MENTAL HEALTH PROPOSALS BY A CLINICAL PSYCHOLOGIST

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The framers of the final report of the Joint Commission on Mental Illness and Health (5) have presented us with much courageous and enlightening material for future action. Their recommendations range from new Federal laws to a new set of college textbooks which do *not* portray the schizophrenic as a dehumanized conglomeration of symptoms and do not give the fallacious impression that all is "sunshine and health" in mental hospitals (5, 14). But I wish to add a few unsolicited comments on pressing issues given little space in the *Action for Mental Health* report.

These comments are framed by myself as a member of the professional group of clinical psychologists who have sometimes been called too diffident (13). My assumption is that if the mental hospital wishes to attract the services of dedicated clinical psychologists, it must offer them opportunities for relating with the psychiatrists in the real life of the hospital, for voicing and practicing their theoretical inductions, and for growth as psychotherapists, as real persons (8). Accordingly, I herewith submit the following three proposals for a utopian or modern *treatment* mental hospital which would not only expand and encourage the work of the psychologist, but, of course, ultimately benefit the patients and the community.

Termination of Professional Exclusiveness

Anyone who has labored long in neuropsychiatric institutions is aware of the unpublished prejudices and double binds (7) resulting from practices based upon institutionalized priesthoods. For example, we have state laws which would compel such knowledgeable psychologists as Erich Fromm and Rollo May to be supervised by the most fledgling osteopath extant. Most psychiatrists and psychologists *when they know and accept each other* are willing to consider such edicts in the context of a preliminary effort to cope with quackery and will continue to learn from each other. But in the absence of safeguards for open exchanges, the prevalent prejudices will multiply and such labels as "omnipotent" and "pushy" will proliferate to the detriment of the patient and ultimately society. Why in all our efforts to de-

scribe personalities of patients, aides, and nurses have we stopped short of probing the psychiatric-psychologic cold wars? The rejection mechanism so ably described by the Commission does not apply to patients alone.

Witness the plight of the poor clinical psychologist. Through his five years or more of graduate school he carries the extra burden of non-clinical courses yet is always the "unscientific" outcast. Even heads of university psychology departments, as a rule, subtly reject clinical psychology (15). Then, his preferred niche in the typical mental hospital carries no authority and he is better liked "if seen and not heard" (10, 12). Further, the administrative role is medical; a medical man controls the supply (patients) and demand (request for services). Therefore, the ward administration can starve out the psychologist by controlling the flow of patients; later on he can remove patients from therapy or research, using a thousand verbal safeguards. These psychologists may not be "the salt of the earth," but the psychiatrists by reducing some of the psychologists' tensions are liable to gain life-long friends.

PSYCHOLOGICAL ORIENTATION

It may be that the future will show the present psychotherapist to be the most pathetic of all creatures: a poor soul who attempted to talk a sufferer out of an organic condition. But until that happy day arrives when there is a consistently successful organic treatment (and my own biases and experiences tell me it will never come for schizophrenics), we would do better, tentatively to accept a psychological explanation for schizophrenia. This would involve learning more about psychological needs (3) and learning theory, especially secondary reinforcements (7), while also contributing to the literature by both anecdotal reports and controlled studies. Such an orientation is not easy because one must think about one's own stimulus value in treatment: yet one can find it ultimately rewarding to mature and also to realize that one is lucky enough to be toiling in a personalized profession in which one can contribute to the general fund of knowledge.

We should know from experience the pitfalls of a rigorous somatogenic approach to schizophrenia. Inherent in a hard organic view are "the incurability myth," with its hopelessness (1); the futility and despair of the paramedical professions which only add to the chronicity of the patient (6); and the reactive indolence, depression, and

other signs of frustration of creativity throughout the mental hospital hierarchy (10). Better to have an "as if" theory which, even if not ultimately true, would bring satisfaction, rather than misery, to many.

If the future should bring an organic solution to the schizophrenic problem, the hospital would still be faced with people who would have failed in their periods of somatic dysfunction to develop adequate social competence and "outsight" for optimal satisfaction of psychological needs. It is a relatively simple matter to transform an acute into a docile chronic schizophrenic. But the treatment hospital's task, regardless of etiological factors, is to educate the patient to live a worth while life.

EXTRA-PATIENT TREATMENT AND EXTRA-HOSPITAL THERAPY

As a corollary of a sincere acceptance of psychological factors in schizophrenia, the ideal treatment hospital would follow the lead of a few courageous hospitals in seeking more extensive ways of reducing schizophrenogenic factors operating outside the patient (2, 4), and teaching him modes of increasing his self-esteem, beyond giving him gratuitous attention (9, 11). Even though it may be the patient's perception of the world which makes it threatening to him, we can help him to mitigate the realistic situations and to enlarge upon his mastery skills for relative solace in interpersonal situations (e.g., patient and family in therapy together). The ideal treatment hospital paradoxically will feel involved and secure enough to extend its treatment beyond its isolated buildings and grounds. When such a happy day arrives, patients will be exposed to community resources and not merely feted with sweets on the premises.

SUMMARY

This article is an unofficial attempt to add the point of view of the psychologist operating in a mental hospital to the *Action for Mental Health* report. Three suggestions are made for increasing the effectiveness of his work and his own professional growth. The call is for less professional staff exclusiveness, increased concern for psychological theories of personality change, and a widening of extra-hospital therapies, if the mental hospital is to become a center for the investigation and treatment of human problems. Only hospitals giving evidence of embarking upon such programs should be considered modern treatment hospitals.

REFERENCES

1. BOCKOVEN, J. S. *Moral treatment in American psychiatry.* New York: Springer, 1963.
2. FLECK, S., CORNELISON, A., NORTON, N., & LIDZ, T. Interaction between hospital staff and families. *Psychiatry*, 1957, 20, 343-350.
3. FROMM, E. *The sane society.* New York: Rinehart, 1955.
4. HILDRETH, H., BOSZORMENYI-NAGY, I., MIDELFORT, C., FRAMO, J., & FRIEDMAN, A. Family treatment of schizophrenia: a symposium. *Fam. Proc.*, 1962, 1, 101-140.
5. JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH. *Action for mental health.* New York: Basic Books, 1961.
6. LEFTON, M., DINITZ, S., & PASAMANICK, B. Decision-making in a mental hospital: real, perceived, ideal. *Amer. sociol. Rev.*, 1959, 24, 822-829.
7. O'CONNELL, W. E. Ward psychotherapy with schizophrenics through concerted encouragement. *J. Indiv. Psychol.*, 1961, 17, 193-204.
8. O'CONNELL, W. E. Identification and curability of the mental hospital patient. *J. Indiv. Psychol.*, 1962, 18, 68-76.
9. PRATT, S., REED, P., & ARNOLD, R. Widening the treatment field. *Ment. Hosp.*, 1960, 11, 25-26.
10. PRATT, S. Of myth ("sick role") and models: time for an agonizing reappraisal. Paper read at Amer. Psychol. Ass., New York, 1961.
11. SANDERS, R., & WEINMAN, B. Psychosocial treatment of the chronic mental patient: a rationale. Paper read at Amer. Psychol. Ass., Cincinnati, 1959.
12. SOMMER, R., & CLANCY, I. Ambiguities in the role of clinical psychologist in a mental hospital. *J. clin. Psychol.*, 1958, 14, 264-268.
13. SANFORD, F. H. Psychology and the mental health movement. *Amer. Psychologist*, 1958, 13, 80-85.
14. WILLIAMS, G. Schizophrenia can be cured. *Atlantic Mon.*, 1962, 209 (1), 27-31.
15. ZIMET, C. Clinical training and university responsibility. *J. clin. Psychol.*, 1961, 17, 110-114.