

Schizophrenia and the Sick Role

Miriam Siegler, M.A.,¹ and Humphry Osmond, M.R.C.P., F.R.C.P.

"In the name of humanity, then, in the name of modesty, in the name of wisdom, I entreat you to place yourselves in the position of those whose sufferings I describe, before you attempt to discuss what course is to be pursued toward them. Feel for them; try to defend them. Be their friends — argue not hostilely. Feeling the ignorance to be in one sense real, which all of you confess on your lips, listen to one who can instruct you. Bring the ears and the minds of children, children as you are, or pretend to be, in knowledge — not believing without questioning, but questioning that you may believe."

— John Perceval, 1832

"Listen to one who can instruct you." Has psychiatry and its allied sciences and crafts ever taken Perceval's advice? For if we listen to him and others who have written accounts of their schizophrenic¹ illnesses, we can learn much: these tales are rich in hard-earned wisdom. We might learn, for example, what the world looks like when one's senses overthrow their usual government and become anarchic. We might learn also of the positive aspects of these internal insurrections, for none of these autobiographical accounts would have been written had not their authors wished to convey to us remarkable and often marvelous experiences, as well as terrible ones.

Buried among the more dramatic happenings, there is a quiet thread of a story, which might easily be missed if one were not looking for it. The authors themselves tend to take it for granted, and give it no special attention. It is this: these people, with severe perceptual disorders, are medical patients. They know that they are ill, they know that they are not to blame for being ill. They wish to get well as quickly as possible and to stay well if they can. They seek medical help and they cooperate with that help as best they can. In short, they occupy the sick role (Parsons, 1951), insofar as they are permitted to

¹ By schizophrenic, we mean an illness characterized by massive perceptual distortions. Two of our authors, Clifford Beers and Anthony Rossiter, describe extreme mood swings as well as distorted perceptions. We trust that those who do not agree with our diagnostic schema will nevertheless find our paper of interest.

1 9 Ashton Place, Cambridge, Massachusetts 02138

1 Director, Bureau of Research in Neurology and Psychiatry, Box 1000, Princeton, New Jersey 08540

do so. They are grateful whenever it is offered to them and they do not abuse its privileges. Since they illustrate all four aspects of the sick role as Parsons described it, we shall enter their accounts under these four headings.

What of our sample? How representative is it? We doubt whether writing an autobiographical account of an unusual experience is a usual thing to do, regardless of the nature of that experience. Most people who endure hurricanes, concentration camps, wars, heart transplants, trips to the moon, or other such happenings do not write about them; some, however, do. But that does not make such accounts any the less valuable, for they can teach us what questions to ask of all returned travellers, whether they have literary talents or not.²

The first rule of the sick role is that one is exempt from some or all of his normal social responsibilities, depending on the nature and severity of the illness. This rule presents the ill person with several knotty ethical problems. He must ask: am I now too ill to be responsible for my behavior? How much of what I am experiencing is illness, how much still part of my normal self? How ill am I? These questions are particularly critical at the onset of the illness, when the schizophrenic person finds it more and more difficult to maintain his usual social role and yet does not want to surrender himself to illness. Perceval (1961) has recorded this moment of going over the brink:

"At last, one hour, under an access of chilling horror at my imagined loss of honour, I was unable to prevent the surrender of my judgment. The act of mind I describe was accompanied with the sound of a slight crack, and the sensation

²Those interested in further study of this valuable literature will certainly want to see the following: Kaplan, Bert (ed.) *The Inner World of Mental Illness* (New York: Harper and Row, 1964); Landis, Carney, *Varieties of Psychopathological Experience* (New York: Holt, Rinehart and Winston, 1964); Sommer, Robert, and Osmond, Humphry, "Autobiographies of Former Mental Patients," *Journal of Mental Science*, 106, 1960, 648-662; Sommer, Robert, and Osmond, Humphry, "Autobiographies of Former Men-tar Patients: Addendum," *Journal of Mental Science*, 107, 1030-1032, 1961.

of a fiber breaking over the right temple; it

reminded me of a mainstay of a mast giving away; it was immediately followed by two other cracks of the same kind, one after another, each more toward the right ear, followed by an additional relaxation of the judgment. In fact, until now, I had retained a kind of restraining power over my thoughts and belief; I now had none; I could not resist the spiritual guilt and contamination of any thought, of any suggestion."

Lara Jefferson (1964), who evidently had a more insidious onset, also describes this experience:

"I must have had a fair share of intelligence, or I could not have conducted myself according to the rules as long as I did. But now I cannot conduct myself as the rules set forth because something has broken loose within me and I am insane..."

Now that she can no longer sustain her normal social role, she finds that she has been offered the impaired role (Siegler and Osmond, 1969) rather than the sick role. But she sees this as the easy way out and rejects

it:

"The State has adjudged me insane and I am no longer responsible for anything, so it is stupid and senseless for me to try and salvage anything out of the tangle. But since the tangle is I, I cannot let it lay as it is. Even though that would be better — still, I cannot do it. I still have a life on my hands — even though it must be lived out in an insane asylum. Though I have lost every encounter, I am still not dismissed from the conflict. If all my weapons have failed, I must find some others."

Even after accepting their altered status, our authors still try to fulfill their usual social obligations whenever it is possible to do so. They do not assume that the sick role exempts them from all responsibilities. They find it disturbing when the circumstances of hospital life make it difficult to be as responsible as the illness allows. To take a pedestrian example, even hospitalized psychiatric patients are subject to tooth decay, and, like the moral citizens that they are, they believe they ought to do something

about it. Perceval complains:

"I repeated my request to be brought to town if only for three weeks to see the surgeon alluded to above, and to take the advice of a lawyer; also to have my teeth attended to, which were in a state of decay, not having been washed for a whole year."

Barbara Field Benziger (1969) also worried about dental problems, fears that her status as a mental patient precludes getting dental treatment:

"My gums were bleeding very badly, but I would not tell anyone. The dentist sounded like a monster, and who was going to believe me in my present state when I said I was allergic to novocain? How could I get hold of some vitamin C? They never gave you any juices here. Less petunias and more oranges and lemons were needed — but of course visitors wouldn't see the oranges and lemons."

Perceval was much bothered by not being shaved. He says:

"It was also one of the circumstances that touched me with most sorrow and indignation, when I came to myself. For as a military man, I had always shaved every day; and I thought, if my friends had been disposed to show me any delicate attention during my illness, it would have been to have kept up my ancient military habits."

He also felt that another of his normal habits could have been preserved:

"In my opinion a few glasses of wine would have done me no harm, and I was accustomed to drink wine."

Our authors tell us that they try to stay away from situations where they fear that their controls will not prove adequate. Perceval explains why he prefers not to go to church:

"I found, however, that my feelings were too acutely excited by the liturgy and the recollection the service awakened for me to command them; and that, unless I wished to expose myself more disagreeably, my only chance was to turn things to ridicule. I was laughing, therefore, the whole service through, and, fearing that that in the

end would harden my heart, I applied for leave to abstain from church."

For the same reason, he did not wish to see his family: "For I knew my strength, and did not wish to try it beyond its power. .."

These examples show that schizophrenic patients are keenly aware of the extent to which they can play their usual social role and undertake its responsibilities, and although they try to behave as normally as possible, they soon learn what activities are precluded by their illness. They also tell us that, in their efforts to maintain such control as they can, they are greatly aided by the presence of social normalcy around them. Perceval describes dining with the doctors of the asylum where he stayed:

"I contrived to get through dinner without any very extraordinary actions or expressions, and afterwards I used to dine occasionally in the old doctor's mansion, in greater company; and though yet in a dream, my behavior there was still more moderate. My spirits directed my attention with great rapidity to the objects of furniture, books, curtains, pillars, glasses, etc. in the room, and to little acts of civility. And I attribute my better manners to the greater occupation given to my imagination by variety of situation and ornament, and to my being in circumstances more congenial to my habits and sensible of the impression of decent conduct and formalities around me." Judge Schreber (1955), whose symptoms included uncontrollable bouts of bellowing, has this to say on the question of self-control in social situations:

"All these events together with other considerations made me decide about a year ago to work for my discharge from this Asylum within a measurable time. I really belong among educated people, not among madmen; as soon as I move among educated people, as for instance at the table of the Director of this Asylum, where I have taken my meals since Easter 1900, many of the evils caused by miracles fade away, particularly the bouts of so-called bellowing, because during such times I

have the opportunity by taking part in open conversation to prove to God that my mental powers are undiminished. Although I have a nervous illness, I do not suffer in any way from a mental illness which would make me incapable of looking after my own affairs ... or which would allow my detention in an institution against my will on the grounds of administrative law."³

Later on, Judge Schreber tells us in more detail how he controls the attacks of bellowing:

"The attacks of bellowing, although not completely gone, are less severe, particularly because I learnt to counteract them successfully when they might be a serious nuisance to other people . . . By continual counting, I can also prevent bellowing almost completely in public places, in the theatre, in an educated environment, etc., or during pauses when not carrying on a conversation aloud. I may have to make some little noise like coughing, clearing the throat or yawning somewhat ill-manneredly, none of which is likely to give particular offence."

Like Judge Schreber, Perceval describes himself as a nervous patient. So does Mary Cecil (1964), whose doctor said to her:

"How about coming into the hospital for a while, because I do think you have a nervous disorder."

She comments:

"What excellent wording! Now if he had said mental disorder, I would never have trusted him again."

Our authors seem to prefer the term "nervous," with its more narrow medical meaning, to the more global term "mental," which we interpret to mean that they prefer the sick role to whatever role is implied by the latter designation.

¹Judge Schreber and his doctors were never able to reach agreement as to where the line was to be drawn between his delusional system and his religious experiences; nevertheless, both agreed that he had a nervous illness (paranoia) and both agreed that he had a normal, indeed superior, personality, which was distinguishable from his illness. Our interpretation of this lack of consensus is that the Judge, a brilliant man, successfully used his high status to put the doctors off their shot; and that the doctors, for their part, failed to use their

Aesculapian authority with sufficient skill to gain the upper hand with the Judge.

The second rule of the sick role is that the sick person cannot help being sick, and is not to blame for it. Lara Jefferson says that madness is beyond human control:

"Madness knows nothing at all of the human fears which hold us. It knows nothing of wrongdoing — has no such thing as conscience — no fear of Gods or Devils. Nothing in this world can stay it when it has claimed its own. The one whom it has chosen has no choice in the matter. They must follow and obey and try with desperate effort to deliver a satisfying performance."

This statement is particularly compelling coming from a person who has already made it clear that she has no intention of abdicating responsibility for her life.

Hennell (1967) describes madness thus:

"Neither will nor thought of my own possessed my mind, but an urgent, continuous and involuntary stream of thoughts and directions."

Judge Schreber and his doctors agree that his symptoms are involuntary:

"That I neither simulate nor provoke the bellowing purposely — it is after all a hard burden on me too — is apparently not doubted by the medical specialist ... he recognizes that it frequently requires the greatest effort on my part to prevent the bellowing noise, and that such noisy outbursts occur completely against my will, automatically and compulsively."

Beers (1908), in discussing the question of responsibility for his attempt to kill himself, maintains the interesting position that this cannot be called an attempt at suicide, "for how can a man who is not himself kill himself?" He later expands on this:

"When one who is possessed of the power of recognizing his own errors continues to hold an unreasonable belief — that is stubbornness. But for a man bereft of reason to adhere to an idea which to him seems absolutely correct and true because he has been deprived of the means of detecting his error — that is not stubbornness. It is a symptom of his disease and merits the indulgence of forbearance, if not genuine sympathy. Certainly

the afflicted one deserves no punishment. As well punish with a blow the cheek that is disfigured by the mumps."

Our authors find their lot a difficult one when their doctors, who should be a source of exoneration, instead accuse them of being bad. Perceval eloquently describes the bind in which the mental patient finds himself:

"He is professedly a pitiable object of scrupulous care, the innocent dupe of unintelligible delusion, but he is treated as if responsible, as if his dupery is his fault; yet if he resists the treatment, he is then a madman; and if, as in my case, he is agonized and downcast by a continual and unmeasured self-accusation of his great guilt in being insane, he receives no correcting intimation that he has something to say for himself, that he is the appalling witness of the power of disease; no encouragement, no inspirations of self-confidence; but all around tends to keep down his spirits, to depress his energies, to abuse and degrade him in his own estimation."

Mary Cecil found herself in an awkward spot when, after she had voluntarily admitted herself to a mental hospital, she was thrown out again by a psychiatrist who believed that she was bad, not ill:

"The psychiatrist was the cold kind. He said bitingly:

'You've made a pretty good fool of yourself, haven't you?' he thundered contemptuously ...

'Very,' I agreed again and again.

Your parents will fetch you tomorrow and you'd better behave yourself in the future. Try to think a little of their feelings. Next case.'

. . . They were throwing me out. They didn't think I was ill. What was I to do?"

Mrs. Benziger experienced being confined in the hospital as a punishment, rather than as a medical precaution:

"Please don't cage me in this way. I will become more and more insane. What is this prisoner, criminal attitude? I don't get it — I haven't done anything wrong. I'm just sick and need help. I asked

for protection, but not Alcatraz, for God's sake."

Interestingly enough, this attitude on the part of the hospital quickly called forth a corresponding attitude in Mrs. Benziger: she soon began to conceal her clothes by hiding them under the mattress, and she stole a quarter from an aide in order to make a phone call, should she manage to evade supervision and escape.

Of all our authors, the one who suffered the most from being deprived of the blame-free aspect of the sick role was Gregory Stefan (1966). Far from assuring him that his illness was nobody's fault, his analysts located the source of the illness in his wife, his in-laws or in Stefan himself. During the onset of the illness, Stefan would be seized with panic attacks while in his office. He was especially fearful that some great catastrophe would befall his wife. When he told this to his analyst, the response was: "It could be, Mr. Stefan, that you have a subconscious death wish toward your wife."

The analyst also attempted to trace Stefan's symptoms to the fact that he came from a poor Greek family, while his wife came from a wealthy, French-German family. "Naturally," he explained, "you must have some hidden resentments toward them which you'd do well to admit, instead of repressing them." Stefan says: "I hadn't noticed these resentments before. Laurie's family had accepted me from the first as one of their own."

Later, the analyst offered the opinion that the illness was the fault of Stefan's wife:

"Mr. Stefan,' he said at length, 'you are an intelligent young man. A sensitive young man. Now I'm certain that you are intelligent enough to realize, by now, that your wife is the source of your difficulties. Certainly any young man who is constantly challenged intellectually, artistically and socially by his wife, any man who is forced to be idle while his wife becomes the breadwinner of the family, will inevitably be unable to satisfy his wife sexually.'"

Under this barrage of fault-finding, Stefan and his wife took turns at accusing each other of being to blame:

"'It's all my fault, Greg,' she kept saying. 'I'm not good enough for you, Greg. I'm making you sick. I know it.' She was convinced that she was to blame for my condition."

Then it was Stefan's turn:

"I told her that I was no good, that I was a failure in my career and as a husband, that I didn't deserve her. She pleaded with me to remember the past and all our hopes and dreams."

When Stefan was hospitalized, he pleaded with his new doctor:

"Dr. Gression, the psychiatrist I was seeing before ... he made me blame her for everything ... for my sickness ... kept telling me to ride her, abuse her. Please take the blame off her. .. it's his fault ... make him tell her she's not to blame ... please ... she's so sensitive ..."

The new doctor replied that he did not blame anyone. But he was no more inclined than his predecessor to confer the sick role.

Stefan found that, in this psycho-analytically-oriented hospital, the patients all spent a great deal of time blaming other people, usually immediate relatives, for their illness.

"One would complain bitterly, as if that were the cause of his illness, about his mother who had slapped hell out of him at the age of five. Another would complain about his father who had belted him at the age of nine. Another would blame everything on his wife because the woman wouldn't have intercourse with him more than twice a week. Another would blame her husband for not understanding her. Another would be convinced that he had suffered a breakdown because his niggardly boss hadn't offered him a raise ..."

While it is hardly a requirement that those who use a psychoanalytic model and occupy the analysand role engage in blaming themselves or others for their illness, preoccupation with blame occurs frequently. The sick role appears to be the only blame-free role available to schizophrenics and their families.

We know that our authors follow the third rule of the sick role — that they try to get well as

soon as possible — because they tell us in considerable detail what helps to make them well and what does not.⁴ Not surprisingly, one of the most important ingredients in a recovery from a schizophrenic illness is hope. Judge Schreber, believing that he had been abandoned medically, made an unsuccessful attempt to hang himself. He reports:

"I was therefore greatly surprised when on the following morning the doctor still came to see me. Professor Flechsig's Assistant Physician, Dr. Tauscher, appeared, and told me that there was no intention whatsoever of giving up treatment; this coupled with the manner in which he tried to raise my spirits again — I cannot deny him also my appreciation of the excellent way he spoke to me on that occasion — had the effect of a very favourable change in my mood. I was led back to the room I had previously occupied and spent the best day of the whole of my (second) stay in Flechsig's Asylum, that is to say, the only day on which I was enlivened by a joyful spirit of hope."

Norma MacDonald (1964) writes:

"There are some highlights to the months spent in mental hospital, times when I grasped ideas that led to a new world of light. One was the realization that I was sick and could get well — this I recall was promoted by a 'sane' fellow inmate who suffered from nothing more than alcoholism."

Mary Cecil is particularly eloquent on this point:

"... I got no inkling of hope, no hint of a solution until in the ward which dealt out shock treatment, I met a lady doctor, very kind and interested, not so detached as the men on the ground floor. One time when she was questioning me and I'd been having a specially foreboding session with my inhabitant, I burst into tears. She laid a hand on my knee and said:

'You are going to get better, you know.' Well! Why hadn't anyone told me this

We have chosen not to discuss the various medical treatments to which these patients were subject, as the information provided by them is too sketchy to help us much.

before? I'd been telling them the awful fates in store for me, the impossibility of ever being so much as my old self again which was bad enough anyway, and they'd smiled or not smiled, whichever kind they were. The lady doctor said:

'You must be patient, that's all. You've had a bad nervous breakdown.'

Another miracle tossed up my mind like a pancake and slapped it down the other side. I had been hanging on the edge of a precipice all those months and all the time I was over it. The worst had happened. It was so wonderful I left the little room in a swirl of heady triumph."

Both Hennell and Perceval believe that clear information about the illness and its treatment would have been helpful. Hennell writes:

"A diagnosis generally has to be written out in each case; yet it is not thought wise to tell the patient plainly what is thought to be the matter with him, or how he may cooperate to circumvent the ill. So the patient either resents being treated as a fool or else behaves as one, in consequence of being treated so."

Perceval has much the same view:

"Instead of my understanding being addressed and enlightened, and of my path being made as clear and plain as possible, in consideration of my confusion, I was committed, in really difficult and mysterious circumstances, calculated of themselves to confound my mind, even if in a sane state, to unknown and untried hands; and I was placed amongst strangers, without introduction, explanation or exhortation."

He goes on to say:

"I mean, that I was never told, such and such things we are going to do; we think it advisable to administer such and such medicine, in this or that manner; I was never asked, Do you want anything? Do you wish for, prefer any thing? Have you any objection to this or that?"

Both Beers and Perceval found letters from their families helpful in combating delusions. In Beers' case, a letter brought to a dramatic end a delusional system of two years' duration. He wrote his brother,

asking him to bring that letter back as a passport, to show that he really was George Beers, and not a detective in disguise. Beers says:

"The very instant I caught sight of my letter in the hands of my brother, all was changed. The thousands of false impressions recorded during the seven hundred and ninety-eight days of my depression seemed at once to correct themselves. Untruth became Truth."

Perceval wrote his mother to ask if he was really her son. His mother sent him a certificate of baptism. Perceval says that he needed circumstantial evidence to correct his errors.

Three of our authors are outspoken on the need for physical exercise. Hennell asks: "What was the cause why so many fairly able-bodied persons were kept so long in bed without opportunity for physical exercise, or any profitable activity?"

Beers notes that both the patients and the staff need exercise:

"I found also that an unnecessary and continued lack of outdoor exercise tended to multiply deeds of violence. Patients were supposed to be taken for a walk at least once a day, and twice when the weather permitted. Yet those in the violent ward (and it is they who most need the exercise) usually got out of doors only when the attendants saw fit to take them ... The attendants need regular exercise quite as much as the patients, and when they failed to employ their energy in this healthful way, they were likely to use it at the expense of the bodily comfort of their helpless charges."

But Perceval suffered exquisitely from the lack of exercise:

"My idleness of mind and body left me at the mercy of my delusions; my confined position increased or caused a state of fever, which brought on delirium; and they kept drenching my body to take away the evil which their system was continually exciting; and which ultimately triumphed completely over me. My want of exercise produced a deadly torpour in the moral function of my mind, combined with the

ruin of my spirits by their diet and medicines. I foresaw a dreadful doom which I could not define and from which, like one in a dream, I attempted in vain to run away. Inwardly I adjured my Maker and expostulated with the voices communing with me, in me or without me, to allow me exercise as the only means of saving me."

Perceval had been accustomed to three hours daily of active exercise.

Gregory Stefan and Mary Cecil both mention diet as a means of staying well. Stefan says:

"A friend of the family who happened by one day recommended that I try to follow a vegetarian diet. He persuaded me to cut out meat altogether and subsist on a vegetable and fruit diet. Curiously, the results were immediate. Many of my symptoms vanished within a few days. The deep depression and anxiety also passed away."

Mary Cecil, who also favors a vegetarian diet, remarks that the "starchy" diet typical of mental hospitals is inappropriate, and that fruits and vegetables would be more beneficial.

There are several views on how to prevent recurrences of the illness. Alertness to the onset of symptoms is one weapon. Beers writes:

". . . within six months I found myself writing with a facility which hitherto had obtained only during elation. At first I was suspicious of this new-found and apparently permanent ease of expression — so suspicious that I set about diagnosing the symptoms. My self-examination convinced me that I was, in fact, quite normal. I had no irresistible desire to write, nor was there any suggestion of that exalted, or (technically speaking) euphoric, light-headedness which characterizes elation."

Anthony Rossiter (1969), an artist, finds that he must give up his previously abandoned and emotional way of drawing:

"I would look at the few remaining drawings from Creek days, realize the cost, and resolve not to express myself in this way again. It was probably wise at the time. My mind still needed rest and could not afford a torrent of ideas to flood it. Even

now I have to ration my painting, for I know there is a danger point which can only lead to the uncontrolled swing of the pendulum. I work these days with more caution than I would have guessed possible a few years ago, at full tilt for a while, but with a keen ear for the shrill scream of the pendulum."

For Lara Jefferson, it is depressive thinking that is the symptom to be watched for:

"Like an alcoholic who knows he cannot take even one drink or a diabetic who must forever forego any sugar, I knew I must pass up all depressive thinking. I could not swear off forever. Life is lived hour by hour, so I must adjust my rebuilt and overhauled mind to a leaner mixture."

Norma MacDonald was fortunate in that her doctors provided her with a sensible regimen while she was in the hospital; she was not left to figure it out for herself. She writes:

"Simplest of all is perhaps the knowledge that this illness rests very definitely on physical factors. When I was in hospital the doctors told me that if I hoped to remain well, I must have three square meals, my necessary nutrients, and at least eight hours sleep nightly. Lapses have proven to me that they were absolutely right. I know that by going without food for a day or two or by missing sleep two or three nights in a row, I could (and do) lapse into a state where dreams worry my mind at night, fatigue sets in, voices begin to pester me, and suspicion of the motives of even my best friends rises to turn my life into a living hell."

Miss MacDonald dreams of a day when she can say to her employer: "I am mentally sick and I need a day in bed." But the stigma which still attaches to schizophrenia makes it difficult for those who have the illness to demand what they need in order to stay well.

The fourth rule of the sick role is that the sick person must seek appropriate help, usually that of a physician, and cooperate with that help toward the end of getting well. But it sometimes happens, both in physical and in mental disease, that the onset of the illness is so sudden and dramatic that the

patient becomes too ill to seek help himself, and is hospitalized by someone else, usually his family. This was the experience of four of our authors: Beers, Perceval, Rossiter, and Norma MacDonald. The proof that they did agree to be patients, however, can be found in statements about their willingness to be re-hospitalized should they ever get sick again. Beers makes this particularly clear:

"Though several friends expressed surprise at this willingness to enter again an institution where I had experienced so many hardships, to me my temporary return was not in the least irksome. As I had penetrated and conquered the mysteries of that dark side of life, it no longer held any terrors for me. Nor does it to this day. I can contemplate the future with a greater degree of complacency than can some of those whose lot has been uniformly fortunate. In fact, I said at the time that, should my condition ever demand it, I would again enter a hospital for the insane quite as willingly as the average person now enters a hospital for the treatment of bodily ailments."

Perceval, in spite of his very bad treatment in a private mental hospital, said:

". . . / felt so sensible of my need of observation that I would not accept my liberty if it were given to me, but should place myself immediately under the eye of some one I could rely upon

Of those of our authors who did seek psychiatric help, none needed it more or was more grievously disappointed in its quality than John Balt (1966). For Balt, plunging deeper and deeper into a schizophrenic psychosis, murdered his beautiful and much-loved wife. In the trial which established that he was not guilty by reason of insanity, it was shown that he had made many desperate attempts to get help from psychiatrists:

"A statement made by my father-in-law established the fact that I had never shunned psychiatric aid but had actually begged for additional visits from the men concerned."

Balt was unable to get his analyst, Dr. Grossler, to take his illness seriously. When he reported strange "castration pains," in his penis and prostate, the doctor had prescribed hot baths in Epsom salts;

when he told the doctor that he was having hallucinations, he was told that they were not hallucinations, but "sensations."

Balt was hospitalized briefly in a general hospital, where he had his last interview with Dr. Grossler before the crime:

"Dr. Grossler spoke about the termination of our relationship as if it had occurred in coldly rational circumstances, neglecting to mention my desperate phone calls to him, some in the middle of the night, and all on file because they were toll calls. Our last interview occurred in the general hospital, where all day Sunday I had waited for him as if he were some kind of savior, in a state, to quote the hospital record, of 'agitation and fear' ... until he arrived, very annoyed, at five in the afternoon. I told him that I wanted to be a male nurse and invest in apartment buildings, and that I feared I would hurt Claire.

'I'm afraid that I've become some kind of madman,' I said from the hospital bed. 'I'm afraid that I might hurt someone. I'm terribly afraid.'

'Why don't you get yourself another doctor,' he told me. 'You're a hospital case now and I've got an office practice.' He walked out and that night I was transferred to the private psychiatric sanitarium where I came under the treatment of Dr. Blutman. Although Blutman kept an office only a few doors down the hall from Dr. Grossler's, the two men never consulted about the case."

Judge Schreber, more fortunate in his doctors, notes that during his first illness he had only favorable impressions of Dr. Flechsig's methods of treatment, and so, when the illness recurred, he naturally returned to him:

"My illness now began to assume a menacing character; already on the 8th or 9th of November Doctor O., whom I had consulted, made me take a week's sick leave, which we were going to use to consult Professor Flechsig, in whom we placed all our faith since his successful treatment of my first illness."

Note that the Judge did not conclude from

the recurrence of the illness that the previous treatment was a failure; his illness was a chronic one, and he was not surprised at its recurrence.

Thomas Hennell sought help for his illness on Harley Street:

"Dr. Dreamer, in his Cromwellian consulting room, probed me with his glance as one who deeply penetrates the mysteries of being. I was resolved to show him all my private soul, to set before him nakedly my present distress, and to desire, from his wisdom, a clear diagnosis and remedy. For Mrs. Baker had promised me that he was the man to advise me — the best psychiatrist in London."

But the doctor did not show much interest in his actual symptoms:

"In thus following what seemed to this scientist to be the larger issues of life, my acute problems — two of which were an almost constant headache and a morbid fear of policemen — seemed to me to be a little neglected."

Still, Hennell believed he had come to the right place:

"So careful and minute were his questions that I was sure a practical plan pervaded his mind which these means contributed to develop."

It seemed, however, that what the doctor had in mind was a change in life-style for Hennell, one involving more sexual freedom.

". . . at last he said that there was hope for me, though my upbringing had involved me in serious disadvantages. How terribly these half-known things now loomed, almost as the phantasmal perturbations of one who begins to wake from a heavy anaesthetic, whose self-possession is too weak to defend him against them! What the doctor called my life-style' had been formed in my earlier years; it had included inhibitions which had been confirmed by schooling and now I clung to fallacious, impossible ideals, to protect those very faults which should be brought to light and cast out. 'Change your lifestyle!' he cried."

Hennell rebels:

"A certain stubbornness had risen in me against Dr. Dreamer and his promised land. Perhaps I

should not much like it, even if he did make me a 'success.'"

Hennell did not return to Dr. Dreamer, and soon after had a psychotic episode in which he became delusional and was picked up by the police.

Mrs. Benziger also had the experience of seeking help from a doctor who did not seem to understand the urgency of the illness:

*"I was troubled about my relationship with my doctor. I liked him very much, but I simply couldn't discuss my reading with him, because I hadn't absorbed it. I really wanted to shout at him, 'Please, you don't understand. I am terrified that I am going to kill myself, and you must do something helpful right now. I can't wait, because I can't live with these feelings much longer.' He tried to steer me away from this kind of talk, and I left the interviews with him more scared than ever, because we hadn't touched on anything real to me." **Discussion***

We have followed Perceval's advice and have listened to "those who can instruct you." Their histories, records of bitter and terrifying experiences, cover almost 140 years, the earliest describing an illness of the 1830's and the most recent occurring in the 1960/s. What have we learned? Or what have we had the opportunity to learn?

Perhaps the most important lesson is that our authors were clearly responsible human beings who, when confronted by a massive, and mysterious illness, did their best to make sense of what happened to them and tried to behave morally. It is not their intelligence or their moral sense which was at fault, but the fact that their perceptions were so different from other members of their culture that they found themselves, for reasons which were not always clear to them, in an impossible situation.

They resemble, closely, those "cognitive exiles" whom Berger (1971) describes. These are people who move from their own to another culture and find that beliefs which they have taken for granted, whether these be astrology, cannibalism, or polyandry, are no

longer acceptable in their new surroundings. The cognitive exile then faces many doubts and uncertainties deriving from this crisis in values. Berger writes:

"There are various ways of coping with doubt. Our cognitive exile could decide to keep his truths to himself — thus depriving them of social support — or he could try to gain converts; or he could seek for some sort of compromise, perhaps by thinking up 'scientific' reasons for the validity of his astrological lore, thus contaminating his reality with the cognitive assumptions of his challengers. Individuals vary in their ability to resist social pressure. The predictable conclusion of the unequal struggle is, however, the progressive disintegration of the plausibility of the challenged knowledge' in the consciousness of the one holding it."

There is now ample evidence (El-Meligi and Osmond, 1970; Hoffer and Osmond, 1966; and Kelm et al., 1967) that the schizophrenic patient is a "perceptual exile" who has exactly the same moves open to him as Berger's cognitive exile. The outcome, however, is not the same, for while the cognitive exile has his "knowledge" undermined by his day-to-day experience of the new cultural setting, the schizophrenic perceptual exile is constantly being reinforced in his "knowledge" by his malperceptions, which have the overwhelmingly convincing quality of perceived reality, that irreducible sense-data upon which we depend for survival. Until he finds that there are other schizophrenics in the same boat and learns how to communicate with them, he is in a constant minority of one.

Once the sick role has been conferred and accepted, the schizophrenic patient benefits immediately because this carries the automatic implication that other people have suffered from, or are enduring, the same condition, for every disease entity is shared with some other people. Although new illnesses are discovered from time to time, there are no unique illnesses, that is, an illness confined to only one person. Very rare illnesses, or those just being recognized, confer a high status upon patients, because doctors show a special interest and concern in rare and strange diseases. Schizophrenia is not a rare disease, and there is nothing to suggest that it has ever been rare. The current figures (Hamburg, 1970) indicate that it afflicts at least 1, and probably 2, percent of humankind.

Once a schizophrenic patient has been accorded and accepted the sick role, he now has a socially

acceptable and respectable explanation for his cognitive eccentricity arising from malperceptions. One can now say to the schizophrenic patient: "The reason that the world appears and feels so different to you than it does for the rest of us is that you, like others suffering from this condition, have a disease which disturbs your perceptions in such and such a manner."

If it is true, as we claim that the sick role would be and is so helpful to schizophrenics, why then is it usually offered reluctantly and with such half-hearted, indeed incompetent, explanations that patients frequently do not recognize it? This is an age in which physicians and surgeons have become frank and straightforward in explaining the origins, nature of treatment, and outcome of most illnesses, following a trend begun in the early 19th century by Dr. Matthew Baillie (Mac-Michael, 1968), John Hunter's nephew and pupil. One suggestion for the reticence and ambiguity of psychiatrists has been that if schizophrenics were allowed to see themselves as sick (that is, occupying the sick role, really ill, not "sick, sick, sick"), then they would take advantage of this and indulge in all kinds of forbidden behavior. Naturally, no society would grant complete license to some of its members to do exactly as they wish for an indefinite length of time. Apparently some normal people believe that this possibility is so dangerously alluring that we must guard constantly against malingerers pretending to have schizophrenia. Even today these unrealistic apprehensions are fanned by authors, such as the Braginskys (1969) and Ederyn Williams (1971), while at the same time other authors such as Szasz (1963) and Laing (1967) insist that large numbers of healthy people are shanghaied into mental

hospitals and kept there against their will.

Our authors' accounts do not support either of these factions. Far from being malingerers, they have shown the utmost courage and ingenuity in maintaining their moral selves in the face of what seemed to have been crushing difficulties. These narratives are not those of hedonists trying to live a life of idle pleasure at the expense of others, but tell of responsible adults striving to maintain themselves under great duress. Yet none of these writers claimed that they were improperly or unfairly incarcerated, even when the conditions in which they found themselves were most unpleasant. They did not suggest that they should at once be released from their confinement and set free. They were soberly aware of the grave illnesses that afflicted them and considered that they required more and better treatment, not less.

What kind of help do schizophrenics get from professional people when they become ill? According to our authors, whom we find unpleasantly convincing, they see our efforts as fitful, inconsistent, poorly coordinated, lacking conviction, and often self-contradictory. Any person suffering from schizophrenia today, or at any time during the last 130 years, has no assurance that upon asking for help from a doctor in a hospital purporting to treat psychiatric diseases, he will be treated like a sick person, given intelligent and intelligible medical advice about the nature and extent of his ailment and treatment both humanely and medically.

He may receive a stern lecture about his bad behavior, an approach more suited to a penal or religious institution than to a hospital. However, he may equally well be told that a lengthy enquiry into his early life will make it possible for him to relinquish his unreal symptoms, of which one authority has written (Menninger, 1951):

Tor in spite of the apparent suffering which is sometimes manifested, such a state was sought as a refuge from the less obvious but certainly greater suffering incurred in the world of reality."

Or he may discover that becoming ill shows that he is the healthiest member of his even sicker family, who are, oddly enough, to blame for his illness. Then he may be told that he is a social victim who may expect to recover when a better world has been built. Only the unhistorically minded are likely to gain much comfort from this. Or, again, he may be informed that he is the unlucky victim of a conspiracy, thus reinforcing one of the more frequent delusions from which a number of our authors suffered and wisely rejected, often with the greatest difficulty. Since other doctors today insist that the patient is on the road to enlightenment if he would but persist in his folly, our authors showed commendable caution in assessing the value of their frequently extraordinary experiences. Some patients are urged to desist from any hope of recovery, accept their impairment, and lead a retired and reduced life making the best of it.

One deplorable feature of these various approaches is that the patient is usually deprived of that best of medicine — hope. From the gloomy and evasive reticence of many psychiatrists, one would never guess that schizophrenia has long been known to have a sizable natural recovery rate of between 25 and 40 percent of cases. Indeed, when any success is reported with a new treatment, it is held to be suspect because "so many schizophrenics recover anyway." This is another curious example of our peculiar attitude toward this great illness, in which even the fact that many schizophrenics recover spontaneously is a further reason for increasing pessimism. One well-known psychiatrist (Menninger, 1951), discussing spontaneous recovery some years ago, felt obliged to give a long explanation for his unorthodoxy. Yet well over a century ago such recoveries were perfectly well-known and had been described in detail by the admirable and astute clinicians of those times, many of whom were remarkably well-placed to follow up their cases. One of them, Dr. Woodward (Grob, 1966), of Worcester State Hospital, was using hope in the 1830's as a deliberate therapeutic technique. We have a

contemporary account of his method:

"His intercourse with the sick was so gentle, cheerful and winning that he soon gained their confidence and love. He nourished their hopes of recovery by holding up the bright side of their cases. They anticipated his visits with pleasure, as their physician and their friend. He recognized the influence of the mind over the physical functions, and, by his relation of agreeable stories and successful cases of a similar kind to theirs, he animated their hopes."

Our authors seldom had their hopes animated by their doctors or anyone else. But when they did, they were extremely grateful and record this with joy and thankfulness.

Schizophrenics can and do occupy the sick role: they want it, they recognize their need for it, they strive to obtain it, and they fully deserve it because they are so ill. Yet, as our authors show, they rarely receive it explicitly, quickly, and graciously. When it is eventually conferred, this is usually done by implication, sometimes even by mistake, and often with suspicion and reluctance. Once they have been diagnosed as having schizophrenia, or indeed any other illness, they are entitled to all the rights and privileges of the sick role, while at the same time they are obligated to assume its concomitant duties. Our authors are clear enough that this is the role which they are seeking and that they understand the nature of this contract.

Doctors who, for whatever reason, either withhold the sick role from the schizophrenic patient or who fail to confer it explicitly upon them, as is the general custom in medicine, should ask themselves what the consequences of their eccentric action is likely to be. What other role do they propose for their "nonpatients"? If they have discovered some new role which is better for patients than the sick role properly used, it should be disclosed at once. This would be a great discovery, and schizophrenics would be the first to applaud an event which would greatly improve their prospects. However, until this hypothetical and more beneficial role is found, our authors would, it seems, be glad to settle for the ancient, venerable, and familiar sick role from which they are so often excluded to their detriment.

When a doctor fails, whether by omission or commission, to accord schizophrenics, or indeed any other patient, the sick role, they are left adrift in

a limbo where they are likely to become increasingly alienated and bereft of social contacts of a supportive kind. When this has happened, and their affliction makes them despairing and desperate, their friends and relatives are likely to see them as unpredictable and a danger to themselves and others. They are then likely to be given the role of madman, which has from time immemorial called for either expulsion from the community or incarceration within its boundaries. This entails a catastrophic rupture in social relationships which is far harder to repair after recovery than the well-understood reduction of social activities and responsibilities resulting from the sick role.

It seems likely that much of the success of that splendid era of mid-19th century Anglo-American psychiatry, sometimes called the moral treatment, whose exemplary figures were men such as the Tukes (Ackerknecht, 1959), Woodward (Grob, 1966), and John Conolly (1964), derived from the sustained and adroit use of the medical model. These great psychiatrists showed remarkable skill at installing and maintaining their patients, among whom were many schizophrenics, in the sick role. It is very much easier for us to do this today,⁵ yet if one measures our achievement against theirs, it is doubtful whether we can claim to be doing anything like as well as they did over 100 years ago.

⁵Recent advances with the quantitative EEG, biochemical tests such as the mauve factor, pink spot and histamine levels, and especially quantitative evaluations of the patient's experiential world, such as the H.O.D. (Kelm et al., 1967) and the E.W.I. (El-Meligi, 1970), make it possible now to provide schizophrenic patients with objective information regarding the current state of their illness. This makes them much more like patients suffering from medical and surgical diseases. As Roth (1963) emphasizes in his study of tuberculosis, it is difficult to get the full cooperation of patients today unless an objective series of ratings or classification is now used, as is now customary in much of medicine. It is, however, essential to understand that tests of this kind are not only of direct benefit to the physician, and so indirectly for the patient, but they have a direct and very important function in reinforcing the schizophrenic patient in the sick role.

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