-patient clinics at certain general hospitals in the catchment area but there was no assurance that the doctor who initially saw a patient there would be on the team



that saw the patient in hospital; and there was no likelihood that the doctor who treated a patient on the admission ward would be the doctor who followed him up in the community after he had left the hospital. Although in 1964 the Ministry of Health suggested regionalization (Ministry of Health, 1964), meaning the division of the hospital into sub-units each taking patients from one geographical subdivision of the catchment area, this policy was not put into effect at the research hospital until 1972. At first none of the senior staff wanted such a change.

The wards of the hospital were grouped into three types of unit: nursing units, each headed by a pair of assistant matrons or assistant chief male nurses; medical units, each headed by a consultant; and buildings. These three types of unit did not coincide. The Admissions Building, for example, contained two nursing units and parts of three medical units, but each medical unit also had wards in other nursing units and buildings. The chronic building contained four nursing units, involving one whole medical unit and bits of three others. The three types of unit thus overlapped in a complex fashion such that a ward was not contained within a unit larger than the ward but smaller than the hospital as a whole. The opportunities for confusion and misunderstanding were impressive. It was particularly difficult to initiate a therapeutic change. Since the wards of one medical team did not coincide with nursing units and therefore had little autonomy, it was impossible to confine the effects of a ward change to one medical team. A change reverberated through the hospital, causing the maximum amount of upheaval. To be successful a ward change had to be planned at the top, involving not only the ward doctor, the consultant, and the senior nursing staff, but also the medical superintendent. Sometimes the senior administrative staff had to be brought into the consultations as well, and, if the change involved other central services such as those provided by the psychologists, occupational therapists, and social workers, both the immediate workers involved *and* the heads of their departments also had to be brought into the planning, often over a considerable period of time. This arrangement had developed more or less by accident in the 1940s and 1950s. Everyone agreed that it impeded change, but no one was keen to alter it. They could not see how such change would benefit individual patients, and during the 1950s and 1960s the treatment and care of patients as individuals were the primary interests of the senior medical staff.

These were times of therapeutic innovation and ferment. Several new methods of treatment were being introduced and doctors were very much involved in their success. The hospital was generally thought of as psychodynamic in orientation, and its medical superintendent and senior medical staff had a reputation for allowing junior medical staff to develop their own ideas and therapeutic experiments. Senior staff also allowed and encouraged junior medical staff to train in individual psychoanalysis, although this training was

not specifically or immediately usable in the hospital setting. Some psychotherapy was practiced with selected patients from 1950 onwards and some group therapy was also practiced in the early 1950s, but this psychodynamic orientation did not preclude physical treatments. Electroconvulsion therapy had been adopted in 1944, insulin therapy in 1947, transorbital lobotomies from 1947 to 1950 and tranquilizers in 1956/57. Insulin therapy was discontinued in 1958; no surgery had been carried out for several years when I arrived; and by the 1970s ECT was rarely though occasionally used. From 1956 onwards various forms of social therapy were introduced, especially group nursing and an integrated program of occupational therapy and industrial rehabilitation on chronic wards, and ward community therapy on two admission wards (Jones, 1952; Rapoport and Rapoport, 1957; Rapoport, 1960). The occupational therapy and industrial rehabilitation program was also used for patients on admission wards. In the mid-1960s Scott began his method of family therapy, ward management and community psychiatry. By the late 1960s he had evolved a method of ward, team and community practice quite different from the traditional hospital matrix in which it had evolved.

Several of these experiments led doctors and ward staff to establish new types of contact with relatives, community social workers, hostels, etc., but they were hampered in the development of a community-based approach by the fact that the hospital was not regionalized. Usually the attempt at social therapy was eventually given up before it had led to a redefinition of the unit of treatment as the patient in his environment instead of the patient as an individual.

### *Living with Madness*

The Chronic Hospital was the most peaceful part of the system and remained so even though many changes were introduced into it. It was mainly located in a very large old building containing twenty-four wards of long-stay geriatric patients, including their admission wards. This building also contained the offices of the medical superintendent and all the other senior staff except the other three consultants. It was ten minutes' walk to the Admissions Hospital, but socially and emotionally the Chronic Hospital was in another world—peaceful, orderly and dominated by the ethos of the nursing staff.

The medical superintendent and an experienced senior hospital medical officer were in charge of the geriatric wards for women. The doctors of the other wards in the Chronic Building were mainly junior, temporary and psychiatrically inexperienced, though each ward doctor was responsible to one of the three consultants. But the sisters and charge nurses\* thought of the junior

\*The head nurse and her deputy in a ward.

doctors mainly as general practitioners who were dealing with their patients' physical ailments. The nursing staff looked to the senior nursing staff as the people they were responsible to. In this respect the socio-medical organization of the Chronic Hospital was similar to the organization of the whole hospital during the custodial period, when the nursing staff managed the wards under the leadership of the senior nursing staff and the medical superintendent, with the doctors acting as visitors to individual patients but taking no part in ward management.

Only the doctors, especially the young ward doctors, and occasionally a social worker, felt vexed by the inertia of the chronic wards; they thought relatives and patients were virtually malingering and that many patients should have been having a go at life outside. Nurses did not like being accused of institutionalizing patients, but the young doctors soon left to do their stint in the admission wards. In spite of the general atmosphere of changelessness and tranquility, many changes were adopted on the chronic wards in the 1950s and 1960s: nearly all ward doors were unlocked; patients were accordingly re-grouped; group nursing was started; patients were given individualized clothing; tranquilizers were introduced; more recreation was provided; and an extensive program of occupational and industrial therapy was developed. New programs were readily absorbed into the even tenor of chronic ward life. The new activities made life more pleasant, but they did not lead to a vastly increased number of discharges of chronic patients.

Over the years the chronic part of a mental hospital develops a chronic culture, a set of customary methods of living with madness and disablement. Compared to the American mental hospitals described in the sociological literature, the chronic culture of the hospital I studied was kindly and humane, though slow moving and sometimes tranquil to the point of unreality. (For studies of chronic culture see especially Belknap, 1956; Dunham and Weinberg, 1960; Salisbury, 1962; Goffman, 1961; Bucher and Schatzman, 1962.)

Nurses usually adhere to the cultural definitions of madness as something to be shunned and, even though they know that many of their patients do not typically behave in a mad way, the fact that patients have been medically defined as ill means that it is legitimate to regard all of them as mad. Since nurses cannot get away from the madness physically, they get away from it emotionally; they develop some form of relationship that locates madness in the patient and sanity in themselves, with a barrier to prevent contamination. (See also Hinshelwood, 1986.) Such an arrangement allows the nurses to stay in the situation without feeling that their minds are being damaged. It justifies the use of control by the nurses, entitles patients to care and refuge, and is a virtual guarantee that they will continue to be thought ill and therefore will not be sent outside.

The basic method by which nursing staff stay physically in contact with

patients while leaving emotionally consists of some form of routinization—a concentration on activities rather than on the people who do them. (Cf. Cohler and Shapiro, 1964; Tudor Will, 1952, 1957; Moss and Hunter, 1963; Coser, 1963; Hinshelwood, 1979, 1986; Donati, in press.) All these authors discuss in various ways the anxieties and defenses involved in nursing psychotics and/or chronically ill patients.

The simple realities of life on an understaffed large chronic ward provide ample opportunity for concentration on routine, which is simultaneously used to avoid contact with patients and to get the work done. One of the characteristic expressions of concentration on routine was the attitude towards talking to patients. If there were two nurses on a shift, they talked to each other, not to the patients. Several students who worked temporarily on chronic wards reported that if they talked too much to patients the sister or the nurse would say, “You’re supposed to talk to me!” Talking to patients is dangerous because it threatens to puncture the barrier that keeps sanity and madness in their proper places.

There were two main forms of routinization, one involving an *authoritarian regime* based on strict rules, the other based on *a form of unconscious collusion* between patient and nurse.

The *authoritarian regime* was most common on male wards, especially on those where the patients were young or middle aged. On such wards there was an undercurrent of tension and fear; the atmosphere was often military, sometimes quite explicitly so; frequently the charge nurses had been in the army. The role of army sergeant was one of the few acceptable models for a male charge nurse, one that countered the public stereotype of nursing as a female occupation. Many of the male nurses I talked to were very contemptuous of what they called the “Florence Nightingale” approach of the female nurses, and made it clear that they themselves had more realistic as well as more conservative attitudes towards the whole situation of mental hospitals and patients. Many authors have described similar attitudes as characteristic of male nurses in other hospitals. (See especially Jones and Sidebotham, 1962; Martin, 1962; Cumming, Clancy and Cumming, 1956; Scheff, 1962; Belknap, 1956; Bucher and Schatzman, 1962.)

The other form of routinization, the *collusive* type, was more common on female than on male wards. It involved a curiously peaceful but unreal atmosphere in which the nurses were thoughtful, even tender to patients, and patients seemed passive and dependent on the nurses, especially the sister. When she passed by their faces lit up; when she was not there they lapsed into apathetic withdrawal. It seemed probable that this sort of relationship was based on unconscious collusion between patient and nurse. The nurse acted as if she were the psychological recipient of the patient’s capacity to think, whereas the patient acted as though she were the recipient of the nurse’s

unwanted feelings. By this means patients were felt to be as different from the nurse as possible. Madness was safely lodged in the patient, and the fear of the patient contaminating the nurse with it was reduced by the sense that the patient was helpless and dependent because the nurse had absorbed all the available willpower and capacity to think.

Many sisters and a few charge nurses expressed considerable emotional satisfaction from having this sort of relationship with patients, though they were not aware of their use of projection or of the collusive element in their adaptation. The closest anyone came to expressing it directly occurred in the case of a sister who said she liked looking after psychotic patients because they were helpless and needed care, and that many of her personal problems had disappeared or become less troublesome since she had taken up psychiatric nursing. Sometimes patients pointed out a sister's or nurse's use of projection. One such patient on a disturbed ward had a fit of temper and broke a lot of dishes. The assistant matron looked at her angrily and said, "*Now* look what you've done!" to which the patient replied, "That's not my bad temper. That's sister's bad temper and I'm letting it out for her." The junior staff and several patients exploded with laughter because everyone knew that that particular sister had trouble controlling her temper.

The chronic wards I observed gave an impression of being bare of an indigenous patient culture and informal social structure, a state of affairs that Somner and Osmond (1962) aptly describe as the "schizophrenic no-society," though one might equally well describe it as the "chronic ward no-society." There appeared to be none of the inventiveness and zest that one finds among normal people even in prisons and other conditions of deprivation. Shared perceptions and shared interpretations of them, which form the basis for the growth of culture and social structure, did not appear to be present in their usual forms. Insofar as a patient culture operated, it seemed to be mediated through the staff. In terms of my hypothesis, this occurred because patients lodged much of their capacity to think in the staff.

In Britain there are sometimes reports of individual instances of cruelty to patients. It seems inevitable that the structure of the nursing situation should lead to occasional outbursts of violence from both nurses and patients. In the authoritarian form of routinization, violence is always just below the surface. In the collusive form, the helplessness of certain patients is likely to stir such feelings of guilt in the nurse that she or he may lash out in rage at the offensively submissive object. Sometimes patients, safe in their cloak of illness, may provoke the staff knowing that staff are not supposed to retaliate and may be punished for it.

Some of the problems of living with madness and disability will arise in any form of socio-medical organization—in hostels, in foster families, perhaps even in group homes. The definition of personal disablement as a medical

problem has a debilitating effect, which could perhaps be mitigated in a different form of organization. In the present system patients have to act as if they were more ill than they really are to retain their social refuge; nurses have to engage in considerable self-deception because the care they provide for social reasons is regarded by society, including relatives, as a medical rather than a social necessity.

### *Conflict, Defense and Change: The Admissions Hospital*

The Admissions Hospital was situated near the entrance gates, expressive of its close contact with the outside world. It contained four wards for women and four for men, in each case consisting of a psychotic admission ward, a neurotic admission ward and two medium-stay wards. The task of the Admission Hospital was to treat patients and send them home if possible. Patients who became long stay eventually got sent to the chronic wards.

The three consultants (excluding the medical superintendent) spent most of their time in the Admissions Hospital though each was also responsible for a number of chronic wards. Each consultant was the leader of a "firm" (team) of four or five doctors who were in immediate charge of the wards. Compared to the Chronic Hospital the Admissions Hospital was lavishly staffed with nurses, psychologists, social workers and occupational therapists, as well as doctors.

In the socio-medical organization of the Admissions Hospital the consultant was the leader of his team of doctors and there were frequent meetings both of this group and of a larger set of staff including nurses, occupational therapists, psychologists and social workers, depending on the plans of the particular therapeutic program. The ward doctor and/or consultant was the leader of the ward and the sister or charge nurse was immediately responsible to the doctor rather than, or as well as, to the senior nursing staff. It was universally agreed in the Admissions Hospital that a major aspect of any treatment program was the way the ward was run—its organization as a group, its activities, its rules, its personal relationships. In some programs it was the *only* form of treatment. The doctor was no longer only a visitor of patients as individuals; he defined his job as manager of a group enterprise whose purpose was therapeutic. Thus by the late 1950s it was clear that a major change had already taken place in the definition of treatment as a social enterprise and in the role relationship of doctor and nurse.

Because of the doctors' interventions in ward management, the executive management function of the most senior nursing staff on treatment wards had declined and their job, so far as the Admissions Hospital was concerned, came to consist of staffing the wards with nurses, whom they also recruited and trained. The senior nursing staff thus provided a central service for the several medical teams of the hospital. They played no executive role in forming the

therapeutic policies of the various medical teams and conflict therefore easily arose. The medical teams were likely to think that the nurses essential to their therapeutic policies were being arbitrarily shifted about in order to obstruct the therapeutic goals of their team. The senior nursing staff were likely to think that the consultants were willfully ignorant of the demands of the other teams, of nurse training, of the nursing profession, and of the standards and expectations of external bodies. To “improve communication” in matters of this sort involved everyone in endless meetings. Because they wanted to get on with their clinical work, the consultants were content to let the medical superintendent “bring the matron round.”

Several new methods of physical and social treatment were adopted during the period of my study. All these innovations aroused considerable enthusiasm but none were spectacularly successful in the research hospital or elsewhere—nothing comparable, say, to streptomycin as a cure for tuberculosis. Drugs and other physical treatments relieved symptoms. Psychotherapy was not practicable or effective in a mental hospital setting because it conflicted acutely with the control function and in any case could not be used on a wide scale. Industrial therapy, at least at the research hospital, made an enormous difference to the quality of life of both patients and staff, though it did not increase the outflow of chronic patients. Ward community therapy aroused immense enthusiasm for a time but the results were not of such obvious efficacy as to be adopted by the unconverted; it was extremely arduous for the staff without giving any clear evidence that the effort inside the hospital had improved patients’ ability to cope with life outside.

My impression was that several customary features of hospital practice were acting not only as methods of getting the work done but also as defenses against the anxieties inherent in the mental hospital situation, especially anxieties concerning the use made of the hospital by society and anxiety that existing treatments were not as successful as people wanted them to be. (See Jaques’ [1955; Vol. I, “On the Dynamics of Social Structure”] and Menzies’ [1960; Vol. I, “Social Systems as a Defense Against Anxiety”] work on institutions as defenses against anxiety.)

Throughout the hospital at various times it seemed that there was a defense of “not knowing”—a disinclination to find things out, especially anything that might threaten the prevailing *modus vivendi*. No systematic attempt was being made, for example, to evaluate various treatment methods. The nature of therapeutic work with patients is such that meaningful measures of effectiveness are exceedingly difficult to devise. In the research hospital it was striking that even simple crucial facts were not known. Records, for example, were kept in such a way that no one knew how many patients were becoming long stay or whether the various therapeutic programs were having an effect on chronic hospitalization. Until my investigation no one knew that the first-