Hospitalization of Acute Psychotic Patients in Mixed Closed Wards

Dr. Yaacob Dafna*

Acute psychotics are often hospitalized in closed wards, even against their will. In such cases society grants itself the right to isolate such patients from their surroundings, deny them access to their property, and restrain their natural drives by physical force and medication. In addition the patient may be stripped of both status symbols (academic titles, military rank, religious office...) and individual identity (pajamas).

Justification for this radical step of official intervention, denying the rights of the individual to conduct life as the patient may deem proper, is based on the assumption that the patient's perception of reality and capacity for judgement are abnormal. He suffers acute disorganization and may endanger himself and others.

It is of course important to minimize encroachment on the rights of the individual. Legislatures have therefore limited such official intervention by strict regulation of compulsory hospitalization, its timing and maximum duration, the requisite procedures, and the patient's right of appeal, etc.

It is my contention that hospitalization in closed wards which are mixed (i.e. men and women together) often encroaches on the rights of acutely psychotic patients. Such hospitalization does not contribute to their well being; and, as will be shown later, mixed wards may actually interfere with treatment and be harmful.

I. Hospitalization in a mixed ward overstimulates the acutely psychotic patient, and places an additional burden on him at a time when he already has difficulty in restraining his drives.

II. Sexual activity in closed wards may be initiated by the patient due to lack of judgement and self-control, or the patient may be a passive victim of sexual exploitation by others. In any event, there are several possible outcomes of such encounters.

a. When the psychotic episode passes and the patient recalls hospitalization in the mixed closed ward he might experience feelings of guilt and degradation, or the patient might experience feelings of antagonism toward the staff who failed to protect when such protection was needed.

These emotions may interfere with the relationship between patient and therapists by lowering the patient's sense of confidence in them, by acting-out with respect to their therapeutic instructions, and in extreme cases by the patient's refusal to cooperate with the staff.

b. When the patient comes from a family or from an environment with a system of values which contrasts with the behaviour manifested in the hospital, such encounters may lead to clashes between the family and the staff, thereby undermining the sense of security and trust in the ability of the staff to provide protection and proper care for their relative. This may intensify feelings of guilt by the family for having agreed to unjustified hospitalization, and in extreme cases may lead to refuse cooperation.

c. Similarly, when the patient comes from a family or from an environment with a system of values inconsistent with his behaviour in the hospital, such encounters may result in strains between the patient and his family, increased difficulties in adaptation to environment, and in extreme cases a dissolution of marriage (e.g *halacha* prohibits a *kohen* from cohabiting with his wife who has committed adultery, even if this took place only during a state of psychosis).[1,2,3]

Such an inadequate relationship between the patient and the staff, between the patient's family and the staff, or between the patient and his family may interfere with therapy and lengthen the period of hospitalization.

In the social sciences there are several models for closed psychiatric hospitals ("total institutionalization"). The most well known of these is Goffman's Asylum.[4,5,6] In this model the closed psychiatric hospital is isolated and socially humiliating. Instead of allowing concrete change in the patient's condition such hospitalization tends to perpetuate the psychosis.

Levy, Kupper, and Elitsur claim that both in general and in psychiatric hospitalization there are elements of de-individuation and social degradation. But "these phenomena reverberate dramatically in closed wards of psychiatric hospitals (page 44)."

*Chief Psychologist, Community Center for Mental Health, Pardesia-Netania; Pardesia Psychiatric Hospital; Taiba; Clinic for Treatment of Children and Youth, Netania

These researchers reject the idea that hospitalization for acute psychotic conditions inevitably leads to social degradation. They suggest a distinction between types of degradation:

a. "Substantial-dynamic" degradation is a stage in the process of altering the hospitalized patient's social personality and is characterized by loss of status symbols, dispossession of the patient's identity and status, submissiveness and acceptance of the pain and discomfort of therapy.
b. Irrelevant and superfluous degradation is not an active component of any socialization process leading to alteration and is characterized by negative and humiliating elements.

These investigators summarize their findings with the unambiguous statement that "The substantial dynamic model for degradation does not exempt us from trying to alleviate the patient's degradation in closed ward; there should certainly never be any additional, unnecessary degradation imposed on the patient (page 46)."

In attempting to come to terms with the criticism leveled against Goffman's model of the psychiatric hospital as a total institution, Jones[7] and Stanton and Schwartz[8] developed the idea of a therapeutic community, which constitutes a different approach to the treatment of the mentally ill patient.

In this approach the "therapeutic community" is a tool for rapid socialization and prevention of hospitalization. Rapid return to society is accomplished in this approach by creating a framework which is similar in its norms and values to the societal frameworks in which the patient grew up and to which he will return.

It follows that stress develops when the values and principles of the "therapeutic community" are opposed to the values of the society from which the patient comes. This stress is characterized by repeated withdrawal and anxiety which delay the process of return to society.

CASE REPORT

M., 40 years old, religious, married, and the father of several children. He has a responsible position in government service.

When hospitalized in 1987, his discharge record stated: "No previous psychiatric history, disorientation subsequent to high fever, restlessness and anxiety. Episode resolved without medical therapy. Probable cerebral inflammation without complications."

Unfortunately, the patient expressed suicidal thoughts and was hospitalized in a mixed closed ward. Because of his state of disorientation and his emotional turmoil he remained in hospital for four days. During this time he had sexual relations with two female patients.

After resolution of the cerebral inflammation M. recalled his experiences in the closed ward and was overwhelmed by feelings of guilt and acute degradation. But for rapid and effective intervention by the therapeutic staff and the patient's speedy discharge from hospital, he would have experienced an emotional crisis greater than that for which he was originally hospitalized.

M. and his family would clearly have been candidates for breakdown and family crisis had they been informed of the details of M.'s "adventures" in hospital.

On the other hand, had M. been hospitalized in a separate closed ward for men, he would not have been exposed to overstimulation and it is reasonable to assume that he would have successfully controlled his drives. Thus his unnecessary hospital experience would have been avoided.

SUMMARY

In light of the articles and the case study referred to above it is reasonable to assume that avoidance of overstimulation and the creation of continuity and maximal similarity between the community in the closed ward and the patient's own natural environment would shorten the period of hospitalization. This would lead to rapid socialization and prevention of continued hospitalization, and aid the patient's re-integration into his normal societal framework.

RECOMMENDATIONS

1. Every framework for psychiatric hospitalization should include separate closed wards for men and women as well as a mixed closed ward so that the patient and his family can choose the hospital framework corresponding with their values and principles, thereby maintaining (as far as possible) a sense of continuity between the closed ward and the patient's natural environment.

2. Further research is needed in order to compare the therapeutic results in mixed closed wards and separate closed wards in order to formulate a hospitalization policy based on empirical findings.

NOTES

1. Tur, *Even ha'Ezer* 6.
2. Rambam, *Hilchot Issurei Bi'ah* 18:7.
3. *Yevamot* 56.
4. Goffman, E. , *Essays on the Social Situation of Mental Patients and other Inmates*, England, 1973.
5. Goffman, E. *Notes on the Management of Spoiled Identity*, New York, 1963
6. Goffman, E. "Characteristics of Social Institutions," in, *Symposium on Preventative and Social Psychiatry*, Washington, 1975.
7. Levy, Kupper, and Elitsur, "Degradation and Degradation Strategies in Psychiatric Wards: Alternatives to Goffman," (in Hebrew, *Sihot* 1:1, Israel, August 1986.
8. Jones, M. "The Concept of Therapeutic Community," *American J. Psychiatry* 112: 1956.
   Mai, T., "The Hospital as a Therapeutic Institution," *Bulletin of the Menninger Clinic* 10:66.
9. Stanton, A., and Schwartz, M., *The Mental Hospital*, New York 1954.