cultural frontiers in the mental health service*

R. D. Scott

The view we, as researchers and clinicians, take of mental illness depends not only on our attitudes and experiences but also on the actual place—that is, the physical facility and “catchment” area—that forms the base for our work and observations. Because cultural values very much determine the attitudes of society toward mental illness and mental patients, the right place to study these issues must be a base that is representative of society and that deals with patients who are representative of illness in the community; it should also be a place where one may experience the full force of attitudes of society toward the mentally ill and toward those who care for them. The “right place” means a mental hospital or unit with a large catchment area, and a place of observation centered on the boundary between the hospital and the community served; the hospital has an allotted place in society with obligations it cannot evade. In Great Britain, where this research was undertaken, the National Health Service hospitals occupy this position—they are the end of the road in the sense that very few psychiatric crises requiring admission can avoid coming their way.

Napsbury, the hospital involved in this report, is a conventional mental hospital that is part of the National Health Service. It has about 1,400 inpatients and serves a catchment area of 500,000 or so. The team of professionals involved in this project at Napsbury is responsible for about a third of the hospital and its services. In recent years, our team has made a transition from a hospital-centered to a community-centered psychiatry, and this has led us to center our treatment program at the boundary between the hospital and the community.

Perhaps, a brief history of Napsbury, derived from a unique study by Bott (1974), will help to put our evolving treatment program in perspective. Between 1905, the year the hospital opened, and 1945, the pattern of hospitalization in Napsbury was static. In period 1, the custodial era, the proportion of the population to be hospitalized remained constant; of those who were admitted, about 60 percent never left the hospital again; and of those who were discharged, few were readmitted. These figures express the relative lack of progress in dealing with mental illness made during the first half of this century. In 1944, just before the end of World War II, the pattern began to change: between 1944 and 1955 the first-admission rate per unit of population doubled. A whole new segment of the population began coming into the hospital. In contrast with period 1, the hospital appeared to have become a center of active treatment, but Bott's data put the changes in perspective. In the 1940's, 1950's, and 1960's, new methods of treatment were introduced within the hospital, but until 1968 they had no noticeable effect either in decreasing the rate at which patients became long-stay residents or in increasing the rate at which chronic patients were successfully discharged. During this second period, mental illness was seen as being treatable. But because our viewpoint remained hospital centered, we did not perceive that this impression was largely based on our experiences with a type of patient who previously would not have been admitted; nor did we perceive that changes in pattern of hospitalization were more closely associated with changes originating in our catchment area than with any treatments given within the hospital. It was not until period 3, when we came to establish a community-centered psychiatry, that we began to appreciate the relationship between events in the catchment area and events in the hospital. Our growing understanding of this relationship led to a reduction of about two-thirds in the population of our admission wards.

The relationship between the hospital and the com-

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1 These included electroconvulsive therapy, insulin, tranquilizers, community therapy, and an extensive program of industrial therapy.
munity becomes visible at the boundary between the two, and quickly disappears from sight the farther we go from it. Several levels of relationship between the hospital and the community may be defined: At the interpersonal level, we have the relationship between the patient and his relatives, and between the hospital staff and the relatives. At the cultural level, the relation is between the hospital and what the community expects of it—expectations determined by cultural mores as they are expressed by patients, relatives, and others in the community. It seems that the community's cultural values lie very close to those values represented by the administratively powerful official bodies—the Department of Health and the Regional Hospital Board—to which the hospital is responsible.

The research that has assisted our understanding of the boundary area between the hospital and the community has mainly concerned the relationships between schizophrenic patients and their relatives. Findings from this research have helped members of our small research team to realize the importance of certain powerful cultural assumptions about mental illness and mental hospitals—assumptions on which the customary organization of our services for the mentally ill is based. These assumptions are present mostly at a primary level of unreflective awareness. One assumption, for example, would be that most patients are admitted because they are ill. Most hospital staff know that this assumption is incorrect—but they seldom acknowledge it.

**Human Relationships and Mental Illness**

It is not only therapies that have governed the treatment of the mentally ill. Treatment has been, and in my experience still is, much more determined by cultural attitudes. But cultural attitudes are not human relationships.

In period 1, the custodial era, the insane were banished into asylums; they were regarded as being beyond human relationships. In period 2 (1944-68), the term mental illness was introduced, implying that illness and hence also treatment was the issue but that it was an illness that differed from other illnesses and required treatment in special mental hospitals. Currently, in period 3 (1968 to date), the meaning of the term mental illness has been changed by the innovators in our culture to imply an illness similar to any other illness, and one that consequently should be treated in general hospitals.

These images have governed a massive program of structural change. As stated above, under the period-3 image, mental hospitals are being replaced by small units attached to general hospitals. The aim is to keep admissions short, and to keep the patient in contact with his normal life and relationships. Our research findings suggest, however, that maintaining the bonds of relationship between those who have been diagnosed as mental patients and their relatives is much more revolutionary in its implications than is apparent from the humanitarian values that have guided this change.

Our own approach at Napsbury appears to be much in line with that proposed by Great Britain's Department of Health: We take human relationships seriously, and we consider and treat psychiatric disturbance in the context in which it has occurred. This approach does not sound revolutionary, but in practice we have found that, when mental illness is the issue, the taking of relationships seriously touches the raw nerves of society. It brings to view deeply entrenched beliefs whose violation is seen as a matter of life and death.

Therapeutic approaches that see the relationship between a patient and his involved others as an essential part of mental disturbance are recent developments in the field of psychiatry and, as such, have not yet become part of established psychiatric practice.

Stierlin (1958 and 1969) has described how cultural issues, especially those prevailing in Europe, have set an almost impassable barrier to giving relationships a place in psychiatry; and he has pointed up the peculiar position of the schizophrenic in leading some workers to realize the importance of relationships. Stierlin describes features in the social climate of the United States that have favored the emergence of the participant observer—mobility, initiative, distrust of authority, eagerness for change, and a forward-looking view. In Europe, however, Stierlin believes we have been so hedged in by tradition and authority that European psychiatrists have been forced to become distant observers, that is to say, psychiatrists who write textbooks and classify mental disorders, which are seen as internal disease processes. As far as Great Britain is concerned, Stierlin is certainly right. The barrier through which we must penetrate to reach our patients is not only set by the schizophrenic and his family; it is also a general cultural barrier.

Psychiatric illness more than any other illness involves cultural values and the violation of these values. Why
should the introduction of human relationships into psychiatry constitute a violation? The true introduction of relationships into psychiatry was initiated in the United States in the mid-1950’s when schizophrenics and their parents were studied in vivo, a research development that led the way into family therapy. It had long been known, however, that disturbances suffered by parents could affect their children. Why, then, was this most obvious area for psychiatric study and treatment so long ignored? I believe the study of parental pathology was avoided because it would, of necessity, violate a strong cultural taboo—the exposing of parents in front of their child. When there are painful conflicts within a family, in the course of which a son or daughter is brought for psychiatric treatment, parental authority is likely to be shaken and partially disqualified by the very act of seeking help from an authority outside the family. Perhaps it is to help parents maintain their status, to shield them from humiliation, that the customary practice has developed of defining one person within a family as ill. By this means, the pain of interpersonal conflict and the bonds of attachment and hatred are converted into an impersonal force—the relentless disease process—for which no one is to blame. Should we refuse to play the expected role and try to deal with parents as people struggling with painful issues of human relationship, they are likely to feel that we are violating something they hold sacred. Indeed, they sometimes will call in representatives of our society to stop us, thus revealing their belief that we are transgressing not only cultural values but personal values as well.

Research on Schizophrenic Patients and Their Relatives

In our research, we have considered a series of schizophrenic patients and their parents from two points of view: (1) We took the ways in which these families resembled one another and found we had extracted essential elements of the cultural image of mental illness. We then defined the details of how families used this image in their mutual relationships, and in their relationships with ourselves and the health service authorities. (2) We conducted a study that revealed how the relationships between patients and parents determined hospital outcome, the central issue being whether or not the patient violated parental identity. This study shows the way in which what happens inside the hospital can be determined by its relationship with the significant part of the outside community.

A Study of Individual Families

During the first 5 years of the research, we studied a series of 24 families in which a schizophrenic son or daughter had been living with one or both parents before admission. Usually, the patient and parents were seen together. Most of these conjoint sessions were held at home, except when the patient was hospitalized. Most of the families were seen for interviews every few weeks over a period of 2 to 3 years. Three dimensions and an interaction process were the main areas of study.

Horizontal Dimension

In a horizontal dimension embodying the geographically social world outside of the patient’s home, available both to the parents and to the patient, we found a group of patients who could not cross the boundary of the world known to their mothers and to themselves. They could neither visit places nor get to know people who were not known to their mothers. There was another group of patients whose worlds were also excessively tied in to the world of their parents, but who could cross the boundary of the family world and enter a world that their parents did not know; they could go outside the family circle and make friends of their own. Finally, there were some who could cross the boundary but who drifted aimlessly once they had done so.

Whether or not a patient could cross the boundary of the family world did not appear to be determined to any great extent by injunctions from the parents. There were such injunctions, but mostly they were not necessary. They were not necessary in the first group because the patient feared loss of personal identity if he entered a world outside of any world that his mother could have in mind, while the mother feared that the patient might get lost for good if he were somewhere that she could not imagine him to be. Thus the mother had to know where the patient was, and her consequent anxiety seemed as great as or greater than that of the patient. Should discord occur, the relationship was likely to become critical, and this occurred most frequently through the patient’s seeking to punish the mother by getting “lost.” Patient and mother become locked in a battle for psychic survival—a battle that I have termed
“identity warfare” since the personal identities of those involved are threatened. In the type of situation that I am considering, the move by the patient to get lost usually ends in hospitalization. Once he is in the hospital, we, as doctors, are held responsible by the mother for keeping the patient “under observation,” and for knowing where he is at all times—since he is “not responsible.” These types of mothers are very likely to bring charges of negligence against us if we allow the patient the independence of going off on his own. The mothers’ charges are aimed at getting us under control as their agents, and in this respect the mothers usually get the backing of higher authority. We then learn what it is like to be in the firing line of an identity war—the mother threatens our professional identity.

Thus the study of the family boundary has helped us understand phenomena occurring at the boundary between the hospital and the community.

External Temporal Dimension

An external temporal dimension is so described because it is composed of elements of family behavior that are visible, or that are likely to have been visible in the past. We are here concerned with a comparison of the family world as it is remembered as having been before the first breakdown of the index patient with how it has become after. Nearly all parents describe the patient’s breakdown as being the most awful thing they have ever experienced. Not only may the patient’s life suffer arrest after breakdown, but the family life may suffer as well. Although many of our parents had previously led rather restricted lives, after the break there was often a further and substantial arrest of family life. Before the break, the patient’s position in the family was likely to have been more central than that of his siblings; and after the break, his position was almost always even more central than before. This movement toward the center was most marked in the case of patients who became chronically hospitalized. The parents denied themselves satisfactions and made the patient the grave of their sacrificed lives. Hospitalization did not “relieve the burden on the family.”

Internal Temporal Dimension

In the majority of families studied, there was one parent who suffered from an inner dread that eroded his self-confidence and belief in a future. This dread usually had a history: in 16 of the 24 families, it was associated with an experience of having a first-degree relative who had had a psychosis and with whom the parent had been very involved; in 4 families, it was associated with the death of a person with whom the parent had had a unique and close relationship. These parents were haunted by fears portending a repeat of past disasters; they were also more involved with the patient than was the other parent who did not have this type of history. This inner dread was likely to contain an imprint, in unmodified form, of cultural attitudes about mental illness that stemmed from the custodial era (pre-1940), leading the parent to impose these attitudes and expectations upon the index patient. This fear probably influenced outcome for the index patient (Scott and Ashworth 1967 and 1969).²

Interaction

At conjoint meetings, the study of interaction between the members of the nuclear family, and between them and ourselves, was a central focus of research. We did not use a control group of families. We investigated the similarity and dissimilarity within the 24 families.

The families differed in many ways: All social classes were represented among them; they had central values that differed; and they differed in various individual and apparently unique ways. One system of values, however, was common to all families, and dominated all others in their interaction: this was the use they made in their relationships of “wellness” and “illness.”³ The line dividing whom they saw as being “well” from whom they saw as being “ill” was crucial to all families. Associated with this value was an affect that was also present in all families—dread. This dread appeared to be the same type as the inner dread described above in the internal temporal dimension.

Associated with what families saw as being “well” were values that were specific to particular families—

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²Nine parents had first-degree relatives hospitalized in the custodial era; in eight of the nine, the index patient became chronically hospitalized. Eleven of the total sample of 24 index patients became chronically hospitalized.

³The terms, “wellness” and “illness,” in inverted commas, refer to the family’s, as opposed to a clinical, view of a given individual’s condition.
values that almost always expressed parental identity (as distinct from identity as husband or wife). These identity-giving values for parents were polarized along a “well-ill” axis (Scott and Ashworth 1965). On one side of the axis were parents relying on these values for their sense of identity; on the other side was “illness.” “Illness” was a threatening sort of nonvalue—in reality an entity, seen by parents, and by patients too, as a disease process inside the patient unrelated to anybody. The affect of dread belonged to this depersonalized system.

In connection with the well-ill axis, it often seemed as if a battle for survival was taking place, the same battle that we came to see as identity warfare. In a number of cases it was quite clear that the parents feared destruction by the patient, that their identity as “well parents” somehow depended on him. In the case described in the study by Scott and Ashworth (1969), the mother’s central value was that parents should be respected and obeyed. Paul, the patient, was the only one of her children who had observed this value: his brothers had been very rude and defiant toward her. When Paul was first breaking down, he, too, had become aware of aggressive impulses toward his mother—for example, he might have wanted to shout at her for leaving the door open. Later recalling such feelings, he said, “I knew I was ill because I stopped respecting my mother.” The mother took a similar view of the matter, saying, “Paul is an insane person.” Another mother gave “answering back” as the first sign of illness. This mother had to be exclusive to her son as the only one he trusted; he “must tell mother everything.” “Not telling” or “answering back” meant a violation of trust, and this meant separation between them. In both cases, any behavior that threatened the mother’s central value was the signal for a cutoff by both patient and mother, a cutoff that deprived the behavior of all human meaning.

The well-ill line is formed by terms that have been deprived of human meaning, as in the above instances. Because critical values are involved, the terms remain strongly polarized opposites—opposites between which there is a gulf instead of a human person to mediate between the extremes. The opposite of “responsible” might be “not capable” or “dependent,” these latter terms being global attributions of illness of the type used by Paul’s mother when she said, “He is an insane person.” On the other hand, a mother seeing herself as “responsible” might define the term as implying absolute independence.

In the family interaction that may be inferred from the above description, the well-ill line represents the walls of the mental hospital, which I described as being the barrier through which we have to penetrate before reaching real relationships. In the interaction we can see, in microcosm, the gulf that culturally divides the sane from the insane. A description of “closure,” the place that officially sanctioned cultural procedures may have had in the formation of the division represented by the “well-ill” line, follows.

Closure

There have been a few cases in which we were present at the beginning of the first psychotic crisis, and in which it was quite apparent that the parents feared utter condemnation and vengeance from the patient for an act of interpersonal violence. Then, a little while later, both the act and the motivation behind the act ceased to be visible. In their place, a well-ill system had become established. It seemed that the “well” and the “ill” had been split apart by an identity murder, and our concern prompted an investigation into what part we as doctors might be playing in the life-and-death drama.

For this purpose it was necessary to find out when, and how, the well-ill system first became part of family relationships. In some of our research families, we noticed, during the course of therapy, that bonds of feeling that had once existed came to life and bridged the well-ill gap. We then found that the well-ill system appeared to have come into operation quite abruptly at the time of the first diagnosed breakdown. At the same time, the bonds of human relatedness had been severed, although in some cases the specter of illness had for years hung in the background of parental fears, the parent having been waiting for the time when “it would happen.” Thus what happens at this juncture we have termed “closure” (Scott and Ashworth 1967).

*The reader should take note of the well-ill axis, or line, for, as is shown in the section on practice, the line connects quite directly with the place of the mental illness in our culture and, also, with our own involvement as professionals. A technique that demonstrates the existence of the line is described below along with the Family Relationship Test.
An official diagnosis by a doctor seems to be an essential part of closure, as this diagnosis gives mental illness a public and cultural dimension.

Closure is defined as a catastrophic event that occurs around the time of the first officially diagnosed breakdown. The preexisting bonds of relatedness between the patient and his significant others are severed. The severed bonds of relatedness are those that sustain personal identity; that is, what a person means to another in an enduring sense. Closure brings a break in a person's sense of his continuity—his sense of having a continuity of identity, like a lifeline extending back into the past and projected into the future. With closure, the past is disconnected from the present. The person is seen, in some essential respect, as being a different person. One mother said of her son at the time of his first breakdown: "John and I have always been very close together. He has always been loyal to the family. Suddenly, when he came home from abroad, it was a stranger." John asked: "Do you really think so?" The mother replied: "I can only speak the truth as I see it and it does have a distressing effect on me when you insist that you are the same, because it means that I am not the same, because I do know that that is the way it has taken me."

The mother experiences identity as a very relative thing; one can see how the identities of mother and son may oscillate around the well-ill line.

In an identity war, the identities of both parties are threatened by severance: "him or me" (Goffman 1969). By giving official recognition to who is ill, we as professionals enter an identity war. It behooves us to become aware of the ways in which we might be used as agents. (This theme is central to the section of this paper entitled "Practice.")

Closure, in itself, is not abnormal or bad. It is a reaction to unbearable stress, pain, and uncertainty. But in the families I am speaking of, one person appears to be completely in the power of the other, and both seem unable to escape from the situation. Thus they are in a position to injure each other very badly. The damage that can ensue at this point of closure can be so painful that human feeling is never risked again, and it can lead to a partial or complete arrest of life.

It is impossible to know how far the depersonalized forms of interaction, so typical of these families, have come into operation through closure at the first breakdown. What matters in practice is that everything is not determined by fate, or by whatever is the inherent weakness in a person liable to a schizophrenic psychosis. At the time of the first psychotic crisis, something extremely dangerous to those concerned can be taking place under our noses. From later experiences, I have no doubt that the outcome of this crisis very much depends on how it is managed by the professionals who are called in at this point.

**Pilot Survey of Schizophrenic Admissions**

What has been described so far represents the position reached after 5 years of work with schizophrenics and their parents. But, in the main, it remained research. At the time, I doubted whether our findings could be representative of schizophrenic admissions from our catchment area. I therefore decided to undertake a project to investigate the matter on a systematic basis. There follows an account of the pilot survey for the project. The survey led to research's becoming connected with practice.

About 40 percent of our schizophrenic admissions had been living with parents before admission. These patients had homes to which they should have been able to return, since they had lived all their lives at home. Some of these patients, though they might have had a series of passages between home and hospital, were virtually chronically hospitalized from first admission onward; others returned to live at home and, although they might be occasionally readmitted, appeared to be in no danger of a chronic hospital outcome; a few others succeeded in leaving both hospital and home.

A decision was made to explore whether patients who became chronically hospitalized, compared to those who could stay at home or leave home, had different types of relationships with their parents and, if typical differences were found, how far these were determinants of the outcomes or simply associated consequences.

**Method for Defining Degree of Hospitalization**

We believed the proportion of a person's life that he spent in the hospital was more important than the number of readmissions he had. Thus we took all
first-admission schizophrenics admitted in a particular year and calculated the percentage of the 2 years after first admission that each patient spent in the hospital.

Figure 1 shows a typical distribution that looks bimodal, though it need not be, since it could have arisen from the followup's having been stopped at 2 years. A 4-year followup showed that, for practical purposes, the distribution is bimodal. Thus two sets may be defined. For Napsbury, the best division between the sets proved to be 70 percent of the 2 years. On the left side of figure 1 is a set of community-centered (C-c) patients who spent less than 70 percent, and mostly less than 30 percent, of the 2 years after first admission in the hospital. They can be expected to spend decreasing proportions of time hospitalized in the future. On the right of the diagram is a set of hospital-centered (H-c) patients who spent more than 70 percent of the 2 years in the hospital, and who are likely to continue to be hospitalized for most of their lives. A 4-year followup showed that about 15 percent of all patients had ascending or descending patterns of hospitalization that led to a change from one set to the other.

At Napsbury, in 1964 and 1965, we found that over 30 percent of schizophrenics from parental homes were becoming hospital centered—a much larger proportion than we had realized.

Outcome and the Two Sets

The distinction between the patients in the two sets is not well related to illness. On the whole, hospital-centered patients have more symptoms than community-centered patients, but the former may be symptom free for years, whereas the latter may spend quiet lives being ill at home. In terms of arrest of life, the difference is drastic, and it is in these terms that I find it most relevant to consider the distinction. For the 24 research families, there was not much distinction between community- and hospital-centered patients in respect to their preillness work records or social life. After the break, all hospital-centered patients suffered contracted and arrested lives; a few of the community-centered patients had contracted lives, but the majority either returned to the "status quo," expanded their lives, or, in four cases, left home to make lives of their own. Other followups (Brown et al. 1966) show that about 50 percent of schizophrenic admissions are functioning well and requiring no help 5 years later. Most of these will be in the community-centered set.

To compare family relationships between the two sets, we used an interpersonal perception technique that we term the Family Relationship Test.

Patient-Parent Relationships of Community- and Hospital-Centered Patients

Family Relationship Test. A number of techniques were developed for scoring interaction. The proposed project required 60 to 70 families. For a sample of this size, only one type of technique could be a practical proposition: an interpersonal perception technique. A list of 48 terms that appeared on the test score sheet is presented in table 1. The father, mother, and patient are asked to use these terms to describe 1) how they see themselves, 2) how they see each other, and 3) how they expect each of the others to see them. The 48 terms are a representative selection of terms used by family members in the research families to attribute identity to themselves and each other. The list took about 3 years to evolve. About 22 of the 48 terms cluster round the well-ill line described earlier. This means that the terms attributing "illness" (I) are polar opposites of those attributing "wellness" (S). Most intermediate terms are classified as nervousness (N). Thus, between the S and the I, the human link between the extremes is likely to have been severed.

Thirty-four families were used in the pilot survey: in 17, the patients had established community-centered outcomes, and in another 17, they had established hospital-centered outcomes. Figure 2 shows the scoring patterns characterizing the parents and patients in these two sets.
 Sets similar. In both sets, the parents see themselves as being “well,” and they expect the patients to do likewise (figure 2, columns 1 and 2); the patients expect their parents to see them as “ill,” they see themselves as “ill,” and the parents see them as “ill” (figure 2, columns 4, 5, and 6).

In both groups, one may also notice an abrupt drop from viewpoints 1 and 2 to the scores in viewpoints 4 to 6. This drop refers to the black-and-white way in which these families see “wellness” and “illness.” Thus the line run across the bottom of the drop is termed the well-ill line (WIL). This line is a visual demonstration, based on how families rated themselves, of the well-ill axis or line that has been described in detail earlier.

 Sets dissimilar. The only viewpoint distinguishing the sets is how the patient sees his parents (figure 2, column 3). In the community-centered set, patients confirm their parents’ self-images and expectations that they are the “well parents” of an “ill patient.” Since these patients can live at home, we understand this profile as indicating a tenable relationship between patient and parents. Hospital-centered patients see their parents in terms that place the parent below the well-ill line, and the parents do not expect this lack of confirmation. If these patients go home, tension leading to a crisis soon builds up; thus we see this profile as indicating an untenable relationship between patient and parents.

The untenability implied by the hospital-centered profile could be seen as arising from the patient’s taking an irrational, deluded, and unrelated view of his parents and thus proving to be a disturbing and intolerable nuisance to them (the medical view). If this were the case, then one important factor distinguishing the sets would depend on how the parents saw the patient. But the scoring puts the matter the other way round. What does this mean? We have found that relationships within these families are maintained near a critical point of balance and that the balance depends on the patient to maintain it. If, however, the patient sees a parent below the well-ill line, this patient would be committing an act of violation that could profoundly threaten the parent, who depends upon the patient for support of his identity. We must go beyond the crude profiles for evidence about this.
Table 1. List of terms used by family members to attribute identity to themselves and each other.

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<th>Classification</th>
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<td>N</td>
<td>Demanding</td>
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<td>N</td>
<td>Sensitive</td>
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<td>Uneasy with strangers</td>
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<td>NE</td>
<td>Devoted to family</td>
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<td>Self-confident</td>
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<td>Open to correction</td>
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<td>Sociable at home</td>
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<td>Easily led</td>
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<td>Responsible</td>
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<td>Emotional</td>
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<td>Inadequate in outside world</td>
<td>S</td>
<td>Capable</td>
</tr>
</tbody>
</table>

1 I = illness; S = "wellness" (strong qualities); N = nervousness or weakness not amounting to illness; and NE = terms that do not come within the other classifications.

2 "Controlling" is an attribute that has proved useful in a unique way that does not fit into other classifications.

Untenability and Violation of Parental Values

Let us use as an example the mother and her son, James, described in Scott and Ashworth (1967, p. 137). Here was a mother who had been banished in shame by her own mother for an illegitimate pregnancy, who had gone mad and murdered one of her illegitimate twins, and who subsequently developed the fixed idea that somewhere the twin was alive and was somehow connected with James, who was not properly alive. If James had ceased to sacrifice his life to maintain his mother and her fantasy, if he had not sustained her sense of being absolutely capable by his dependence through being incapable, he would have made her feel that she was an incapable, not responsible, mother who was useless through having no feeling for her children (emotionally inadequate), and who was fit to be condemned by society and put away. She would then have fought him to the death. (The terms in italics are from the list of test attributions in table 1.)

That this is not a special case is shown by an analysis...
Figure 2. Scoring patterns characterizing parents and patients in community- and hospital-centered sets.¹

<table>
<thead>
<tr>
<th>VIEWPOINT</th>
<th>COMMUNITY CENTERED</th>
<th>HOSPITAL CENTERED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well</td>
<td>Par/Pt/Par</td>
<td>Par/Pt/Par</td>
</tr>
<tr>
<td></td>
<td>Par/Self</td>
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<td>Par/Pt</td>
<td>Par/Pt</td>
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¹Viewpoints. 1) How parents expect patient to see them (Par/Pt/Par); 2) How parents see themselves (Par/Self); 3) How patient sees his parents (Pt/Par); 4) How patient expects parents to see him (Pt/Par/Pt); 5) How patient sees himself (Pt/Self); and 6) How parents see patient (Par/Pt). (The scores in each family, which relate to mother and father individually, have been aggregated and termed “Par.”)

The crude amount of “wellness” (S) and “illness” (I) attributed in a viewpoint is measured by the (No. of S attributes)/(No. of I attributes) scored in that viewpoint and is termed the S/I ratio—the higher the ratio, the “waller.” The viewpoints are ranked in order of their S/I ratios and numbered from 1 to 6. WIL is the well-ill line. (Above the line are “well” views. Below the line are “ill” views.)

of the 34 families in the pilot survey from whose scorings it was found that there were four central “well-parent” attributes. These four attributes were defined by isolating the terms parents saw in themselves but not in the patients: Secure, responsible, self-confident, mixes well. Now let us look at how the patients saw their parents in respect to these four attributions of “well parenthood”: Hospital-centered patients either failed to attribute these terms to their parents, or they attributed them both to themselves and to their parents, thus violating the “well parent-ill parent” role structure. Community-centered patients attributed these qualities to their parents and not to themselves.

Thus the parents required that the patients should keep their places as patients and, further, that they should support parental identity in quite specific terms. During a crisis, the patient ceases to validate the parental value system; commonly, he may be found aiming blows at the most vulnerable areas of parental identity. Thus
we may say that the patient disqualifies the parental value system by an act of violation, an act in the identity war.

**Summarizing the Pilot Survey**

The study of schizophrenics and their parents showed that whether or not a patient became chronically hospitalized was closely associated with his relationship with parents. Current research makes it doubtful whether the hospital plays a significant part in determining the tenability of the patient-parent relationship and the consequences associated with it.

Conceptions of role structure derived from research, which became assimilated into practice and which are used in the section on practice, are listed:

- **Tenability**—a patient’s relationship with the community and his significant others in it: 1) The relation of tenability to violation of community expectations and values; 2) the relation of tenability to violation of the personal identity of others; and 3) violation seen as an act in a battle for psychic survival.

- **Closure**—the point at which intrafamilial stress reaches a degree that leads to an official dimension entering the family world in the form of professional representatives of the cultural image of mental illness whose actions at this juncture may be crucial to outcome.

- **Interaction and the cultural image of mental illness**—concerning the mechanisms associated with the cultural conception of mental illness that are used to dismember human relationships.

- **Hospital-community relationship**—as shown by large scale statistics (the study by Bott (1974), which revealed the power of the community as a determinant of changes within the hospital that had previously been thought to be due to management and treatment policies in the hospital).

These conceptions point to the relationship between the patient and the community, and the hospital and the community, as containing the key to issues affecting outcome. The following section is concerned with the translation of these conceptions into practice.

**Practice**

It was about 4 years ago that research and practice began to connect. The ideas and the findings discussed above are those that seem to have permeated into team practice. I then became aware that the findings presented in the analysis above were common to all families precisely because they represented expressions within the family of values belonging to our culture that are used to define the relationship between a mental patient and his involved others and, at a more general level, to define the relationship between the hospital and the community it serves. I realized that the findings represented elements that form the context of our work situation.

**Approach Developed by the Team**

Of the conceptions derived from research, those of tenability and the violation of identity proved central in the development of a team approach, because these concepts provide a link between individual and cultural values. Thus the actual types of relationship that prove to be untenable in the families of nonschizophrenics are quite different from those in the families of schizophrenics. But there is a general issue concerning tenability that may be stated as follows: If a person violates certain crucial values in his relationships with others, the cultural image of mental illness may be used to remove all human relatedness between this person and his involved others, the removal being achieved by an act of violence akin to severance. This situation represents an attempt to annihilate the agency (intention, motivation) of the person who committed the violation by calling the violation illness. A barrier is thereby introduced between the “patient” and his involved others that, in the extreme case, is expressed by the walls of the mental hospital. Because the issue is defined by cultural boundaries, the individuals concerned receive official sanction for dealing with the matter in this way. They

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7 For example, the type of relationship that is untenable in the case of a depressed middle-aged woman and her husband is one that shows avoidance of conflict in the test profile—a profile that would indicate tenability in the relationship between a schizophrenic and his parents.
are entitled to call in the official representatives of society for this purpose, and these representatives are ultimately medical.

The crimes to which I am referring are seldom dealt with through the courts that deal with crimes such as violence, theft, murder, causing a public disturbance, defamation of character, and slander, though the overlap increases as one moves along the sequence. I am referring to the peculiar type of crime committed in the course of identity warfare, defined as a form of warfare involving threats to the psychic survival of others.

I should make clear that nobody in my team denies the existence of mental illness. Those involved in identity warfare may or may not be ill in the medical sense. Quite a proportion of our patients probably are ill, and for this reason have experienced threats to their own psychic survival whereby they have become experts in identity warfare. Thus they are, in this respect, in a position to be dangerous to others. But we also have many patients whom I would not define as being ill. They are to be found among the many admissions occurring in the course of social stress, social conflict, or simply through the hardship of having to survive in this world, and all these types of admissions are involved in the same type of warfare.

Throughout this paper I have returned again and again to the theme of identity warfare and the battle for psychic survival. Although these battles are an everyday matter, I have found that those who are still held within the traditional approach do not know what I am talking about. I will try to make it clearer by giving an example:

We were called out to see a young married man who had become acutely psychotic. His mother and father lived nearby. His father had kept his mother protected in a manner that had enabled her to live in a fantasy world never perceived by outsiders. Recently his father had died. His mother then tried to enter the married son's family by blackmail, in order to reestablish her special world with him and his wife. They refused. The mother then went to a second son who was alienated from the first, and later returned to her attack on the first son [our patient]. She became mad, deluded, exposing herself and her family in front of neighbors. At this point she told this son that she had done something very bad and said, “I know that you are going to have your vengeance by having me put away.” She implied that the bad thing she had done was between herself and the other son and involved family affairs, but typical of the identity war, left what she had done loose ended, unspecified, so that the son imagined all sorts of things and began to lose his grip on what might be real and what unreal. The mother then got herself admitted to the hospital with an overdose of pills. She was reported as being quite psychotic after recovering consciousness. The son went to see her. We do not know what happened on this visit, but following it the mother became completely well (by the next day), while the son, the following night, became acutely psychotic for the first time ever. Apart from psychotic symptoms, he was also completely identified with his mother’s mannerisms, actions, and hypochondriasis. He was heading as fast as he could to get himself “put away.” This was only the first move in the war of identity.

Why Patients Are Hospitalized

The concept of tenability led us to the discovery that the assumption that patients enter the hospital because they are ill is an assumption and one that is hardly ever true. A patient may be ill, but it is purely incidental to his mode of admission. The conception of violation of cultural values, especially of those closely associated with personal identity, led us to realize the nature of what was untenable in a patient’s community situation. It also led us to see why there was such confusion of purpose between what we saw as treatment and what the community expected of us in the name of treatment.

But, 4 years ago, when members of the team were first becoming interested, none of us had the overall view of our working situation that I have just outlined. Mostly we were concerned about depersonalization of relationships caused by the generally accepted idea of mental illness. We knew our patients often possessed agency and intention to a degree that was seldom realized, this realization having been occluded from awareness by the cultural image of mental illness. Yet, despite our knowledge, we were as blinded by the power of the assumption of illness as were the relatives.

The conception that most patients are admitted because their situations in the community have become untenable in various ways led our attention to the boundary between the hospital and the community, and
so to an exploration of why patients come to the hospital.

We started by studying the matter from the patient's end. We asked our admissions a few simple questions: "What is the trouble?" "Is there anything we can do to help you?" "Since you do not appear to want anything from us, do you want to leave?" Of course, we knew full well that mental patients are not supposed to know the answers to these questions, but we had never explored the matter on a systematic basis. We found that irrespective of whether they were schizophrenic, neurotic, or suffering from social discord, patients were loyal to the image of being a "mental patient" to a degree that staggered us. We found that very few patients came to the hospital for treatment. It became clear that most often they wanted refuge, unconditional refuge, on their terms, not ours. If they wanted treatment, they did not come into the hospital but sought it elsewhere, for example, as outpatients. The mode of admission that enables patients to adopt this attitude is admission by crisis, and nearly all our admissions are by crisis. Following admission, it is very rare for patients to admit that they want anything from us. It may be obvious that they want to stay, but it is almost impossible to get any patient actually to say so. They may say they want to leave and then fail to do so. In the case of patients we knew well through previous admissions, we might make careful arrangements by asking them to keep in touch and feel free to come to the hospital any time they liked if they were in distress. Nearly always these patients were readmitted by crisis. In this way we learned that patients wanted unconditional refuge and there must be no commitment on their parts for wanting it—"the doctor" must put them in.

I have described an approach in which it is assumed that patients are still human beings. Our failure to uphold the mental patient's image of being "not responsible" reduced some patients to utter perplexity—"I've never been treated like this before," complained one patient.

Patients can act in this way through the conscious or unconscious use of the tremendous power contained in the cultural image of mental illness. In our culture, this role is understood by the community to mean that we, as a mental hospital, have an absolute obligation to hospitalize anybody the community regards as being mentally ill. Both general practitioners and the police are so convinced that this is our role that they have frequently made all arrangements for admission before they have even contacted us. Thus our patients can sit in the hospital secure in the secret knowledge of their power. They have only to go to the nearest police station and say, "I'm from Napsbury" or "I was in Napsbury," and admission is almost certain. On such occasions I might say to the police officer who phones, "It is very kind of you to offer to bring him back, but I think that it would be good for his independence if he found his own way." The likelihood is that the patient will still arrive in a police car; or if the police have accepted my advice, the patient is likely to phone his parents, who immediately accuse me of negligence and threaten to report me to a higher authority if I do not immediately send for their son.

We began to understand why the statistics in Bott's (1974) study showed that changes within the hospital bore little relation to our treatments or to our hospital policies, but were related to events and to forces in the catchment area.

Treating the patient as a human being challenged the patient role. It involved letting the patient know that we were not obliged to have him if he showed no sign of wanting anything from us. They may say they want to leave and then fail to do so. In the case of patients we knew well through previous admissions, we might make careful arrangements by asking them to keep in touch and feel free to come to the hospital any time they liked if they were in distress. Nearly always these patients were readmitted by crisis. In this way we learned that patients wanted unconditional refuge and there must be no commitment on their parts for wanting it—"the doctor" must put them in.

We found that the unquestioned assumption that patients entered the hospital because they were ill was a myth, as it was a myth that they came to the hospital for treatment. Mental illness is not a myth, but coming to the hospital because of illness is a myth. Patients wanting help can secure it as outpatients; we have no treatment available in the hospital that is not also available outside. A patient, on admission, may be really ill, and we may consider that he needs admission because of illness, but this is purely incidental to the mode of admission. Equally, an admission may be suffering from no psychiatric illness but may be in retreat from the stress of interpersonal conflict, or admission may be a move in the conflict; yet all must be regarded as ill. From this situation there ensues a tremendous confusion of purpose regarding our own roles.
It may have been noticed that, in speaking of patients seeking refuge in the hospital, I have not specified that from which they are fleeing. I have left the matter open ended, which is exactly what patients and relatives do. Following admission, a chasm opens between the patient and his external situation; this chasm is apparent in the extreme difficulty one experiences in getting from patients or relatives an account of the actual events associated with admission. We decided to go out and see for ourselves what did happen at the community end of a crisis that threatened to lead to admission.

For this purpose, we have been screening all potential admissions from a catchment area of 160,000 over the last 2 years. A doctor, and sometimes a nurse, accompanied by a community social worker and the general practitioner, if available, go out to the home at 24-hour notice. It was on these visits that we began to understand what mental hospitals are all about.

The Psychiatric Crisis

Since family crises are common, and since several family members are frequently disturbed during a crisis, we wondered why we had never been called out to a "family crisis"; rather, we were invariably called out to see one disturbed individual. We wondered how these individuals had become identified as "the patient."

Some sociologists—for example, Mechanic (1962), Erikson (1957), and Kellert (1971)—have described accurately some aspects of the situation that we found. Mechanic's view on how patients are identified and admitted is especially relevant. In essence, he believes that the person identified as mentally ill is brought into hospital primarily as a result of lay decisions. But the layman usually presumes that the patient is brought into hospital as a result of medical decisions and expert knowledge.

We found this to be true: The family had decided who was ill before the doctor was called in, although, more often than we had thought, the patient got himself identified by calling in the doctor. Whichever way round it was, a family member had decided who was ill before the doctor was called in. We cannot remember a case in which the general practitioner, usually the first doctor to be involved, reversed or disagreed with the family decision, although he might have been aware that other members of the family were unbalanced.

We found that we could hold about 75 percent of these crises in the community, either for treatment or until we had got it clear with the family why they wanted a particular member admitted. This decision could be quite difficult. By the time we arrived on the scene the family members were liable to deny that they wanted anyone admitted; it was "the doctor" who had said it was necessary for him to get "treatment." Very soon, the family would cease to see us as "experts" since we had not done what we were told, that is, to sanction admission and give the label of an official diagnosis. The general practitioner was also liable to feel that his expertise was being threatened since he might have promised admission. Here, we come to a position that is peculiar to the psychiatric crisis: that unless the family had a lot of money they could not avoid us; there was no other hospital to which the patient could go. For physical crises, this is not the case. Thus the situation was contained, and the family had to have it out with us.

The identity war that we witnessed in some of the crises could be very frightening. But if we chose our cases correctly, we could refuse to accept delusions or hallucinations as reasons for admission, and we could insist on knowing what was so intolerable that it was demanded that we remove one member. Thus we made it clear to those involved that admission was not for treatment. Sometimes psychotic symptoms disappeared in the course of one interview. Then, as in the example of the widow and her married son, described in the early part of this section, we might come to the real issue that could not be faced.

We found many cases in which admission was fully justified to enable those involved to survive. In these cases, the patient needs about 2 weeks in hospital for the untenable situation that had led to admission to become tenable again. These cases would correspond to the community-centered set of schizophrenics. However, we should be aware that there is a price exacted by the identity war, in that the member admitted suffers an alteration of his identity that is probably permanent.

There are other cases in which admission is a repeated and pointless escape. In these cases, we endeavor to establish a transaction about admission, during which I define the conditions under which I might be able to help as opposed to those in which I cannot offer help. Such an offer of genuine help is quite often received with rage and incredulity: I was "irresponsible"; the patient must be admitted immediately and given "treat-
ment"; it was my duty; there was no question of conditions or approaches to treatment that I considered best. If I put the patient away for "treatment," I was an "expert"; if I offered real help, I was not. The treatment required was punishment for the crime of violation. If, in effect, I did not understand the matter in this way, then my professional identity was threatened. It was becoming clear why those in the community do not hold the psychiatrist in very high repute.

Finally, I must add one further dimension to the picture of treatment that I have just given. It concerns what we take into the hospital along with the patient. As a crisis builds up to a point at which it can no longer be contained in a family, the personal identities of both the patient and the involved others are likely to have been severely threatened (Goffman 1969). By the time the patient has been admitted, the basis of his relationships with his involved others, which has existed in the past, is likely to have been removed (closure) through having been split down the middle into "wellness" in the relative and "illness" in the patient (well-ill line). This division now has official sanction. But, at the same time that this happens, the guilt and fears that haunt the family, and that may have haunted it for generations (Scott and Ashworth 1969), are unloaded into the illness in the patient, and so into the hospital. So much is this so that relatives often feel that their fate depends on the fate of the patient. Thus whole areas of family pathology become totally a medical responsibility, but the doctor is obliged to treat all this as disturbance in the patient. The relatives have the cultural mores on their side. Should the doctor realize what is happening and make the matter a family issue, the relatives may report him to a higher authority with the aim of getting him whipped into line to take a proper view of the situation. We become responsible for the sins of the community and its members, and society is likely to give the family their full support for this under-the-counter deal.

This problem may well give us pause to think what is being asked of society if we are to establish a truly community-based psychiatry.

The basic aim of our approach is to clarify our working situation, a necessary prelude to any treatment. To be seen as an expert if one does what has already been decided by lay people, and irresponsible if one does not, is no caricature. Just as patients have more awareness and agency than is commonly realized, so relatives are more knowing about what makes an expert than psychiatrists commonly realize. It is degrading to be used in this way by half-knowing relatives and by society. In my opinion, this use of the psychiatrist is more responsible for the low status of psychiatry than any other factor. Consequently, our aim is to make a dishonest situation more honest. It is not only necessary for our own sense of identity but absolutely needed in order to clarify an extremely confused situation. If a patient is seeking refuge in a meaningless way, or a relative is seeking punishment for the patient, or control of the patient, then let us not call it treatment.

There are two points I can make about the organization through which we have sought to tackle the situation: First, nearly all threatened admissions are seen together with their significant others, in the community, before admission. Here we seek to get the situation more honestly transacted in the manner I have described. Second, the organization of the team is all important: this way of working requires that staff be prepared to stand a fairly high degree of anxiety. The approach can only be used on a team basis. Especially important is a firm basis of trust and mutual support between medical and nursing staff. We have evidence that the normal division between medical and nursing staff is one of the main holes through which family pathology is taken into the hospital, and that this is associated with chronicity, that is, with an arrest of life.

Results of the Approach

Approach in the hospital. The approach has had a marked effect on reducing psychotic behavior and reducing overcrowding. The population of the admission wards has been reduced by about two-thirds. There have been no bed-pressure crises. But, to me, the most striking thing is how that suffocating sense of arrested life, so characteristic of mental hospitals, has disappeared in the five wards associated with this policy. In the past, we had allowed ourselves to be made responsible for all those elements of arrested life belonging to patients and their relatives, which had resulted from closure. Also, we got rid of that stultifying confusion of purpose resulting from the fact that although we were supposed to be treating illness, we were colluding with the covert task of helping everybody concerned in the community to evade reality.

Approach in the community. The community is like a jungle. Medical staff engaged in community work have to be trained to recognize those family situations from which, should they become involved, they would be
lucky to emerge alive. They have to be taught where to draw the line.

The psychiatric crisis provides a unique opportunity. It is the only occasion on which the three elements of the National Health Service—hospital staff, general practitioners, and community social workers—are briefly brought together on a regular organizational basis. The tripartite division of the health service, as it is called, is recognized as producing impossible inefficiency, and the reorganization of 1974 is intended to remedy this condition. I cannot see how evermore complex administrative structures, superimposed from above, can do anything but make matters worse. A new administrative organization needs to be grown from the bottom, out of the needs of the service. We are making a small start by getting a scheme for the use of our emergency service officially recognized by the two other divisions.

Conclusion

In conclusion, I will return to the study of the schizophrenic and his family, to the vessel from which our generic concepts were derived.

Turning back to the profiles shown in figure 2, let us reconsider the "well-ill" line (WIL). In the original study, the line was seen as a family issue; it is derived from the way family members rate each other and themselves. We may now see it as being connected through ourselves to powerful cultural forces. We, as professionals, have had a hand in creating this line. When as "experts" we gave official recognition to who was "ill," we may have missed the crucially important other half—that we also gave official recognition to who was "well." We may not realize that around this line rages the war of identities.

The patient violates this line at the risk of his life. If he does so, he violates parental identities and is likely to have to spend the rest of his life in the hospital unless he is strong enough to make a life of his own.

Likewise, if we as professionals—instead of "experts," thereby aligning ourselves with one side—take a relative view, which means to seriously consider the relationship issues involved in the battle, we are in danger of violating the line, thereby incurring threats to our professional identities.

There is evidence which suggests that failure to take a relative view of the "wellness-illness" situation is likely to reinforce invalidism. If our culture demands it, society will have to pay.

In my view, a next step is for psychiatry to take a relative view, but there is some doubt whether society is ready for this. The cultural values concerned are something society treats as being sacred.

References


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