Hospitalization of Acute Psychotics in Mixed Closed Wards

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

The justification for this radical step of official intervention denying the rights of the individual to conduct his life as he deems proper is based on the assumption that the patient’s perception of reality and judgement are abnormal. He suffers acute-disorganization and may endanger himself and others.

It is of course important to minimize the encroachment on the rights of the individual. Therefore, legislatures have strictly limited such official intervention by regulating those authorized to compel hospitalization, its timing, its maximum duration, its requisite procedure, the patient’s right of appeal, etc.

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

I. Hospitalization in a mixed ward overstimulates the acute psychotic patient placing an additional burden on him when he in any event has difficulty in restraining his drives.

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

a. After the psychotic episode passes and the patient recalls his hospitalization in the mixed closed ward he might experience feelings of guilt and degradation. Alternatively, he might experience feelings of antagonism toward the staff which failed to protect him when he needed such protection.

These emotions can interfere with the relationship between the patient and his 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 natural environment with a value system which opposes his behaviour, such encounters can lead to antagonism on the part of the family toward the staff undermining their sense of security and trust in the staff’s ability to provide protection and proper care for their relative, increased feelings of guilt for unjustified hospitalization (which feelings will in any event be present), and in extreme cases refusal to cooperate.

c. Similarly when the patient comes from a family or from an natural environment with a value system which opposes his behavior, such encounters can engender stress between the patient and his family, increased difficulties in adapting himself to his environment, and in extreme cases a rift in his marriage (since halacha prohibits a kohen from cohabiting with his adulterous wife). 1,2,3

Such a depressive relationship between the patient and the staff, between the patient’s family and the staff, or between the patient and his family will interfere with therapy and will lengthen the period of hospitalization.

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3. Yevamot 56.
In the social sciences there are several models for closed psychiatric hospitals (“total institutionalization”). The most well known of these is Goffman’s Asylum.\textsuperscript{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 make his condition chronic.

Levy, Kupper, and Elitsur\textsuperscript{7} claim that in both general and psychiatric hospitalization there are elements of de-individuation and social degradation. But “these phenomena reverberate dramatically in closed wards of psychiatric hospitals (page 44).”

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, and 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 researchers 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\textsuperscript{8} and Stanton and Schwartz\textsuperscript{9} 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 hospitalism. 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 will develop when the values and principles of the “therapeutic community” are opposed to the values of the society from which the patient comes. This stress will be characterized by repeated withdrawal and anxiety which will delay the process of return to society.

**Case Study**

M. is a male, 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, patient expressed suicidal thoughts and was hospitalized in a mixed closed ward. Due to his state of disorientation and his emotional turmoil he remained in hospital for four days in a room 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, it is reasonable to assume that if M. had been hospitalized in a separate closed ward for men, he would not have been exposed to overstimulation and would have successfully controlled his drives. Thus his hospital experience, which was in any event unnecessary, would have been less traumatic for him.
Summary

In light of the articles and the case study referred to above, it is reasonable to assume that reduction of overstimulation and creation of continuity and maximal correspondence between the therapeutic community in the closed ward and the patient’s natural environment would shorten the period of hospitalization, change it into a tool for rapid socialization and prevention of hospitalism, and aid the patient’s reintegration in his societal framework.

Recommendations

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

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