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Psychiatric Hospital As Community

A Thesis
in
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of
Sociology and Anthropology

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^o Patricia O'Flaherty

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ABSTRACT

In the current health care environment, there is a great deal of talk about the patients returning to the 'community'. Often, we fail to realize or acknowledge that the patients are, in fact, members of a community already. This 'community' is the hospital. Close examination of the hospital reveals a striking duality of purpose. There is 'our hospital' (the hospital of the staff), and then there is 'their hospital' (the hospital of the patients). The two 'hospitals' may have radically different agendas.

This study looks at the attitudes and perceptions of ten (10) in-patients on one psychiatric ward. The patients consented to answer questions about their feelings towards hospitalization - their friends and relatives, their experiences inside and outside the hospital, the role of the hospital in their lives.

The results indicate an ambivalence towards the hospital. It functions as (1) the community to which they have the greatest attachment and (2) the bane of their existence - the institution primarily responsible for all the woes of their lives. Continued commitment to the psychiatric hospital is directly related to the number of alternative communities to which patients can relate. For the chronic psychiatric patients, the 'core' members of the

community, the hospital exists as a community without option. This hospital provides them with safety, acceptance, makes them feel less alone but can also be perceived as too controlling, as in the case of physical restraints being used.

The creation of 'community' is the patients' method of empowering themselves. To develop more effective health care programs, health care providers must give up some control and patients must be active participants in the provision of their health care.

DEDICATION

This paper is dedicated to my sisters, Margo O'Flaherty Regan and Rosemary O'Flaherty Boyko without whose support and encouragement this project could not have been completed.

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INTRODUCTION

Given the current economic environment, there is a distinct trend towards very brief admissions for psychiatric patients and a return to the community as quickly as is considered possible. Psychiatric hospitals are under pressure to examine the number and length of in-patient stays and to develop a more cost efficient treatment plan which will undoubtedly entail closing in-patient beds. The end result of this plan is increased release of psychiatric patients into the general community. Consonant with this trend, is an inclination on the part of the government and the psychiatric hospitals to underline and embellish on all the reasons why the concept of 'asylum' should be discarded. Patients can live quality lives in the general community we are told repeatedly. But, can they?

My submersion in this argument over the past seven years is the underlying reason that I have elected to describe the psychiatric hospital as a community. The patients have not discarded the concept of "asylum". This paper will attempt to explore how patients transform the hospital from a treating institution into a social world in which they feel a sense of safety and acceptance. I am not arguing here for a return to large mental institutions; nor am I denying that institutionalization can perpetuate mental illness rather, I am taking the perspective that patients are capable of

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exercising their agency in the sense that they use the institution as they need it to provide shelter and security when they need it. The institution has a fluctuating usefulness of which patients are acutely aware. This view is somewhat contradictory to the traditional idea of a total institution where the institution is perceived as all powerful. (Goffman 1960; Cockerham 1989). Psychiatric hospitals are generally associated with such notions as treatment, incarceration, even correctional action. Yet there evolves within the hospital a "lifeworld" completely divorced from these ideas. A sense of community develops because the hospital becomes for many patients, their social world.

This concept of community may be problematic to some who take the theoretical position that communities come about for very specifically stated purposes. For example, in the Milton Park Affair (Helman 1987), a study about the inhabitants of a residential area who unite when their housing is threatened, community is seen as a response to the need for social action. Yet, the question can be asked, in communities of interest, must the interest predate the sense of community or can a community just 'happen'?

In the case of a psychiatric hospital, this is what appears to occur. Patients do not admit themselves initially to hospital in order to form communities. They

come for treatment of illness either voluntarily or by order of the court. They are thrown together, so to speak, and out of this haphazard conglomerate of individuals emerges a community.

This paper will argue that the community evolves in response to a need - a need for safety, acceptance, a familiar world. The need is always negotiable and ever changing and therefore the importance of the hospital community is always fluctuating - a response to the context of the moment.

This paper, which could be considered a sociological study from below, (in contradistinction to the perspective from above, that of the administration) will attempt to explore what hospitalization means to patients on a social level. Is it possible that the social experience of hospitalization, in a sense, validates the identity of patients. Harrison C. White (1992) describes identity as arising from "chaos and accident". He claims that "identities are triggered by contingencies". (White 1992: 5). The claim could be made that patients' identities are contingent upon hospitalization. The hospital is the environment within which the bulk of patients' social interactions take place and could be perceived as nurturing a patient community.

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This patient community is frequently interpreted by staff as a deviant community particularly within the context of the recent debate over misappropriation of psychiatric services, the perception being that a significant percentage of patients gain admission to hospital with non psychotic illness such as personality disorder, alcoholism, transient situational crises (Cooper 1986; Woogh 1986) and that this leads to "dependence and helplessness which become solutions to the patient's developmental and adaptational problems...indeed, it is a well founded suspicion that many patients prefer the hospital environment to their own homes and either inveigle entry and/or resist discharge once this has been gained. It is a recurring aggravation to be confronted by a distressed individual who unabashedly request or sometimes demands admission for a rest". (Cooper 1986: 700).

Yet, the question of deviance is further complicated by the fact that institutionalization creates deviance (Goffman 1961; Cockerham 1989). The staff, therefore, engage in a continual debate as to whether the deviant patient gained entry to the institution to absolve himself/herself of responsibility and be looked after or whether the illness led to institutionalization which led to deviance. It is a question which is virtually unanswerable but which must be acknowledged.

Edwin M. Lemert defines secondary deviation as referring to, "a special class of socially defined responses which people make to problems created by the societal reaction to their deviance...the secondary deviant, as opposed to his actions, is a person whose life and identity are organized around the facts of deviance." (Lemert 1967: 24) This definition is crucial to my argument because I feel that the lives and identifies of many patients are organized around the hospital. It is this process of identification which gives birth to community.

CHAPTER 1 - THEORETICAL FRAMEWORK

But, what is community?

The first basic concept to explore is the notion of "community". G.A. Hillery Jr. (1955) identified ninety-four such definitions in his analysis "Definitions of Community: Areas of Agreement". Almost 40 years later we have added new definitions and are no closer to a consensus than Hillery in 1955. There is considerable consensus that the concept "community" engenders notions of an entity that is smaller than the abstraction we call "society" and more intimate. (Cohen 1985)

In Hillery's compilation of definitions a majority of definitions did include three common components: (1) area or locale (2) common ties (3) social interaction.

Area

The Chicago School certainly viewed area or locale as a critical component of community, and, in fact many so called "community studies" deal with aggregates of people living in a common area such as Suttles' "Chicago Slum" or Claire Helman's "Milton Park". It seems only logical to assume that people who, for whatever reason, live in close proximity to one another and share resources would develop a sense of community. In such instances, the development of

community is a social evolution arrived at with little effort other than the inevitable interaction and sharing of resources which occurs among those who share a common territory. Yet, what immediately comes to mind are neighbourhoods where there is little interaction or sharing. Can this be considered a community? Perhaps, the answer to this is twofold; (1) obviously some form of bonding must take place in order for it to be considered community (2) the recognition and importance of its existence as a collectivity to its inhabitants is variable and I would argue that this is not inconsistent with the notion of community.

Let us first consider the notion of bonding - obviously there must exist some form of attachment but attachment can take many forms and vary in intensity. It could be defined in a neighbourhood as an intense familiarity and sharing with one's neighbours or a variable feeling of belonging and less intense but critical familiarity with people and places which form part of one's environment. For example, if one lived in a neighbourhood where there was little intense interaction between inhabitants, the superficial waves and greetings , familiarity with the neighbour's routine, periodic closeness in crises such as a power failure might very well constitute a community - a mini-society with local joys and problems not shared by the world at large.

The second part of the answer deals with the fact that the community is always increasing or diminishing - it can be constant, yet, lack of constancy does not disqualify it as a community. In other words, the notion of fluctuating community. I will argue in this paper that members of any given community psychologically and physically opt in and out of their community as it suits their purposes to do so.

The importance which the Chicago School and authors such as Suttles attached to area can be readily understood when the idea of community is carefully considered. Common area or locale, as discussed by the Chicago School, provides the medium for common ties and social interaction. Gideon Sjoberg (1965) expresses this well by stating that a community is a "collectivity of actors sharing in a limited territorial area as the base for carrying out the greatest share of their daily activities."

Yet, many authors do not view shared locale as essential to the formation of a community. Anthony P. Cohen defines community as "that entity to which one belongs greater than kinship but more immediately than the abstraction we call "society". It is the arena in which people acquire their most fundamental and most substantial experience of social life outside the confines of the home. In it, they learn the meaning of kinship through being able to perceive its boundaries - that is by juxtaposing it to

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non-kinship; they learn friendship; they acquire the sentiments of close social association and the capacity to express or otherwise manage these in their social relationships. Community, therefore, is where one learns and continues to practice how to "be social". At the risk of substituting one indefinable category for another we could say it is where one acquires "culture"." (Cohen 1985: 15)

In the author's opinion, this is one of the most useful definitions of community. However, even Cohen is somewhat inconsistent in his treatment of community. The actual communities which Cohen deals with are all very traditional localized populations. He gives no examples of the kinds of communities which he seems to envision in his most eloquent definition.

In this study of the psychiatric hospital as community the emphasis will be placed on community as social process, although the community which I choose to describe is certainly influenced by the concept of locale. The patients are certainly influenced by the fact that they are all housed under the same roof. These community members certainly do share territory, influence and are influenced by their physical environment and share and compete for resources which the territory provides. However, what is equally important is the social interactional aspect of the

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environment which results, I will argue, in a sense of shared community identity.

Unique Community

The psychiatric hospital community is distinct from other community studies in several ways. One of the most remarkable differences is that illness is common to all community members. This is underscored by the fact that mental health care workers, in describing the rehabilitation of mental patients constantly refer to returning them to the "community". As we are referring to an extremely heterogeneous patient population, presumably the "community" to which we are referring is the "community" of the mentally well. The patients share illness in common. This "illness" permeates every aspect of their lives. Moreover, we could say that physical illness, in a society which deifies health and beauty, sets one apart from others. How much more isolating is an illness which frequently robs the bearer of the faculties of his/her mind - which robs him/her of the veneer of socialization which enables most of us to function in the social world.

At a recent symposium on working with the chronically mentally ill, where repression was the topic, one of the suggestions put forth to aid patients' survival outside the hospital was to encourage them to repress their crazy thoughts and impulses. We, the "mentally well", do this and

by doing so, we are labeled "sane" and able to continue our lives as productive members of society.

The notion of illness and all that it encompasses is one of the invisible boundaries which separates the community of patients from the "mentally well".

Another aspect which makes this community unique is that it is a "formally organized grouping" (Talai and Foley 1990: 236) the official purpose or mandate of the institution has nothing whatever to do with formation of communities. The hospital is organized and administered to provide treatment for patients. There is no explicit nor implicit mandate to nurture the growth of a patient community.

Nevertheless, the institutional setting provides a medium within which the community can take root and flourish. The community of patients who are often perceived by outsiders as powerless, in fact, develop the ability to powerfully transform the goals of the institution into those closer to their own hearts' desires than to the desires of the administrative officials and policymakers. In fact, this community, traditionally perceived as having no power, has a strong sense of agency - sufficiently strong to bend the institution into services never officially provided.

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Agency of Patients

The ultimate test of the agency of patients, this paper will argue, is the transformation of the treatment institution into a social world. The patients make their lives more liveable by mentally reordering the hospital into their social world. Situated, as they are, in an asymmetric relationship, they "engage in negotiation to subvert authority". (Musolf 1992; 173). "Negotiations relocate power in ways that tacitly decouple aspects of authority." (Thomas 1984; 215). This is precisely what patients do - they renegotiate the meaning which the hospital has for them, and, by so doing, empower themselves.

An examination of the mission statement of any psychiatric hospital will reveal the primary goal of the organization to be provision of care for the psychiatrically sick. Charles Perrow defines organizations as "systems which utilize energy (given up by human and nonhuman devices) in a patterned directed effort to alter the condition of basic materials in a predetermined manner." (Perrow 1965; 913) The hospital, as an organization, is perceived as doing just this. There is a strong sense of patients as materials to be operated upon. In my study, it emerges that there is not enough credibility given to the strong sense of will on the part of patients - their "agency". The general supposition is that the hospital alters patients - the action is presented as unidirectional.

This paper will argue that the alteration flows in both directions - the hospital is altered by the patients, in addition to being redefined according to the meaning it has for patients. This redefinition is, to a certain extent, absorbed by the staff. We react to the meaning it has for patients, and, to a certain extent, accept their meaning.

As mentioned before, one of the unique and most important features about this community is that all members are ill or classified as ill. However, there are those who would argue that this is not so - that the illness is not genuine (Szasz 1974) and that the hospital, in fact, is causative in the illness rather than curative. (Goffman 1960; Rosenhan 1973; Cockerham 1989)

The debate over "mad" or "bad" is a daily occurrence in the mental hospital. There are highly seasoned and highly skilled clinicians who cannot come to a consensus as to whether a patient is genuinely ill or playing the sick role. -opting out of the community of the mentally well and into the "psychiatric community".

It is important to consider at this point (1) the sick role (2) to at least examine the concept of mental illness as a secondary deviation.

CHAPTER 2 - MENTAL ILLNESS AS A DEVIATION

This chapter will explore the concept of mental illness as deviance. It begins with a discussion of the definition of mental illness and proceeds with an overview of labeling theory and deviance.

What is mental illness?

Despite the numerous psychiatric text books and papers in existence, mental illness is difficult to define. The whole concept is problematic and this is attributable to the fact that there is a lack of consensus within the field of psychiatry as to whether mental disorders are, in fact, bona fide illnesses (Torrey 1988; Roth and Kroll 1986) or problems in living. (Szasz 1974). This kind of argument is responsible for the development of sociological theories of mental illness, as the illness is largely viewed as a product of labeling and stigmatization, a response to the reaction of others. This lack of consensus also gives rise to the perception that mental patients are responsible for their illness. Guilt is imputed to them in a manner not applicable to persons afflicted with physical illness.

For the sake of simplicity however, let us state that mental disorders are divided into two general classifications; (1) organic and (2) functional. Organic illnesses are those mental illnesses where there is obvious

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brain pathology, that is, detectable abnormalities of the organ. Functional disorders are thought to exist when, in the absence of detectable brain pathology, the patient's behaviour remains dysfunctional. He/she has bizarre ideas, incoherent thoughts, experiences auditory or visual hallucinations.

An individual suffering from a psychiatric disorder whether it be organic or functional in nature, usually has a profound self-reaction to his/her illness because there is always the potential that it may irreparably alter his/her mind. For example, in the case of a recently diagnosed Alzheimer patient (an organic disease), the patient, in the early phases, where judgement and insight are still intact, is aware of changes which may occur as time progresses. The prognosis may lead to the patient having strong feelings of worthlessness. All illnesses have the potential to alter one's position in society either temporarily or permanently, but a psychiatric illness specifically threatens social relationships, relationships critical to survival in society. (Torrey 1988: 17). Often, relatives and close friends suffer greatly with the patient and sometimes choose to abandon him/her as a self-preservation technique.

Torrey, in describing the prototypical mental disorder, schizophrenia, states, "Schizophrenia is madness. Those who are afflicted act bizarrely, say strange things, withdraw

from us, and may even try to hurt us. They are no longer the same person - they are mad! We don't understand why they say what they say and do what they do...Those of us who have not had this disease should ask ourselves, for example, how we would feel if our brain began playing tricks on us, if unseen voices shouted at us, if we lost the capacity to feel emotions, and if we lost the ability to reason logically. This would certainly be burden enough for any human being to have to bear. But what if, in addition to this, those closest to us began to avoid us or ignore us, to pretend that they didn't hear our comments, to pretend that they didn't notice what we did? How would we feel if those we most cared about were embarrassed by our behaviour each day?" (Torrey 1988: 17). The disruption of social relationships is partially caused by the inability of the patient to resume former roles.

Illness affects social "roles"; depending on the nature and severity of the illness some roles are disengaged from temporarily, some modified, and, in the extreme case, some are forfeited forever. (Kozier and Erb 1983: 44)

Patients afflicted with mental illness seem to have difficulty negotiating and resuming roles (Clinard and Meier 1989: 299). Suchman (1972: 145) describes resumption of roles as a move from what he terms stage 4 or the dependent patient role stage to stage 5 or the recovery or

rehabilitation stage. (The stage at which the sick role is relinquished and former roles reassumed). It appears that mental patients become arrested at Suchman's stage 4 - dependent patient role stage - never moving on to resumption of former roles. But why? It is possible that the inability to resume former roles lies in the subconscious adoption of a deviant lifestyle. What does the patient get out of this lifestyle. What is the secondary gain? These kinds of questions are asked repeatedly in a psychiatric hospital, but, as mentioned before, are very difficult to answer. Mental illness, specifically, in a chronic, degenerative form, tends to lead to personality disintegration. The chronic mental patient may present as being blunted, apathetic, isolative, disorganized - all attributes which would make resumption of pre-morbid roles difficult. As stated before, it is often virtually impossible to separate out bona fide illness from learned behaviour. Szasz addressed this issue in his discussion of the Ganser Syndrome. (Szasz 1974: 239)

The Ganser Syndrome.

Consider Thomas S. Szasz's description of "the Ganser syndrome" in The Myth of Mental Illness. Szasz frankly describes this syndrome as, "the strategic impersonation of madness by a prisoner." (Szasz 1974: 239) What the author is describing here is an attempt upon the part of the prisoner to escape the consequences of his antisocial acts

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by feigning madness. This syndrome was frequently observed occurring among prisoners awaiting trial and was named after the German psychiatrist who first described it in 1898.

Szasz states, "If the Ganser "patient" impersonates what he thinks is the behaviour of the mentally sick person, to plead irresponsibility and avoid punishment, how does his behaviour differ from that of a person who cheats on his income tax return? One feigns insanity, the other poverty. Nevertheless, psychiatrists continue to view this sort of behaviour as a manifestation of illness and to speculate about its nature, causes, and cures." (Szasz 1974: 240)

This discussion serves to underline the problematic nature of discussing and classifying mental illness. The mind is an intangible form. Despite the assessment of the most skilled clinician, when discussing an affliction of the mind or spirit, where does illness end and bad behaviour begin? How does a mental health worker know when assessing the bizarre and often disruptive behaviour of a patient, whether he/she is seeing the end product of a deranged mind or the impersonation of psychiatric illness for the accrual of secondary gain? The answer, of course, is that to differentiate between the two is often impossible largely due to the concept of mental illness as a secondary deviation.

Mental Illness As Secondary Deviation

Secondary deviation, as defined by Edwin M. Lemert, "refers to a special class of socially defined responses which people make to problems created by the societal reaction to their deviance...the secondary deviant, as opposed to his actions, is a person whose life and identity are organized around the facts of deviance." (Lemert 1967: 24). In this definition, Lemert appears to be saying that the reaction of society to an individual alters the self concept of that individual and that the adjustment which the individual makes to this altered self concept constitutes secondary deviance. If one is labeled in a certain way, the process of labeling has a profound effect upon the individual and can reinforce the deviant tendencies of that individual.

It is important at this point to discuss Goffman's perspective as he was one of the first to explain mental illness in these terms.

Goffman and Labeling Theory

Goffman maintained that the mental hospital or institution fosters and reinforces the very behaviour which it is mandated to correct. As Goffman perceives it, once an individual is labeled "mentally ill" and confined to an institution, he/she is deprived of the usual means of expressing anger and frustration and this leads to "crazy"

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behaviour. As an example, he cites the case of a patient in seclusion who is destructive and writes with feces on the wall. This patient is labeled psychotic but Goffman asserts that this is the only means available to the patient to fight against the institution. This example is problematic and questionable in the sense that if the patient is "sane" as Goffman seems to suggest, why would he/she not behave appropriately in order to obtain release? Wouldn't this be a more effective method of fighting the institution - that is, playing the game and obtaining your release.

One of the difficulties with Goffman's theory is that he seems to suggest that, like Szasz, psychiatric patients do not have a bona fide illness but rather have aberrant systems of behaviour. He gives no real credibility to the concept of psychopathology. Psychiatric symptoms do involve deviant behaviour but in the author's opinion it must be acknowledged that some of these behaviours stem from psychopathology. That is not to say that Goffman does not make a valid point in stating that the institution creates deviance - it does, but perhaps the deviance derives from the various social responses to the illness.

Hypothetical Clinical Example of A First Admission Patient

Let us leave Goffman aside for the moment, and try to see mental illness as deviance from a practical perspective, and also within the context of labeling theory.

Consider, for example, the case of a young male who experiences a first psychotic episode. He is eighteen years old, lives at home with his parents and attends university. We will call him Mr. T. Mr. T., within the past month, has become increasingly withdrawn from his family and friends. When at home, he spends most of his time in his room smoking cigarettes and staring out the window. Formerly a good student, Mr. T. can no longer concentrate on his studies and his grades have begun to slip. His family and friends are mystified by his behaviour. They cannot determine what is bothering him. His family wonder if he is using drugs, his friends think he's becoming "weird". One evening, while at home, Mr. T's symptoms begin to worsen. He experiences auditory hallucinations - the voices are telling him that the television downstairs is talking about him - it is telling everyone in the city his thoughts - the television is a devil, it must be stopped. Mr. T., in a state of terror, rushes downstairs to the living room, picks up the television and throws it through the window. His family are horrified and frightened and call the police.

Mr.T. is brought to the emergency room of the nearest psychiatric hospital where he is assessed by the psychiatrist-on-call. He admits to auditory hallucinations, thought broadcasting, and suicidal ideation. Mr. T's diagnosis is "Acute Psychotic Episode". Due to his

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impulsiveness and suicidal ideation, he is placed on a PSY -
an involuntary commitment form. Mr. T. is admitted to an
acute treatment ward - this is his entry into the system.

Several important things have occurred in this
scenario. Mr. T's unusual behaviour has generated anxiety
and bewilderment among his friends and family. Their
attitudes towards him have undergone a transformation. They
perceive his behaviour as unacceptable, as deviant, and
socially approved steps have been taken to insure that Mr.
T. is temporarily removed from society and treated to the
extent that his behaviour is modified to conform to socially
acceptable standards. Mr. T. has been formally assessed by
a psychiatrist, a person of power and prestige, and labeled
as "acutely psychotic". This is potentially the beginning
of the deviant career of a mental patient.

In Patient Phase of Hospitalization

Once the patient has been admitted to a psychiatric
facility, he/she has, to a certain extent, been labeled.
Even given the fact that a patient is not rehospitalized,
the label of mental illness is often internalized by the
individual and can profoundly affect his/her psyche. In
addition, patients internalize the way they are perceived
within the psychiatric hospital by staff and other patients
and reconceptualize themselves in the light of this.

For the sake of simplicity, let us consider patients as falling into one of three categories: (1) individuals who are hospitalized in a psychiatric facility just once (2) individuals who have several admissions interspersed with reasonable levels of functioning in society (3) individuals with repeated admissions who have great difficulty functioning outside the psychiatric milieu, and, who, in fact, adopt the role of mental patient as their career. The purpose of these classifications is to establish who represents the "core" members of the patient community. Classifications (1) and (2) have alternative options as will be explained later in the paper.

Having established these three categories, let us consider the labeling theory of Thomas Scheff.

Thomas Scheff is most noted for his discussion of what came to be known as residual rule breaking. By this terminology, he is referring to social habits and manners of dealing with one another which become so ingrained that they become second nature.

Scheff's claim is that stereotyping of the mentally ill occurs largely because these deeply ingrained habits are violated. At times, everyone violates social norms but the critical factor is "if a person is labeled mentally ill and comes to the attention of a community's formal system of

social control for mental illness...the person will be processed and sent to a mental hospital largely as a matter of routine. When this occurs, that person will be 'launched on a career of chronic mental illness and is thus irreparably stigmatized as a mental patient." (Cockerham 1989: 61).

Scheff, like Goffman, tends to discount the primary deviance which generated and set in motion the system of social controls. He ignores the fact that there exists an intrinsic deranged mental process which is independent of any labeling process.

Given the fact that there is pre-existing psychopathology, how can this be reconciled with labeling theory?

A few pages back, we identified three classifications of patients: (1) individuals who are hospitalized in a psychiatric facility just once (2) repeaters with interspersed periods of functioning outside hospital (3) individuals with repeated admissions who have great difficulty functioning outside the psychiatric milieu.

How does labeling theory apply to these three categories? If we take the case of Category 1, just one hospitalization, the degree of stigma is much less

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pronounced than for (2) or (3). In these cases, the majority come to hospital voluntarily seeking treatment. There is no coercion on the part of the courts or law enforcement agency to bring the patient to hospital- he/she takes this decision upon himself/herself - the degree of social control is minimal. The patient is usually hospitalized for a brief period of time and then discharged home with friends or family. He/she does not remain in hospital long enough to become absorbed in the subculture of the hospital

In actual clinical cases when dealing with these patients it is not uncommon for them to elect to sign out of the hospital and accept treatment on an out-patient basis only. They are shocked and horrified by the in-patient hospital atmosphere and wish to dissociate from it as quickly as possible. The strong desire to dissociate from it is a sign of health; they reject the hospital subculture, they reject the idea that they belong here, they have an overwhelming desire to return to the larger community where they have been socialized and are comfortable. This flat rejection of the hospital s.rves to keep these individuals healthy. These are cases where there may be genuine psychopathology, but the intense striving for normalization may very well combat it or at least help to retard the process.

There are also two other important points to consider here (1) the function of deviance (2) the category 1 patients are themselves stigmatizing other people.

In terms of the function of deviance, we know that the definition of certain acts and manners of behaviour as deviant serves as a form of social control - that is, what is termed 'deviant' is what we "ought not" to be. One-time hospital patients reject the subculture of the hospital and strongly refuse to identify with what they perceive as a deviant subgroup. They quickly reaffirm their allegiance and belongingness to the mainstream of society. However, the fact that they do so, implies that as well as internalizing their positive identification from society, they have also internalized the attitudes of rejection and castigation towards the mentally ill. In addition, the desire to separate themselves from the psychiatric experience can in some cases lead to a flat denial of psychopathology, which ultimately impairs treatment. We can see therefore that the rejection of the hospital by these individuals can have both positive and negative consequences.

The second group which we will deal with are individuals who have chronic mental illnesses but who function well outside the hospital despite relapses.

Through clinical observation, these patients are afflicted with varying diagnoses such as schizophrenia, manic depressive disorder (or the newer terminology - bipolar affective disorder) depression (unipolar affective disorder).

In order to clarify what type of patient would fit into this category, let me provide a clinical example.

Mrs. S. is a 58 year old housewife who has suffered from bipolar affective disorder since the age of 18. She lives in the family home in a quiet area with her husband, has raised three children, and has a circle of family and friends outside the hospital. In terms of treatment, Mrs. S. sees a psychiatrist privately once a month where she receives supportive psychotherapy and a prescription for her Lithium, a drug which controls mood disorders.

Despite this treatment, Mrs. S., on average, has one serious relapse approximately every two years. She becomes very high, argumentative, and belligerent with her family, goes for days without sleeping, spends large quantities of money, and at times is physically aggressive when her family attempt to reason with her or control her behaviour. Clearly, she is a risk both to herself and to others. Her family are gravely concerned about her welfare. There are two ways in which they can proceed: (1) convince Mrs.S.

that she requires hospitalization for a short period of time in order to control her symptoms, (2) if she refuses, the family may take out a court order remanding the patient to the custody of the hospital for an assessment period. The option chosen will depend heavily on the ability of the family to reason with the patient, and, the state of the patient's judgement and insight. It is a difficult and sad decision either way.

However, let us suppose that Mrs. S. is resistant to family intervention and must be brought into the hospital on a court order. Usually, the reaction of the patient is one of anger and hostility. She feels betrayed by her family and friends and will make such comments as 'My husband thinks I'm crazy - that's why he brought me here. Every time I spend a little money he thinks I'm nuts. You know, Nurse, he's the one who should be locked up.'

In considering the concept of labeling theory, with regard to this patient, we find a different dynamic from the first case. Clinard and Meier state, "Where professional treatment by psychiatrists, psychologists, counselors, and others tends to attach the label of mental disorder to a person, it may enhance the stability of the mentally ill role for the person. Once labeled as mentally disturbed, persons may have difficulty in turning to other more socially acceptable roles. They may adopt the deviant role

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as the only one available for them." (Clinard and Meier 1989: 300) This is what Scheff is referring to when he talks about the "social institution of insanity."(Scheff: 1974)

However, does this absolutist statement apply to Mrs.S.? Clearly this lady has a lengthy psychiatric history spanning about 40 years. She has had multiple admissions interspersed with periods of very effective functioning in the community. Mrs. S. has not developed into a career deviant. What accounts for this?

Returning once again to Lemert's idea of a secondary deviant his definition is as follows: "The secondary deviant as opposed to his actions, is a person whose life and identity are organized around the facts of deviance." (Lemert 1967: 24) This is a critical point in considering the effect of stigmatization upon Mrs. S. It is indisputable that Mrs. S. has from time to time been labeled "crazy", "strange", a "mental patient". She has probably internalized these responses to the extent that her own self concept includes the perception of herself as one who provokes a negative response in mainstream society when she is ill.Here, she is immersed in a specific subculture which reinforces and even encourages her socially unacceptable behaviour. Again the question, why does she not become a career deviant?

The reason that Mrs. S. does not become a career deviant may be that she and other patients with similar case histories have developed identities of which mental illness is only a part. Yes, Mrs. S. is mentally ill, but she is also a wife, mother, a homemaker. She has friends and relatives outside the hospital who perceive her and react to her as much more than a mental patient. It is true that during periods of hospitalization, she will immerse herself in the subculture of the hospital, yet, as she becomes well, she will distance herself from this same subculture in order to prepare herself for re-entry into mainstream society.

My point here is that the process of labeling is by no means irreversible. The reaction of the public to a mentally ill person undoubtedly is internalized by that individual. Yet, how overwhelming this internalization is in terms of psychic structure, depends heavily on three factors: (1) the degree of severity of the illness itself (2) ability of the public to readjust their views when stigmatized behaviour is altered (3) Mrs. S.'s ability to reaffirm her identity as clearly distinct from that of a mental patient.

Degree of Severity of the Illness Itself

In terms of discussing labeling theory, and, in particular, the views of Thomas Scheff, my greatest criticism would be that there is very little credibility given to the nature of the illness itself.

The labeling theory is very pertinent and informative with regard to mental illness but can it be regarded as a primary explanation of mental illness? Undoubtedly, once the illnes in entrenchrd, labeling and all that goes with it, serves to reinforce the whole process, but, it is gross error to see it as creating the mental illness it perpetuates.

In order to illustrate this point, let us look at the third category of patients - that is, individuals with repeated admissions who have great difficulty functioning outside the psychiatric milieu, and who, in fact, adopt the role of mental patient as their career.

The most common diagnosis of patients with repeated and lengthy admissions to psychiatric hospitals is that of schizophrenia. In the next few pages, I have set out several definitions and perspectives of schizophrenia. This is not to suggest that the illness is easy to define, but rather to provide the reader with a general understanding of what is meant by that term. The remarks of Hall, Andrews

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and Goldstein (1985) and Torrey (1988) reflect an awareness of the incomprehensibility of schizophrenia. All we really know about it is that it is devastating and destructive to the lives of those afflicted and we are pathetic in our attempts to alleviate the suffering.

What is schizophrenia? The Oxford Textbook of Psychiatry states, " Essentially, in acute schizophrenia the predominant clinical features are delusions, hallucinations, and interference with thinking. Features of this kind are often called "positive" symptoms. Some patients recover from the acute illness, whilst others progress to the chronic syndrome. By contrast, the main features of chronic schizophrenia are apathy, lack of drive, slowness, and social withdrawal. These features are often called "negative" symptoms. Once the chronic syndrome is established, few patients recover completely." (Gelder, Gath, and Mayou 1985: 228)

The individual afflicted with schizophrenia is seriously impaired. Chronic schizophrenia presents in such a manner as to make it inordinately difficult for the individual to function in society, particularly a society such as ours which places such a high value on productivity. The symptomatology frequently robs or seriously impairs the individual's ability to work and form personal relationships.

Hall, Andrews, and Goldstein made a powerful statement about this illness. They stated, "Schizophrenia is to psychiatry what cancer is to medicine: a sentence as well as a diagnosis." (Hall, Andrews & Goldstein 1985)

E. Fuller Torrey, a prominent American psychiatrist states, "Schizophrenia, I said. The word itself is ominous. It has been called "one of the most sinister words in the language." It has a bite to it, a harsh grating sound that evokes visions of madness and asylums. It is not fluid like demence, the work from which "dementia" comes. Nor is it a visual word like "ecrasse", the origin of "cracked", meaning that the person was like a cracked pot. Nor is it romantic like "lunatic", meaning fallen under the influence of the moon (which in Latin is luna). Schizophrenia is a discordant and cruel term, just like the disease it signifies."(Torrey 1988: 1)

The purpose of all this is to underline the severity of the psychopathology, and to stress the point that the deviance comes into being after the illness is firmly entrenched.

There is, however, no doubt that this category of patients (that is those with repeated hospital admissions) are the patients most likely to become career deviants. I

believe that this is primarily due to the fact that the patient becomes overwhelmed with the illness. His/her complete identity derives from the fact of being schizophrenic.

A large number of these patients spend most of their lives in and out of mental hospitals. The nature of the disease renders them unproductive in terms of mainstream society, therefore, the only option left to them is to identify strongly with the mental institution - perhaps we might say that a negative self identity is better than no identity at all.

The mental hospital has been charged with encouraging as much deviance as it corrects, and this is true for it provides an ideal isolated setting for the perpetuation of a deviant subculture.

All human beings are social by nature - we have an inherent longing for belongingness and interaction. Those afflicted with mental disorders are no different. The seriously incapacitated cut off from mainstream society, by virtue of their inadequacies, quickly learn to embrace their illness as a symbol of what they are and where they belong. The more absorbed the individual becomes with institutional life, the more he experiences "deculturation - the loss of

or failure to acquire habits needed to survive in the wider society."(Goffman 1961: 73)

Let us consider an example from the clinical setting. A patient is admitted to hospital for the fourteenth time with a diagnosis of chronic schizophrenia - acute exacerbation. This patient is well known to the institution as he/she has been treated there for years. The patient, upon admission, is acutely disorganized and disinhibited requiring almost constant intervention by staff. As the weeks progress, with appropriate treatment, the patient begins to stabilize. At the same time, other patients are being admitted who now require the time and attention formerly lavished on the first patient. As staff, we give all our time and attention to those exhibiting the most bizarre behaviour, and ,as patients progress and improve, we distance ourselves from them and refocus all our efforts on the most acutely ill. This is done inadvertently - it is the manner in which the institution functions, given the severe staff shortages and time constraints.

Nevertheless, the message is loud and clear - 'Be sick, be bizarre, and you will receive lots of attention and intervention, make progress, get better, and you are on your own.' Of course, there are skilled clinicians who are aware of this syndrome and work hard not to jeopardize the progress of patients whose conditions are improving, but

often it occurs unconsciously, without deliberation on either the part of the staff or the patient.

The very symptoms which mark schizophrenia i.e. hallucinations, delusions, ...these become acceptable modes of communication. (Drake and Wallach 1988). They are further developed and embellished upon in order to gain access to the institution or to remain in the institution when there is really no where else to go. It is a very common occurrence in a psychiatric hospital for patients to become ill again as soon as staff begin to prepare them for discharge. The thought of discharge is terrifying. As unpleasant as the hospital is, at times, it still provides a major point of reference for these patients. It symbolizes belongingness, and a sense of security which is not available to them outside the hospital. These patients are truly 'secondary deviants'. In Lemert's definition, a secondary deviant is 'a person whose life and identity are organized around the facts of deviance.' (Lemert 1967: 24) This is an apt description of these unfortunate patients. The fact of being a mental patient becomes the central organizing force of their lives. Just as we derive a large part of our identity from our work i.e. "I am a doctor, an engineer, a housewife," so, the illness evolves into a major identifying feature for these patients. Thus, "I am a schizophrenic" rather than "I am a person with schizophrenia."

Once the individual has embraced his/her illness, the next logical step is to embrace the patient community, thus attaining a comfortable, or at least a familiar world, in which to interact.

What really is the alternative? Goffman, in 1961, wrote 'If all mental hospitals were closed down today, tomorrow, relatives, police, and judges would raise a clamor for new ones: and these true clients of the mental hospital would demand an institution to satisfy their needs.' (Goffman 1961: 384)

Thirty years later, as we suffer through the aftermath of deinstitutionalization, how prophetic were the words of Goffman. Despite repeated efforts on the part of the hospital to release patients, they and their families continually seek readmission to the hospital. Public policy does not seem to answer patients' needs.

The era of the massive state institution is long gone, but, what is left in its wake? We are left with swelling ranks of homeless and the syndrome of the "revolving door patient." By "revolving door patient", I am referring to the current system in most mental hospitals, where the same patients are repeatedly admitted and discharged - it is a never ending cycle.

Another term which is frequently used with reference to these patients is "transinstitutionalization", that is the closing down of large hospitals only to create smaller institutions. The important point to be drawn from this discussion is that the deviant subculture flourishes despite the closing down of large mental hospitals. Patients who were suddenly cast adrift upon the community quickly realigned themselves with groups of other mental patients. They appear to need the deviant subgroup to reaffirm their identity, or at least to give them some sense of belongingness in the face of rejection and stigmatization by the community.

Closing Remarks

To summarize, it would seem that chronic mental patients certainly form a patient community which could be perceived as deviant. The mental hospital, having as its mandate, the eradication of this unacceptable behaviour, simultaneously provides an ideal setting for the growth and encouragement of these same behaviours. It teaches one how to be deviant. This is not a deliberate event, but, rather a "normal" outcome of the socialization process of the hospital. We all want to belong, to share a common identity, to receive some kind of validation in a group setting. This is exactly what occurs in the hospital setting, and, it is further exacerbated by the fact that these individuals have no alternate option.

I do not believe, however, that the deviance causes mental illness. Symptoms experienced by these patients can often be attributed to psychopathology. Nevertheless, once a patient has been admitted into the system, the complex web of interactions undoubtedly produces and develops 'career deviants.'

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CHAPTER 3 - METHODOLOGY

The data used for this project came from two sources, one informal and one formal.

The informal source was my own immersion in the psychiatric hospital for the past ten years, first, in the capacity of a staff nurse, and, for the past year, in the capacity of a head nurse. The conversations and observations which make up an important part of this essay took place in various settings throughout the hospital; the coffee shop, the smoking room, during outings, in the ward dining room, - mostly informal sources. Some of these conversations were between patients and myself, some between patients and other health care givers, and some were patient-to-patient conversations. I was privileged to be in a position to benefit from this window into the psychiatric world, though, I acknowledge that, as a staff person, my perceptions undoubtedly come from a particular perspective, and, despite my attempts at neutrality, I have never lived through the experience of being a patient.

In instances where I have quoted patient conversations, I have changed patients' names or simply eliminated them to preserve confidentiality.

Use of Narrative

The formal data came from interviews conducted with psychiatric patients who were admitted to hospital. In addition, the in-patient charts were examined to make a comparison between the patient's version and the administrative version.

I have chosen face to face interviews because I believe that the patients, themselves, are a rich source of data. Also, psychiatric in-patients enjoy being interviewed and discussing their cases. From former observation, the patients are often able to identify what their strengths and weaknesses are, and with appropriate questions, are able to best describe their living experience within the hospital.

These living experiences can best be related through the use of stories (Ricoeur 1991: 31) as the patients' lives are enmeshed within these stories.

Denzin (1989: 12) writes "Thick descriptions and interpretations are generated out of these stories and accounts persons tell one another. There is nothing magical or mysterious about this method. It involves using skills any person already has, namely, the ability to talk and listen to others, including yourself, and remembering what you hear and what they tell you". The lives of the mentally

ill may be recounted as narratives as well as other lives (Barham 1984: 131).

Selection of Patients

As the research was conducted in the hospital where the researcher works, patients were selected from wards other than the ward on which the researcher works. This e..clusion was to prevent bias on the researcher's part, and also patients from the researcher's ward might have felt pressured to participate in the study.

Patients selected for interviews were clinically assessed as being in a relatively stable condition. Their acute crises had been resolved. It would have been both unethical and pragmatically unprofitable to interview acutely ill patients as the data obtained would have been unreliable.

Patients were selected for interviews by the head nurse of the appropriate unit. This was not a "scientific" approach, but due to the sensitive nature of the population being studied, it was felt to be appropriate.

Criteria for Selection

(a) any in-patient 19 years of age or older

(b) any patient interviewed was assessed prior to the
     interview as being in a relatively stable condition.
     The head nurse carried out the assessments.

Once a patient had been selected, the head nurse
notified the researcher.

The researcher scheduled an appointment with the
patient

-    the project and its purpose were explained to the
     patient

-    he/she was invited to participate

-    confidentiality was guaranteed to the patient

-    the patient was asked to sign a consent form agreeing
     to the interview and to the examination of his/her
     chart

-    patients were clearly advised that they could refuse to
     answer any question or terminate the interview at any
     time

-    patients were offered an abstract of the completed
     paper

The Questionnaire

The questionnaire was composed of nine (9) open ended questions.(see Appendix) which asked patients about their illness, friends in and out of hospital, feelings about relatives and family, feelings about stigmatizing. The idea was to develop a notion of how patients perceived the hospital and its impact on their lives in a social sense. As health care workers, we seldom address this issue, mired down as we are, in our obligations of treatment and cure. This is unfortunate, as I feel from my experiences in the hospital, that more attention to the patients' social world might be of great therapeutic value.

After the development of this questionnaire, I presented to the Ethics Committee of the hospital in which the study was conducted. It was thoroughly examined by them and after their suggested revisions were incorporated, it was accepted.

CHAPTER 4 - THE STUDY

Analysis of The Study

Ten (10) patients were interviewed. The diagnoses were varied and included paranoid schizophrenia, bipolar affective disorder, depression, and borderline personality disorder.

A general comment about the interviews is that patients with a diagnosis of schizophrenia answered questions more indirectly. The "manics" (bipolar affective disorder) were more articulate and better organized which is in keeping with their diagnoses where there is less disintegration of character, greater preservation of premorbid functioning (Torrey 1988)

The interviews lasted from twenty-five minutes to one and a half hours depending upon the ability of the patient to concentrate. I encouraged the patients to respond at a rate and style with which they were most comfortable.

The content of the interviews is analyzed in this paper with reference to recurring themes - some expected and some quite unexpected.

Theme One - "Safe"

The theme of feeling "safe" in the hospital is central to many of the interviews. One woman described herself as feeling "safe" in the sense that she felt protected from her own suicidal impulses. She had attempted suicide and while in hospital seemed to feel protected from herself and the anguish which her actions caused within her family. She became quite tearful when asked about the importance of the hospital in her life and stated that the hospital was "very very important...because of my suicidality - because of my aggressivity - when I lose control, the hospital controls me."

Obviously, to this woman, the hospital provided a structure which for most of us is internalized. We all have bizarre thoughts at times and perhaps, even daily temptations to "let go" and "lose control", yet, we predominantly do not "act out" these impulses. We repress them and/or sublimate them into some constructive action. This woman felt incapable of doing this - she appeared to need external structure in what seemed the absence of the "internal".

The hospital, in her perception, protected her also from irreparably destroying her relationships with family and friends. She stated of her illness, "it affects my relationship with my family...we stay close but its still

very hard for them." In a sense, she preserved her life outside the hospital by retreating to the hospital when she was "sick". Her unacceptable impulses are normalized, she can be "sick" without forfeiting permanently her life outside the hospital.

Another woman diagnosed with Bipolar Affective Disorder stated, "I feel secure here, I guess you could say there is a sense of safety". This woman also went on to describe a fear of losing control,..."I felt like breaking things - hurting myself - I was afraid I would hurt other people. Here, there is a whole team of people to make you feel normal...doctors, and nurses, and they are always around." In fact, when this woman described her destructive impulses, she remained very calm, displaying very little emotion, and, as the interviewer, do did I. This lack of affective component could be interpreted as a normalization and thus a reinforcement of pathology (Goffman, 1961). However, it also may provide the neutral ground which the woman needs in order to heal. She needs to tell her story, yet, during the course of her hospitalization, she will be asked to repeat it to medical students, student nurses, occupational therapists, until she cannot help but be distanced from it. I, for my part, cannot react with the horror of an uninitiated interviewer i.e. "You mean you wanted to hurt your children!"...because I am desensitized; if I were not, I would not survive here. Consequently, the whole hospital

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environment both normalizes pathology, perpetuates sickness, but, can also help to heal.

The patient herself seems to express a need for distancing when speaking of her "family".."I am not a robot, I can't be everywhere all the time...I still miss them but not as intensely as before. I just need this time for myself." This need for "distancing" recurs constantly with psychiatric patients. (Corin,1990).

The patient, when expanding on the idea of "security" in the hospital, defined this as "seeing" familiar faces. she stated, "its because of the sickness we go through, we try to analyze, try to figure out what happened. Its like, you know how I feel because you've felt it too, and we help each other. The sickness is the bond." What is striking about this statement is the sense of "we-ness" (Stanton and Schwartz 1954). She seems to feel supported and to find safety in the sense of sharing the sorrow of a disorder which takes place between patients. Once again, the issue of "neutrality" interjects here. The knowledge gained through sharing of "illness" and all that it encompasses seems to help the patient to feel less alone, and therefore less culpable. "Safe" in this sense is sharing and understanding - when we share and understand, we accept.

Theme Two - "Sick" "Sickness"

The perception of "sickness" by patients is interesting to consider - especially their expression of their illness, the language which they use to describe it.

The administrative stance is that the patients are hospitalized because they are sick - the hospital exists for the sick. During the course of the interviews, some patients were able to deal with the idea of sickness directly while others are more circumspect about it.

Patient Two answered the question "How do you feel about being in the hospital? with what Denzin describes as an "epiphany" (Denzin 1989) The patient states he feels "settled, calm, and sober". He then goes on to suggest in a somewhat circumventive manner that he was not "settled, calm, and sober" at home. The remainder of his response is as follows: "Would you believe it? At home, my mother almost attacked me with a hot water bottle. A hot water bottle! I got so excited, I can go home for one day at a time, but two, three days, its too much."

It is at this point that the patient's private pain becomes a public issue (Denzin 1989) and his mother called the police. Yet, when asked directly why he was admitted he states 'to participate in a new medication program' and does not link this with his agitated behaviour. If we compare

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the perspectives of hospital and patient there is a startling discrepancy with some degree of truth inherent in each perspective. The hospital says, "you are sick, you need to be here for treatment." This patient was brought to hospital on a court order, therefore, the law says "you must be here for treatment, you have no choice." The patient says, "I came here because there was too much stimulation at home and to help the hospital with their research medication program." He perceives himself to have been admitted to help the Psychopharmacology Unit, and, to a certain extent, he is correct. He renegotiates his stance vis-a-vis the hospital thus empowering himself. As quoted earlier in the paper, "negotiation relocates power in ways that tacitly decouple aspects of authority." (Thomas 1984) This is not to say that the patient has no insight into his illness at all, for, on another level, he does. He stated further on in the interview, "You see, I've been coming here since 1971 - four hospitalizations. The first time I came, they thought I had a physical illness, then they discovered I was mentally sick. Twenty-three years I've been coming here - that's a long time - once I was only here for six weeks, but, on one ward it was eight months."

The patient was very emotional during this conversation shifting uneasily in his seat, crossing and uncrossing his legs. As the interviewer, I felt he was giving an account of a failed life and this caused him tremendous pain. After

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repeating that he had been diagnosed as "mentally sick" the patient went on to state the length of time he was associated with the hospital - twenty-three years. "Sick" to this patient seemed to be an ongoing process - he had an acute awareness of the chronicity of his illness although he did not articulate it as such.

Patient Three who shared the same diagnosis as Patient Two demonstrated a similar awareness of the chronicity of his illness. When asked to identify the most important thing about himself. he said, "I knew a patient - his name was Edward (this is the patient's name) he was in the hospital and he passed away from cancer....I see my illness and I know that I'm not getting any better." There is an acute awareness here of the chronic course of the illness and an expressed fear of dying in the hospital.During the interview, the patient whom I knew quite well from previous admissions told me of his mother's recent death, and I expressed my sympathy. The patient was very impressed with this , pressing my hand and saying, "That's how I want to be - polite, knowing the right thing to say", and later on during the formal interview he said, "The most important thing is to get myself better with the medication I need. I want to be able to be polite with people. to be clean - I've always been too serious". To this patient, the illness was perceived as robbing him of social graces, he felt the medication would calm him sufficiently to enable him to

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interact with others in a way which would be considered socially appropriate.

Another patient expressed her illness as severe ups and downs which were becoming more intolerable. Her perception of her illness was that it had a devastating effect on her relationships with the result of destroying her marriage. Several patients referred to destruction of relationships during the interviews.

This is an opportune moment to discuss the relationship between "sick" and "safe".

In each interview, without exception there is a reference to fear of "losing control". One patient stated that the hospital was very important in her life "because of my suicidality - because of my aggressivity when I lose control ,the hospital controls me. It helps me to be here because I feel safer." The "safety" is safety from one's own impulses which destroys relationships. Acting out aggressively towards oneself becomes somewhat normalized within the hospital environment. The hospital becomes the milieu to express rage thus preserving relationships outside.

Patients' perceptions of their sickness were also revealed in the rating question as follows.

Rating Question

The last question of the interview asked patients to rate their illness on a scale of 1 to 10. This question was extremely distressing for several patients. Interestingly, the patients who experienced difficulty with the question all shared the same diagnosis - chronic paranoid schizophrenia. Diagnostically, these would be the patients with the most severe prognosis and whom one would expect to find at the highest end of the scale. Overwhelmingly, patients rated themselves at the high end of the scale 8-10 regardless of diagnosis . One patient did give himself a rating of 3. This patient appeared very distressed by the question, never seemed to fully comprehend the meaning of it, and after assigning the number 3 to himself stated "but I see my illness and I know that I'm not getting any better." This statement leads one to think that the patient did understand the question very well and, in fact, was saying "I can't assign any number because my illness is beyond that."

Another patient gave himself a rating of -1, which is curious as he had a history of extreme agitation. However, a few weeks after I carried out the interview, I heard a staff psychiatrist say "He does not need treatment, he's just a spoiled fat Irish boy who takes street drugs." The psychiatrist was speaking very seriously and has a reputation as a skilled clinician. One then wonders if, in

fact, the patient was correct in giving himself -1. He said, "I'm not a mental patient, I'm a drug addict."

It is plausible, as several patients reacted badly to this question, that it was a bad question. Several patients demanded extensive clarification, which, as I have stated, led me to believe that the question was difficult to comprehend. Yet, when we carefully consider the responses within the context of the patient's whole experience, it would seem that, on some level, there was a deep comprehension. For example, the patient who gave himself a 3, has actually spent most of his life institutionalized. His extreme irritability with the question might be attributable to a disgust for a process which tried to force him to quantify his illness when it was evident from the tone of the whole interview that his illness had, in fact, permeated every aspect of his entire life. His response which superficially appears incongruous might be the expression of a feeling like, "What does a number matter? I'm not getting any better." In fact, this was the same patient who expressed a fear of dying in the hospital.

Another patient who had difficulty with this question stated, "What is the verity of these numbers? I've been coming to this hospital for twenty-three years. That's a long time. You see my main problem is a nervous condition. Perspiration! Then it gets like steam! But, I'm not

perspiring now." As the interviewer, I felt the patient was incredulous when I posed the question. In essence, he seemed to be saying to me, 'How can you ask such a stupid question? I've spent twenty-three years in and out of a mental hospital."

As mentioned before, other patients appeared to handle this question fairly well. They, however, shared diagnoses of bipolar affective disorder, borderline personality disorder, - suggesting that they are less ill than the chronic schizophrenics who have spent most of their lives in and around the hospital.   .

Theme Three - "Alone"

Another recurring theme was that of being "alone". "When you're alone, its hard to support yourself when everything is put on your back, its just too hard." Patients described feeling less isolated in hospital because of staff presence - a team who knows how to deal with acute illness. Presence of staff was stressed as an antidote to "aloneness" rather than relationships with other patients but this might be due to a desire to please the interviewer who is a staff person.

The patients who stressed feeling "alone" when outside hospital all fall into the category of "revolving door' patients - these patients have spent a considerable part of their adult lives institutionalized and undoubtedly have experienced deculturation, which Goffman describes as the loss of skills and abilities which one needs to survive in society (Goffman 1961). Several weeks ago, at a staff meeting which centred around caring for the chronically ill, one nurse remarked "No matter how hard we try to keep them out (of hospital) they keep coming back - they love this place." Another more insightful member of the group retorted, "If you lived in a one room dump with no money to buy food and no friends, wouldn't you rather be in hospital?" A large proportion of psychiatric patients are unable to work thus devalued and relegated to a life of social marginality.(Barham 1984) The concept of being

"alone" suggests a feeling of keen isolation from others and from any meaningful activity.

Theme Four - "Identities"

In designing the study, I asked this question (What do you think is the most important thing about you?) somewhat expectant that patients might identify their illness as one of the most important things about their life. The results of the interviews do not support my assumption. Only one patient (quoted before) answered with reference to his illness, essentially stating that he did not want to die in the hospital but wanted to get better.

The remaining patients cited family members, personal characteristics or special skills or abilities as essential to their self-definition. One patient responded, "I'm sympathetic but bold. I could huff, I could puff, I could blow your house down, I mean I'm a gentle person. Write this down in capital letters, TOM IS AN OFFICER AND A GENTLEMAN."

Another patient became acutely uncomfortable when this question was posed to him. He stated that life was "like driving a car" and proceeded with an analogy which seemed to express his belief in the unpredictability of life, perhaps symbolizing his own fragility. Yet, he returned to the question at a later point in the interview. He said,' this

will help you' and taking out his wallet handed me a printed card advertising the band which he used to belong to. The card contained his name and instrument. "Yes, I'm a musical person, I played the sax." Actually, earlier on in the interview he had described how a copatient was planning a twenty-fifth wedding anniversary party in about three years for his brother, "maybe we could play - I'm trying to round up the guys - can only find two." Within the psychiatric milieu, this kind of thinking would be defined as "unrealistic", "not grounded in reality", "grandiose". The less conservative assessment might even be "delusional". On another level, however, it can be seen as a strength - spinning fantasies to make life more bearable - most so called "normal" people engage in this to revitalize their mundane lives - the difference being that they do not vocalize it - the fantasy remains "private" whereas this patient has brought it into the realm of the "public". (Denzin 1989)

The point of this narrative is to illustrate that regardless of the level of chronicity, the patients had self-concepts which were not totally bound up in the hospital. There was a dimension to their lives completely separate from their identity as mental patients - this, to me, was reflective of great inner strength and another example of escaping from a situation of powerlessness.

Theme Five - "Bad Patient"

Several patients spontaneously discussed "bad patients" in the hospital. One patient stated, "This project is about community? This is a very difficult community to live in. You see, there is a lady on our ward - she screams all the time - she should be in a geriatric ward, don't you think? Why don't they do something about her? I mean why is she here? How can we get better when we have to live with people like that all the time?"

These kinds of remarks are revealing as they demonstrate that even in what "society" would consider an "aberrant" community, the members have a benchmark as to what kind of behaviour is clearly intolerable. Obviously, the screaming lady had exceeded that limit. Even in a community where bizarre behaviour could be viewed as the norm, there is "more bizarre" than "bizarre" - it is a question of degree. Yet, limits are usually invoked when the behaviour becomes intrusive or troublesome to others - just as in 'society". The renegade patient was deemed so because her screaming was perceived as an intrusion on the rights of others. Regardless of the content of her thoughts, she would have been accepted had she expressed them quietly.

Also in the patient community, just as in any other community, a hierarchy is established. It seems important to all of us to 'lord it over somebody else as some point' and the members of the psychiatric community are no different. Perhaps it is an important ego defense.

Theme Six - "Painting and Music"

A number of patients expressed an interest in and an ability for painting and music. As a nurse, I have frequently been amazed by the paintings and poems which patients have completed. I recall a very manic lady who, while in leg restraints, painted a tree and picnic table which she could see outside her window. It was truly a lovely picture.

Schizophrenia has been described as a problem of language in that the expression of thoughts differs radically from the norm. Perhaps the inability to relate verbally leads to greater clarity in non verbal and artistic expressions.

The other aspect of this is that occupational therapists and art therapists encourage artistic expression as a means of aiding the psychiatrist in forming a diagnosis. We train patients to draw and do sculptures.

Surprise Theme - "Restraints"

I did not intend to address the issue of restraints in this study as I did not conceptualize it as relevant to the discussion. However, this was an erroneous assumption on my part. The questions did not deal with this either directly or indirectly, yet, almost every patient managed to work it into the interview in some capacity and expressed strong emotions with regard to it.

The term restraints is sometimes used to mean mechanical restraints and sometimes chemical restraints. The application of mechanical restraints means securing each limb to the bed and is usually associated with violent behaviour. Chemical restraints refers to the use of neuroleptics (major tranquillizers) or benzodiazepines (minor tranquillizers) or to a combination of both to achieve sedation.

In this study the patients were complaining about the use of mechanical restraints.

In this psychiatric community which we are attempting to describe, ideally, the use of four point restraints is the last resort. Nurses are trained to assess patients for signs of aggression and to intervene before the eruption takes place. The first step would be to (1) determine the cause of the patient's anger or unrest (2) offer

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reassurance, help the patient explore their anxiety (3) offer medication (4) seclude the patient (5) restrain. After step 3 has passed, seclusion becomes necessary. Seclusion is necessary when the patient is destroying property or is in a state of uncontrolled intrusiveness but is not considered physically dangerous (Blumenreich, Lippmann and Bacani-Oropilla 1991). Once the patient becomes physically dangerous, the last resort is to call a psychiatric emergency code (show of force) and place the patient in four point restraints.

Staff perceptions about the restraint of patients are fairly consistent. They feel it is emotionally difficult for them to restrain patients but that they do so to protect other patients and themselves from harm. There is a lot of underlying fear.

The patients, however, expressed feelings of keen injustice around the use of restraints.

One patient who had been restrained during a previous admission on the ward of the interviewer began the interview by stating emphatically "I don't want to be tied down - that's what I'm most afraid of ...I don't want to be tied down. Sometimes other patients here do tricks in the dark." An examination of the interviews reveals that patients who had been restrained expressed feelings of helplessness,

physical discomfort, humiliation. One patient described it as "physical agony."

An important link to make here is with the previously identified issue of wanting to be controlled by the hospital when the patient feels that he/she is losing control of himself/herself. This was discussed under the theme of "safe". Patients expanded on that term by stating that they wanted to be "controlled" when they felt they had lost control. The application of physical restraints, however, was not perceived generally by patients as helping them to control themselves. but as punitive.

Despite this, I can recall several patients asking to be restrained when they felt they were losing control. One evening, a young schizophrenic man came to the nursing station complaining of auditory hallucinations. He requested restraints stating that he did not want to lose control and hurt someone as he had in the past. The patient was placed in restraints quietly, and, in a few hours, was removed at his request when he felt more composed.

Perhaps it has to do with the patient's ability to assess whether or not he can control himself. Another young patient told me , "I really want to say something about restraints. I mean, why do they have to be so damn thick and leathery. I've spoken to Dr.X and recommended a

different type. Once in the emergency room, you know Cathy? A guy jumped on her and nearly broke her neck. My father and I saved her. She would be decomposed in her coffin now if it wasn't for us. I don't want restraints, change that! Put a person in a room, lock the door, watch them - but not tied down! Its terrible! You see I have a bladder problem and its terrible when you can't go. And I get so thirsty and sometimes there's no one to give you a drink. In the old emergency room (the emergency has just recently moved to a new building) they never tied you down! I know all the nurses, but, there's that dumb foolish blonde, Rachel, you know the one I mean, and she gets scared and puts on the restraints and starts talking about sending me to the Douglas!"

The patient was identifying fear in the staff as the reason for restraining him. His perception was that the fear was not grounded in reality. The patient might be correct. He was a very big man with a very loud voice. However, I felt very comfortable with him as the interview progressed. In fact, he had said, "I can huff, I can puff,"yet that was really all he did -make a lot of noise which terrified staff who did not know him well. However, the day after the interview, I heard that the patient had been so agitated that he had been placed in restraints with the help of the police.

The issue is extraordinarily complex. I raise it here as, despite the fact that I never addressed it in the questionnaire, it reoccurred constantly, without prompting, in the interviews. Every patient who had ever been in restraints managed to bring it into the conversation. It is a clinical issue which very obviously needs careful research.

Summary of Findings

The patients spoke about the hospital as being a 'safe haver'. The idea of safety which they were proposing seemed to suggest safety from themselves, the safety of others from themselves. The hospital was an environment which allowed them to be "sick".

"'Sick" was a theme which also surfaced during every interview and was defined as "losing control" "aggressivity" "suicidality" "inability to function" "severe highs and lows".and "chronicity". Several patients referred to the length of time they had spent in hospital i.e. "I've been coming here for twenty-three years " "'I've been coming here all my life " - statements suggestive of the fact that their lives were enmeshed with the hospital.

They also spoke of the comfort of seeing "familiar faces" "knowing the staff". One patient described his doctor as a paternal guidance, a spiritual guidance' by whom he had been treated for twenty-two and one half years.

The issue of being "alone" outside the hospital was raised and how overwhelming this loneliness became especially when the patients became ill.

Patients spoke about feeling stigmatized during their first admission but described how their sensitivity to this lessened with future admissions.

The issue of the "bad patient" was raised and patients obviously establish limits and a hierarchy within their own social world.

Restraints were perceived as "punitive" and non-therapeutic by all patients who addressed the issue, and, one patient described the hospital community as not conducive to 'getting better due to irritating copatients.

The hospital was a "safe" place in which to be "sick". One felt "controlled" "less alone" and were comforted by "familiar faces". Stigmatization was an important issue during and after the first admission, but, patients des ribed feeling more indifferent to it with each succeeding admission.

The hospital was reprimanded for physically restraining patients which was thought to be due to "fear" on the part of staff.

Ambivalent feelings about hospitalization were detectable in almost every interview.

CHAPTER 5 - GENERAL DISCUSSION

The patients who were interviewed for this study and who are usually found in this psychiatric community generally fall into three social types (Denzin 1989). These social types or classifications are as follows: (1) individuals who are hospitalized in a psychiatric facility just once - the illness in these cases is usually precipitated by a stressful life event (2) patients with a history of multiple admissions but the admissions are annual or biannual and between admissions these patients function adequately outside the hospital. The diagnoses are varied - unipolar depression, bipolar affective disorder (manic depressive psychosis), schizophrenia, and acute psychotic reaction. These patients often have involved family members, are able to live and care for themselves independently , and are able to work. (3) The majority of class 3 patients are afflicted with chronic degenerative schizophrenia - these are called 'revolving door patients'. They tend to have lengthy admissions with short periods outside the hospital. While living outside the hospital, they tend to live in supervised settings (usually foster homes with other psychiatric patients) or with family or friends. These patients do not work, and usually their source of income is welfare or some form of disability pension. Classification 3 form the 'core' of the hospital community.

Core Members of Community

These patients spend most of their lives in the hospital. Their friends are there. They know the staff, who are the "good" patients and who the "bad". They know intimately the physical layout of the hospital.

The symptoms of their illness such as auditory hallucinations, delusional thinking, withdrawal, apathy - these are commonplace occurrences within the community. If they behave bizarrely by the standards of the wider society, they will be tolerated here.

In a psychiatric hospital, there is nothing unusual about observing a patient talking to himself/herself, or performing rituals. I recently observed a patient who would stand up from her bed, walk out the door of her room, stop, then return to bed. She repeated this exact sequence for about two hours. Other patients came up the hallway, observed her behaviour, and went on their way. This example illustrates that what would be perceived as bizarre in the larger society, becomes normalized within the hospital. Even if the behaviour does not become normalized, it becomes tolerated and unremarkable.

In addition to this, patients do sometimes develop caring attitudes towards one another. With depressed

patients who refuse to eat or drink, other patients will save cookies and dessert for them from the cafeteria.

Patients learn all the rules and regulations of the hospital and to a certain extent attach great significance to these. When a new patient arrives on the ward, older residents will come to the nursing station to find out about him/her.

Recently, a seventy year old lady who has been hospitalized for two years came to the nursing station one evening just after a new patient had arrived. She demanded to know his diagnosis, what kinds of privileges he would have (full privileges, clothing privileges etc,) which doctor he would have , and what kinds of medications would be prescribed for him. She then stated, "Well, he's going to be a troublemaker, I knew that the moment I spotted him. The only thing that will help him is shock treatment!"

The purpose of these anecdotes is to demonstrate the degree to which patients become immersed in the world of the hospital. When Cohen speaks about community as a place where people 'acquire their most fundamental and most substantial experience of social life outside the confines of the home' (Cohen 1985: 15) this is very applicable to hospital life, for, to many patients , the hospital is their "social world". In the preceding example, consider how

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adept the patient was at using all the terms of the hospital; diagnosis, privileges, shock therapy. A psychiatrist recently stated of a "revolving door" patient, "he could probably go to another hospital and pass himself off as a psychiatrist, he is so familiar with all the policies and procedures."

Consider for example the reactions of many patients to discharge. It is frequently quite a negative reaction particularly within the chronic group of patients (Class 3). As the discharge date approaches, it is not unusual for a patient who has been progressing well to begin to develop acute symptoms once again. It is an attempt, perhaps even unconsciously, to remain in hospital with those who are accepting of their behaviour, and with whom they have shared experiences.

Social Boundaries

Social boundaries develop as a result of the community comparing itself to other communities or to the wider society (Cohen 1989; Talai 1990) - the notion of what one "is" relative to another, or in this case another community, sometimes referred to as "relational boundaries".

Applying this concept to the hospital community - patients do develop their sense of community partially through this kind of comparison.

As mentioned previously, the core of the hospital community is composed of what are termed chronic or revolving door patients. A good number of these patients had their first admission at 17 or 18 years of age. By the time they reach 37 or 38 years old, they have been admitted perhaps 15 or 16 times. They do not work, most of their friends are patients. As mentioned previously, they become submerged in the hospital culture - they derive their identity largely from their hospital experience.

Several years ago, while on my way to lunch, I overheard the following conversation between two patients on the elevator;

Patient 1: "How long have you been here? I've never seen you before."

Patient 2: "About 3 weeks, I was really bad this time eh? In restraints for 2 weeks almost, I scared everyone, even myself. I usually go to the X hospital, but this time they couldn't deal with me, so they sent me here."

Patient 1: "What is your diagnosis?"

Patient 2: "I'm manic depressive, you?"

Patient 1:   "Schizophrenic - actually I've had every diagnosis under the sun (probably true I thought) I'm a little bit of everything! Ha! Ha! What kind of pills do you take?"

Patient 2:   "I've been on everything - Largactyl, Trilafon, Stelazine, Haldol - you name it, I've had it all."

Patient 1:   "Maybe this time you should try Moditen, or shock therapy, yah! shock therapy - that might work."

This is not an unusual conversation. One need only sit in the patients' cafeteria, coffee shop, gym and this conversation will be replicated over and over again with a few minor changes.

Patients discuss their doctors, medications, their acts of violence, in the same way students discuss their teachers, exams, and courses. These topics are the routine everyday concerns which make up their lives. They discuss shock therapy the way we discuss taking the family car in for a tune-up.

In reality, patients do not all receive the same treatment, yet, there is truly a commonality of forms. This is one world they can make sense of - one place to which they can truly relate. When they compare themselves to the wider society - there is a stark recognition that they have not achieved what they perceive "non-patients" to have achieved.(Thoits 1983, 1985) The most commonly cited deficit is the inability to marry and have children. Patients have an acute awareness of what the perceived "normal" roles are in society - they have an equally acute awareness that they cannot meet these expectations. In order to cope with these inadequacies, they employ what Cohen would call "symbolic reversal". They embrace their 'patienthood' so to speak.

Cohen states, "People create a symbolic world which is a kind of fantastic reconstruction of empirical society: the dialectical contrast between the two is resolved by a reassertion of the inevitability and desirability of the first through recognition of the fantasy and impossibility of the second ...people become aware of their culture when they stand at its boundaries; when they encounter other cultures, or when they become aware of other ways of doing things, or merely of contradictions to their own culture." (Cohen 1985: 63, 69).

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All human beings are social by nature - we have an inherent longing for belongingness and interaction. Those afflicted with mental disorders are no different. The seriously incapacitated, cut off from mainstream society by virtue of their inadequacies, assert this very lack of normality as symbolic of who they are and where they belong. The more absorbed the individual becomes with institutional life, the more he/she experiences "deculturation , the loss of or failure to acquire habits needed to survive in the wider society," (Goffman,1961:73) They divorce themselves from one culture to embrace another.

Stigma

Thomas Scheff has conducted a number of studies using labeling theory applied to mental patients. Cockerham states, "(Scheff's) work implies that in the minds of others in the community, once a mental patients, always a mental patient. That is, once labeled as "mental patient", the person begins a long term (chronic) career as a mental patient since it is exceedirgly difficult ever to shed the label once applied. Thus, the deviance becomes stabilized and more or less permanently part of the person's identity."(Cockerham 1989, 1990)

The patients who were interviewed in this study, in fact, described feeling stigmatized during their first hospitalization, yet admitted to adjusting to this concept during further admission.

Considering the effects of stigma and patients' own tendencies to mark themselves as "different" from the wider society - I must point out that this type of community seems to be nurtured by the fact that members often have no other available option. It becomes a community of 'necessity'.

Either patients transform their interactions into a sense of shared "communality" within which they have a sense of belonging or they do not 'belong' at all, anywhere. This seems a good point at which to discuss community membership.

Flexible Boundaries and Community Membership

In order for any community to thrive, there must be a sense of commitment to community. A community faces dissolution when its members come to the realization that they have more in common with outsiders than they do with members of their own community. Yet, members of most communities opt in and out of their communities when it is advantageous for them to do so. (Cohen 1985; Talai and Foley 1990) How does this concept apply to the psychiatric hospital? Which members are most likely to strongly identify with the community? What tends to weaken or sever the attachment?

Up to this point, I have focused primarily on the chronic patient population. I would now like to introduce a consideration of other individuals such as first time admissions, and patients with several admissions but periods of high functioning outside the hospital.

These patients, unlike our chronic patient population tend to have much stronger ties in the wider society. In other words, they have not experienced "deculturation". (Goffman 1961).

They tend to have involved families, friends, jobs, and some form of leisure activities. By virtue of their

involvements, exterior to the hospital, they may belong to several communities simultaneously - an ethnic community, a work community, perhaps a neighbourhood community. At the time of admission to hospital, these patients may be exhibiting very disturbing psychiatric symptoms - they often blend very quickly into the hospital community. They make immediate friendships, form love relationships, and behave just as disinhibitedly as the chronic population. Their very symptomatology such as auditory hallucinations, delusions, - these symptoms enable them to share in the experience of other patients.

Yet, as this group of patients begin to regain their health they will quickly disassociate themselves from the hospital community. Frequently, with first time admission patients they become so shocked and frightened by the behaviour of others that, they will sign out of the hospital and agree to treatment on an out-patient basis. The more seasoned patients who have had several admissions but function well within the wider society, will develop a benign tolerance towards the behaviour of copatients. They recognize that they are part of this community when they are ill, but, the restoration of their health will quickly awaken within them an acute awareness of their strong ties outside the hospital.

These patients know that they have more in common with communities outside the hospital, therefore, they will quickly disinvolve themselves from the hospital community in an emotional sense.

It is curious to note however, that it is often these patients who will be most active in organizing ward groups and ward activities. This is partially attributable to the fact that these patients are the healthiest members of the community and possess the necessary organizational skills to carry a project to its completion.

The kind of community we see evolving here is a community of necessity - with the core members having very few, if any alternative choices. The healthier members will come and go - but, for the most part, the core will remain constant.

Constant Community

Several years ago, I recall going to work one morning and, upon arrival on the ward I was greeted by a nurse who had taken a two year leave of absence. This was her first day back at work. Looking at the names of the patients posted on the board she exclaimed, "I can't believe it - I know almost every patient here , they were here when I left. Doesn't anyone ever leave this place?" Of course, many of these patients to whom she was referring, had, in fact been

discharged and readmitted several times within the two year
period. Nevertheless, the composition of the ward, and, in
fact, hospital, remained relatively constant.

Another factor which contributes to this constancy is
the Quebec government's policy of sectarization. In Quebec,
each city or geographic area is divided into sectors. All
residents of a given sector, when seeking psychiatric
services, are assigned to a specific hospital. It is the
right of any citizen to demand treatment at his/her centre
of choice, but few actually do this. Most citizens go to
the hospital to which they have been assigned. In addition,
most patients prefer to return to the hospital where they
have received previous treatment.

The hospital also perpetuates the constant composition
of wards in that readmitted patients, if at all possible,
are reassigned to their former ward. This facilitates the
continuity of care as their cases and histories are already
known by the treatment team.

This community, therefore, is not transient to the
extent that some other communities are. Many community
members have spent most of their lives in the hospital.
They have a true sense of shared history with other members.
In-patients will often swap stories of former times with
their copatients and staff. It is remarkable how patients

who, in other areas appear confused and disorganized will remember, in detail, the histories of aggressive patients, what the repercussions were, where they were sent for punishment, and so forth. (Drake and Wallach 1988) They will also reminisce about dances that were held, outings - all of these are aspects of their common identity.

I am not suggesting that psychiatric wards are communities of idyllic harmony and peace - this is obviously not the case. Yet, for these chronic patients, it is the setting within which the bulk of their social interactions take place. As with all social interaction, there is a considerable amount of conflict within the hospital community.

Intra-Community Conflict

The hospital community has an added burden to its cohesiveness in that members actually live in the same building or adjoining buildings. They share rooms, eat together, they are almost constantly thrown together. Obviously, they irritate one another. Their psychopathology exacerbates the potential for conflict as paranoia and delusional thinking can cause behaviours of others to be misconstrued. Yet, there are probably just as many conflictual situations which evolve from the same petty jealousies and frustrations which occur in any other type of community.

There is, however, the added power component within the hospital. All communities experience power conflict, yet, the situation is quite marked within the hospital community due to the perceived control which staff are purported to have over patients. Staff undoubtedly are perceived by patients as being very controlling. This creates much bitterness and resentment within the patient community. Members of the treatment team can decide when patients may wear their own clothing, when they may graduate from a locked ward to an open ward, when visitors can be received. The possession of the power to grant or withhold privileges inevitably leads to anger on the part of patients. This anger is usually expressed verbally, but, does, at times, progress to the physical level.

Despite the intensity of the anger, it does not seem to weaken the attachment to the hospital. To illustrate this, I will recount the incident of a young schizophrenic male who had been hospitalized for three months. One evening, after being chastised for smoking in his room, he said to me, "Tomorrow, I'm signing out of this hell hole. Most of the staff here are playing around with my head. They are all laughing at me. After tomorrow, its good-bye to this dump! You won't see me for a long long time." In fact, this young man did sign out of the hospital the next morning, and was in the emergency room three days later

begging for his room once again. When he was refused admission, he even came straight to the ward saying that if there was no bed available, he would be willing to sleep in the TV lounge, as long as we would let him stay.

When patients are finally discharged and sent to foster homes or back to their apartments, they frequently return to the hospital, hanging around the coffee shop and smoking rooms seeking companionship among their old friends and acquaintances. Recently, I spoke with a patient who was discharged and readmitted within a four day period. He had managed to convince the staff in the emergency room that he had become psychotic once again.(Drake and Wallach 1988) I asked the patient outright "Why do you want to be here so much?" He smiled and said, "You know the old saying, home is where the heart is." This is a form of what Robert A. Stebbins calls "continuance commitment". He describes it as the 'awareness of the impossibility of choosing a different social identity ...because of the imminence of penalties involved in making the switch." (Stebbins 1976: 35) What Stebbins seems to be describing is that the social identity for these patients is bound up with the hospital. Rejected by the wider society, and rejecting of the wider society, to a certain extent, these patients pledge a total allegiance to one community - it is almost a community without option, "If we don't belong here, where do we belong?" Perhaps, for

this community, a negative self-identity is better than none at all.

More generally, in considering the relationships between individuals and communities, I would think that a good many of us belong to competing communities: ethnic communities, work communities, perhaps neighbourhood communities. We have the option of involving or disinvolving ourselves in these communities in varying degrees. We continually alter our degree of involvement in these communities in accordance with the advantages and disadvantages of such involvement at any given point in time. Our allegiance to these competing communities is probably always partially negotiable. Unfortunately, many of these patients lack the kinds of options which are available to most people especially as they do not work (Barham,1984) Their social lives tend to be centred almost exclusively around the institution of the hospital. This arbitrary relationship becomes the foundation for the construction of their social world. The patients, to a certain extent, deconstruct the hospital as 'we' the staff conceptualize it and reconstruct it in accordance with the meaning which it has for them. (Blumer 1969). In order to understand this reconstruction, we need to examine the hospital from 'our' the staff perspective.

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The Psychiatric Hospital as "Unique Community"

The mental hospital has been referred to as a 'unique community' with special social structures in terms of status and decision-making powers. (Clinard and Meier 1989: 314)

The psychiatrist is the most powerful person in the institution. His/her decisions have standing before the law. The psychiatrist decides who should be admitted and who should be discharged. The psychiatrist decides when a patient needs to be committed, what privileges a patient will have, what the plan of treatment will be - in other words the psychiatrist supposedly acting in the best interests of the patient, theoretically, and, often practically, makes many decisions which directly impinge on the patients' lives. Possessing all these powers, he/she is frequently the least accessible member of the health team to patients. Therefore, the person whose word carries the most weight, listens the least frequently to patients. As one patient remarked to me recently, "I tried to speak to Dr. X the other day when he was walking down the hallway; he just waved me aside and said "we'll talk later" but, nurse, you know that later never comes.'

Next in the ranks of hospital hierarchy are the psychologists, occupational therapists, and social workers. The amount of time which they spend with patients is variable and contingent upon their degree of dedication and

comfort with close involvement with patients. it may range from one half hour per week to several hours per week. Their input to the psychiatrist is valued and team decisions are often made in the light of their input.

The nursing staff and orderlies function very much as first line soldiers. They are responsible for working with patients on a twenty-four hour basis. Even in the most acute care institution much of the work they perform is custodial.

In recent years, the presence of orderlies in the psychiatric hospital has dramatically declined resulting in an average of one orderly per unit. Orderlies have now been excluded from all ward meetings and have virtually no formal input into the decision-making process. Yet, they often spend large amounts of time with patients.

Nurses occupy formally a professional position and realistically a semi-professional position. Nursing surveillance of patients is twenty-four hours a day. With the decline in the number of orderlies, some of their tasks have been reassigned to nurses, the principal one being the policing of patients. In the event of aggressive behaviour, nurses play a critical hands-on role. Yet, the value of their input is subject to the whim of the attending psychiatrist. Their involvement in the decision-making

process is highly variable - ranging from considerable to minimal.

A general comment about the psychiatric hospital staff is that there is a social distance between patients and staff. We create a them/us situation for our own protection. Psychiatric staff become experts at disassociating themselves from patients in order to escape a deeply-ingrained self-reflective process.

The purpose of this description of the psychiatric hospital is to demonstrate the power of staff - with the most influential individual being the one who is least accessible to patients. Patients are acutely aware of this situation and will curry favor with doctors in order to obtain favors. (Clinard and Meier 1989: 314)

Patients occupy the lowest level in the hierarchical structure of the hospital. They represent the raw materials which are to be operated upon. (Perrow 1965: 913) Once individuals come through the doors of the institution they acquire the status of 'mental patients' and, to a certain extent are stripped of their identity. They acquire a diagnosis, their personal clothing is removed, they may be prevented from seeing family and friends, they may be denied the right to make phone calls, they may be physically and chemically restrained against their will - all in the name

of treatment. Once more, their speech and behaviour is subject to constant scrutiny and may be assigned meanings which are convenient to the purposes of the health care team (Rosenhan 1973). This is a very important manipulation on our part. The changes of the meaning of patients' behaviours is a glaring example of the power of staff.

As health care givers, we "need" to see psychopathology in patients words, actions, and family dynamics. It makes our jobs and our lives easier to bear to have a framework which neatly categorizes lives and behaviours. In a sense, if we did not manipulate meanings, we might be out of our jobs, or, at least appear without innovation. We manipulate meaning to gain power and control. A psychiatric colleague voiced this by stating, "There is no illness, we make it up, otherwise, what would we talk about at rounds?"

Of course, this statement is not to be taken completely at face value, but, there is more than an element of truth here. The environment is such that words and actions are assigned a pathological meaning because they occur within the context of the psychiatric hospital. To illustrate this point, about two years ago I was working one evening with a chronic paranoid schizophrenic. Around eight o'clock in the evening, he came to me and said. "I know now that they are really trying t persecute me. A few moments ago, that man (indicating a copatient) carried a huge crucifix down to his

room. They are going to crucify me like Christ." I tried to reassure the very frightened man insisting that he would not be harmed on the ward, and, that the crucifix was a visual hallucination which he should try to ignore. The next day, I discovered that Mr. X. (the copatient) had constructed a life size crucifix in occupational therapy and had placed it in his room. I recalled my somewhat patronizing speech to reassure the patient that no such object had ever been on our ward.

Obviously, the patient did suffer from persecutory ideation, but, part of this story was thoroughly grounded in reality. Within the context of the psychiatric milieu, I pathologized the story in its entirety. This is an extreme example, but there are other less dramatic but equally powerful examples of how 'we' 'the staff' medicalize patients' words and actions.

Patients' Manipulation of Meanings

Often, as health care givers we comment on the 'community' of the psychiatric hospital as it exists for patients and we do so disparagingly. Such remarks as 'this place is like high school, only, nobody ever graduates' suggest the staff are aware of the community bonds and that we resent them. There is a sense that somehow patients have tricked us. They have given their meaning to the situation which differs radically from ours; by so doing, they move

from a state of powerlessness to one of power. They reframe the experience in such a way that they emerge with a stronger sense of agency. (Musolf 1992; Thomas 1984) They move from the powerless position of materials to be operated upon (Perrow 1989) to creators of community where they renegotiate the terms of the experience in such a way as to render it more helpful to them. Talai and Foley express it as ,'the capacity of people to invest institutional or bureaucratic structures with extrinsic personal meanings and relationships. That is to say, that people can transform the necessity of interaction in work or education into valued associations and social groups. In doing so formally organized groupings can take on some of the voluntary and affective characteristics more usually associated with other kinds of collectivities.' (Talai and Foley 1990:248).

Frequently, after patients have been discharged, they will come back to the hospital to visit friends, to exchange tapes, to socialize. Staff can be heard making such comments as 'they can't stay away from here'. On a deeper level we know that the patients have achieved some power through their reinterpretation of the situation.

Viewed in this light, the hospital community could be defined as deriving from a need to transform an essentially powerless and dependent situation into one of greater power and control. Musolf expresses this well through

paraphrasing Thomas, "Negotiation empowers those at the bottom of total institutions with mechanisms for altering the asymmetrical hierarchical power relations. The need for social order dramatically alters the hegemonic power structure...Negotiation can also affect an organization's career by reframing purposes and goals." (Musolf 1992).

This transformation can be perceived as detrimental to patients because it reinforces their estrangement from the wider society (Drake and Wallach 1988; Goffman 1961; Szas 1971) or it can be viewed as an example of the strength of their agency. (Musolf 1992; Thomas 1984)

This study focused on the second perspective - that the transformation of hospital to community is a mechanism through which patients make life more bearable for themselves. (Thomas 1984; Denzin 1989).

Returning to the more general notion of community, isn't this use of community by patients comparable to the use 'we' make of it? Community can therefore be seen as a way of dealing with the "overwhelmingness" of the "world". We all make our lives more bearable through the localization of joys and pains and the imposition of social boundaries. This provides us with the interpersonal intimacy we need in order to achieve a comfortable sense of "belonging".

Implications for Practice

This study focused on patients' perception of hospitalization and their creation of . ocial world - their "community". The patients emerged through the interviews as strong, creative individuals who are capable of forming a partnership with health care givers in the designing and carrying out of their treatment plans. Denzin states that "The perspectives and experiences of those persons who are served by applied programs must be grasped, interpreted, and understood if solid, effective, applied programs are to be created" (Denzin 1989: 12).

The creation of community by patients demonstrates a recognition on their part of the need for "asylum" - we discarded it, they recreated it in accordance with their needs.

As Denzin (1989: 12) suggests, we need to really listen to patients if we are to improve quality of care. For example, patients expressed the need for "control", yet rebel against "restraints" - we could say this was ambivalence but it also could be our inability, as health care givers, to limit ourselves. The descriptions of the patients' experiences with restraints are harrowing. One patient described being in restraints as "sheer agony". We need to look closely at this clinical issue and ask ourselves such questions as, why do we really restrain

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patients?   What is accomplished by it?   Does restraining
patients have a therapeutic value?

At the hospital where I work, we are in the process of
establishing a Restraints Committee to consider these issues
and attempt to develop alternative solutions.   I feel that
the patients' obvious concern with this issue as expressed
in the interviews, further sensitized me to the importance
of reviewing carefully why we do this and what is
accomplished.

The issue of restraints is really about the issue of
control, and, in a sense, the community of psychiatric
patients is about patients taking control.   If this study
contributes anything to practice, it must be that we need
to give up some control - patients need to take a more
active role in the provision of their health care.   If this
could be accomplished, health care programs would be
grounded in more realistic needs.

Patients' perspectives must be respected.   Their
variable dependence on the hospital can be perceived as
healthy, asylum when they need it.

Our practice should not encourage institutionalization
on a long term basis for the majority of patients.   As
stated earlier in the study, the hospital environment

creates as much deviance as it cures, but, it should permit dependence during periods of acute illness. Also, there will always be a minority of patients for whom the hospital will become their social world and we should allow this without resentment. This is allowing patients to take control, giving credibility to their perception of the hospital.

For the majority of patients however, we need to provide asylum in a non-institutional setting through the development of community resources; improved, supervised living arrangements, more psychiatric day care programs, more support for families of the mentally ill. Only when these needs are met outside hospital, will patients have alternative communities to which they can belong.

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DEFINITIONS

The following definitions are taken from the Diagnostic and Statistical Manual currently being used in assigning diagnoses. Each diagnosis in the DSM 3-R is number coded and I have included the number codes should the reader wish to refer to the L3M 3-R at any time.

295 Schizophrenic psychoses

A group of psychoses in which there is a fundamental disturbance of personality, a characteristic distortion of thinking, often a sense of being controlled by alien forces, delusions which may be bizarre, disturbed perception, abnormal affect out of keeping with the real situation, and autism. Nevertheless, clear consciousness and intellectual capacity are usually maintained. The disturbance of personality involves its most basic func.ions which give the normal person his feeling of individuality, uniqueness and self-direction. The most intimate thoughts, feelings and acts are often felt to be known to or shared by others and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the schizophrenic person's thoughts and actions in ways that are often bizarre. He may see himself as the pivot of all that happens. Hallucinations, especially of hearing, are common and may comment on the patient or address him. Perception is frequently disturbed in other ways; there may be

perplexity, irrelevant features may become all-important and, accompanied by passivity feelings, may lead the patient to believe that everyday objects and situations possess a special usually sinister, meaning intended for him. In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the forefront and utilized in place of the elements relevant and appropriate to the situation. Thus thinking becomes vague, elliptical and obscure, and its expression in speech sometimes incomprehensible. Breaks and interpolations in the flow of consecutive thought are frequent, and the patient may be convinced that his thoughts are being withdrawn by some outside agency. Mood may be shallow, capricious or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism or stupor. Catatonia may be present. The diagnosis "schizophrenia" should not be made unless there is, or has been evident during the same illness, characteristic disturbance of thought, perception, mood, conduct, or personality - preferably in at least two of these areas. The diagnosis should not be restricted to conditions running a protracted, deteriorating, or chronic course. In addition to making the diagnosis on the criteria just given, effort should be made to specify one of the following subdivisions of schizophrenia, according to the predominant symptoms.

Includes: schizophrenia of the types described in 295.0 -
295.9 occurring in children

Excludes: childhood type schizophrenia (299.9)
infantile autism (299.0)

295.6 Residual schizophrenia

A chronic form of schizophrenia in which the symptoms that
persist from the acute phase have mostly lost their
sharpness. Emotional response is blunted and thought
disorder, even when gross, does not prevent the
accomplishment of routine work.

296.0 Manic-depressive psychosis, manic type

Mental disorders characterized by states of elation or
excitement out of keeping with the patient's circumstances
and varying from enhanced liveliness (hypomania) to violent,
almost uncontrollable excitement. Aggression and anger,
flight of ideas, distractibility, impaired judgement, and
grandiose ideas are common.

296.1 Manic-depressive psychosis, depressed type

An affective psychosis in which there is a widespread
depressed mood of gloom and wretchedness with some degree of
anxiety. There is often reduced activity but there may be
restlessness and agitation. There is a marked tendency to
recurrence; in a few cases this may be at regular intervals.

300.4   Neurotic depression

A neurotic disorder characterized by disproportionate depression which has usually recognizably ensued on a distressing experience. It does not include among its features delusions or hallucinations, and there is often preoccupation with the psychic trauma which preceded the illness, e.g., loss of a cherished person or possession. Anxiety is also frequently present and mixed states of anxiety and depression should be included here. The distinction between depressive neurosis and psychosis should be made not only upon the degree of depression but also on the presence or absence of other neurotic and psychotic characteristics and upon the degree of disturbance of the patient's behaviour.

308   Acute reaction to stress

Very transient disorders of any severity and nature which occur in individuals without any apparent mental disorder in response to exceptional physical or mental stress, such as natural catastrophe or battle, and which usually subside within hours or days.

309   Adjustment reaction

Mild or transient disorders lasting longer than acute stress reactions (308.-) which occur in individuals of any age without any apparent pre-existing mental disorder. Such

disorders are often relatively circumscribed or situation-specific, are generally reversible, and usually last only a few months. They are usually closely related in time and content to stresses such as bereavement, migration or separation experiences. Reactions to major stress that last longer than a few days are also included here. In children such disorders are associated with no significant distortion of development.

311   Depressive disorder, not elsewhere classified

States of depression, usually of moderate but occasionally of marked intensity, which have no specifically manic-depressive or other psychotic depressive features and which do not appear to be associated with stressful events or other features specified under neurotic depression.

295.4   Acute schizophrenic episode

Schizophrenic disorders, other than those listed

OTHER DEFINITIONS

community resources: significant others, acceptance by the community, leisure activities, adequate housing, and supervision to insure compliance with treatment.

major chronic mental illness: diagnosis of schizophrenia, manic depressive psychosis (bipolar affective disorder), major depression, and borderline personality disorder.

revolving door patient: a patient with a history of readmission. For the purpose of this study, a patient with more than one admission in a twelve month period.

* These definitions differ from those on the previous page in that they have been specifically developed for this study.

Concordia
UNIVERSITY

TITLE: PSYCHIATRIC HOSPITAL AS COMMUNITY

PURPOSE OF THE STUDY

This study is being conducted to explore the concept of the psychiatric hospital as a community.

The researcher is Patricia O'Flaherty, a student of Concordia University and also head nurse on the Brief Therapy Unit.

I understand that if I participate:
(1)   I will have a tape recorded interview with the researcher. Tape recordings will be coded, no names will be used.
(2)   the tape will only be heard by the researcher and no one else
(3)   after the information has been typed, the tape will be erased
(4)   I am completely free to refuse to answer any particular question during the course of the interview
(5)   my personal privacy will be protected as my identity will remain unknown
(6)   I am under no obligation to participate and should I decline to participate, this will in no way affect the quality of care I receive in the hospital
(7)   I may withdraw my consent at any time
(8)   I will not immediately benefit from the study, but future patients may benefit
(9)   the results of the study will be presented as a thesis at Concordia University in August, 1994
(10) I am entitled to an abstract of the project if I so request

I agree to participate in this study.

SIGNATURE   **DATE**

WITNESS

I also agree to having my hospital record examined to clarify reasons for my admission or readmission.

SIGNATURE   **DATE**

WITNESS

INTERVIEW QUESTIONNAIRE

(1) How do you feel about being in the hospital ?

    - are you angry, uncomfortable, relieved

(2) What would you say was the main reason for your admission ?

(3) Do you have family or other relatives in the city? How do you feel about them when you are here ?

(4) Do you have some friends here in the hospital ?

    - new friends or people you knew before ?

    could you tell me a little about how you made friends with these people ?

(5) When you are outside the hospital, who are your friends ? Where do you meet them ?

(6) When you are living outside the hospital, how do you feel others treat you ?

(7) How important do you feel that the hospital is in your life ? Why ?

(8) What, do you think, is the most important thing about you ?

(9) How would you describe yourself in your life outside the hospital ? How important is your illness ? (1-10 scale)

PATIENT 1

(1) Well, I was really sick - I feel safe here.

(2) I wanted to kill myself - I tried to cut my wrist with scissors and then I overdosed on my medication.

(3) Yes, I live with my husband and two daughters - they are a lot of work, my daughters. Girls are more dependent than boys - but I guess I made them that way. When I'm in the hospital, I feel distanced from them, but you see, this is good because we have some family problems and it gives me the chance to be more objective.

(4) I had one very good friend - we used to talk a lot but she had her discharge last week. I'm not that close to anyone else - I mean I talk to them, but its not the same. There is one woman that I can't stand - she's very dirty and screams and whines all the time - all the patients hate her. If they put her in my room, I'm signing out, I've already told them that.

(5) I don't really keep in contact with old patients - once I did though and we kept in touch for five or six weeks - then I dropped it. I have my own friends - I invite them to my house or often we go to restaurants.

(6) My family are supportive but sometimes they get tired of my illness - the friends that really care - they accept me - they accept but they don't understand - I can tell by the questions they ask that they really don't understand.

(7) Very very important. Why? Because of my suicidality - because of my aggressivity - when I lose control - the hospital controls me. It helps me to be here because I feel safer. I guess everything helps - the medications, the hospital, the psychiatrist.

(8) My family - my daughters and my husband.

(9) When I'm well, I'm a very active person. I love sports - weightlifting, swimming - to be outdoors. I do some article writing for a book club - but, its funny, I forgot to tell you the most important thing about myself - I love painting - I've sold some of my paintings.

On a scale of 1 - 10, I would say 8.
Why? Because I can't function when I'm sick. I can't even answer the phone or see my friends. My life stops when I'm like that. And it affects my relationship with my family - we stay close but its still very hard

for them. My daughters, one would like to become a social worker and the other wants to do occupational therapy - they know I'm sick and they want to help people like me.

(1) Settled, calm and sober. Would you believe it - at home my mother almost attacked me over a hot water bottle. A hot water bottle! I got so excited - I can go home for one day at a time - but two, three days - its too much.

(2) To participate in a new medication program. Its Risperidone for Chronic Schizophrenia and acute supersensi'ivity psychosis.

(3) My sister lives in B.C. - I write letters, we talk on the phone - but I don't see her that often. I live with my mother. I went there Saturday and Sunday - I didn't get a wink of sleep all night - too much noise at home. It was the hockey game - shouldn't have watched it - Toronto and the Nordiques - I'm a Canadiens fan, but I wanted Quebec to win - they lost 6-3. I feel content here - I keep in touch with my mother, I phone her but not too much. When I was first here, I used to phone her five or six times a day, I guess that was overdoing it a bit, eh?

(4) Everyone is familiar, that's positive. Mr. R. is my best friend, you see we went to high school together,

we weren't friends in high school, we didn't even talk
but we are friends now.

(5)   You see I belonged to this band.   I played the sax.
This was around 1981.   In 1987 we disbanded - no work -
we got refusals, everyone cancelled, I don't know why.
Since 1987 - well - here, everyone's familiar.   Mr. R.
said in about three years he'll have a party for his
brother's 25th wedding anniversary - said maybe we
could play - I'm trying to round up the guys - can only
find two.
I know people where I work.   It's a shipping company -
lots of people from the Douglas hospital work there.

(6)   (The patient became very anxious, shifting in his seat
- appeared flushed and very nervous)
Everything's OK! Fine! Fine! It's like driving a car.
Sometimes you go fast and sometimes slow.

(7)   (The patient looked very sad)
I think its important.   You see I've been coming here
since 1971 - four hospitalizations - the first time I
came, they thought I had a physical illness, then they
discovered I was mentally sick.   23 years I've been
coming here - that's a long time - Once I was only here
for six weeks, but on ward it was eight months.

(8) (The patient became very anxious once more, crossing and uncrossing his legs)

Everything - I don't know - well life is very important - it involves a lot of things. Life is a big struggle - it never finishes. Its like driving a car - you're going along fine, then bang, you get a flat, right out of the blue. If you have the equipment, of course, you can fix it. I'm still learning. It's like a car - the most important thing is if it starts in four seasons.

(9) I can't answer that - No. I'm a good person. You see - that band - we could play at all occasions - Well this will help you (hands the writer a card advertising the band). Yes, I'm a musical person. I played the sax. The rating scale really upset the patient). What is the verity of these numbers? I can't answer that. I've been coming to this hospital for 23 years. That's a long time. You see my main problem is a nervous condition. Perspiration! Then it gets like steam! But, I'm not perspiring now!

Chow, Patricia.

PATIENT 3

(1) I don't want to come back to this ward - I don't want to be tied down - that's what I'm most afraid of. I don't want to be tied down. Sometimes, other patients here do tricks in the dark.

(2) There was blood in my urine - and I was on a new medication Clozapine, Clozaril - it wasn't working.

(3) I live with my father - have a sister-in-law, nieces, well, Patricia, you know me - I like to have a single room, I like to be all alone, quiet.

(4) I have good friends - I know the staff. I like human beings who like me.

(5) I like helping the neighbours, but, you see, they change so much - they move in, they move out, its their right, but, too much change - they sign a lease but they can get out.

(6) I don't want to be a faker - my best friend is me - my worst friend is me - I try to do the best I can.

(7) Well, you see, I started with a depression, then, they said it was schizophrenia, - I've had lots of accidents in my life and come here a lot. You see, its hard to go back to the house. When you're alone - its hard to

support yourself when everything is put on your back, it just too hard.

(8) I knew a patient - his name was Robert - he was in the hospital and he passed away from cancer. The most important thing is to get myself better with the medication I need. I want to be able to be polite with people - to be clean - I've always been too serious.

(9) I don't know, well, you see I'm a patient - I need to take pills - like I said, I want to be polite and clean, but, I need someone to help me.

Those numbers - no - don't draw them - what do they mean? This is March the third, the third month of the year, the number three - but I see my illness and I know that I'm not getting any better.

(1) To tell you the truth, at this point, I'm fed up. I'm bored with the hospital. But when I first came in I was really angry. They put me in restraints and I was in physical agony. I couldn't sleep the whole night because I was so uncomfortable. I called to the orderly to loosen the ties but he was miserable - I can tell you I was in agony. After I was out of restraints I couldn't life my left arm for five days. Let me tell you, the first few days were not glorious!

(2) I was sleep deprived. You see I was in France and I got really manic and I couldn't sleep at all. Then I got jet lag, I just couldn't sleep for weeks.

(3) I have two daughters - 25 and 23, and my mother lives in the city. They don't live with me, but when I'm here I think about them a lot. Their visits are really special - I always love to see them, but, when they come here, there is something special.

(4) Well, one of the nurses here, I remember her very well from the last time. I had one good friend here, but, he is gone. I think we will keep in touch because I really like talking to him.

(5) Most of the friends I have outside are people I've known for a long time - I went to school with them and have known them for years. Usually, when we get together we'll go to a film or eat out at restaurants or they come to my house.

(6) The first time I was in here, I had a terrible stigma. It wasn't because my friends treated me badly - it was what I thought. I was terrified people would find out! I was so angry at ending up in such a place. The second time it was no big deal. Now I don't feel like that at all (stigmatized). My real friends are glad I'm here because they know I need help. I'm really hoping that the Lithium will help me - I want to feel more in control of the highs and lows - the lows are getting worse.

(7) At first, I think the hospital had a terrible impact on my life. I was so angry at being here. now, I know I need help - I need the medication if I'm going to live a normal life.

(8) To me the most important thing is my individuality. I'm terrified of losing myself with the medications - I know the effect its supposed to have is to cut the severe ups and downs, and I want this, but I don't want to be flat. I don't want it to take away my character.

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(9)   I'm an individualist - I don't think like other people
       - I like to do things on my own. I mean I like to do
       things with other people but I like to be alone too. I
       like art - to paint and to draw.

       I would say 9. It had a tremendous impact on my life
       because it affected all my relationships - it ended my
       marriage, that's for sure - I didn't realize it at the
       time but I sure see it now.

       This project is about community? This is a very
       difficult community to live in. You see, there's a
       lady on our ward - she screams all the time - she
       should be in a geriatric ward - don't you think? Why
       don't they do something about her? I mean why is she
       here? How can we get better when we have to live with
       people like that all the time?

PATIENT 5

(1) I feel secure here, I guess you could say there is a sense of safety. Before I came in I was in a state of shock. I felt like breaking things - hurting myself - I was afraid I would hurt other people. Here, there is a whole team of people to make you feel normal. A whole team? I mean doctors and nurses, and they are always around.

(2) I was pushed to the edge. You see, I was seeing a therapist, and she started to bring up subjects that I couldn't deal with and I ended up being very depressed.

(3) I have my husband and a stepson who is 22. I also have a 13 year old son. And I have my parents and my three brothers. How do I feel about them? Well, the first few times I was hospitalized I had this tremendous feeling of guilt that I was away from them. But, the last two hospitalizations, well, my family understand more about my illness now. After all, I'm not a robot, I can't be everywhere all the time. They understand this more now. I mean, I still miss them but not as intensely as before. I just need this time for myself.

(4) Well, definitely, when you see the familiar faces it gives you a sense of security - when I make friends

here, it's because of the sickness we go through together, we try to analyze, try to figure out what happened. It's like you know how I feel because you've felt it too, and we help each other. The sickness is the bond.

(5) Most of my friends are recent - I've met during the past five years. We're four or five girls, we go out for supper together or to the theatre.

(6) I felt labeled, after the first few hospitalizations I felt people used to label me and it really bothered me. Now, it doesn't, my real friends won't ask about this place. I know there is a part of me that is sick but I asserted myself. I said to myself, I'm not an invalid, I still want to live and do things when I am well.

(7) The hospital has really helped me a lot. It has helped me to reorganize my image of myself. My therapist has helped me to see myself in a different way. I used to have a certain image of myself, the therapy helps greatly, the image has changed. The hospital helped me to have more trust, more self-confidence.

(8) Knowing what I want - I feel that now I am a person that knows what I want.

(9) I see myself as a very outgoing person - I am open. When I become depressed, this blocks me - but, I am determined to go ahead with plans. That is not easy to do. It takes a lot of determination - but I have a lot of determination. At this point, 8.

PATIENT 6

(1) Sad. Because my sickness doesn't progress.

(2) I came here by myself because I was too down - very depressed.

(3) My girl, my boy. They live with their mother. They are 16 and 15. We are separated (the patient appeared very sad and close to tears). I miss them and I worry about them. There is a restraining order, you understand, because I hit my girl.

(4) Not really friends, but some company. I recognize people. I'm glad to see familiar faces.

(5) I live alone in an apartment - I don't have many friends. Sometimes I meet people when I go bowling.

(6) They treat me normally.

(7) Well you feel more safe here when you are sick. There are lots of people here to take care of you - doctors and nurses. In an apartment you are all alone.

(8) My children.

(9) I'm not very open to people. I would say 9.

(1) Uncomfortable. Wouldn't you rather be outside in the fresh air having a picnic? Or spending time with your girlfriend? Or having a nice lunch downtown?

(2) Medical problems, not psychiatric. I had heart failure, kidney failure, liver failure. I was intoxicated with Lithium. You know what lithium is? Its a light metal. If you look at the table of elements, you'll see it there. Its a conductor - ions and electrons. It has some effect on dopamine in the brain - too much dopamine! You see my blood wasn't being monitored - Dr. X, he gets the results but never looks at them! The last time I saw Dr. X, my father came - He's getting old, my father (patient became very tearful) 66 next Tuesday. I hope my parents live forever. I hope to see them celebrate their 75th wedding anniversary - I've been to their 25th , 35th.

(3) I live with my parents - I have one sister - she is a rat. A rat! I mean like prostitutes are rats - she ran away from home at 19 and married a Lebanese. What can you expect? My brother is an angel - he's married with kids. An angel? I mean he belongs in heaven or at least the highway to heaven!

(4)   Write this down - Tom always gets sick in the autumn and spring.   I was given Lithium Carbonate, 900mg. and nobody told me about it.   My best friend is Anna - look what they've done to her.   I've just fired my social worker, I don't need social workers, psychologists, neurologists.   Nurses and doctors are good.   See if you can do something about the black people here.   A lot of them are very jealous of me, you know, during the night.   I've known Dr. X. for twenty-two and a half years.   I feel he is a paternal guidance, a spiritual guidance - he helps me out of awkward situations.   The last time I saw him, my father came with me, and he said if my father ever came again, He'd call about twenty policemen and have him thrown out.   Dr. X. has about twenty microphones in his office, not always turned on.   You see, he is intimidated by me - the last time I was in his office, he had his feet like this (patient placed his feet in a rigid fashion indicative of fear)   but, you know, (looking sad) I would never hurt him.

(5)   My girlfriend is my best friend, I meet people playing pool, bowling, skating.

(6)   Very fine!   Like when my girlfriend and I go to a restaurant, she takes the trays and I pay, or she pays.

(7)   I really want to say something about restraints.   I
      mean, why do they have to be so damn thick and
      leathery?   I've spoken to Dr. X. and recommended a
      different type.   Once in the emergency room, you know
      Cathy, the nurse? a guy jumped on her and nearly broke
      her neck.   My father and I saved her.   She would be
      decomposed in her coffin now if it wasn't for us.
      I don't want restraints!   Change that!   Put a person in
      a room, lock the door, watch them - but not tied down!
      Its terrible, you see, I have a bladder problem and its
      terrible when you can't go and I get so thirsty and
      there's no one to give you a drink.   In the old
      emergency, they never tied you down.   I know all the
      nurses, but, there's this one dumb foolish blonde,
      Rachael, you know the one I mean, and she gets scared
      and puts on the restraints and starts talking about
      sending me to the Douglas!   I mean, don't confuse
      patients!   This is a mental hospital!   We're already
      confused!   Do you think I wouldn't like to have an air-
      conditioned office like this, seven blue lockers and a
      red candy horse?   I hope one day we'll all have
      bookcases with flowers on them.

(7)   Non-existent!

(8)   I'm sympathetic but bold!   I can blow, I can huff, I
      can puff, I can blow your house down!   Write this down

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in capital letters and underline it 'TOM IS AN OFFICER AND A GENTLEMAN.'

(9) Externally fine and internally fine when my mother is in a good mood. At home, I get pissed off (I know you won't take offense at that word, Patricia, because if you go to Concordia you've heard it - its part of the graffiti on the walls - See, at home, they fight a lot - that's why I'm here. Like my mother says to my father 'I hope you've got cancer of the spine.' Yeah, she says that. To a sick man! But, she's a sick woman! She has been in and out of St. Jean de Dieu for years. Now that's a lousy hospital! Lousy sanitation! Its a big hospital! Bad hospital! You see some real freaks there!

Ten, because I have manic depressive psychosis! Write this down - Tom is a thirty-eight year old Italian Canadian who attended Concordia up until third year communication arts but got sick and never finished.

(1) Basically, I'm pretty ticked off with it at this point. Its a good hospital, and in the beginning I guess I was paranoid, wouldn't talk, didn't recognize myself in the mirror, but now I'm tired of it.

(2) I bought a dog, a beautiful Chow Chow, and a pellet gun, and I was going to hunt, and my mother gets all excited about the gun, I can't do anything in that house. You see, my family hasn't raised me properly.

(3) I live with my parents, and I have a big family in the city; cousins, nephews, but I don't miss them. Although, I do want to go home, I'm fed up living in hospitals and jails.

(4) I do have some friends, you know Louis? from your ward? We talk and smoke together. But, some of the people here are not my type of people.

(5) I'm pretty much of a loner, I don't hang around with anybody. I stay home most of the time and listen to my music. I do have some friends that like music and we do drugs together but I'm trying to get out of that.

(6) They treat me fine. I mean, the first few times I was here, it was difficult when I got out, but that's all over and done with now. I used to feel insecure about being a patient here, but not now. When I'm out with my friends, we smoke hash, I feel it helps me. I become more outgoing and creative. I play my music better.

(7) Very important, because it helped me to change my life around. This is my 'helping ground'. They know me so well here! And I meet people I know here.

(8) My music - the love I have inside of me for myself. The love I have for my music, I couldn't live without music.

(9) I'm outgoing. I'm a very musical person, I love playing the drums. As long as I keep busy with music, I stay out of trouble, if not, I meet up with bad people. Like they wanted to murder me in prison, I know it.
On a scale of 1 to 10, I would say negative 1, because I don't have an illness, I'm a drug user. I have a serious addiction problem, I'm not a mental patient. I don't need medication, I need a girlfriend.

(1) I feel safe here. The whole team makes me feel safe, the nurses, everyone.

(2) I had a major depression, I couldn't sleep or eat.

(3) My husband, my sisters. I miss my husband when I am here.

(4) I have two very good friends, one on the other unit, and one on this unit. We're not friends just because we're all sick but we have the same tastes in other things.

(5) I have a few friends...they're all my neighbours - I met them in the neighbourhood where I live.

(6) OK, but I have one sister, she really hurts me. She can't accept my illness. She is incapable of understanding what I'm going through.

(7) A little bit too important! I come here too much - too many times I'm here.

(8) Music.

(9)   I used to be a hard worker. I try to be optimistic. I

would give myself a 6.

(1) I have mixed feelings towards the hospital- well, its very embarrassing to be here. For other people to know. On the other hand, I feel safe here. I'm much less tense than I was outside - not completely relaxed, but less tense. I'm not alone here. There's always someone to talk about your problems with. Outside, I talk to my mother, but I need to talk with someone not as close to me - someone in your family is too close.

(2) Short term - I wanted to kill myself. Long term - my father. He left when I was two years old and that was very hard for me. I missed having a 'father' not so much 'my father' because I didn't 'know' him, but, to me, there should be a mother, father, and children in a home. It wasn't balanced. You need a father to keep a good equilibrium.

I felt like I had to fill two roles. In a way, I had to replace my father. I have three sisters (you said four - you knew - you see that is a sign) I was the only boy.- I missed another masculine person. Short term reason? I wanted to hang myself. I went up to the roof, and I had the rope and everything, then, I got very hot and I couldn't do it. So, I came downstairs, and I called the Detox Center. I free-

base.- I'm a cocaine addict.   No, I hadn't taken any that day, but the day before.

(3)   My mother, my cousin. I have three sisters but I don't see them very much. When my mother visited here, I was glad to see her. But, when she left, my thoughts were here. I need to be away from her at this time.

(4)   The word 'friend' to me is a big word. I have two 'real' friends. on the outside. But, here, I wouldn't really call them friends.   Perhaps, acquaintances. One, though, I share a lot with - we are living through a similar experience. But, we don't always talk about being sick, we have other things in common.

(5)   I have two good friends. When I say 'good' I mean that I confide in them a lot.   Like about my father, my addiction problem.   One friend I met when I was in school. The other, I was short of money one day, and I was panhandling and this guy gave me some change. We started talking and we became friends.

(6)   When I'm outside, I feel uncomfortable.   I have a sensation of being 'negatively' different. Not lost, but, I can't protect myself from others because they don't understand. I don't want to be judged by them.

That's why I take drugs because it protects me from suffering.

(7)   Very important because I'm with others who are going through what I'm going through. We all have emotional problems. That doesn't mean that we're all the same. In some ways, I suffer more, but in other ways, someone else suffers more than me. But, we understand each other.

(8)   The most important thing is eternal life. When I read the bible, I recognize signs . For example, God sent me here, I knew that when I saw the mountain - the mountain is the sign that I'm on the right track. There is a lot for me to learn here.

(9)   Outside the hospital? Crazy in the eyes of the world - wise in the eyes of God. To the world, I can't function normally. But, God is calling me. People don't understand that.
Nine and one half. Its because of that I wanted to destroy myself.