

IDENTIFYING CASES OF THE SOCIAL BREAKDOWN SYNDROME

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A usable operational definition of the social breakdown syndrome requires a method for obtaining standardized, consistent, and concrete information regarding each patient's function during an assigned period.

THE MENTAL HOSPITAL SCHEDULES

In the exploratory phases, randomly selected mental hospital staff members were questioned about patients on their wards who were randomly selected from ward lists. Each staff member was asked to describe the patient's behavior in the few days preceding the interview. Three general areas were explored: First, what kind of useful things had the patient been doing? Second, in what ways was the patient trying to take care of himself? Finally, in what way was the patient a trouble or burden, either because help in daily living had to be provided or because he was socially disturbed?

Staff were asked which type of personnel would, in general, most likely be able to answer specific questions and whether they would always know about each area. It appeared that a seven-day period was long enough to permit adequate sampling of the patient's characteristic behavior and that ward attendants or nurses were the people who would most likely be able to answer the questions involved.

Since the hospital operates on a three-shift system and since no attendant is ever on duty for seven consecutive days, three schedules were developed, each concerned only with the patient's behavior during

an eight-hour period. There was a different schedule for the morning, day, and night shifts, each covering the same general aspects of behavior but each containing some questions specific to that shift, for example, regarding the patient's getting up or going to bed. Thus 21 questionnaires covering a seven-day period were completed for each patient.

The questionnaires were concerned with observable aspects of behavior and called for statements of fact. On each topic the informant was asked to check the statement which was true for that particular shift. The multiple choice statements describing the possible behavior were lined up on the left of the form and an abbreviated, telegraphic restatement was lined up on the right, with a corresponding series of check boxes. Once the attendant, or nurse, was familiar with the form, he could rapidly check the appropriate statements for each patient in his care.

After the shift, the questionnaire schedule was completed and returned to the Research Office where it was checked for impermissible multiple responses, inconsistencies, and omissions. Any queries thus raised were cleared up with the informant during his or her next period of duty. A member of the research staff was always available for help in completing the questionnaires.

The ease of completion of the questionnaire and the prompt personal feedback of queries undoubtedly contributed to the high level of cooperation and completion of schedules.

These three schedules were used in units of 21 consecutive shifts (one week) from September 1959 in following the fate of the Dutchess County cohort in residence at that time and their control group.

THE INTERVIEW SCHEDULE

A multiple choice questionnaire was developed for use with ex-patients in the community from the same set of questions. In the community, however, only a single informant was used to describe the patient's function during the seven days prior to the interview. Here the informant was, wherever possible, the former patient himself, but the questions in the schedule were directed to the interviewer. The interview itself did not follow a narrowly prescribed sequence. It was required of the interviewer that he observe or ask about each aspect of behavior until he was satisfied that he had sufficient information to answer the relevant question. Thus there was no standard interview

method; each interviewer was instructed to use his own judgment in his approach to a particular individual or question.

The interviewers were given both oral and written instructions regarding the technique and context of the interview, and the development of rules regarding question interpretation were under constant review.

Certain concepts such as "active recreation" were frequently re-examined. Does being directed to stand up in a circle in the ward while a medicine ball is passed from hand to hand constitute "active recreation?" We decided that it did not. We eventually ruled that drinking in a bar is "active recreation," while watching TV is a "passive recreation." Many of these judgments were arbitrary; common sense and consistency were the prime considerations.

It will be noted that patients in the hospital were not used as informants. There remains a tendency, even in units such as the one being described, to regard the patient as incompetent. Since this assumption was questionable, a pilot study was done in which both ward personnel and patients were asked about the same time period. The results suggested that the patient was at least as accurate as the ward personnel in describing his own functions.

Therefore, at the beginning of 1964 the interview form was modified so that it could be used either in the hospital or in the community. It was then specified that the patient should be the informant wherever possible. At the same time additional social and demographic data were obtained regarding each individual.

When the patient was unable to provide the information required, the interviewer was instructed to approach relatives, friends, ward staff, and other sources in order to build up as complete a picture as possible of the patient's behavior during the week.

Many problems of administration and interpretation came to light, but we believe that we now have sufficient experience with this instrument to specify conditions of administration and rules of interpretation which would enable this method to be used in different communities to obtain comparable data on the prevalence and incidence of severe social breakdown syndrome.

SCHEDULE CONTENT AND SOCIAL BREAKDOWN GRADIENT

The questions addressed to the ward staff or interviewer are concerned with two main areas of the patient's life in the previous seven

days: the presence or absence of troublesome behavior and his social function. A rating of 0, 1, or 2 can be obtained in each of these areas.

Troublesome behavior during the survey week is rated 0 if during the survey any *one* of the following was reported:

1. considered suicidal;
2. harmed self;
3. was placed in restraint;
4. was physically controlled during the night;
5. resisted eating a meal;
6. was assaultive;
7. was incontinent;
8. resisted arising;
9. resisted going to bed;
10. was mute during the entire week.

If the patient was not rated as 0, but one of the following less extreme items was reported he was rated 1:

1. precautions were taken to prevent self-harm;
2. was restricted to part of the ward or was held for a period;
3. wandered and resisted returning to bed during the night;
4. needed much help at meals;
5. was noisy or threatening;
6. had to be escorted to the toilet;
7. needed much help in dressing;
8. needed much help going to bed;
9. did not initiate conversation during the entire week.

If a patient was not rated either 0 or 1 on "troublesome behavior," he was rated 2, indicating no troublesome behavior or only minor manifestations during the survey week.

The patient's function during a survey week was rated 0 if the following were reported on *all* appropriate shifts during the week:

1. never away from supervision of ward staff;
2. did no work;
3. did not attend occupational therapy sessions;
4. did no reading or writing;
5. had no recreation.

The highest function rating of 3 was assigned if all three of the following criteria were reported during the week at any time (not necessarily on the same day):

1. away from supervision for three or more consecutive hours;
2. worked or did occupational therapy for two or more hours;

3. read or wrote for one hour or more *or* participated in active recreation.

A person who did not meet the criteria for a rating of 0 or 3 was rated 2 if he met one or two of the three criteria listed above, and was rated 1 if he met none of the three.

A combined index of Social Breakdown Syndrome Gradient was derived by adding the rating on troublesome behavior and the rating on function:

| | | Social Breakdown Syndrome Gradient Index ¹ | | |
|-----------------|---|---|---|---|
| | | Troublesome Behavior Rating | | |
| | | 0 | 1 | 2 |
| Function Rating | 0 | 0 | 1 | 2 |
| 1 | 1 | 2 | 3 | 4 |
| 2 | 2 | 3 | 4 | 5 |
| 3 | 3 | 4 | 5 | 6 |

For ease of reference, these five grades were assigned names as follows:

- 5—social breakdown syndrome absent
- 4—moderate social breakdown syndrome
- 0–3 severe social breakdown syndrome

The person described above with a score of 5 (the highest achievable by these criteria) is not necessarily a “normal” person. Passing this grade is certainly far below an optimal level of functioning. A person who takes care of his own personal hygiene and spends the rest of his time sitting around the house doing nothing, except for one occasion in which he plays a poor game of ping-pong would pass this test. He could even be a terror to his family and still pass this test, as long as he did not induce precautions against suicide and did not hit anyone. In short, his adaptation to life can be pretty shabby or appear very fragile, still by these criteria he will get a full score and not be counted as a case of severe social breakdown syndrome. This low level of performance was selected as the cut-off point precisely because it was these severe manifestations which are: 1. the most alarming to the social environment and, 2. are believed to be most readily prevented by appropriate care. The selection of this low level is not to be mistaken for an *optimal* level of personal functioning, nor as an argument against setting higher goals for mental health programs. The selection of this level reflects a deliberate selection of modest goals.

REFERENCE

¹ Gruenberg, Ernest M., Kasius, Richard V., and Huxley, Matthew, Objective Appraisal of Deterioration in a Group of Long-stay Hospital Patients, *The Milbank Memorial Fund Quarterly*, 40, 90-100, January, 1962. This article summarizes the same data in terms of five "levels of deterioration;" their "moderate level" includes both grades 3 and 4.