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Models of Madness*

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Schizophrenia is disputed territory. Thus, the numerous theories put forth to explain it are of all sorts: biochemical, genetic, religious, psychoanalytic, sociological, cross-cultural, interactional, legal, moral, and so forth. These theories resemble, in a curious way, the productions of the schizophrenic patients on whose behalf they are constructed; they tend to be self-involved, and while they often display much internal consistency, they lack any comprehensible relation to each other.

Can these theories be made comparable, and if so, how? Now, to the extent that schizophrenia is an object of normal scientific research there is no special problem of comparability. There seem to be well-understood rules for comparing one biochemical theory with another, or one epidemiological theory with another. Those scientists working in some well-defined field will see no need to compare their theories with those that lie in very different disciplines.

But schizophrenia has vast psychological, moral, medical and social implications. In short, it is a social problem as well as an object for scientific inquiry. Because it is a social problem, various arrangements, or programmes, arise to deal with it. Some of these programmes are the deliberate implementations of particular theories, while some are based on theories which are poorly articulated and which lie outside of awareness. Most programmes unknowingly involve two or more theories which, if seriously and consistently applied, would have diverse and mutually incompatible consequences. In short, to inquire into the theoretical underpinnings of a particular programme, such as that of a hospital, is to uncover a Tower of Babel.

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It is not desirable that this Tower of Babel of non-comparable theories should exist. In a laboratory study, such confusion would be merely unworkable; in the daily care of schizophrenic patients, it is likely to be disastrous.

The theoretical underpinnings of various programmes can be learned by interviewing the participants, by observing the programmes in action, and by reading the professional literature. At first, the sheer number of theories† involved seems to make comparability hopeless, but they can be readily sorted into a small number of types, or models.

We have sorted these theories into six models: medical, moral, psychoanalytic, family interaction, conspiratorial, and social. We have made the theories into models by arranging them along a set of dimensions, and in this way they have been made comparable. The dimensions raise a set of questions about what sort of thing schizophrenia is, what should be done about it, and how the people involved in it ought to behave. The dimensions which are used here derive from the medical model, since they must derive from somewhere and the medical model is the most strongly held at the present time. The evidence for this is that schizophrenic persons are usually called "patients", the buildings they live in are called "hospitals", and those who care for them are called "doctors" and "nurses". They are "diagnosed", given "treatment" and offered a "prognosis".

Like all typologies, the worth of this system of models lies in its usefulness and its completeness. So far, it seems to be useful, and it has been successfully applied to thinking about other disputed ailments, such as alcoholism and drug

† It may be worth noting that from our point of view there is no such thing as a "crackpot" theory. Fashions change, and a theory which is given crackpot expression at one time may reappear later as eminently respectable. The reverse may happen also.

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addiction. It also seems to be complete in that none of the new theories which have been examined since the models were constructed has required an additional category, but it is too soon to know whether the present models account for all the major theoretical differences. However, the number of dimensions continues to grow as we consider more and more questions which must be put to a theory if it is to be implemented as a programme.

It is hoped that the models will be useful in analysing and constructing hospital programmes, in sharpening the discussion among professional people, in explaining the meaning of a hospital programme to patients and their families, and in making the hospital programme familiar to incoming staff. The models can also be used as a guide to reading the literature and as an information-retrieval device or filing system.

Of the six models, we will describe four in detail and two in summary. The first four are: medical, moral, psychoanalytic, and family interaction. The other two, which are used in fewer current programmes, are the social and the conspiratorial. The models will be discussed in terms of twelve dimensions. The first six (diagnosis, or definition, aetiology, interpretation of behaviour, treatment, prognosis, and suicide) deal with the course of the illness. The next three (function of the hospital, termination of hospitalization, and personnel) deal with the hospitalization or incarceration of the patient, and the last three (rights and duties of patients, rights and duties of families, and rights and duties of society) deal with the question of defining responsible conduct for the participants.

We will also discuss some of the general problems involved in comparing the models. Detailed comparisons are clearly not possible in an initial paper, and must be reserved for future communications.

The Medical Model

1. *Definition or Diagnosis*

Definition, or diagnosis, is very important because treatment is intended to be specific for each illness or syndrome. The patient is told a ch corresponds to "diabetes" or "pneumonia" in level of information; this is in order to rule out other possibilities, which he may regard as more frightening, and as a beginning point of discussion about what he may expect in the way of treatment, length of hospitalization, prognosis, his own behaviour, and so forth.

2. *Aetiology*

The aetiology of schizophrenia is not yet known, but, with present medical progress, there is every reason to hope for answers in the near future.

3. *Behaviour: How it is to be Interpreted*

The patient's behaviour may give the staff some clue as to how sick the patient is at a given time. Behaviour is an inadequate measure of the degree of illness, so that its importance will certainly diminish as better instruments are developed for greater understanding of the patient's inner state.

4. *Treatment*

Treatment consists of medical and surgical procedures, accompanied by nursing care. The patient is given a thorough medical work-up first, as part of the process of diagnosis, and also to ensure that certain procedures are not contraindicated. Treatment is meant to be as specific as possible, according to the diagnosis.

5. *Prognosis*

At present, prognosis for schizophrenia is quite mixed. Some patients will get well spontaneously, or with minimum treatment, after a short while. Others must expect to come back into the hospital from time to time as their symptoms recur. Some patients apparently do not respond to any of the treatments available, and they must expect to spend much or all of their lives in the hospital. However, medical science continues to make new discoveries and find new drugs, so that even for very sick patients, there is always some hope.

6. *Suicide*

In schizophrenia there is a considerable risk of suicide. Instruments must be developed that

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will enable the staff to know in what states patients are likely to be suicidal.

7. Function of the Hospital

The function of the hospital is to care for, treat, and, hopefully, cure the patients who are suffering from the illness called schizophrenia. Mental hospitals resemble other hospitals for long-term illnesses, such as tuberculosis sanatoria, leprosariums, etc.; they necessarily take over aspects of the patient's life, such as his social life, that would not be of concern in a general hospital. As with other hospitals devoted to the treatment of long-term illnesses, the mental hospital is greatly concerned with rehabilitation. It is understood that as soon as medical science provides a short-term treatment for mental illness, mental hospitals will quickly revert to the appearance of general hospitals, except for such special features as are peculiar to this kind of illness.

8. Termination of Hospitalization

The patient leaves the hospital when the doctor feels that he is well enough to live outside the hospital without immediate or long-range damage to himself or others.

9. Personnel

Psychiatrists are the appropriate personnel for the care of the mentally ill. In the hospital setting, nurses, attendants, and other auxiliary and para-medical personnel may also be employed.

10. Rights and Duties of the Patient

There are two versions of the medical model with respect to this dimension. First, there is a "factory" version, in which the patient is on an assembly line; experts will work on different parts of him until he gets well. In this version, the patient has only the right to demand that the experts are really expert; he has no right to inquire about the nature of his illness, the reason for any treatment, or his hopes for the future.

The other version is that of the "responsible patient". Here, the patient has the right to know everything about his illness that he can possibly understand. He has the right to be treated as a responsible adult. When is he acutely disturbed, he has the right to be treated as one would treat a responsible adult who has a high fever. The patient has the duty to co-operate with the staff toward the goal of his own improvement, however distasteful or painful the treatment may be. He has the right to be praised for bearing up bravely during his illness. He has the right to expect that the staff will respect his privacy, and that they will limit their inquiries about him to matters clearly related to his illness.

11. Rights and Duties of the Family

Families have the duty of bringing their mentally ill relatives to the hospital where there are experts in mental illness who know how to treat the patient so that he may improve or recover. They have the duty of learning about their patient's illness and of co-operating with the staff with regard to the treatment. They have the right to be given information about the illness and about their patient's progress. They have the right to expect that they will be treated courteously and sympathetically, for they are not to blame for the patient's illness.

12. Rights and Duties of Society

Society has the duty to protect its well members from its mentally ill ones; therefore, patients who are temporarily dangerous may be kept isolated from the larger society until they are better, just as patients who are suffering from contagious illnesses may be kept isolated. Society ought to be sympathetic and helpful to its mentally ill members, and this may involve the use of public funds to create proper medical facilities for their care.

The Moral Model

1. Definition or Diagnosis

The primary concern is with the unacceptable behaviour of the patient rather than with his inner experience. Moral models range from those in a religious framework, such as Mowrer's (3), to those with a behavioural or operant conditioning framework, which derive largely

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from the work of B. F. Skinner.* The unacceptable behaviour may be called sin, irresponsible, socially deviant, etc. In any case, this behaviour violates that social agreement which we call the "mores" of a society, and it is the behaviour itself which is the target for change. There is no "illness", and it is a great tactical error to allow the patient, or rather, inmate, to hide behind this convenient label.

2. *Aetiology*

Aetiology is a great mystery in the moral models, unless the patient-inmate comes from a family with similar behaviour, in which case it is probable that he learned it directly from them. However, this is not important; the main thing is to change the behaviour.

3. *Behaviour: how it is to be interpreted*

All behaviour is to be taken at face value; it requires evaluation rather than interpretation. It may be evaluated as legal-illegal, moral-immoral, responsible-irresponsible, socially deviant-socially acceptable, and so forth. It is an error to look for unconscious meanings in behaviour, because one is then by implication excusing it and reinforcing it.

4. *Treatment*

Treatment is at the heart of any moral model. Its basis is that even the most seriously deviant patient-inmate can be made responsible for his behaviour, and it is the task of the staff to find ways of gradually increasing the patient-inmate's responsibility until it is at a level with that of people who live outside the hospital. Treatment may range from simple moral exhortation to the most sophisticated forms of behaviour therapy. First, the patient-inmate is brought within the controlled atmosphere of the hospital. Second, the staff reviews with him those aspects of his behaviour which are unacceptable. Third, the staff outlines some kind of step-by-step programme, usually involving positive and negative sanctions, for gradually altering the patient-inmate's behaviour.

5. *Prognosis*

Initially, prognosis is good. The patient-inmate has been taken into a sanctioning system which is especially designed to alter just such behaviour as he demonstrates. However, if he fails to improve fairly soon, the prognosis becomes gloomy. Either he has stubbornly, wilfully, refused to co-operate, or else the staff has been unable to construct a workable sanctioning system for him.

6. *Suicide*

Suicide is the choice or option of the patient-inmate. It ends once and for all the possibility of further behavioural change.

7. *Function of the Hospital*

The hospital is a correctional institution, different from a prison in that that patient-inmate has broken social rules, rather than laws, and that it is not a punitive institution. Keeping the patient-inmate in the hospital is a negative sanction; he understands that he may leave when his behaviour has sufficiently improved. At the same time, hospitalization creates a special, "total institution" atmosphere in which it is believed that it will be easier for the patient-inmate to change his behaviour than in the outside world.

8. *Termination of Hospitalization*

The patient-inmate leaves the hospital when the staff and the family agree that he no longer displays the unacceptable behaviour which was the cause of the hospitalization.

9. *Personnel*

Practitioners of moral models need to be responsible, moral people. In addition, they must have expert knowledge of the problems of altering undesirable behaviour. While ministers of religion and experimental psychologists might qualify, psychiatrists would not, since nothing in their medical training would give them these skills, and it would be confusing for

* See, for example, T. Ayllon's "Intensive treatment of psychotic behavior by stimulus satiation and food reinforcement", *Behaviour Research and Therapy* (*An International Multi-Disciplinary Journal*). Oxford: Pergamon Press, 1963, 1, 53-61.

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the patient-inmate to be sanctioned by someone whose usual role is to treat the ill.*

10. *Rights and Duties of the Patient*

The patient-inmate has the right to be released from the hospital when his behaviour has reached the standard set for him by the staff and his family. He has the right to be told whether his behaviour is acceptable or not. He has the right to be rewarded for improved behaviour and negatively sanctioned, or punished, for unacceptable behaviour. He has the right to have his behaviour taken seriously and literally, not treated as delusional or wishful. He has the right to suffer while learning new behaviour, and soft-hearted therapists must not deprive him of these rights. He does not have the right to regard himself as "sick". It is his duty to co-operate with the sanctioning system as best he can.

11. *Rights and Duties of the Family*

Families have the duty of bringing their deviant relatives to the staff who are trained in behaviour therapy, because their own sanctioning system has somehow failed. They have the right to expect that the staff will have a better system. Deviant families are not likely to bring their deviant relatives in, as they would have no quarrel with them; such patient-inmates would only be seen by the staff if the community was sufficiently offended by their behaviour.

12. *Rights and Duties of Society*

Society has both the right and duty of imposing extrinsic sanctions, such as incarceration, on individuals whose behaviour violates the social mores. When this behaviour has been rectified, the patient-inmate may regain his membership in the larger society. Society has the duty of providing facilities for such people.

Psychoanalysts and other practitioners who claim to "understand" the so-called mentally ill and physicians who claim to "treat" them are in fact condoning and reinforcing deviant behaviour.

* Glasser, in his book, *Reality Therapy* (New York: Harper, Row, 1965), mysteriously suggests that three years of psychiatric residency are the proper training for his moral practitioners.

The Psychoanalytic Model

1. *Definition or Diagnosis*

There is a continuum of emotional difficulties, from mild neurosis to severe psychosis. The emotional problems of the psychotic are far more severe than those of most people, but they are of the same kind. The exact name of the patient's illness is not important; discussions of diagnosis with the patient or his family are at best a poor use of time, and at worst, an attempt to evade more important issues.

2. *Aetiology*

Aetiology is very important. Theories of aetiology range from those which emphasize infantile (or even pre-natal) emotional experiences to those which focus on successive stages of psychosexual development. Psychotic individuals have either had unusual or traumatic early experiences, or else have failed to negotiate some critical stage of emotional development, or both. Theories about the aetiology of a particular patient's illness are constructed from history-taking, free association, dream interpretation, and other psychoanalytic techniques.

3. *Behaviour: how it is to be interpreted*

All of the patient's behaviour is to be interpreted symbolically; it is the therapist's task to "de-code" it. The therapist makes hypotheses about the meaning of the patient's behaviour, which are constantly revised in the light of new evidence.

4. *Treatment*

The core of the treatment is the individual psychoanalytic hour. How the patient spends the rest of his time is far less significant. The nurses and attendants present a problem, because, unless they understand psychoanalytic principles, they may inadvertently undermine the therapy. This may be handled either by trying to train them to use the psychoanalytic framework, or by strictly limiting their interactions with the patients.

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5. *Prognosis*

As psychosis represents the extreme on a continuum of psychosexual difficulties, the prognosis is naturally much worse than that for neurosis. Psychotic patients usually have very little ego strength, because they were damaged so early and so severely. They may require supportive therapy most of their lives.

6. *Suicide*

Suicide is aggression turned in upon the self. The therapist may be able to prevent suicide by making the patient angry with him, for an angry person is less likely to commit suicide. Ultimately, the patient would have to learn to express his anger directly instead of turning it on himself.

7. *Function of the Hospital*

The function of the hospital is to bring the patient into maximum contact with psychotherapy and with a psychotherapeutic environment. At the same time, hospitalization removes the patient from his home environment where his problem originated, or, in the case of an adult patient, where it is being re-enacted. It may be easier for the patient to work at his analysis if he does not have to use all his energy to cope with the difficulties of his home environment. The hospital also serves to protect the patient from himself, as he might commit rash actions while greatly disturbed.

8. *Termination of Hospitalization*

The patient leaves the hospital, ideally, when he has insight into his problems, which is reflected in his behaviour. Especially important would be evidence that the patient had achieved genuine emotional independence from his family.

9. *Personnel*

The appropriate personnel for working with psychotics are psychoanalysts or psychoanalytically-trained psychotherapists. It is essential that the therapists themselves should have undergone therapy, or some equivalent.

10. *Rights and Duties of the Patient*

The patient has the right to expect that his words and actions will be regarded as symptoms, and not judged morally. It is his duty to co-operate fully with his therapist. He has the right to sympathetic understanding for the difficulties he has had in living in an emotionally unhealthy environment.

11. *Rights and Duties of the Family*

The family ought to seek psychoanalytic treatment for their psychotic patient. Family members ought to co-operate fully with the therapist, which will involve giving a complete history of the patient and of the family. The therapist will probably ask them to limit their contact with the patient, as their presence may interfere with the therapy.

12. *Rights and Duties of Society*

Society ought to be sympathetic with the patient, who is ill because he was not given the kind of emotional nurturance which individuals need in order to attain sane adulthood. While moral censure is to be avoided, the patient is more likely to receive sympathy than the parents, because the seeds of the illness were sown in childhood, and a child is clearly more vulnerable than his parents. Society ought to provide more opportunities for psychotherapeutic training and treatment, and there ought to be more education of families in healthy child-rearing.

The Family Interaction Model

1. *Definition or Diagnosis**

In the illness called schizophrenia, it is the whole family that is sick, not just the so-called "patient". As Meissner puts it, "The fundamental insight of family therapy and the basic

* Mishler and Waxler ("Family interaction processes and schizophrenia: a review of current theories", *The Merrill-Palmer Quarterly of Behavior and Development*, October, 1965, **11**, No. 4, 269–315) distinguish three main schools of family interaction therapy, those headed by Bateson, Lidz, and Wynne. Of the three, only the Bateson group falls entirely within our model; the Lidz group overlaps the psychoanalytic model, and the Wynne group the social model

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premise of family theory is that the family is the basic unit of conceptualization. The patient is thereby only externalizing through his symptoms an illness which is inherent in the family itself. He is a symptomatic organ of a diseased organism . . . " (p. 29).*

2. *Aetiology*

The "index" patient is ill because he has been selected by his family to act out the family pathology. The family is ill because the parents themselves came from families who were similarly ill. It is not clear, or important, how this originated.

3. *Behaviour: how it is to be interpreted*

All behaviour of all family members is symptomatic, including the behaviour of absent members who refuse to consider themselves part of the illness. Of particular importance are actual, current exchanges among family members, which, when analysed for their implicit meaning, may prove to be efforts at "coalition", "evasion", "subversion", and so forth.

4. *Treatment*

Treatment consists of a form of group therapy in which family members are taught to correctly identify the double-binds, ploys, gambits, manœuvres, scripts, etc., of other family members. Therapy breaks up double-binds by means of meta-communicative statements, and also creates therapeutic double-binds in which members are forced to choose new and healthier ways of interacting. Any change in one member will force the others to change, as they will no longer be able to obtain the same responses to their manœuvres.

5. *Prognosis*

Prognosis is good. If young schizophrenics and their families are treated at an early point in the illness, one may expect a considerable remission of symptoms in the index patient and a general improvement in the mental health of the family. The initial improvement in the index patient will be followed by an increase of symptoms in the parents and siblings, but these in turn will yield to therapy.

6. *Suicide*

Suicide can be regarded as a final move in the family game made by a member who has lost the game; the other family members are able to score against him, but he is no longer able to score against them. This member need not be the index patient, so the therapist must watch the whole family for signs that someone is consistently losing the game, and thus liable to commit suicide as a parting shot.

7. *Function of the Hospital*

Hospitals mistakenly play along with the desires of families to maintain homeostasis by extruding one member. Hospitals ought not to accept the index patient as a patient; this simply reinforces family pathology. Theoretically, hospitalizing the whole family would be a better move, but thus far this has been possible only for research purposes.

8. *Termination of Hospitalization*

If the index patient were hospitalized, this would end when the therapist had successfully transferred the definition of the illness to the whole family. Therapy would then take place in the doctor's consulting room, or the family home.

If the whole family were hospitalized, the family would leave when all members could demonstrate that they understood that the apparent illness of one member was really an expression of family pathology. The family would have to demonstrate insight about the patterns of family interaction.

9. *Personnel*

Psychotherapists trained in interactional techniques are the appropriate personnel for treating schizophrenia.

* Meissner, W. W. "Thinking about the family—psychiatric aspects", *Family Process*, **3**, No. 1, March, 1964, 1–40. Lest this be thought an extreme position, or an obscure one, it should be noted that this quotation comes from the leading article of an issue of *Family Process*, the journal which best represents this model.

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10. *Rights and Duties of the Patient*

The index patient has the right to expect that all other family members will agree to being defined as patients and will fully co-operate with the therapy. Each family member has the right to expect that the therapist will treat him as his patient, for they are all patients equally. All family members have the duty of participating and co-operating in their group therapy. Families do not have the right to make a "scapegoat" of one of their members by declaring him mentally ill.

11. *Rights and Duties of the Family*

See No. 10 above.

12. *Rights and Duties of Society*

Schizophrenia can develop in any family which acquires certain types of pathological communication patterns. Society has the duty of providing facilities that will allow families interacting in pathological ways to be identified early and helped.

The Conspiratorial Model

The conspiratorial model focuses on the civil liberties aspects of mental illness. It notes that calling someone crazy is a good way of getting rid of him, and that the staff of a hospital may conspire with or co-operate with a family who wish to do this. This model notes that mentally ill behaviour can be defined in such a way that it will include the understandably frantic behaviour of someone who is not mentally ill, but who is trying to get out of a mental hospital. Certainly, many of the methods of treating mental patients have the effect of teaching them to behave in such bizarre ways that it is difficult to imagine that they could function outside hospital.

The conspiratorial model, in its milder form, calls attention to the fact that patients are often not treated like human beings; their dignity is violated, and this is made possible by the fact that they are defined as mentally ill. This has been Goffman's emphasis (2). Recently, however, a more extreme version of this model has been put forth by Thomas Szasz (6). Szasz says that there is no such thing as mental illness at all, and there should be no mental hospitals. He holds that it is for the individual to decide whether or not he wishes to change his personality or behaviour, and that if he thinks this appropriate he ought to contract freely with a psychotherapist for treatment. Szasz believes that this free contract is essential to psychotherapy, and that involuntary psychotherapy can only be a form of brain-washing. He does not believe that the therapist can represent the interests of anyone but the patient; if he tries to behave as an agent of the society, he will inevitably fail the patient. Szasz fears that psychiatrists may come to wield a kind of social and political power in which they are free to label eccentric, radical or other behaviour as "sick" and set about "treating" it, armed with the laws covering insanity.

At first glance, the conspiratorial model seems to be a kind of moral model in which it is the families, the staff, and the society, rather than the patient, who are immoral, with the patient their victim. In both models there is no illness. But Szasz, the chief protagonist of the conspiratorial model, clearly disassociates himself from the moral model as represented by Glasser in his review of the latter's book (7). His chief objections to Glasser's theory are that Glasser wishes to see the patient in an institution so that the therapist can exert control over his life, and that Glasser fails to distinguish between the moral standards of the therapist and those of the patient. With Szasz, the customer is always right; with Glasser, he is always wrong. Thus, the conspiratorial model sees the society as presently or potentially dangerous to the patient, while the moral model sees the society, through the agency of therapy, kindly, wisely, and firmly re-socializing wayward individuals. This gap seems sufficiently great to warrant the two models being described separately.

The Social Model

A social model is one in which the presence of mental illness is held to be related to the malfunctioning of society. There is a tendency for the holders of this model, noting the shortcomings of any particular society, to conclude that therefore mental illnesses must be becoming more frequent or even greatly increasing. It is

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often thought to be only one of the indications of a "sick society", others being a high divorce rate, juvenile delinquency, increased drug addiction, and so forth. Sometimes it is held that simpler societies, or less competitive societies, have less mental illness than our own. A much-discussed possibility is that because the strains of society fall more heavily on poorer people, therefore more of them will become mentally ill.

Most of the theories under the heading of the social model are the work of epidemiologists, rather than political scientists, and as such are not concerned with a total political analysis of a culture in which mental illness occurs so much as they are with the possible differences of sub-populations and individuals which might make them particularly vulnerable to mental illness. Dunham lists possible factors of this kind as: social isolation, anomie, marginal status, role strain, psychological stress, excessive competition, and culture conflict (1). Recently, the emphasis has been on the family disorganization which occurs as a result of low status and which produces psychological difficulties for the family members (4).

The epidemiological theories are not, so far as we know, directly connected with any practical measures for identifying, treating or rehabilitating the mentally ill, and as such they have no programmatic consequences and cannot be included in our models. But there is a "folk" version of the social model which does seem evident in the daily life of mental hospitals, and this is the vague equation of the mentally ill with the poor. Most patients in public hospitals are poor, of course, and if they were not poor when they entered, they often come to look poor and to behave as if they were poor. Some of the social activities and occupational therapy programmes seem to be designed for people of a generally deprived state, rather than for people who have a specific illness. The hospital may then be seen as a kind of shelter for people who are too battered by life to live outside. If this philosophy creeps into a hospital programme, it may subtly undermine consciously-held programmes for getting patients well and out again. We suggest that programmes which have "poverty" rather than "schizophrenia" as their base should be clearly labelled as such, because the intended goals and possible outcomes might be quite different in the two cases.

Comparing the Models

Until a definitive treatment for schizophrenia is discovered and widely accepted, large numbers of schizophrenic patients are going to be living in buildings called "hospitals" within programmes which have as their theoretical basis one or more of the models described above. How then should we compare the models and the ways in which they are expressed by particular programmes?

It is, of course, possible to compare the models in terms of the evidence which supports or confutes their premises, but this is not our present intention. For the moment, they can all be considered to be "true": schizophrenia is indeed an illness, the behaviour of patients *can* be radically altered with sanctioning systems, schizophrenics *do* have unusual family histories, the families of schizophrenics demonstrably interact differently from non-schizophrenic families, lower class people *are* over-represented in mental hospitals, and the civil rights of mental patients are undoubtedly violated from time to time. It is no accident, then, that all these models exist; they all represent aspects of the truth. Whatever the relative claims of each model may be, we have not discussed them in these terms, because we strongly suspect that objective evidence is not the basis on which the models are accepted or rejected as programmes.

We believe that a model is likely to be accepted when it provides a clear-cut function resulting in a satisfactory job or role for all the participants and when the activities which the model implies do not conflict with the morality of the people concerned. Compared with the question of evidence, these may seem pedestrian or even frivolous concerns, but in fact, no theory, however much evidence exists for it, can be incorporated into a workable programme unless the people who are to carry out the programme understand their functions and are able and willing to perform them. This means that each person's function is capable of being expressed as a series of rights and duties, or, to

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put it more mundanely, as a job description which he or she agrees to and to which he can be held by appropriate sanctions.

It will be evident to the reader that while some models are complete in all our dimensions, others do not seem to be. It is not easy to guess how one would operate a programme in terms of these less complete models, when decisions have to be taken and yet the models give one no guidance as to the correct course of action. One might suppose that models which lack certain dimensions would produce insecurity and confusion among those who are attempting to run programmes based upon them. It would be difficult to decide what actions were right (i.e., moral), so that such programmes would depend greatly upon improvisation and would be liable to become very difficult to run successfully. It is only the presence of an unusually charismatic individual, closely identified with the particular programme, which enables such programmes to continue to function. Bureaucracies require simple and easily understood rules which apply to all situations which their members are likely to encounter; lacking such rules, breakdown will probably eventually occur. Hospitals using the psychoanalytic model, for example, provide elaborate instructions for the psychotherapist and, through him, for the patient, but the instructions for the lower-echelon staff and for the family have been notoriously poor, so that these participants have been forced, by default, to employ some other model.* One hospital, attempting to provide explicit instructions for nurses in the use of the psychoanalytic model, ran into the difficulty that the instructions, while consistent with the model, required a "permissive" attitude which was contrary to the nurses' ideas of right and moral behaviour (5).

Completeness and morality are not the only problems which confront those who neglect to discover what models are currently in use in their particular establishment. The use of different models which have apparent compatibility in some dimensions can be just as harmful, though more difficult to detect, than the use of clearly dissimilar models. The apparently similar models might be used together in a relatively satisfactory fashion until decisions had to be made in which the models suggest contradictory courses of action. Extreme confusion is then liable to occur, for it is improbable in such a situation that those who have co-operated for some time will believe that their premises have always been different. Recrimination will follow, since no one has any way of recognizing why the earlier harmony has been inexplicably shattered. For example, a family bringing their schizophrenic adolescent to a doctor who used the psychoanalytic model might agree to the treatment which was offered, however strange it might sound to them, because "he is the doctor" and he knows what "treatment" is best. But if it should happen that the patient does not progress, the family will be properly outraged at the analyst's suggestion that this is because the family does not really want the patient to get well, or that the family damaged their child so much that he cannot benefit from treatment. It is not consistent with the medical model to accuse families of causing or worsening their patient's illness; it is a working assumption of medicine that families wish their members to be well and will co-operate, providing that they have sufficient information to do so.

* This is nicely illustrated in the novel, *I Never Promised You a Rose Garden* (New York: Holt, Rinehart and Winston, Inc., 1964), in which the analyst disclaims any responsibility for the mistreatment of her patient by the attendants, who, in the absence of any psychoanalytic instructions, use some combination of the medical and moral models.

Summary

In this paper we have called attention to the existence of many non-comparable theories about schizophrenia; we have described six models into which these theories may be sorted, and we have suggested how we might begin to compare the models. We have also suggested that those who employ models may not be aware of doing so, and that it will be beneficial for them to become aware of this commitment. Those who use a particular model need to understand the consequences, intended or unintended, which must arise from its consistent employment. Similarly, if two or more models are being used, it is surely prudent to compare them, dimension by dimension, and so be prepared for the discrepancies that are bound to

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arise. It appears to us likely that those who plan programmes will find it helpful to define them in terms of models and to develop strategies appropriate for those particular models and not deriving inadvertently from irrelevant, or even opposed ones.

REFERENCES

1. DUNHAM, H. WARREN (1965). *Community and Schizophrenia*. Detroit: Wayne State University Press.

2. GOFFMAN, E. (1961). *Asylums*. Garden City: Doubleday and Co. Inc.

3. MOWRER, O. H. (1961). *The Crisis in Religion and Psychiatry*. Princeton: D. Van Nostrand Co. Inc.

4. MYERS, JEROME K., and ROBERTS, BERTRAM H. (1959). *Family and Class Dynamics in Mental Illness*. New York: John Wiley.

5. SCHWARTZ, CHARLOTTE GREEN (1957). "Problems for psychiatric nurses in playing a new role on a mental hospital ward." In: GREENBLATT, MILTON, LEVINSON, DANIEL J., and WILLIAMS, RICHARD H. (ed.) (1957). *The Patient and the Mental Hospital*. Glencoe: The Free Press.

6. SZASZ, THOMAS S. (1963). *Law, Liberty, and Psychiatry*. New York: The Macmillan Co.

7. —— (1966). "Equation of opposites." *The New York Times Book Review*, Feb. 6, 1966.

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