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The Social Breakdown Syndrome and its Prevention

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THE SOCIAL BREAKDOWN SYNDROME AND ITS PREVENTION

The social breakdown syndrome (SBS) is the name given to certain features of psychiatric patients' deterioration. It is a useful concept because it specifies those features of patient functioning, especially extreme withdrawal and aggressive behavior, that become less common when new systems of delivering psychiatric services are introduced.

The social breakdown concept emerged from experiments with new psychiatric service delivery systems. Evaluation research of a later demonstration of this new psychiatric service delivery system in Duchess County, New York, developed it further.

This chapter traces the concept's evolution, beginning with the early open hospital systems, started in some communities during the late 1940s, and shows its evolution and elaboration up to the present. As our experience and knowledge grow, our thinking about the social breakdown syndrome changes. Less than half the social breakdown syndrome episodes occur in people with schizophrenic disorders, the others being scattered among a wide variety of diagnostic groups. (See Table 47-1.) Social breakdown syndrome's distribution in the population differs markedly from that of schizophrenia. (See Chapter 30, "The Epidemiology of Schizophrenia.")

The Open Hospitals

In August 1954, Dr. T. P. Rees (Warlingham Park Hospital, Croyden) and Dr. W. S. Maclay (British Board of Control) reported[1] on how three open hospitals functioned in Britain, impressing many American psychiatrists who were present. The practical experience of these three programs in the community care of the severely mentally ill was accompanied by a remarkable lessening of the severe chronic troublesome behavior and extreme chronic withdrawal of mental patients. Psychiatrists previously had assumed that these phenomena were owing to certain severe mental disorders rather than secondary complications, which could be avoided by reorganizing the delivery of psychiatric services.

These three experiments started by trying to give patients with severe mental illness more humane care. Locked doors and physical or chemical restraints were used less, and short voluntary hospitalizations for short-term indications, more, and the emphasis was on the long-term availability of services while chronic patients lived in the community. The three mental hospitals, serving well-defined populations, carried the direction of change so far that their medical staffs were devoting half their time to patients who were out of the hospital, all the mental hospital wards were unlocked, and very few admissions used legal constraints. Patients rarely stayed more than two to three months following admission, and the hospital census was falling

despite a greatly increased admission rate. (During the same period, mental hospital censuses were rising elsewhere.)

Patients' behavior as a whole had, to the surprise of the directors, taken on a different appearance by the time the programs had reached that point. The chronically disturbed (suicidal, assaultive, destructive, or soiling) and the chronic severely withdrawn patients (mute, self-neglectful, staring, regressed) became extremely rare.

Notions regarding what causes symptoms in severe mental disorders required reexamination. Since treatment reorganization led to large-scale disappearance of severely disturbed or withdrawn behavior, some of the disturbed behavior appeared to change when staff-patient relations were modified. Hence, a secondary, sociogenic syndrome of severely disturbed behavior was postulated and became known as the "social breakdown syndrome." Earlier thoughts along the same line had not carried the idea so far.

Only when three pioneer services had transformed the psychiatric care for entire communities into the new pattern of community care, interrupted by short-term hospital treatment in open hospitals with minimal legal restraints, did the large-scale change in patient functioning become obvious. This occurred during the early 1950s. The three pioneer services were those

of G. Bell (Dingleton Hospital, Melrose, Scotland), T. P. Rees (Warlingham Park Hospital, Croyden, England) and Duncan Macmillan (Mapperley Hospital, Nottingham, England).

The New Delivery System

Macmillan, writing in 1957, described how the integration of locally operated services and mental hospital services in Nottingham, England, began to become unified in 1945. Through "a policy of continuity of care" the

social worker who first saw the patient in the community continued to see the patient in the hospital, took part in the arrangements for employment and return to the home, and then paid the aftercare visits upon the patient's discharge. The medical member of the hospital staff who first saw the patient either at the outpatient clinic or on a domiciliary visit to the home usually carried out the inpatient treatment and then arranged to see the patient at his aftercare clinic.

By 1952 this integrated system was operating in a city where the only mental hospital (Mapperley) had given up all locked doors and all forms of physical restraint.

We make every effort to treat the patient as a personality and to maintain and restore his self-confidence. We go to great lengths to obtain his

cooperation . . . admission has to be repeated . . . but the end result with this repeated form of treatment is very much better, and the patient then adjusts to life in the community.

Table 47-1. Clinical Diagnoses[a] of the 139 Prevailing Social Breakdown Syndrome Cases,[b] Ages 16-64, in the Duchess County Study Population[c] and Their Status as Inpatients or Outpatients at the Time of a 1963 Point Prevalence Survey

N	DIAGNOSIS	IN HOSPITAL	OUTd
72	Schizophrenia	57	15
11	Psychoneurosis	3	8
8	Psychosis due to circulatory disturbances	6	2
7	Psychosis with mental deficiency	6	1
5	Psychosis associated with organicity	4	1
4	Involutional psychosis	1	3
4	Alcoholic psychosis	3	1
4	Other nonpsychotic disorders	1	3
4	Psychosis due to epilepsy	4	—
4	Alzheimer's	3	1
3	General paresis	3	—
3	Psychosis with psychopathic personality	1	2
2	Manic-depressed psychosis	—	2
2	Psychosis or personality disturbance due to trauma	2	—
1	Conduct disturbance	1	—
1	Presbyophrenia	1	—

1	Psychosis with epidemic encephalitis	1	—
1	Psychosis due to intracranial neoplasm	1	—
1	Paranoid condition	1	—
1	Undiagnosed psychosis	—	1
139	Total	99	40

a Diagnosis categories are listed in the New York State Condensed Form of New Classification as approved by the American Psychiatric Association council and used in the New York State hospitals during 1963. Diagnoses were obtained from clinical records.

b Data-gathering methodology is described elsewhere.

c The population ages sixteen to sixty-four was approximately 100,000 people.

d "Out" means in the community, including family care.

Many symptoms that made unlocking wards difficult disappeared. They had been regarded as due to the psychosis but terminated with the removal of restrictions. "No proper staff-patient relationship is possible," until legal certification is removed. It causes the community to regard patients as people apart, different from other human beings.

The resentment and the feeling of injustice which certification causes in the mind of the patient is intense and it lasts for many years. When patients are in a state of emotional upset, when their self-confidence is already seriously undermined and disturbed, to deprive them of civil rights, depletes that stock of self-confidence even more at this critical phase of their life. One

can hardly imagine anything more likely to upset them. The depressed patient becomes more depressed. The delusional patients become more fixed in their reactions and consider that they have justification for them. Withdrawal symptoms become more pronounced.

This system had become fully operative before the phenothiazines and the new group of psychotropic drugs had been discovered. Like some other important advances in medicine and public health, the realization that more could be done to help psychotic patients control their disturbing symptoms through new methods of psychiatric service organization came to this country from the other side of the Atlantic, a process that was facilitated by the World Health Organization and other international health organizations.

The Social Breakdown Syndrome Is Named

As Alfred Stanton stated, perhaps the fact that it was named by a committee reflects the social mechanisms by which this preventable complication of mental disorders became recognized. The American Public Health Association's Program Area Committee on Mental Health stated in 1962:

There is one type of mental malfunctioning which occurs in many different chronic mental disorders, particularly schizophrenia, mental retardation, and various organic psychoses. It is responsible for a very large

part of the institutionalized mentally disordered; it is responsible for much of the other forms of extreme social disability seen in these illnesses. This form of mental reaction in the presence of mental disorders is largely a socially determined reaction pattern which the committee believes can be identified as a major target for community mental health programs today . . . this particular reaction . . . came into sharp prominence because of its great commonness and its sensitivity to improved organization of services. It has not had a name in psychiatric literature in the past. In the absence of a better term, it is called "The Social Breakdown Syndrome." ... It is necessary to have a term to describe what one is talking about when one has found something so worth describing. It is largely because of current successes in dealing with this syndrome, it is believed, that for the first time in two generations the census of patients occupying beds in mental hospitals has started to decline in the English-speaking countries.

Many mental disorders, particularly the psychoses (both "functional" and "organic"), are frequently accompanied by distortions of personality function which are associated with more or less severe destruction of the affected person's social relationships. These reactions can be viewed as following one of three patterns: (a) withdrawal, (b) anger and hostility, (c) combinations of these two.

Withdrawal is manifested by loss of interest in the surrounding world,

sometimes accompanied by intense preoccupation with an inner phantasy life. As patients withdraw in this way they lose interest in social functions such as work responsibilities, housekeeping functions, and ordinary social obligations. Interest in personal appearance, dress, bodily cleanliness and toilet also decline. In the end comes the standard picture of the deteriorated, dilapidated, unresponsive, soiling, helpless, vegetative creature who in former times inhabited our mental hospitals' backwards.

The pattern of anger and hostility is manifested by expressions of resentfulness, quarrelsomeness, and hostility. When more advanced along this path the patient may accuse others of intent to harm him and become physically aggressive and assaultive. He may turn his wrath upon physical objects and become destructive of windows, furniture, or household fixtures; or his wrath may become directed at himself and this may lead to self-mutilating activities or outright suicide.

In those instances where the pattern pursued mixes tendencies to withdraw and tendencies toward hostility and anger, combinations of the features of both paths may appear. In addition, there is a way of withdrawing aggressively by distortions of the usual responsiveness to other people, for example, by stubbornly echoing whatever anyone else says, by assuming bizarre poses of body position or speech patterns, by odd gesticulations, and so forth. These modes of response avoid the "non-responsiveness" of pure

withdrawal and the overt expressions of resentment such as cursing and striking out, while effectively preventing real personal contact and indirectly expressing resentment or enmity.

The Duchess County Experiment

Experience had shown that the chronic social breakdown syndrome's frequency depends upon the social setting and the way other people and social institutions and medical facilities respond to the underlying disorders. The first U.S. program to implement these ideas in the post-drug era was launched in Duchess County, New York, in 1959.

Dr. Robert C. Hunt, then director of the Hudson River State Hospital, stated during 1959 that "our present methods are not very effective in preventing or curing the psychotic illnesses, but we do now have the tools to attack the associated disability. We can relieve much of the disability which has already occurred; we can prevent its future occurrence and minimize its extent." He pointed to

a tradition in our society of almost automatically hospitalizing persons with psychoses; also a tradition and current practice of not using community psychiatric facilities for the seriously ill. It sometimes appeals that the richer a community is in its health, welfare and psychiatric facilities—as in large metropolitan centers—the more difficult it is to bring them to bear to help the

seriously ill person.

These factors were considered first even though “Hospitalization as such is among the causes of disability. This is especially true of the traditional, highly security-conscious hospital.” What was needed was “flexible continuity of care for the individual patients” by undoing “specialistic compartmentation,” which fragments patient care.

The major hypothesis to be tested in this pilot program is that chronic hospitalization and disability can be reduced by supplying the population with a comprehensive psychiatric service based upon a small community-oriented, open public mental hospital so organized that there is maximum continuity of care over both inpatient and outpatient phases of treatment.

It was implemented by organizing what is now the oldest geographically decentralized county unit in a state hospital. “This is simply a new method of organizing and administering present services with nothing particularly new in the services themselves.” The one new function, which is pre-care, is an emergency psychiatric consultation service to the community.

Those who commonly initiate moves toward hospital admission, such as physicians and police, are encouraged to first give us a call when they have a patient for whom admission is contemplated. A consultant can often give better service to the patient without hospitalization, by recommending

certain treatment measures to the family physician, by referral to a psychiatrist or clinic, by placement in a nursing home, or by admission for day or night hospital treatment . . . patients who are admitted for full-time hospital care will, through this advance medical contact, have a healthier relationship with the staff and make greater use of voluntary admission procedures.

It was hoped that this reorganization of services would result in less long-term hospitalization and less chronic deterioration.

The Research

The prevention of long-term hospitalization was to be achieved through encouraging the reorganized system of psychiatric service delivery to release patients before full recovery and to maintain these patients in the community unless need for rehospitalization would initially become less common through the shift in policy. If long-term hospitalization was not reduced in frequency, it would be postponed. In any case, its measurement presented no problem, and in fact it did become less common.

The measurement of long-term deterioration presented much more difficult problems. First, since the mechanism for preventing long-term deterioration included encouragement of early releases, it was necessary to plan studies not only on patients currently in hospital but also on all former

patients. Second, deterioration, though a dramatic enough phenomenon when observed in the mental hospital, was not clearly and objectively defined.

In order to execute that aspect of the research, lengthy discussions were held with those who had faith that the new system would make a difference in deterioration. Their ideas regarding deterioration could be broken down into two general areas: disturbance and function loss. In order to test this hypothesis research techniques were developed with a questionnaire for ascertaining cases of deterioration covering sixteen areas. (See Table 47-2.) To conduct systematic research it was necessary to specify what bad functioning was in terms that could be recognized both in the mental hospital and in a patient living at home. Because the researchable, hopefully preventable, condition was more precisely conceptualized than the older, broader term "deterioration," the newly specified condition was called "social breakdown syndrome" after the American Public Health Association 1962 publication.

Table 47-2.

	DISTURBED BEHAVIOR		SOCIALLY INTEGRATED BEHAVIOR
1.	Danger of self-damage	1.	Being away from the ward
2.	Self-destructive acts	2.	Making money
3.	Control of physical movement	3.	Work assignment
4.	Disturbing noisiness	4.	Occupational therapy

5.	Resisting meals	5.	Reading or writing
6.	Soiling	6.	Recreation
7.	Not speaking	7.	Having money
8.	Help arising and dressing		
9.	Help going to bed		

In order to conduct the research, exact criteria were needed to specify whether or not a particular person was deteriorated in functioning at a particular time. It was necessary to define the behavior that would be regarded as illustrating each of the sixteen actions itemized in Table 47-2 in a repeatable, reliable way, not relying on the varying judgment of each data gatherer regarding each phrase's meaning. Selecting the ascertainable items and specific manifestations of severity required much pilot work. Making such rules is a time-consuming operation; training people to follow the rules takes a week or two; supervising their work and keeping the standards consistent require time and skill. The criteria used were objective and left little room for variation due to observer differences. These detailed criteria can only be mastered through demonstration of the rules in concrete instances.

The data showed that symptom formation and symptom continuation were highly dependent on the social organization of treatment services and on staff and community attitudes. Several findings contribute greatly to

understanding the social breakdown syndrome's characteristics.

It occurs in many different psychiatric conditions. Many cases occur outside the hospital. The 1963 prevalence of social breakdown syndrome (see Table 47-1) associated with a psychosis was 1.5 per 1,000, ages sixteen to sixty-four, in the whole population. The number of new chronic (over one year) episodes beginning each year dropped about 50 percent between 1960 and 1963. This was the first demonstration that service reorganization can lower any disorder's frequency in the population for whom the delivery of services was reorganized.

This practical demonstration confirmed by evaluation research calls for a new theory about symptom pathogenesis to explain why reorganization prevents chronic social breakdown syndrome. This theory must explain why this way of organizing psychiatric services is associated with less chronic social breakdown syndrome than another.

Social Breakdown Syndrome Manifestations

People working in these new community-care programs are often not aware that they are applying new and better ways of organizing treatment, but think they are implementing changes brought about since 1955 by the tranquilizing drugs. These new drugs do make it easier to care for psychotic patients, both because they directly affect the patient's behavior and because

they have a placebo effect on the staffs administering them. Both the predrug pilot programs of community care and the postdrug experiences at Graylingwell, Plymouth, Fort Logan, and Duchess County showed very similar results. Reorganization without drugs showed major improvements. Drugs without reorganization sometimes show little improvement. We can infer two types of symptoms from these findings: the direct consequences of mental disorder and the secondary complications whose appearance and continuation depend on circumstances and are apparently preventable. Those secondary manifestations that are mainly prevented by using the best systems of care we call the "social breakdown syndrome."

Manifestations and Course

The social breakdown syndrome can be manifested by a wide range of overt disturbed behavior. Withdrawal, self-neglect, dangerous behavior, shouting, self-harm, failure to work, and failure to enjoy recreation are the main manifestations. Either troublesome behavior or functional performance deficit may predominate. Each type occurs separately or in conjunction with the other. Severity ranges widely. (Hallucinations, confusion, phobias, and other subjective experience were not included in the studies because, first, many patients in improved programs describe these symptoms and, second, the field study techniques developed could not systematically investigate subjective experiences. Their exclusion did not prejudge the possibility that

these too may often be secondary manifestations in the same sense, readily modified by the social environment and therefore properly regarded as manifestations of the social breakdown syndrome.)

At present, under the best conditions, almost all SBS episodes end within a few weeks, and episodes lasting for months are very rare. The onset is sometimes insidious, the course indolent, and the end the vegetative state described in textbooks. More commonly, onset occurs in a single, explosive leap, beginning with violent behavior or the sudden termination of all ordinary social roles, often accompanied by a confused or clouded state. About two-thirds of the episodes start outside the hospital. Spontaneous remission often occurs in days or weeks without admission or any treatment. Other cases progress for a while and then arrest for a long period at a particular stage, which is sometimes followed by recovery. Some other cases pursue a remitting course. First episodes and relapses show similar patterns. It is instinctive to compare these course patterns with those described for schizophrenia by Bleuler. (See Chapter 30, "The Epidemiology of Schizophrenia.")

SBS occurs among psychiatric inpatients and in people in need of hospital admission. The syndrome usually begins outside the hospital, its components being the common justifications for admission "incapable of caring for himself," "dangerous to self or others." Thus, the social breakdown

syndrome describes the severe burdens the community experiences in dealing with these individuals, and these burdens account for the decision to extrude them from the community. SBS also describes common reasons for keeping a patient in the hospital, an indication that hospital admission does not always terminate SBS.

Social Breakdown Syndrome Pathogenesis

A pathogenesis of chronic SBS can be postulated. Seven steps lead to the chronically deteriorated picture formerly seen in the back wards of mental hospitals. The social breakdown syndrome describes the way in which the relationship between a person and his social environment breaks down. The syndrome seems to emerge as a result of a spiraling crescendo of interactions between the patient and the people in his immediate social environment.

1. The push, common in ordinary life, consists in a discrepancy between what a person can do and what he is expected to do. Such discrepancies are ordinarily transient: They are eliminated by a change in performance, by escaping from the demanding environment, by a change in environmental demands, or by an explanation that relieves the individual of the responsibility for the discrepancy.

2. Heightened suggestibility. When the discrepancy persists, the failing individual on whom the demand is being placed is held responsible for his

failure to perform as demanded. The individual and those making the demand agree about his responsibility. He wonders what is wrong with him. A diffuse uncertainty regarding his own nature and value system develops and produces hesitancy or impulsiveness (or both). He has become more dependent on current cues from the environment regarding right and wrong. This increased sense of uncertainty about himself, his values, and his customary ways of dealing with life produce a readiness to consider new ways of doing things, new ways of looking at things, new ways of looking at himself. This is the precondition for constructive changes in attitude and behavior that, when the environment is suitable, leads to corrective modifications of functioning. Every psychotherapist, every army sergeant, and every job supervisor has seen this process; such behavioral modifications are part of normal life. But inability to modify his behavior in the expected way creates a special danger when the individual accepts the environment's expectations.

A common way to deny that the expectations are appropriate is to conclude that those making the demands on the individual have misunderstood his true nature: They are asking something appropriate, but they are asking it of the wrong kind of person. He decides that for this task he is too young, too old, too short, too tall, too blind, too crippled, or too ignorant to be expected to do what was asked. The failing individual's sense of responsibility for his failure to comply with the demands is relieved, and

since he no longer holds himself responsible for the discrepancy these explanations can be called “exculpating.” (As will emerge below, the discovery of suitable exculpating explanations can play a large role in preventing chronic SBS.) When the discrepancy between environmental demand and individual performance is not terminated that way, the individual takes an unsatisfactory step to rectify the situation. But this only arouses fears or resentment, further putting him out of gear with the people around him. This produces an increased need to satisfy increasingly urgent demands. But his response to this still more tense situation has the opposite effect, resulting in still more misunderstanding and hostility. This process of action reaction, reaction to the reaction, and reaction to that goes on either toward an explosion and social extrusion of the individual or toward his progressive withdrawal from interaction, and hence from his usual roles and functions. This is when the social breakdown syndrome begins.

3. Labeling. He is then labeled as “crazy” or otherwise not right in the head, leading to a vague or rejecting diagnosis, such as schizophrenic or psychotic or just plain mentally ill, and to the recommendation that he be sent to the hospital.

4. Extrusion. Admission to the hospital can itself contribute to the further development of the social breakdown syndrome. Formal legal commitment is most damaging with its petitioning mechanism by which

those closest to the prospective patient join with the community establishment to engage in the labeling and rejection process.

5. Institutionalization. An overly sheltering hospital environment can further exacerbate the social breakdown syndrome. In his community, he may have been expected to do things he could not do, but in the old-fashioned hospital he is expected to do nothing except what he was told to do (or, of course, to try to run away). Whatever the patient's behavior, no one expresses surprise. He is called sick and is told that he must be cared for. Thus he is morally relieved of responsibility for his failures at the price of being identified as having a condition that makes his own impulses, thoughts, and speech largely irrelevant to any practical activities of daily life.

6. Compliance and isolation. The social breakdown syndrome progresses another step when the patient, though still viewing himself as different from the other patients, complies with the older type of hospital's rules of accepted behavior to stay out of trouble. He becomes isolated from his former ties. The family is told that everything necessary will be done by the staff; visiting is restricted to a few hours; staff members familiar with the patient's case are often unavailable to the family.

7. Identification. Next the patient comes to identify with fellow patients, anticipate staff demands, "fit in," and become a "good patient." Sometimes he

fits into one of the available rebellious roles for which the hospital is equally prepared. In time, whatever his former capacities were, his ability to carry out ordinary social exchanges and work tasks decreases and becomes awkward from disuse. The end of this process is most readily seen in the mental hospital's chronic wards.

Prevention of Chronic Social Breakdown Syndrome

Even the best psychiatric service cannot today prevent all onsets of social breakdown syndrome because often it arises before the individual becomes a patient. Prevention of onsets may, in fact, be occurring among chronic patients, but no research data on this phenomenon are available at present.

Chronic SBS is prevented today by encouraging early recovery from episodes after they start (secondary prevention). The reform in practices regarding encouragement of early voluntary admissions to inpatient services is probably having such an effect. The fashion for early release, facilitated by the tranquilizing and antidepressant drugs, is also probably having this effect. Even the early releases produced by hard-nosed budget-cutting may have this effect in general in spite of inadequate aftercare; but if it is benefiting some patients by preventing chronic SBS it is seriously endangering others who are grossly neglected.

In addition to these preventive activities, which are going on for various reasons, the unified clinical team staff member is in a position to do many things to facilitate early recovery from a SBS episode.

When a patient presents the early manifestations of the social breakdown syndrome, or appears tense and fearful that he will lose control and either withdraw or become violent, the psychiatrist, or other professional, might do well to try to locate the nature of the demands the patient is unable to meet.

The internalized demand for a performance that the patient cannot carry out is rarely conspicuous. The patient does not see the conflict consciously. Clinicians do not usually focus on it, so they rarely enter the relevant facts in the medical record. Occasionally, however, the relevant facts are recorded, and then a reader of the record can identify this demand-performance conflict. The following brief summary of one such case throws light on three issues: (1) how the demand-performance conflict develops and is responded to; (2) how the patient's struggles in this conflict tend to bring his attempts at solution to the surface and how the consequent symptom formation attracts the clinician's attention; and (3) how the orderly response by a clinical team operating in a unified service helps lead to the social breakdown syndrome's early termination.[2]

A laboratory scientist was admitted to the mental hospital from a general hospital emergency room where he had been brought in a distraught state following an altercation with his children, the oldest of whom he threatened to throw out of the window. The argument began immediately after the patient had come home after he was discharged from a commercial salesmen's training program he had been attending. It was the first day of the training program. He had verbally abused the instructor in front of the class, passionately lecturing him on his dishonest attempt to brainwash the students into misrepresenting the firm's product when selling it. "Liar, thief, reprobate" were the burden of his accusation, but the wording and tone were much more abusive. Forcibly removed from the classroom, he was sent home, an unemployed trainee salesman.

This episode ended six months of trying to find work after having been included in a mass layoff. A rigid person with high standards for his own performance at work and as a husband, he could not accept the much lower-status salesman role. But neither could he reject it as it represented his first work opportunity in half a year.

This demand performance conflict's importance was intensified by the fact that, after the mass layoff and during the period on welfare, his wife had lost interest in him and developed interest in someone else. In addition, one of his relatives near his own age had long been a competitor for the position

of family success. Although the competitor made more money, our man was in an adequate position so long as he was a professional in contrast to the nonprofessional super-salesman.

Our man took steps to rectify his situation: He tried to define those making the demands on him as not entitled to respect (the instructor), but this maneuver only served to arouse fears putting him further out of gear with the people around him. This produced an increased urgency regarding his unsuccessful role as breadwinner and household head. His response to this tense situation was apparently to define his oldest son as unsuitable for membership in the family. This led to increased hostility and also fear, which brought him to the general hospital admitting room following the explosion with his son. He was extruded from the household.

On arrival the complaint was not a demand performance contradiction but his bellicose behavior. The staff's diagnostic formulation referred to a schizophrenic psychosis and their treatment recommendation was tranquilizing medication and open-ward care. The bellicose behavior disappeared almost immediately on arrival at the hospital, and within a few weeks the patient was home again.

Since the episode of SBS behavior stopped abruptly we may ask how the demand performance conflict was resolved. Performance was clearly

unimproved. But the troublesome behavior was explained by the presence of a sickness, and this sick role also removed our man from the demand that he perform as had previously been expected, at least for the present. This cannot be done without paying some price, and this man had to pay in several ways. Being defined as mentally ill does not enhance self-respect or the respect of others, but the fact that the disorder was described as responsive to known treatments minimized this effect. Though frightened by the events, he and his family were sufficiently reassured regarding the prognosis so that the latter could supply some encouragement after he left the hospital and all could recognize that his unemployment in a bad market was not entirely his doing. The assurance that the clinical staff's interest would not end with release from the hospital further helped the patient and family to bring out whatever healthy functioning he could muster.

The initiation into the sick role was done in a way that aborted his severely disturbed behavior and extreme subjective distress. Not only were the old mistakes—encouraging community rejection and impersonal admission procedures—avoided, but there was an active constructive use of medical authority (to borrow a phrase T. P. Rees often used). Such constructive use of medical authority is the opposite of permissiveness because it identifies the complained about behavior as unacceptable, insists that the patient can stop it (with help), defines his problem as a sickness requiring medical care, and takes on responsibility for terminating his

condition (with the patient's cooperation). This was done in a manner to strengthen the family ties, not weaken them.

To understand how the staff's actions helped abort this episode, the actions must be viewed as forms of communication that alter the patient's view of himself and his relationships and alter the family's view of him. The relevant communications were implicit in the actions taken, not explicitly worded. Concern about the patient's behavior was taken seriously; questions to ensure understanding of the complaints reinforced the serious attitude. The inner distress and the belligerence were not denied or ignored but explicitly accepted as grounds for concern and as justifying special help. They did not indicate his worthlessness or undesirability but his need for help in dealing with a condition that he did not bring on himself and that the clinical staff would work on (but only with his cooperation). He needed treatment; he accepted treatment; and he accepted the transfer to the nearby mental hospital. (The legal compulsion of a health officer's certificate was used but could probably have been avoided, particularly if the mental hospital doctor had gone to the emergency room for a pre-care consultation. This would have lessened the damage to self-respect caused by the use of compulsion.) As soon as he arrived at the mental hospital, he saw his psychiatrist who spent time with him and with the family before going to the open ward. The psychiatrist told the family, in the patient's presence, that they could visit at any time and that he would likely be home in a short time. These steps rapidly

redefined his situation in a hopeful way. By prescribing drugs to reduce tension and assure sleep the first night, the doctor further asserted his medical authority and responsibility, defined the complaints as due to something the doctor could be expected to know about and could help, and relieved any notions that the patient was responsible for his condition and therefore for his failures. The drugs' efficacy as predicted enhanced the validity of all these messages. Guilt and fears about his behavior were quickly reduced; he began to feel responsible at once; and his family was able to acknowledge their affection for him and to look forward to his hoped for early recovery.

This man will, of course, continue to be in trouble after he leaves the hospital. The wife apparently thought that "for better or for worse" did not oblige her to remain loyal when the labor market turned worse; she was not likely to become more loyal when "in sickness and in health" came to mean in sickness. He left her. A man so preoccupied with the outward symbols of success is not going to find it easy to adapt to a world in which the super-salesman is outrunning the competent professional in earning these symbols. He may well need another period of inpatient care (he did).

But the quick resolution of the crisis must be recognized as an accomplishment, freeing him to struggle with these more longstanding problems. The method used was to modify expectations as indicated above,

and the means used to modify these expectations were adherence to some old valuable clinical rituals in the needed way and under organizational conditions that gave them maximum effect. Careful attention to eliciting and recording the complaint and a complete and thorough present illness history are this ritual's main features. Attention to the complaint reinforces the notion that those making the complaint know what they are talking about and that the clinician regards it as a legitimate basis for going further. Taking the history implicitly questions any theories regarding cause expressed while stating the complaint and further asserts the medical authority to question and expect answers so as to relate this person's story to the doctor's prior experience with other patients. Such a history always involves asking about symptoms not present, and this suggests that things could have been worse.

This initial examination itself involves so many crucial transactions that the process can redefine the problem and the clinician's relationship to it to such an extent that the crisis atmosphere dissipates and a treatment plan begins. Pre-care consultations have been done in Duchess County, New York, since i960 by Dr. C. L. Bennett and his associates for patients referred as possible mental hospital admissions. In about two-thirds of the pre-care consultations a skillful clinician can define the patient's problem in such a way that alternative treatment forms can be arranged: outpatient treatment, day hospital treatment, social work family counseling, or advice to a general practitioner. In almost all of the other third, the patient has voluntarily

entered the hospital phase of treatment before the consultation is over.

At present, these are the mechanisms apparently being used to terminate incipient or new social breakdown syndrome cases. Whether a more conscious attention to the nature of the contradiction between the demands being put on the patient and his capacity to perform would lead to a more efficient and effective termination of these episodes cannot be said with certainty until some clinical groups try it. In reviewing a recent group of consecutive cases, the social breakdown syndrome stopped within two weeks of entering treatment in more than half the cases, yet only a few could tell what the contradiction between performance and demand was, and even in those, these contradictions did not enter into any clinician's recorded formulation of the case.

These preventive measures may be contrasted with what would have happened to a man with a similar episode when the 1930 depression began. After shouting at the teacher perhaps, but certainly after trying to eject his child from the window, the police would have brought him before a magistrate for an involuntary commitment. His wife and perhaps other relatives would have been urgently pressed to sign a petition begging relief from responsibility for his care and for the court to arrange care and treatment in a mental hospital. His admission would have started with a brief perfunctory contact with an admitting psychiatrist whose main

preoccupation would have been with the state of the papers ordering the admission, and this would have passed through half a dozen people's hands in as many hours in order to process him into the hospital. During this whole period he would encounter no one with a substantive interest in his complaint or his view of it: fingerprinting, searching for scars and recording them, a rectal temperature, a compulsory X-ray, routine blood tests, inventory of property, a shower, and a switch to institutional clothing would all take priority. It might be several days before a psychiatrist sat down to take a history. It would usually be weeks before this initial clinical evaluation was reviewed through two echelons and finally reached the clinical director who would have to decide the diagnosis and treatment plan. All prior judgments would have been temporary. How would our patient have reacted to all this? We do not know enough to say, and we would not know enough even if we were thoroughly acquainted with him and his mental status. But it is reasonable to suspect that the people whom M. Bleuler describes as pursuing the catastrophic course in a proportion of schizophrenic admissions prior to 1942 were not very different from him. (See Chapter 30, "The Epidemiology of Schizophrenia".)

Unified Clinical Teams

The preventive measures described are most easily executed when a single professional team takes comprehensive responsibility for the whole

course of treatment: Pre-care , inpatient care in an open hospital that minimizes restraint and legal coercion, and aftercare. This unified clinical team needs close ties with the whole complex of community services and access to a full psychiatric service (inpatient, outpatient, and transitional forms of treatment). Even today such a unified clinical team operation is rare.

Many communities in the United States currently offer services that include the five elements making up the comprehensive services required for federal funding of community mental health centers: inpatient services, outpatient services, emergency services, partial hospitalization, and consultation and education. But these elements are usually run by separate clinical teams.

Despite proliferation of such comprehensive mental health services, many people with severe mental disorders needlessly become chronically deteriorated in their social functioning because no single team is able to follow them throughout the entire course of their illnesses. Besides being concerned with treating the patients' mental disorders, the team must focus on the mission of preventing the chronic social breakdown syndrome.

No amount of coordination or working integration of fragmented clinical teams, each working in its own service, can be expected to overcome the fact that clinicians working in these fragmented teams will have to make

decisions on insufficient information. It is obvious that they will not know enough about what the other clinical team would wish to do. It is obvious that the new clinical team will take time to learn about what was going on during the earlier period, even though some administrators are cleverly using office reproduction equipment so that records can get to them quickly. What is not obvious is that in our present state of ignorance no clinical team can have confidence regarding how the patient will make out in the next service; this arises from the unpredictability of the course of the chronic mental disorders. "Unpredictability" means we do not know enough to make predictions with any degree of confidence. Our state of knowledge in this matter is not any better than the weather predictor's ability to tell us about tomorrow's rain or sunshine. While pursuing efforts to learn more we can protect our patients optimally by making decisions tentatively and letting those familiar with the patient and his prior responses continue to care for him. And why not? Because of some mistaken ideas that it is inefficient to have clinicians working in more than one location. This arbitrary concept of efficiency will cost many man years of serious deterioration in our mental patients.

Stanton correctly said, "I believe that statements like patients should be outside if they can be, or they should be kept out, or they should be gotten out, are stated uncritically." We can agree that the generalization that "It's better to be out of the hospital than in the hospital whenever possible, under all conditions," is nonsensical. Two contrasting models are current in the

literature. In one, the mental hospital is seen as incorrigibly bad, nothing but damaging, and therefore every possible means should be used to keep people out and, once in, to get them out rapidly. The other model is that the mental hospital has never been static at any point in its history, has always been changing, has developed some patterns of excessive retention but can be transformed into an acute service with specific goals for each admission and can work in close conjunction and as an intimate part of comprehensive community service (when its physical location is appropriate). In the first model, a return to the hospital is seen as a failure of the release. If the patient is released from the hospital and comes back again within a year it is seen as a failure to set up an adequate community treatment program for him. In the second model, where the hospital is seen as an active and integral part of the community program, readmissions are expected and are part of the release plans. In fact, you can only release patients properly into the community in certain mental states when the hospital really is highly accessible for unpredictable as well as some predictable needs to return. The therapeutic community inpatient service and the revolving-door inpatient service, run as part of a unified clinical team's resources, relate the hospital's resources to the patients in entirely different ways. To make the whole life of the hospital part of a therapeutic experience for the patient, as developed by Max Jones, extends the milieu treatment concept into something much more dynamic and structured, creating an intensively planned set of relationships for each

patient to work through. However, if the hospital is used for acute, intermittent care of psychotic patients with specific indications at certain stages of the disorder as part of a community-care treatment program, admission should not integrate the patients into hospital life. A therapeutic community in a hospital cannot provide quick rotation, revolving-door service. The two types of service interfere with each other. The therapeutic community involves patients in many aspects of hospital life—ward activities, patient government, and so on. It has unique advantages in changing attitudes and behavior. But the revolving-door pattern deals with the patient's problems much in the way that a general hospital deals with such episodes as cardiac decompensation or appendicitis: The hospital is a special place to go to for a short period, for specific purposes. These patients interact with the rest of the hospital and the other patients only to the extent that it is necessary to get through the few days, or week or two, that they are there. An acute service should not be operated as a therapeutic community, nor should a therapeutic community be used to deal with the problems of acute decompensations in long-term community-care patients.

Hospitalization in a good community-care program has five main uses.

1. To provide a treatment that cannot safely be given on an outpatient basis, for example, to give a dangerous drug requiring continuous observation for safe administration, to adjust drug dosages where outpatient treatment would be unduly

hazardous, or for electroshock treatments.

2. To protect the patient from his own uncontrolled dangerous impulses or the consequences of self-neglect, namely, the old legal justification for involuntary certification, that the patient is a danger to himself or others.

3. To remove a person temporarily from an environmental stress during a period when he cannot cope with the stress or cannot be helped to cope with it successfully.

4. To temporarily relieve the patient's associates who are managing to live with him but at significant costs to themselves, which include the loss of the caretakers' free time and the emotional energy mortgaged from other potential forms of emotional investment.

5. To communicate two ideas: (1) that the patient's difficulties are because of sickness and (2) that the hospital is available to the patient and to his family for assistance while living with a chronic incurable disorder (but not as an unloading clinic).

Conclusions

A practical finding—that certain deteriorated behavior patterns of people with psychoses are prevented by altered systems of delivering psychiatric services with consequent changes in staff attitudes and practices—drew attention to the fact that this syndrome occurs in people with many

different mental disorders. Hence, this syndrome is not inherent to the mental disorders, but is a secondary, modifiable syndrome. What was once looked on as the strongest evidence of the presence of certain psychoses became evidence of sociogenic secondary complications. (See Chapter 30, "The Epidemiology of Schizophrenia.") Much of this syndrome's pathogenesis and progress can be understood in terms of interactions between a patient and those around him.

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Notes

1 At the time of the Toronto Conference of the World Federation for Mental Health, in August 1954, an international symposium on problems of partnership in mental health and public health was held with the assistance of a grant from the new Hope Foundation of New York. During the following year, the surgeon general of the U.S. Public Health Service requested that the World Health Organization give Dr. Robert C. Hunt a traveling fellowship to study these newer developments in Europe. Partly as a result of his reports, Commissioner Paul Hoch (New York State Department of Mental Hygiene), in 1957, appointed a committee of six New York State mental hospital directors to study these open hospitals under the guidance of Dr. T. P. Rees, who had retired that year. (The Milbank Memorial Fund provided the grant that made this possible.) The committee's 1957 report to Commissioner Hoch was also presented in part at the Milbank Memorial Fund's thirty-sixth annual conference16 and at the ninth mental hospital institute.

2 The assistance of my associate, Danielle Turns, in locating such a psychiatric record and in developing the necessary camouflage is gratefully acknowledged.