A Tale of Two Hospitals: A Comparison of Treatment Programs for Schizophrenia

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Often by the time the patient reaches the hospital, he or she has already consulted a physician. However, previous contact or not, people tend to face hospitalization knowing little about what to expect. Generally, this paucity of information characterizes the whole hospital experience: the patient may also leave the hospital without an adequate understanding of either his or her illness or treatment program. This was the norm at one of the two hospitals at which I was a graduate student acting as participant-observer in treatment programs for schizophrenia. At the other hospital, patient education was a mainstay of treatment

Both hospitals are state-funded. Accounts of other types of hospitals—general or private—reveal that care does not differ radically from hospital to hospital. The kind of care can be located on a continuum from intensive, analytically oriented psychotherapy in private and/or teaching hospitals, to intensive drug therapy in general and/or state hospitals. The difference in emphasis often has as much to do with economics as it does with treatment philosophy.

In addition to sharing treatment programs, most of these institutions also share a particular deficit—none responded adequately

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to the patient's or family's questions about schizophrenia, its treatment, or the hospitalization experience. Unfortunately, the concept of patient education has few champions in these institutions. However, Bryce Hospital in Tuscaloosa, Alabama attempts to educate the patient about his or her illness.

This was not the case at the teaching hospital in the Northeast where I participated in the medical students' psychiatric rotation. This particular hospital enjoyed an illustrious reputation. However, I believe it is atypical only in its relative reliance on analytically oriented psychotherapy. Many hospitals use some variation of this type of therapy; this hospital also uses anti-psychotic medication. The following is a typical account of a patient's stay there.

A Day In the Life

The names and certain facts of patients' lives have been changed to protect their anonymity.

Anita was transferred here from a city general hospital after she struck a nurse in the emergency room; it was her second psychiatric admission. Shortly after being admitted, she was diagnosed as schizophrenic. When I began to meet with her, she had been in the hospital several days, and was reported to be responding favorably to

anti-psychotic medication. She did, however, complain to me about how the medication was making her feel.

Anita impressed me as a very strong woman who had had a difficult life. Generally, her struggles were similar to those of most working class single mothers. In addition, she was an alcoholic who, with the help of Alcoholics Anonymous, had been without a drink for several months. I should note, parenthetically, that it is not uncommon to encounter schizophrenics who are also alcoholics, possibly because alcohol can help dampen some of the symptoms of schizophrenia. Employees with whom Anita had worked usually found her open and friendly. I liked Anita, too, and, as is often the case with patients I meet, I was impressed by her courage and her desire to get well and return home to her small child.

Anita slept in a dormitory with five other female patients. Sometimes, when the hospital was overcrowded, more beds were placed in her room. She sometimes complained about having to sleep with so many other patients. I would often find her lying alone on her bed during the day. The staff did not encourage such behavior but this was the only time and place she could be alone and lie quietly without being disturbed by other patients.

Although occupational and group therapy were offered, much of Anita's time was spent just sitting with other patients in the large day room. The only alternative area was a slightly smaller room with a television. These rooms and the sleeping quarters, like most other areas in the hospital, looked and smelled unclean.

It is to the credit of the staff that attempts were made to establish and maintain contact with each patient. However, direct questions concerning treatment and hospitalizations were usually referred to the primary therapist, who was either a social worker, psychologist, or psychiatrist. These therapists were usually seen twice a week. The psychiatrist in charge of Anita's case was in psychoanalysis himself and tended to interpret complaints about medication and hospitalization as some deep-seated resistance to treatment. Indeed, very few of Anita's versions of her experiences were taken at face value: for example, she was not trusted to report accurately about her reactions to the various drugs that were used for her treatment. To my knowledge, no one other than myself attempted any explanation to Anita about schizophrenia and its treatment. When I asked the Chief of the Service the reason for this policy, he replied that information about schizophrenia might increase the patient's resistance to the therapeutic process — a sure sign of the hegemony of the psychoanalytic model. In view of this philosophy, which assumes a psychological origin of schizophrenia, any rationale for the anti-psychotic medication must have been very confusing to the patient.

Clearly, a number of models co-existed in the hospital, but the predominant one was the psychoanalytic model. It seems that in the past, the hospital had boasted several famous and forceful personalities who had been leaders in the use of analytic therapy with most patients, including schizophrenics. On the other hand, some of the most powerful evidence against the efficacy of psychotherapy, as compared to drugs alone, had originated here. This contributed to my perception of the hospital when I was there in 1977: it seemed to be an institution so set in its ways that, even in the face of mounting evidence that these ways were ineffective, it clung tenaciously to them. While most psychiatrists admitted the utility of neuroleptics and used these medications to treat their patients, they continued to use analytic techniques in therapy. In other words, while lip service was given to the medical model, the patients were still perceived and treated as if the cause of their illness was faulty parenting.

So Anita's therapy was aimed at analyzing her past life, not at helping her cope with the very real unpleasant dilemmas she presently faced as a result of her illness. Her immediate problems with medication and hospitalization were often disregarded entirely, except as reflections of animosity toward the therapist or resistance to the therapeutic process. Having been divested of her credibility she, like other

schizophrenics here, lost her personal integrity. I believe this is what Rosenhan had in mind when, denoting the powerlessness of the institutionalized patient, he observed that the staff invariably assumed that the patient's disturbance could only be the result of his or her pathology. Never did they entertain the idea that the patient might have some valid complaint about the hospital environment or the behavior of one of the staff.

Even as some psychiatrists at the medical school associated with this hospital continue to amass evidence of a genetically predisposed biochemical etiology of schizophrenia, others continue to use the antiquated psychoanalytic model. The patient gets lost in the confusion. Anita received little information about her illness and the medication used to treat it, nor was her aid enlisted to determine the optimum dosage of the best anti-psychotic agent.

Conversations with colleagues who have worked at this hospital more recently than I have confirmed that this confusion of models still abounds. In addition, the hospital is faced with the exodus of its top somatic therapy researchers and a number of first, second and third year residents. It appears that the patients are not the only ones who suffer from inadequate treatment methods and hospital facilities.

Osmond has delineated six criteria by which to judge a mental hospital: (1) the provision of single rooms, (2) cleanliness, (3) clearly marked directions to different parts of the hospital, (4) comfortable furniture, (5) space to lock up valuables, and (6) clearly marked clocks and calendars. This hospital had clocks on the walls. However, I, myself, got lost and the furniture was dirty and uninviting. I have already described the lack of privacy and cleanliness. Such an environment cannot possibly be good for the patients or the staff. But the staff went home every night.

Although my time here was enlightening in a number of ways, it was not particularly heartening in any way. I was not unhappy to leave those surroundings but was sorry to have to leave Anita in that environment. While my experience there was disheartening, the same cannot be said of my impression of the Psychology Learning Center at the Bryce Hospital in Tuscaloosa, Alabama; this program endeavors to educate patients about schizophrenia.

The Hospital

You may recall that Bryce Hospital was involved in the landmark Stickney vs. Wyatt case (1972). Since that case, much attention and funding has been directed toward improving the hospital's in-patient treatment programs. At one time, Bryce Hospital had the dubious distinction of being listed in the Guinness Book of World Records as the largest institution under one roof. The Pentagon now enjoys that listing.

As is the case with most state hospitals, the in-patient population at Bryce has been steadily declining since the 1950's. It now numbers approximately 1,500. Although the Psychology Learning Center is located in one of the hospital buildings, it is in some ways segregated from the rest of the hospital. Had I not toured other areas of the institution and spoken to staff members from other departments, I would have left Bryce with an incomplete understanding of the institution. In some units, such as the Treatment Center for Adolescents, I got the impression of an enthusiastic return to the medical model, complete with nutritional guidance, experimentation with the orthomolecular approach and the beginnings of a patient education program. In other units I was frightfully aware of the inadequate staff-to-patient ratio caused by funds that were too slow in coming. However, under the circumstances, some of the new programs at Bryce Hospital are very encouraging. One of these is in the Psychology Learning Center (PLC).

The Psychology Learning Center

Under the tutelage of Humphry Osmond, whose ideas about the medical and patient education have been germinal, and under the direction of Cindy Bisbee, the PLC strives

to orient patients to their hospital surroundings, to teach them about mental illness and to initiate and develop the patient's responsibility for his or her own care. For a comprehensive report about the use of patient education at Bryce Hospital, consult C. Bisbee, j. of Orthomolecular Psychiatry, 8, No. 4, October, 1979.

Specific classes in the PLC include: (1) Orientation/Responsible Patients, (2) Exercise and Relaxation, (3) Community Resources, (4) Learning to Live Effectively, (5) Principles of Mental Illness, (6) Family Dynamics, (7) Problem Solving, (8) Nutrition, and (9) Medication, Health, and Hygiene.

As a number of class titles imply, the use of the medical model does not connote a lack of psychological counseling. Several classes are devoted to developing psychological skills for coping outside the hospital. This program also stresses the fact that certain skills are needed to cope with the schizophrenias per se. Among these are a thorough understanding of schizophrenia, the drugs used to treat it and the part the patient must play in getting better and staying out of the hospital.

The Orientation/Responsible Patient Class deals with many of these issues. It begins by familiarizing the patients with Bryce Hospital, its services, the staff and the human rights representative. The instructors articulate the legal rights of mental patients and explain the mechanisms by which they may have been committed to the hospital. This part of the class is designed to dispel the sense of powerlessness so common in a mental hospital.

The second portion of the class introduces the important concept of the patient's responsibility in co-managing the treatment of his or her illness. Specific suggestions include: 1) ways to construct and follow a daily treatment routine, 2) ways to cooperate with the treatment staff (by reporting symptoms, reactions to medications, etc.) and 3) ways to prevent re-hospitalization (by following the treatment regimen and getting help where needed, based on self-observation).

Most classes are taught by mental health technicians. They function as assistants to the psychiatrists, psychologists, and social workers and are responsible for some aspects of the patient's supportive psychotherapy. In terms of educational, socio-economic and cultural background, they are much like their patients. This, to me, is an excellent strategy. Communication in these classes is much better than in those taught by MSW'S, psychologists, or medical personnel. Another important aspect of this program is recognition of the value of exercise and proper diet. Exercise classes are held daily, and, while no attempt is made to control meals, sugar is absent from coffee breaks and patients are encouraged to eat healthy foods.

Even this brief look at the PLC should illustrate one crucial difference between the treatment outlook embodied in this program and that at the first hospital at which I worked: the PLC seeks to diminish the patient's sense of powerlessness and to enlist his or her participation in the treatment of schizophrenia. Apparently, very little in the way of decreasing the patient's sense of powerlessness is done at the other institution. To my knowledge, there was no organized effort to orient patients to hospital services or personnel, or to inform them of their rights as patients. As I have already pointed out, few patients were entrusted with any explanation of schizophrenia, to say nothing of sharing the job of monitoring their medications.

The viewpoint of those at the Psychology Learning Center is that mental patients can exercise judgement in their own self-interest. Indeed, most judicially mandated standards concur with this viewpoint. I agree, with an important exception: there are obviously times when the schizophrenic patient is extremely disperceptive and incapable of reasonable judgement. Often, this disperception is controlled by anti-psychotic medication. However, it appears that the policy at the first hospital which I discussed expects the patients to be completely incompetent and irresponsible, regardless of the status of his or her illness. Consequently, the patient is released knowing little about the illness he or she entered

with, how to manage it with the proper medications, or how to know when to seek help for a recurrence of symptoms or change in medication. The importance of patient-physician communication in drug compliance is well documented. Therefore, the lack of trust between patient and doctor observed at the Northeastern hospital tends to undermine drug compliance and efforts to avoid re-hospitalization.

Initial Results of the Program

As the program at Bryce continues to evolve, several problematic issues have become evident. However, it appears that most of these, noted below, are now being addressed by some of the staff.

The population of the surrounding area is such that most of the patients are. educationally, severely disadvantaged. While most of the classes are taught orally and some excellent visual aids are employed, such as pictures and movies, some material is still imparted in writing. Interest obviously wanes when concepts are written on the blackboard. Possibly patients who cannot read are intimidated by this. The vocabulary used in some of the classes can also be intimidating. A careful analysis of the education level of the participants would help to establish the level on which concepts can be explained, or how much written material, as opposed to oral and visual material should be presented.

Generally, participants in the program have been in the hospital two or three weeks, and most have been stabilized on medication. However, some patients are still too disperceptive to benefit very much from the classes, and often disrupt their classmates. I believe this is a referral problem, that reflects the tenuous communication between the staff of the Psychology Learning Center and the other staff members at Bryce Hospital. Conversations with these staff members has often revealed a lack of understanding (or interest) in the goals of the PLC. It seems that psychiatrists are the most resistant to this new approach. This lack of understanding and communication is manifested by the numerous referrals who are too disperceptive to participate in the program. Clearly, the program will be much more effective when the rest of the staff understands the aims of the program and believes in the benefits of patient education also. If the process can be continued on the wards, even to the extent of posters reinforcing classroom material, so much the better.

Another step which would help to reinforce the skills taught in the PLC is the involvement of family and friends in the educational program. A family that understands about the patient's illness and treatment—and, most importantly, that they are not to blame—can be an invaluable asset to post-hospital adjustment.

Clearly, resolution of these problems will take time as well as a careful study of the strong and weak points of the program. Presently, however, my informal polls and conversations with the patients show that their response to the program is quite good. In addition, the morale of the PLC staff is very high; everyone seems enthusiastic about participating in such a unique program and more than willing to hear suggestions. I feel confident that, under these circumstances, the program will continue to improve.

Conclusion

In this article I have offered a glimpse of two hospitals. At one, many staff members treat patients with medication, yet hold to a treatment model that implicitly conflicts with this approach, a model whose efficacy is, at best, unproven. Clearly, the psychoanalytic model affords little help to the schizophrenic. I maintain that this therapy invades the privacy of patients, robs them of their credibility and dignity, and does not adequately prepare the patient for life outside the hospital.

The other hospital hosts a program which is geared specifically toward preventing re-hospitalization by teaching the patient to participate in his/her own treatment program.

It remains to be seen whether patient education will effectively reduce re-hospitalization of the schizophrenic. However, for those who feel, as I do, that information about the patient's illness is his or her right, the issue of the efficacy of patient education is really secondary.

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