Social and Community Psychiatry and Its Effect on the Family

WILLIAM W. JEPSON

Department of Psychiatry, University of Minnesota
College of Medicine, Minneapolis 55415

Psychiatry has lagged behind the other medical specialties for some time now, but it is finally emerging from its 19th century concepts both in theory—as represented by social psychiatry—and practice—such as the development of community psychiatry. Its theoretical constructions are beginning to rest more firmly on a broad scientific base, and in its clinical applications it is beginning to find a place in the mainstream of medical practice. Some like to say that psychiatry is currently undergoing its third revolution. Both of these developments will increasingly view the family as the basic unit of biopsychosocial maladaptation. In the explanation and treatment of mental, emotional and behavioral disturbances, greater attention will be given to the interface and interaction between the individual and his environment rather than to the individual alone, as has been the practice in the past. In his book *The Psychodynamics of Family Life*, Dr. Nathan Ackerman (1958) has said,

The single, most encompassing reason for our conspicuous failure thus far to prevent mental illness derives from our failure to cope with the mental problems of family life. We have somehow kept ourselves so busy, so preoccupied with studying and treating the suffering of individuals, that we have, in effect, blinded ourselves to the significance of the concurrent struggles of the family for mental health and to the way in which the ongoing content of family experience affects the emotional struggles of its adult members. I do not mean to imply that the treatment of the individual patient, the alleviation of the very real sufferings of a single human being, is unimportant or unnecessary. To the contrary. But I do question the effectiveness of any such treatment that does not take into consideration the sum total of this individual, which must of necessity include his environment and his interactions with it.

Simplistic Theoretical Basis

I am fond of announcing to trainees that they already know more about the specialty of psychiatry than they do about any other specialty of medicine, because they have actually been taking a course in human behavior since they were two years of age; yet at the same time they know less about the sciences contributing to psychiatry than they do about the sciences contributing to any other specialty, because this has not been taught in the medical schools. Our medical school pedagogy has focused its attention largely on classification of syndromes and upon the doctor-patient relationship. Curricula rarely include such topics as the emotional and behavioral correlates of physiologic and biochemical factors; heredity, instincts, drive, and maturation; perception and cognition or operant conditioning; family and group dynamics; role theory and communication; ethology or cultural anthropology; or even psychology and sociology. Fortunately, this situation is undergoing rapid change. While many medical schools are making major modifications in their overall curricula, many are inserting the basic sciences of human behavior in place of several hundred hours of anatomy.

Dr. Bond has outlined perspectives in the field of behavioral sciences. Particular notice should be given to the word “field,” for the concept of a field of determinants is absolutely essential to our understanding and treatment of behavioral disorders. I recall that, as a resident in Cincinnati, one of my favorite teachers—our host, Dr. Lederer—pointed out to us that much of psychiatric theory was imbedded in the 19th century constructs of linear and singular causality. He contrasted this with later concepts of Maxwell and Lewin and urged us to expand our scope of conceptualization to include the entire field of variables and determinants of human behavior, which range from the molecular to the social levels.

This contrasts to the old “disease model” which, in order to explain a syndrome, often conceives of illness as resulting from some prepotent singular or primordial cause. Although this bears fruit in explaining infectious metabolic and surgical conditions, it is totally inappropiate for psychiatry. Simplistic explanations, such as “early childhood trauma,” “the XYY chromosome of psychopathic personality,” “imprinting in schizophrenia” and the “biochemical basis of depression,” are inadequate and insufficient. Such ideas lead to the belief...
that emotionally ill persons have something noxious within them which must be removed—that is, excised or exercised. Psychiatry has also been haunted by some anachronistic remnants of hydrodynamic and mechanical models. We still speak of such conditions and situations as “dammed-up tension or hostility which needs more outlets,” “carrying around a lot of guilt” (as if in a sack), “he had a nervous breakdown,” “his nerves are tied in a knot” and “he blew his lid.” These depict people like antacid commercials on television. Even modern physicians will tell a patient, “It is just your nerves”; or “You have too much tension.”

Such oversimplifications have done much to retard the understanding and alleviation of interpersonal disturbances. Social and community psychiatrists are particularly vociferous in their attack upon the “disease model.” Although they do recognize that within individual persons there are constitutional and learned defects which greatly handicap their adapting to the environment, these psychiatrists also center much attention on the transactions occurring at the interface between the individual and his environment. A fuller appreciation of the role of learning in personality development reveals that behavioral patterns are largely shaped by environmental experiences. This, of course, is particularly true for the experiences in the family during early life. Furthermore, there is fuller recognition that, to a great extent, present illnesses are responses or reactions to present external life situations. They recognize that an individual’s thoughts, emotions and behavior cannot be fully understood without an appreciation of the past and current fields of socio-ecologic factors which impinge upon him and a realization that mental illness will neither be prevented nor often cured without modification of, or at least awareness of, the patient’s relationship to his milieu. Many of these variables are cultural, social, economic and situational, but the most immediate and powerful factors are those found within the family itself—its configuration and the acts and attitudes of its members.

**Exclusion from the Community**

If the theory of psychiatry has been 50 years behind schedule, it can only be said that the practice has been 100 years behind. Around 1850 such personages as Dorothea Dix indefatigably promoted improvements in hospitals for the insane. Thomas Kirkbride (1847) proposed that such facilities be in the country—not within less than two miles of a large town—and have no less than 50 acres of land. There certainly is no doubt that the intentions of these leaders in the mental health movement were humane. Unfortunately, however, providing these institutions, which involved such enormous cost that they had to be operated by the state, shifted the responsibility for the care of the mentally ill away from the community. Consequently, these institutions evolved into places to hide the banished. It has probably always been true that, if a person should become a bother or a burden (i.e., mentally ill), he could somehow be ostracized from the community. In the old Western towns he could be put on a horse and told to get out. Today we send him out of town on a medical-legal rail called a commitment proceeding, which takes only the signature of several doctors and, perhaps, a fee to an official. In creating such hospitals we have assured the availability of a place to put such troublesome—or troubled—people. As for the family, it is often not very difficult to extrude one of its members who has become too disturbing to it. This member, of course, is not necessarily the sickest; he may simply be the weakest.

By the establishment of these state institutions, not only have families and communities been able to eliminate their bothersome members, but the medical community has been able to abnegate its responsibility to the mentally ill. Physicians and hospital administrators can declare that such patients are the responsibility of the state, and that, therefore, they need not attend to them. In addition, to avoid providing funds for their care in the community, local officials can maintain that the mentally ill are a state responsibility. Hospitals—be they voluntary, university or even public general institutions—and all physicians—be they psychiatrists or family doctors—can and do at times refuse to provide care to the mentally ill. This occurs not only because the patients are too poor, but also often because they are too unattractive, inarticulate, or disturbing. Some reasons given for such rejection are: “Sorry, we have no more beds,” “My appointment book is filled,” “Our intake is closed—we will put you on the waiting list”; and even “The patient is too sick for treatment”—the last an incredible excuse for a physician. That famous statement “This person needs help” all too often has the unspoken addendum “by someone else.”

Who is that someone else? It has been the state hospital. We should remind ourselves that only state hospitals have had a legal obligation to accept all cases; only they have had an inclusive admission policy. As a result, their facilities have always been overburdened and, consequently, the standards of care greatly compromised. Physicians working in the community, who would not think of lowering their own standards, have been complacent or critical about the standards in state institutions. Have you ever wondered what would happen if judicial commitment were removed and state institutions had a legal right to refuse patients? Recently, in Saskatchewan, there was such an experiment in which
the provincial hospital was closed to a certain segment of the population. Local physicians and other community care-givers became involved almost immediately in providing needed services. Speaking facetiously, I venture to say that undoubtedly the best way to immediately establish community psychiatry would be to demolish the state hospitals.

Return of Responsibility

Of course, what I really believe is that we should take the inclusive admission policy and shift it over to the local community where it belongs. Actually we might retain the state institutions to carry on new and sophisticated treatment modalities but disallow their use as collection agencies for the banished. By returning this responsibility to the community, we could undo the well-intentioned error of the 19th century. In my opinion, the cardinal characteristic of the community mental health movement is the community's reassertion of its responsibility to provide the necessary care to its members. Not only the patients, but also the funding and administration should be returned to the community. Furthermore, the "treatment" of these disturbed persons should not be given entirely by local hospitals and physicians but should involve participation of a great many other community care-givers, such as social workers, clergy, associates at work or school, friends, and, above all, the person's own family. We now understand that the disturbed person's rehabilitation is severely handicapped as a result of the dehumanization and desocialization inflicted by removal from society and family.

Several conditions are permitting this revolution or reverse shift to take place. Not the least of these is a change in attitude among people concerning psychiatric illness and emotional problems. A good deal of credit must go to their attainment of psychodynamic insights, many of which have been acculturated through popular communication. In addition, psychiatry has acquired new understandings in such matters as interpersonal relationships, family and group dynamics, communication, social roles and individual and cultural differences. The increase in liberal social attitudes has resulted in public policies which seek the implementation of new humanitarian programs. Community mental health legislation, which has been passed in well over half of the states, is one good example. In the majority of this legislation the states make grants to local communities covering anywhere from 50% to 90% of the costs for broad-based programs of community services. They include not only direct clinical services to care for people at home, but also public information and education programs; consultation to other care-giving professionals, such as general practitioners, public health nurses, social workers, probation officers, clergymen and teachers; information and referral services; and suicide prevention programs, half-way houses and social and vocational rehabilitation programs. Not only are state funds subvented to the local community, but the administration of such programs is also transferred to local mental health boards rather than kept in the hands of absentee state officials. These local boards, which are often non-profit corporations, or the local public health departments are in a much better position to know intimately the needs of the community and to achieve cooperative and coordinated arrangements of services not only in the public sector, but also from private voluntary practitioners and agencies. Furthermore, they provide a source of continued advocacy for the program.

In recent years there has been a tremendous growth in the number of community general hospitals that have accepted psychiatric patients either on their general med-ical wards or in special psychiatric units. The Federal Community Mental Health Centers Construction Act has been a boon to many hospitals willing to develop such services. Regulations require that basic services be conducted within the framework of a mental health center, meaning that in addition to inpatient services, the hospital must also provide day care, 24-hour emergency care, and outpatient and consultative services. It will probably not be long before all general hospitals of significant size will be required to have psychiatric services in order to gain accreditation, a factor which can be expected to have a major impact in retaining people in the community. Greatly facilitating this step has been the introduction of the new psychotropic medications which, in addition to their direct benefit to the patient, quickly temper his behavior so that he is far less likely to incur rejection by nurses, physicians, family and others.

New Modes of Intervention

Of all the things which have enabled patients to be retained in or returned to the community, perhaps the most important have been the many new therapeutic approaches developed by psychiatry in recent years. Community mental health centers, in particular, are prepared to present a comprehensive array of treatment modalities which can be offered according to the patients' individual needs. In the past, psychiatric practitioners had a penchant for employing only their favorite treatment method, be it electroshock therapy, psychoanalysis, pharmacotherapy or counseling. Now, in addition, we can offer such diverse methods as conjoint family therapy, video confrontation of group therapy, crisis intervention, behavior modification based on learning theories, and resocialization activities. Other methods include special evening pro-
programs for adolescents and their families, augmented outpatient care—where patients come in for portions of a day rather than one hour per week—suicide prevention services and detoxification units.

In a community mental health center the array of treatment methods is compiled into one organizational unit or program. This permits the patient, family or individual members thereof to receive whatever kind of treatment is appropriate for him, it permits experimenting with different approaches, and, most important, it enables patient care to be continuous. Thus, from the inception of his difficulty, throughout the course of his illness, and on to the point of rehabilitation, there exists a continuing interpersonal relationship and a continuing professional responsibility which eliminates any necessity to transfer the patient out of the program.

A community mental health center is also a form of corporate practice. In many respects it is like group practice, with many of the professionals being on salary. With staff members receiving salary, rather than having their income derived from fees, the center is able to assume such functions as emergency room coverage, consultation liaison, conferences and supervision and training. In addition to the psychiatrists, who bear ultimate medical responsibility, there are psychologists, social workers, public health nurses, activities therapists, case aides and others. This expands the base of mental health manpower and allows the center to capitalize on the expertise of the other disciplines. Not only are many paramedical professionals involved in treatment, but even volunteers and other patients are asked to take part in the therapeutic community. Furthermore, family members are often not only asked but required to participate in the therapeutic effort. In the local center it is far more feasible for the family physician to maintain a substantial continuing role and to act as a consultant. The physician's intimate knowledge of his patient and his family and life situation over a period of time can be of enormous value and need not be lost if the patient remains in his home community. After all, such a doctor rarely needs to take a family history.

Family Relationships

A great many psychiatric problems, both acute and chronic, are what we often refer to as "disposition problems." That is to say, the patient has no place to go—he is in the wrong domicile. We are well aware of this in the case of the chronically mentally ill and know that many people, particularly the aged, must be placed in custodial care, either in a nursing home or state institution, because the family can no longer tolerate them. One of the principle problems that a state hospital has in trying to return patients to the community is to find a place where they can live. Often they will seek to return the patient to his family, but many times this is not acceptable; so that, in the absence of nursing or boarding homes, the patient who cannot manage alone must remain in the custodial institution. Simply returning a patient to his family is not always the best solution, because many times that was the very environment which precipitated his mental illness. It is also true of acute psychiatric disturbances that a key question is whether or not the patient will remain in his family. It may be that he cannot stand the family or the family cannot stand him. Many youths have the former problem and attempt to solve it by going to live with their married sister or the father who left the family years ago. Often they have no place to go, and it may require fast footwork on the part of a social worker to find one. It is not unusual for an acute inpatient psychiatric ser-
those in trouble expanded to include uncles and aunts, grandparents and in-laws. This doubtless gave a healthy perspective which is not now available to our isolated and mobile small families. It may be that mental health professionals along with other helpers, such as clergymen, social workers and general practitioners, are asked to fulfill some of these roles. In the final analysis, helping people is as much a humanistic as a technical enterprise.

Without further detailing the methodology, I would like to emphasize one point, i.e., a psychiatric crisis need no longer be considered the point of departure for a family member, but rather can be regarded as an entrée for helping the entire family to cope with its interpersonal conflicts. With the kind of help offered in a mental health center, families as total units can often attain a better adjustment than before, and the illness stemming from interpersonal difficulty will not rest entirely on the scapegoat member.

In summary, I should like to emphasize that modern psychiatry is beginning to see the family rather than the individual as the fundamental psycho-social unit for both diagnosis and treatment of disorders. At the same time, community mental health centers are bringing facilities back into the community as a means of repairing rather than rupturing families.

References


