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Conversations With Chronic Schizophrenic Patients

By ROGER MORGAN

SUMMARY An account is given of some of the topics discussed during a small informal weekly open group meeting of chronic schizophrenic patients, based on occasional notes compiled over eleven years. The main feature of the patients' condition as displayed was poverty—clinical, social, behavioural, material and financial—and certain features suggested an organic aetiology. Reasons are given for considering that the patients' condition was predominantly caused by schizophrenia rather than by institutionalism.

When it opened in 1961 as a regional psychiatric rehabilitation hospital (Morgan, Cushing and Manton, 1965), St Wulstan's adopted a system of twice weekly staff-patient meetings copied from those at Netherne Hospital (Bennett, Folkard and Nicholson, 1961). In the quarter of the hospital considered here and known as Blue Unit there is a formal large group meeting of some 40 to 60 people on Mondays at noon and four separate informal small group meetings on Wednesdays at noon, each conducted by a doctor or nurse. I have attended one of the small group meetings ever since. In 1967 I started to make notes, either during the meeting or immediately afterwards, if something interesting had been discussed. Eleven years later, I have notes on 70 out of about 500 meetings, and those notes form the basis of this paper.

The small group which meets on Wednesdays is an open group whose membership slowly changes. Attendance is expected and encouraged but not compelled. It makes patients half an hour late for their mid-day meal a delay which some cannot abide. Of about 18 eligible to come at any given time, about 6 to 15 usually do, the number dwindling erratically over the years. (We tried holding the meetings after lunch and more patients did come, but half of them went to sleep.)

A total of 25 patients have attended altogether. Some came for a few months, the average was four years and the oldest attendant (apart from me) is Harry who has clocked up nine years. They are the most severely disabled patients in this hospital.

They were a highly-selected group with three definable stages in the selection process. Firstly they fell ill years ago, entered conventional mental hospitals, received custodial care, and despite the introduction of phenothiazines they stayed in hospital as representatives of the 'old long-stay'. Secondly, they were submitted to me by their parent hospitals and accepted by me as suitable candidates for further rehabilitation with a chance, however slim, of managing one day to dispense with sheltered living conditions. Thirdly, after selection and transfer to this hospital they had shown a disappointingly limited capacity for improvement and were relatively more severely and intractably disabled than the rest of our intake. After an average of nearly four years in this hospital they had gravitated to Blue Unit, which is the section of the hospital reserved for patients of this type. Even so, they were not as disabled as chronic patients can be; for example none of them was incontinent or required help with feeding.

Apart from one inadequate epileptic and one leucotomized obsessional neurotic, they were all schizophrenic and very chronic. Six patients were women. The average patient (± S.D.) was aged 47 (± 8 years) on accession to the group and had been ill for some 21 years (± 9 years), most of that time being in hospital. Twelve patients showed moderate clinical disability (Wing, 1961) and the other thirteen

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were severely disabled, eight of them being nearly mute, three floridly deluded and two prone to incoherence. Their average score for Social Withdrawal (Wing, 1961) was 3.6 (± 1.7, range 1–8) and their average I.Q. was 75 (± 15, range 50–104), though only one had been mentally retarded (and only mildly at that) before acquiring schizophrenia. In terms of their fathers' occupation, only three are known to have had a middle-class background, and these all broke down young and never worked; the remainder were working-class in origin and in occupation. Every schizophrenic patient was on appropriate antipsychotic medication under regular review, several having been tried without and become worse mentally.

The topics discussed by the group are presented under the headings which follow, but these overlap considerably. Frequencies are difficult to present, the group being unstable in size, so when relevant I have worked out percentages and adopted the following convention:

Percentage	*Noun/Pronoun*	*Adverb*
0	none	never
1–20	few	rarely
21–40	some	sometimes
41–60	half	often
61–80	many	usually
81–99	most	mostly
100	all	always

Daily life

The patients said that they told which day of the week it was by such things as predictable items on the food menu, ('fish and chips means it's Friday'), pay-day etc. Half the patients could not say how to distinguish one day from another, beyond recognizing that working days were week-days.

Most patients reserved their greatest interest for food, money, smoking and sleep. All agreed that bacon made the best breakfast. Chicken was the most popular meat. All evening meal dishes were popular except spaghetti. Fish and chips was many people's favourite. Most patients expressed decided views with unusually clear answers and I quote these views as an indication of the level at which their minds were fully engaged.

Most patients knew the amount of their weekly earnings (these fluctuated, being piecework), but few could contend with the notion of their average earnings, which appeared to be an abstraction that was beyond their grasp. Half made their income last the week, others were broke within two days or more. A few spent nothing and saved the lot, but without any aim in mind. Most money was spent on consumables, especially cigarettes, tea, sweets and beer. Only a few of these patients ever bought extra clothes or other possessions. Only some of the patients had any savings apart from small sums in their hospital accounts. All denied being in debt, but a few commonly were.

We discussed smoking often, but never did they show so much resentment about anything as they did after the 1977 Budget when the tax on 20 cigarettes went up 4p. Most patients were smokers, and each favoured his particular brand. Yet all were vague about the price and expressed it in shillings and pence even though these had been replaced by decimal currency six years earlier, and all had had repeated instruction in the mysteries of the new system. None admitted that they knew smoking was harmful, though every cigarette packet says so and I had often told them. Ignatius, who gets severe recurrent bronchitis, gave a knowing smile and withdrew from the discussion by sliding into incoherence.

Most of these patients went to bed very early in the evening and therefore had little leisure time (see below). They showed quite unusual determination to have their own way about this but could never satisfactorily explain why. This was the group at its woolliest, but it could be very different. When I asked each of them to name his or her partner on the ward washing-up rota, I got prompt accurate answers with several terse comments on the partner's performance and reliability.

At one time of asking, all possessed a comb except Bernard who used to borrow Harry's. Some had a hairbrush, some had nail scissors, many claimed inability to use scissors (which I found a surprisingly large proportion) and either prevailed on staff to cut their nails or

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resorted to biting them. When provided with scissors or clippers they had lost them. Many had toothbrushes (and Brendan indeed had four), but some indicated that cleaning their teeth was right outside their curriculum and always had been, so a toothbrush was unnecessary. Brendan wore a watch, Joe owned one but did not wear it, Bernard had recently lost his for the second time, and Albert had possessed a series of two and lost both. Many patients neither had a watch nor admitted ever having had one in their lives.

In very hot weather we would often discuss suitable clothes to wear. One or two of the more alert men, as well as myself would be in shirtsleeves and the women would be in summer dresses, but the rest of the men would be wearing jackets and thick pullovers, shirts, and vests, just as in mid-winter. It made them sweat but they always denied 'feeling hot'. Nothing short of compulsion would make them change their habit.

It was the same on hot summer nights. Adaptable Arthur had removed all his bedding except one blanket. All the other men had one sheet three blankets one counterpane and thick winter pyjamas with vest and pants on underneath. All said they were comfortable, not too hot, and slept soundly without waking up; all except Ted, who volunteered that he found it agreeable to poke his feet out of the sides of the bed to cool them off. Their behaviour put one in mind of young children who have not yet learnt to identify the cause of their discomfort or to take appropriate action if overheated. Their flushed appearance argued against the possibility that phenothiazines were lowering their temperature.

Another childlike characteristic of the group was the inability of many members to understand slang or figurative expressions, whose meaning they tended to take literally. This led us (Cheadle and Morgan, 1972) to devise a questionnaire and test a sample of 90 patients the level of whose understanding corresponded to that of 8 to 9-year-old children. We thought that this failure of comprehension might be part at least of the explanation of their frequent inertia in response to advice or instructions (Cheadle and Morgan, 1975) or indeed throughout everyday life.

Personal history

Half the patients gave their present age correctly; the other half were either wrong in either direction or, though numerate, had no idea. All knew their own birthday, but some did not know their year of birth. All but a few knew their birthplace accurately. Nobody knew the birthdays of both parents; a few could remember one parent's birthday. Most could remember their father's occupation. Half knew roughly the age to which their parents lived, but the other half could give no idea. Only some knew their own age (even approximately) on first admission to a mental hospital, important landmark though this was in their lives.

Some had served in the Forces during the war (illiterate Harry and flat-footed George in the Pioneer Corps and Ignatius from Belfast who had 'joined up in the Irish Free State Army and deserted'). The others were either too young or already in hospital.

Jim had been taken as a child on a family visit to London, and Albert had gone on a school outing to see the Wembley Exhibition, but none of the others had ever been to London. Of those whose home was not in Birmingham (our nearest city) none admitted to having ever visited the place, and Gladys asked 'Where is Birmingham, is it near Wolverhampton?' Only one patient, a doctor's son, had ever been abroad.

Orientation

Some items already recorded (e.g. present age) are to do with orientation in the sense of self-image and personal identity. The small group setting also lent itself readily to examining the patients' knowledge of other people's identity. Much time was spent by the group on this topic, leading me ultimately to carry out a formal study (Morgan, 1967) on a sample of 68 patients. Compared with 29 controls, the patients performed poorly at naming other people from their photographs, and even worse at naming them from descriptions. The schizophrenic patients were poorer performers than the others, lacking curiosity to discover names

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in the first place, and appearing also to lack the normal capacity in their memories to keep in store those names they had learnt. In the group it was no insuperable handicap if they could not name people present (who were by definition wardmates or workmates and usually both) because if need be they could and did resort to pointing. But if they or I wanted to refer to anyone not present and they did not know the absentee's name it meant that communication effectively ended at that point. It was surprising at first to find out the extent to which social intercourse is prevented by the lack of a name as a tool of communication. We found no way of helping these patients to overcome this handicap (Morgan and Jones, 1968). It arose apparently in large part from schizophrenic withdrawal, and once acquired it certainly was a factor in maintaining and reinforcing the withdrawal, as presumably the schizophrenic intended it to be.

Orientation in time and place were also disturbed. In February 1977 we made a game of each trying to remember our situation exactly 25 years earlier at the time of the Queen's accession. At other meetings we tackled 12 years ago and 30 years ago. Some patients were wrong (or had no idea) over the 12 year span, and half the patients were wrong across 25 and 30 years, but no comparison is valid because the composition of the groups was different. Common to all three exercises was the patients' approach to the problem set them. A few dealt with it perfectly capably as healthy people would, either by just knowing or by using their age at the time or other landmarks to draw inferences and work it out. But for many there was a poverty of events, landmarks etc. in their past lives, or their memories were very poor and they lacked the mental ability to use such as there were.

Once I confronted them with a large framed aerial photograph of the hospital (which consists entirely of single-storey huts). We spent some time re-arranging ourselves out of the usual circle to get a proper view and adapt to its unfamiliarity. They were unusually interested and attentive. A few grasped the idea and gave near-perfect answers to simple questions. Some had an inkling and were occasionally right. That left many who were quite lost, made wild guesses, failed to perceive the pattern at all, or gave up before they had started.

A similar lack of verbal and other ability made Charlie appear totally incompetent at one meeting. He had graduated to becoming a day patient and he was asked to describe his lodgings and his journey to the hospital. He did not know the name or number of the house, the name of the road or the name of the district where he lived. He could not name the three people with whom he shared a room. He could not say the time when he had to set out, or the place, time or number of the bus he caught in the mornings. Nor could he describe in any way the succession of three buses that he had to catch to get home at night, or where he had to get off the final one. Any clinician relying only on the patient's answers to questions would have been bound to regard him as showing no evidence of correct orientation. Yet he had coped perfectly for two years with a five-mile journey to and from the hospital by public transport.

General knowledge

One topic that was invariably unpopular with the group was current events. They signified their hostility by yawns, resigned-looking grins, and silence, thereby generating considerable group tension and discomfort. Whatever their reason (and, of course, they would not say) their displeasure served to make current events a rare topic since one recorded meeting in January 1968. It was an eventful month and I had no difficulty in listing in advance ten items of news as a checklist. The well-informed Ted knew vaguely about U.S.S. Pueblo being captured, about the previous Saturday's F.A. Cup third round results, and about the train robber Wilson being caught. The burly Cyril, with his reputation for getting the wrong end of every stick, had heard this last item and told us that Prime Minister Wilson had been sent to goal. No other patient had anything spontaneous to contribute. Yet they keep the radio on all day, or so it seems, and some watch television, and there are newspapers in each ward.

Only George had watched any of the 1968 Olympic games, and his account of what he saw was typically fragmentary ('running, swimming,

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weight-lifting'). Gladys and Ignatius had seen some of the 1974 Commonwealth Games and described them just as above with no grasp of different events, distances, countries individuals etc. Ignatius said 'It's not so real on TV'.

Football and boxing made better talking points because of the relative simplicity of the results, and interest was shown every year in the outcome of the F.A. Cup Final. But nobody who watched it could describe what they had seen, and even the soccer fans were completely confused by the complexities of the 1978 World Cup.

They showed no evident sign of political awareness, but they were prepared to commit themselves on clear-cut political issues. They divided 8–6 against the Common Market in 1971. Before the 1970 General Election they recorded (unofficially) five Labour, three Conservative and two Liberal votes and agreed with most other commentators in predicting a Labour victory, wrongly as it turned out. In February 1974 a slightly different group showed a definite swing to the right with nine Conservative votes to four Labour and one Liberal; and by 8 to 4 with 2 abstentions predicted a Conservative win, again wrongly.

Social skills

All patients had an individual issue of personal clothing. The hospital would make good any shortages that occurred in time through clothes wearing out, getting lost etc. It was the patient's personal responsibility to take care of his stock of clothing, enter in his laundry book whatever items he sent each week, check them on return, and tell the staff if he required any replacements. Whenever I enquired, it was rare to find a man with more than two pairs of socks or a woman with more than two pairs of stockings or tights. They would let the original issue of six pairs dwindle to two or even less before doing anything about it, if then. The same applied to handkerchiefs. It was hard to believe that some patients had ever met a handkerchief before coming into hospital; they would put a brand new white one into their jacket pocket and leave it there until it eventually became so grubby that it was really only fit to destroy. They would fail to send laundry at all, send it but fail to record it, lose it (some became notorious for their speed at losing whatever they were topped up with) and a small few would sell the more marketable items like shoes for cigarette money.

I took a telephone directory to one meeting and invited each of them to look up a named person's number. Nobody managed it. Few had ever used a telephone in their lives outside (or inside) hospital. None admitted having earlier attended special classes here to learn this and other skills. Some claimed to know how to use a directory. Ted said 'alphabetical order' and Sid recited the alphabet. Irene, who claimed to know, was persuaded to have a second try and proceeded as follows. She leafed randomly through the pages, eventually finding the right initial by accident, went beyond the name, didn't know how to turn the pages back, gave up, was helped to the right page, looked randomly, gave up, was shown the correct column, gave up, was shown the actual name, read the number from the wrong line, gave up, tried again, read the wrong number, gave up, tried again, read the right number, was asked for the exchange, gave up, was reassured and gave the exchange correctly. She and the taciturn Sid who did equally badly were the best in the group.

In October 1973 I started asking about the patients' plans for the forthcoming Christmas. Two patients had homes and went there regularly, so had no problem. Five patients had no homes to go to, so would have to spend Christmas in hospital. That left four patients with a possibility of going somewhere if only they set about asking their relatives in time. So I asked them to do that. Gillian responded by not coming to the next two meetings. Harry got his Charge Nurse to write for him. After one week Derek and Alf had done nothing. After two weeks Derek, perfectly capable of writing, had conned an inexperienced nurse into doing it for him. Alf had still done nothing about it; in his passive dependent apathetic but likeable way he seldom grasps why on earth it is ever up to him to do anything for himself.

Another time, three years later, with only four patients in the group, it was ten days before Christmas and we talked about sending cards.

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Alf had excelled himself (or was it the change to haloperidol?), had bought two cards weeks ago and had already sent them to his mother and brother. Gladys had found the canteen sold out and was too sluggish to go out to a local shop, so she had written a letter to her cousin explaining why she was unable to send her a card. George had not sent his brother one but promised to think about it, which is George's invariable way of telling any intruder to get lost. Ignatius, the bronchitic soldier, had not done anything this year but was quick to point out that he had sent his family a card last year, very much with the air that that should be quite enough for them to be going on with.

Leisure interests

Many of the patients were able to recall having leisure interests in earlier life before they fell ill. Altogether in four different meetings they listed sixteen different former interests. Only the one neurotic patient kept his particular interests alive. Harry from Stoke on Trent knew the name Gordon Banks well enough but did not realise he was Stoke's goalkeeper; actually he supported Port Vale but knew nothing about them either. Ted, the boxing enthusiast, knew all the names from 1935 to 1945 but nothing about recently televised bouts or current world champions. Brendan, the collector of stamps and toothbrushes, could be persuaded to glance through his albums but lacked the drive to do more. In a way these men in their forties and fifties reminded one of elderly gentlemen 20 or 30 years older reminiscing about the past.

Television could have provided them with the way to keep up to date, but they lacked the ability to use it. None disliked it for either rational or delusional reasons. None viewed it selectively, though programme times were readily available in magazines and papers. It is uncertain how much they grasped of what they did watch, for few could string together a coherent account of what they saw (the same applied to films). The few who claimed to be interested in particular programmes (Coronation Street, Opportunity Knocks) could rarely say the day, time and channel for viewing them. Few of the patients in the group would consider watching anything that started after about 7 p.m. because of their self-imposed compulsion to go to bed about that time if not sooner. They taught me how powerful this compulsion is and led me to carry out formal studies of their sleep pattern (Morgan and Drew, 1970) and body clock speed (Morgan, 1977).

At Christmas, Easter and Whitsun they would face three or four consecutive days off work and I would often ask them beforehand about their plans and afterwards about their achievements. A few would be at home on leave, another few would venture forth once to the shops, another few would go on a hospital organised coach trip, and Harry could be relied on to go every morning to the local pub for a skinful. The remaining half would do absolutely nothing. They welcomed a holiday from work but had no idea what to do with it; alternatively, if you like, they knew exactly what they wanted to do with it—nothing. They resented my efforts to stimulate them into activity and usually reacted with mute hostility. The only time that Mary, normally placid, got angry with me was on this subject. I realised, and sympathized with, their lack of unlimited money, of transport and of family or friends to prompt them into activity. But if all else failed the Malvern Hills were easily accessible and free. Some had been taken up the hills once or twice by a visiting relative, Jimmy had walked up by himself but never left the road and a few had been taken in an organised party. That left many who had never in several years felt inclined to go.

They all went for one or two weeks holiday to the seaside. One time in 1973 four members of the group went together as part of a larger party, and on their return I got them to describe what happened. They all travelled, ate, slept, smoked, drank tea or beer, and walked up and down the front. For the three men that was all, and they looked on it as a perfectly satisfactory and complete holiday. They did not swim or even paddle. They bought nothing to bring back and remember the holiday by. They went on no sightseeing trips. They went to no shows or pictures. They did not even play Bingo. Gillian was more enterprising, though leucotomized and still psychotic. She went to a show with two other patients and she bought

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herself a handbag and a nightie. She did not know the other patients' names. Nor did Alf know the name of the man he chose as his companion all the week; he looked on it as a piece of unnecessary knowledge since they never spoke to one another.

Discussion

This has been a very unsystematic account of some aspects of mental hospital life as seen and lived by a small highly selected group of very disabled (and almost entirely) chronic schizophrenic patients. Despite their disability 11 of the 25 patients have at some time achieved discharge from here, but 6 have subsequently had to be readmitted, and another 2 (Cyril and Ted) have subsequently died leaving only 3 (Brendan, Mary and the pyknic Desmond) who in 1978 are continuing to survive outside hospital. As a group, therefore, they are more disabled than those patients who are capable of more permanent resettlement from this and other hospitals; and they are somewhat less disabled than the many thousands of patients in other hospitals whom I would consider too disabled ever to accept for transfer here. Severe as the cognitive and other defects of this small sample were, it is likely therefore that the cognitive and other defects of the typical long-stay chronic schizophrenic patient in a conventional mental hospital are even more severe.

It would be a mistake to picture my 25 patients as having just emerged from a restrictive custodial regime. They were transferred to this hospital from other hospitals in the West Midlands Region between 1961 and 1972, and in many of those other hospitals active rehabilitation and a better quality of care had become available before and during that period. Nor, of course, did they enter the small group immediately on admission to this hospital; on average they entered it nearly four years later, having been exposed here to a rehabilitation regime that was as intensive as we could make it (and as they could tolerate) during that interval. Some of the stimulant ingredients of the regime have already received incidental mention—the full work programme, piecework payments, various instructional classes, individual clothing and laundry, promotion of leisure activities, travelling, shopping, summer holidays and indeed the small group meetings themselves. It was only after an average of nearly four years of all this (and more) that the patients' responses and performance in the small group began to be recorded.

The various disabilities I have described amount, therefore, to residual disabilities still present after a long and intensive course of rehabilitation. Barton (1959), referring to Institutional Neurosis, wrote 'The condition may be indistinguishable from the later stages of schizophrenia. Often it is complicated by residual schizophrenic features such as delusions or hallucinations. In such cases the diagnosis can only be made retrospectively after subjecting the patient to an intensive course of rehabilitation'. If Barton is correct what my patients demonstrated was chronic schizophrenia in a relatively purified form after removal of any removable admixture of institutionalism.

Despite what had already been done for them, many remained severely disabled. The persistent deficits in their comprehension, orientation and memory, the strong suggestion of a decline in I.Q., their crippling dysphasia, and the way they could handle only concrete rather than abstract terms, were features that suggested an organic aetiology (cf. Crow and Stevens, 1978; Johnstone *et al*, 1976). The keynote of their various disabilities was poverty. There was evidence in most cases of social, cultural and material poverty in their original upbringing. Clinically, there was poverty of intellect affect and volition. This showed in their behaviour in a lack of curiosity, initiative, ideas interests, plans, ambitions, activity and articulacy. They were all unmarried, and though several had surviving relatives they almost all lacked close family ties and support. They had comparatively little money, few possessions and no friends.

The foregoing generalizations apply more or less within narrow limits to all 23 chronic schizophrenics and to the one inadequate epileptic patient. Except that he too is unmarried, none of them applies to the one leucotomized neurotic patient, although his history and length of stay are both long. Although I can produce data relating only to these

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25 patients, they are not, of course, the only patients whom I have known for a long time. In patients outside this small sample I find the same features as I have described within the sample. The non-schizophrenics tend not to be disabled in the way described. Those paranoid schizophrenics whose personalities remain more or less intact resemble non-schizophrenics in this respect. It is only in my experience those schizophrenics whose illness is either more severe or of a different kind and in whom a process of mental disintegration occurs who develop the various disabilities described here.

I take the above factors to be evidence, (strongly suggestive but not conclusive) that the disabilities described are due to schizophrenia rather than institutionalism. I anticipate, therefore, that the current community-orientated style of managing such illnesses will result in such chronic schizophrenic patients becoming no less disabled outside hospital after a similar length of illness.

Another school of thought appears to expect community treatment to abolish chronic schizophrenia. If its members are right then production of such disabled people as I have described is going to stop or has already stopped. In that event it would be as well to have a description of them on historical record before the last of them disappears. When put in that way I doubt if such an optimistic outcome sounds credible to anyone with close knowledge of chronic schizophrenia.

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