VIRTUAL INSTITUTIONS: COMMUNITY RELATIONS AND HOSPITAL RECIDIVISM IN THE LIFE OF THE MENTAL PATIENT.

by

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ABSTRACT

The transformations, since WW II, of the system of mental health care in the U.S.A., have been described as a movement from exclusion to inclusion. One of the most important changes, the expansion, through patient's rights litigation, of the mental patient's constitutional rights, has had the effect of making traditional exclusionary forms of care in the large state mental hospital ethically unacceptable. The result has been a form of inadvertent inclusion of the mental patient in the community. Because of altered commitment procedures and reduced lengths of stay, the mental patient now spends most of his time in the community. In this service context, high rates of readmission to public mental hospitals developed into a major public problem. High readmission rates are seen as the result of a mismatch between available services and the chronicity of the patient's disorder.

The subject of this thesis is the social situation of the formerly hospitalized mental patient in the community. With the use of qualitative research methods the patient's relations to the principal domains of community life -- marriage, family, work, and housing -- are analyzed. The patient's life in the community is described as perennially disordered. His relations to these recognized institutions of community life are characterized by unresolvable tension and discontinuity.

This puts him at considerable risk for rehospitalization. Due to his persistent lack of resources, he becomes exceedingly vulnerable to adversity. Relatively small problems turn into major, acute crises, from which only such services of last resort as the police, the emergency room, or the mental hospital offer relief. In this way the patient's social and economic environment in the current system of inclusionary care contributes to the "chronicity" of his disorder.

Thesis Supervisor: Martin Rein, Professor,
Massachusetts Institute of Technology.

"First, we must see that the discreteness of entity in which the disorder exists is questionable.....In so far as the patient's symptomatic behavior is an integral part of his interpersonal situation, the server would have to import this whole situation into the hospital in order to observe the patient's difficulty and to treat it. Instead of there being a relatively benign and passive environment and an isolated point of trouble, the figure and ground of usual service conceptions merge into one, the patient's interpersonal environment being inseparable from the trouble he is experiencing."

Erving Goffman, Asylums.

CONTENTS

ACKNOWLEDGEMENTS

Writing and completing a dissertation amounts to a succession of firsts. For most of us it is the first time that we, reluctantly, find ourselves committed to our ideas as they have become the foundation of the undeniable, day-to-day reality of a large research project. Transforming data into insight is the first experience with the art of, in my case qualitative, data analysis. Writing the thesis implies, after a prolonged diet of ten-page term papers, the sustainment of an argument over several hundred pages. All these tasks so far, formulating a question, collecting and analyzing data, reporting one's insights, are nothing more or less than the search for a style of research and writing that best suits one's temperament and sensibility. And above all, a dissertation involves the first exposure to the humbling, but ultimately rewarding experience of confronting long-held, comfortable prejudices to the unrelenting persuasive force of empirical data. I am forever grateful to the members of my dissertation committee, Martin Rein, Dan Lewis, Robert Weiss, and Sheldon White, who helped me chart this formidable obstacle course of firsts. Quite simply, without their continuing support and friendship this study would not have been.

In addition, many people have offered their time and assistance in helping to bring this study to a successful end. First and foremost, I thank the seventeen people whose life stories have formed the basis of this study. The openness and patience with which they explained to me what it is like to cope with mental disorder and its social and personal consequences was truly gratifying. Similarly I thank the families and friends of the patients whom I interviewed. Their's was not a simple situation and I can only hope that I have done justice to it in this study. Finally I'd like to thank the treatment coordinators in the mental hospital and the therapists, clinical workers, and other professionals in the various community facilities who, despite their overwhelming workload gave me generous amounts of their time to answer my questions about their clients. The insights that each, from their own perspective, gave me in the functioning of the contemporary mental health system have been invaluable.

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Finally, my greatest debt is to my wife Marjolein, whose unfaltering support carried this work from inception to completion.

PART I: FROM EXCLUSION TO INCLUSION: THE MENTAL PATIENT'S RETURN TO THE COMMUNITY

1. EXCLUSION, INCLUSION AND THE PROBLEM OF READMISSIONS TO PUBLIC MENTAL HOSPITALS.

1.1 Cases.

Let's edge into the complex subject of readmissions to public mental hospitals by considering some concrete examples.

Early in March of 1986, Jack, a single, white man, calls up the C-South unit of Chicago Read Mental Health Center, and asks if they have space to admit him. Jack looks much older than his 32 years. His hair and clothes are disheveled, he walks in a stoop, and he squints severely. He suffers from diabetes; recently the disease has begun to affect his eyesight which has deteriorated rapidly to the point that he is now legally blind.

Jack knows C-South, and its staff and patients, well. Since Christmas 1985, he has been admitted there three times, each time for only a few days. He greatly resented his last admission, which took place after he had created a disturbance in a residential rehabilitation center for the visually handicapped. During an altercation with a staff member he had put his fist through the window of the nurses' station and had badly hurt his hand. While he was treated in a nearby hospital, the center let the hospital know that it wouldn't take him back. As a result Jack was admitted to the mental hospital. Jack recalls bitterly:

"Because I have nowhere to go, (the center) has to send me

here. That's why they said I had to see a psychiatrist, to be able to send me here."

This time however Jack decides to call the mental hospital himself. He lives alone in a dilapidated apartment in a crime-ridden neighborhood on Chicago's West Side. He says that he was disturbed by noise from the street and voices of people, and that he was not sure that the voices were real or imaginary. The nurses at C-South were very friendly, according to Jack, and assured him to come by, and even told him that two of his friends were also admitted right then. He said, he then put his coat on, closed the door behind him, had breakfast at MacDonald's, and walked the ten miles from his apartment to Chicago Read.

Chip, a 39 year old, unemployed, black man, was admitted after he had taken his father's brand new car, with the purpose, as he said, of selling it. After driving around aimlessly for a number of hours, he decided to visit his sister. The sister persuaded him to return the car to his father. His father was furious and threatened to call the police, but Chip preempted his father's threat by calling his uncle, a police officer. On Chip's request the uncle arranged for his admission at Madden Mental Health Center.

The intake officer at the mental hospital was initially reluctant to admit Chip because he thought there was nothing wrong with him. But when the latter declared that he hears

voices, he is admitted. As Chip says:

> "I signed myself in, voluntarily. They didn't want me to come in, because they thought there was nothing wrong with me. But I convinced them that I had no place to stay. How did you convince them? They asked me if I was hearing voices and I said yes. (Laughs) It's not hard to act crazy with all the experience I have."

Within two days Chip is transferred from Madden to Chicago Read Mental Health Center. Chip is undomiciled, but Madden had established that he had received his SSDI check in the catchment area of Chicago Read. At Chicago Read, in turn, every effort is made to establish that Chip has actually lived with relatives in the catchment area of Tinley Park Mental Health Center to be able to transfer him there. And although Chip's treatment coordinator had persuaded several family members to state that he had lived with them recently, Tinley Park refuses to accept him. It is probably not coincidental that Chip, who has been admitted 35 times since his first admission in 1975, is intensely disliked by the hospital staff. His treatment coordinator calls him a sociopath, a distinction which, although it represents a recognized diagnostic category, carries an intense negative meaning in the world of the mental health provider. She thinks that Chip has himself admitted to the mental hospital to avoid jail. According to her every hospital is aware of this and accordingly doesn't want to deal with him.

Finally, there is Rosa, a 47 year old, slightly build,

black woman, with closely cropped grey hair. She has observing, intelligent eyes and usually an ironic smile plays around her lips. She is admitted at Chicago Read by the police, the day after she was discharged from Madden, because, according to the medical records, "she created a disturbance at a Walgreens drug store" in downtown Chicago. However, when I ask her about the events that precipitated her admission, she acknowledges that something happened, although, she claims, it was in a fast food restaurant, but that she decided to come herself because she had no place to stay:

> "I needed help, and I thought this was the place to come for help, since I've been here through my sickness. I needed help to find me a place to live. Who took you to the hospital? No one. I walked in."

How to resolve this apparent contradiction? Her treatment coordinator at the mental hospital is inclined to believe Rosa. He says that she denies to have acted bizarre, but is personally convinced that she did. However he thinks that her behavior was wilful, that she acted in a way she knew would draw the attention of the police. He says that he likes her and that he considers her a smart woman. He thinks she uses her delusions for her own benefit. This admission was Rosa's 28th admission in the Illinois state system.

What is it we have witnessed here? What happens in a person's life to turn an admission to the mental hospital, in a matter of weeks, from something that is resisted and defied,

into something desirable, or at least acceptable. Why would someone feign psychopathological symptoms to gain admission to a mental hospital? How are we to understand a delusion, something to which the patient, by definition, is subjected, involuntarily, against his will, which somehow serves a deliberate purpose? What factors decide when someone goes to jail or to the mental hospital? In what way do loneliness, lack of money, or lack of shelter influence the likelihood of someone's readmission? And, finally, to what extent is the professional typification of the individual's problems an accurate representation of the reasons for his admission?

These and similar questions reflect the many contradictions and complexities which surround a person's readmission to a public mental hospital in the contemporary system of community mental health care. Somehow the examples go against our commonsense notion of what it takes to be admitted to a mental hospital. All three individuals exhibit the expected clinical symptoms --- hallucinations, delusions, disorders of mood or character --- but the examples make clear that the clinical circumstances alone fail to adequately explain the person's return to the hospital. Rather it seems that the scale is tipped by the person's social, economic, and institutional circumstances. Jack seeks admission because there is no one to listen to his fears and anxieties. Chip seeks admission to avoid a conflict with his father. And in Rosa's case, her homelessness has even influenced the timing

and expression of her clinical symptoms.

1.2 The Transition from Exclusion to Inclusion in Psychiatric Service Delivery.

On a more general level of analysis it is fair to say, that both the frequency of readmissions as the circumstances that surround the patient's return to the institution, speak to the drastically changed role of the mental hospital in the contemporary system of mental health care. The last three decades have seen a sea-change in the organization and financing of services for the mentally ill. Both the scope and the impact of these transformations in social policies towards the mentally ill make them particularly hard to interpret for the policy analyst. Not only have they affected almost every aspect, of mental health care, like the location of care, the balance between the public and the private sector in the delivery of care, average length of stay in mental hospitals, the number of treatment episodes in both inpatient and outpatient facilities, and, most important, the relation between patient and provider, but many of the changes, like the rise in the number of admissions to state hospitals, or the community tenure of formerly hospitalized mental patients, have been the unintended byproduct of deliberate policy implementations.

Many of the specific changes in social policies toward

the mentally ill were the result of different interests following their own agenda. Legal advocates vied for a restoration of the mental patient's constitutional rights. Reform minded professionals contended for less segregated forms of care. Fiscally concerned state legislators aimed at a decreased role for the state in the provision of care for the mentally ill. Following Stanley Cohen, these complex and interlocking agendas can perhaps best be summarized as a movement from an exclusionary towards an inclusionary system of care for and control of the mentally ill. Whatever their particular motivation, the efforts of the various participants in the mental health reforms were inspired by a general inclusionary impulse: the wish to define society's relation towards the mental patient --- and deviant, marginal groups in general --- in more egalitarian fashion. Integration into society and the restoration of the patient's civic autonomy as an ethical and professional ideal, was at the top of the reformers' agenda during the years of community mental health. As Cohen writes: "Inclusion was the positive as well as abolitionist message of the destructuring movements: integration in the community rather than segregation in the closed institution, decentralizing, weakening or diverting from various systems of exclusion, classification and control; even accommodation or non-intervention".1

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1 Stanley Cohen, Visions of Social Control. Crime, Punishment and Classification, 1985: 267

With this agenda as the ideological standard, the inclusionary movement in mental health care has led to mixed, even paradoxical, results. For example, in the current system of care, many patients, including some of those formerly admitted to mental hospitals, live in community residential facilities like nursing homes, board-and-care facilities, and halfway houses. Admission to and discharge from these facilities almost always occurs in agreement with the resident. So, strictly speaking, this new generation of patients has successfully traveled the trajectory from exclusion to inclusion, from custody in large-scale mental institution, segregated from the rest of society, to voluntary treatment in small-scale facilities located in the community. Yet, many of these residential facilities use the same kind of paternalistic and dehumanizing social control practices, and rely as much on psychotropic medication as a means of constraint, as the former large, custodial mental hospital. In fact many of these newer community residential facilities represent a continuation of traditional exclusionary forms of care and control, a circumstance which have led some observers of the field to dub this category of facilities "nontraditional institutions".2 In the case of community

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2 Paul Lerman, Deinstitutionalization and the Welfare State, 1982: 59: " Available evidence supports the thesis that restrictive living is not only associated with traditional institutions. Newer forms of institutions, such as nursing homes, use locks, physical restraints, and seclusions. These older social control-practices tend to be associated with medical-type facilities for adults. Yet children's

residential facilities, inclusion has amounted to a relocation, or rather a dispersion of exclusion.

The mental hospital, the topic of this study, provides the best example of the complexity and ambiguity of the changes in psychiatric service delivery. In terms of numbers the hospital has never lost its prominence as the most important provider of psychiatric care. Although the year-end census count in state mental hospitals had decreased to an all-time low of 121,000 in 1982 (down from over 500,000 in 1955), during that same year 344,000 additions (admissions, readmissions, and returns from leave) and 342,000 discontinuations (discharges and placements on leave) had been registered.3 Today as many, or more, people see the inside of a public mental hospital as three decades ago at the heyday of the large custodial mental institution.

It is true that, in terms of the number of treatment

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facilities, regardless of medical auspices, utilize physical controls in a variety of group settings.

Besides these older modes of control, the new facilities also enforce curfew rules and restricted access to the community, spending money restrictions, and psychotropic drugs. This latter mode of influencing resident behavior appears to be the most widespread control device. Psychotropic drugs have been found to be prescribed in unusual amounts and combinations in nursing homes, special children's treatment facilities, board-and-care homes, group homes, and halfway houses, as well as in special hospital units and correctional facilities."

3 Leona L. Bachrach, "Deinstitutionalization: What do the Numbers Mean?", Hospital and Community Psychiatry, 37, 2, February 1986: 118

episodes for psychiatric care, the mental hospital is surpassed by the general hospital, but there is evidence that general hospitals cater to a different, less impaired, population.4 The growing importance of general hospitals in the provision of psychiatric care, thus, seems to represent an example of "supplementation", or expansion of care. Populations which until recently had rarely been touched by mental health care, such as alcoholics, or neurotics, are now drawn into the system of general hospitals and community mental health centers, while the mental hospital continues to care for the traditional group of indigent, psychotic, troublesome, and dangerous patients.5 Thus for its traditional clientele, the mental hospital, the quintessence of exclusionary care, has retained its central position in the system of psychiatric service delivery.

What has changed however, under the influence of deinstitutionalization, is the way in which the hospital delivers its care to its traditional clientele. Under the influence of extensive patients' rights litigation in the late 1960's and early 1970's the emphasis in the commitment and treatment of mental patients has shifted from clinical to

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4 Ch. Kiesler & A. Sibulkin, "Episodic Rate of Mental Hospitalization: Stable or Increasing", American Journal of Psychiatry, January 1984.

5 Stanley Cohen, Visions of Social Control: 49.

legalistic criteria.6 The decision to admit or release became, for all practical purposes, voluntary. An array of legal aid attorneys and patients advocacy committees now closely monitor the implementation of due process in the relation between patient and hospital.

Lewis and Reed argue that it is difficult to overestimate the effect that this influx of legal advocates has had on the organization of the mental hospital. While the traditional large-scale mental institution was largely segregated from civil society, the contemporary mental hospital had to open its doors to a variety of organized interests, such as unions, patient advocacy groups, accreditation and licensing committees, and policy making bodies. The effect has been a complex change in the relation between the patient and the hospital, a transformation which so far has been insufficiently understood. On the one hand, many hospital workers complain that in decisions involving patients, the patient's needs take second place to the demands of the hospital's regulatory environment. On the other hand, both in its organization of treatment and its decision making with regard to discharge, mental hospitals have become more integrated with the large social service network outside its walls.

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6 Dan A. Lewis & Susan Reed, "The State Hospital in Mass Society: A Re-examination of Mental Health Policy", draft, 1987. The analysis on this and the following pages draws on the ideas expressed in this paper.

Hardly less important than this breakdown of the hospital's civic isolation has been the reduction in length of stay in public mental hospitals. The availability to discharged mental patients of federal income support programs, and a professional ideology that promoted community over institutional care, stimulated state departments of mental health in the late 1960's to reduce the length of the patient's admission to the mental hospital. Between 1970 and 1980 the median length of stay in state and county mental hospitals dropped from 41 to 23 days.7 In practice many patients are discharged after much shorter periods. The time-consuming and complex legal procedure that governs involuntary commitment forms a powerful incentive to hospital staff and public aid lawyers to avoid these types of commitments as much as possible, and to persuade or coerce the patient to sign voluntarily. This then automatically puts a cap on the time that the patient can legally spend in the hospital.8

So, the change in the patient's legal status, and the reduced length of stay have diluted the traditional segregated, exclusionary aspects of the public mental hospital. But the most far-reaching inclusionary effects of

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7 Source: National Institute of Mental Health, mimeo, unpublished.

8 See Dan Lewis, Edward Goetz et.al., "The Negotiation of Involuntary Civil Commitment, Law and Society Review, 18, 4, 1984. In our study of hospital admissions in the Chicago area we found that less than 3 percent of admissions were involuntary commitments.

the community mental health movement have been the unintended side-effects of these changes in the hospital's mode of operation. To this we turn in the next section.

Ironies of Inclusion: The Mental Patient's Return to the Community.

For the patient the main effect of these changes in the organization, administration, and financing of psychiatric service delivery has been a shift in the focus of his world from the mental institution to the community. Despite often frequent rehospitalizations patients spend the largest part of their time outside institutional walls. Michael, provides an example. In the twelve months preceding his latest readmission, he has been hospitalized three times. As table 1

Table 1: Michael's Admissions, June 1985 - June 1986

Date	# of days in hospital
11/12/1985 - 12/03/1985	21
01/26/1986 - 02/06/1986	11
04/13/1986 - 04/25/1986	12
05/02/1986 - 06/05/1986	34
	78

shows, despite a total of four admissions in one year, Michael spend 287 days outside the mental hospital in that period.

Fred, one of the most frequently admitted patients in our

sample, provides another example. As table 2 shows, between March 1985 and March 1986 Fred was admitted a total of five times. Yet despite his recurrent hospitalizations, and one unusually long admission, he still spend 191 days of the year outside the hospital.

TABLE 2 Fred's Admissions, March 1985 - March 1986

Date	# of days in hospital
03/25/85 - 03/26/85	1
05/10/85 - 05/17/85	7
06/06/85 - 09/30/85	116
10/25/85 - 12/09/85	46
03/15/86 - 03/19/86	4
	174

Data about the community location of discharged mental patients are conflicting. Studies done in the early 1960's, during the first wave of deinstitutionalization, show that 70 to 80 percent of patients return to their families after their release. The remainder live alone or in boarding houses.9 However, more recent studies, studies that focus on chronic patients, and studies done in highly urbanized areas, generally show a smaller proportion of patients returning to their family. Goldman estimates that in 1975 approximately

9 Kenneth Minkoff, "A Map of the Chronic Mental Patient", in John A. Talbott (ed), The Chronic Mental Patient. Problems, Solutions, and Recommendations for a Public Policy, 1978: 17-18.

one million patients (65% of 1.5 million admitted patients) returned to their families after their discharge from the mental hospital; 25 percent of these are thought to be chronically mentally ill.10 A 1972 follow-up in California of patients under 65 years of age shows the following distribution of location after discharge: 26 percent live with relatives, 11 percent alone, 4 percent in satellite housing, 9 percent in convalescent hospitals, 1 percent in prison, and 49 percent in boarding houses.11 Most of the community facilities where these patients reside are unsupervised and do not provide any form of therapy or rehabilitation. Despite incomplete and inconclusive data, it is fair to say that the majority of mental patients return to the community after their release from the mental hospital, and are largely thrown back their own resources to maintain themselves in the community.

Yet, for the patient, more is involved than merely a change in his location. These figures about the patient's location in the community tell us nothing about how he lives: with whom he socializes, how he secures himself an income, where he works, what he does in his spare time, and how he spends his money. The transformation in the organization of

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10 Howard H. Goldman, "Mental Illness and Family Burden: a Public Mental Health Perspective", Hospital and Community Psychiatry, 33, 7, July 1982: 558

11 Minkoff, "A Map of the Chronic Mental Patient": 18.

psychiatric service delivery has brought with it a concomitant change in the organization of the patient's life-world. Traditionally the mental hospital provided total care for the mental patient. In addition to treatment for his mental disorder, it fulfilled the patient's need for shelter, food, vocational activity, and friendship. For many long-term patients the mental hospital was a self-contained world in which their basic needs were taken care of.

Today, the mental patient first of all has to rely on community institutions for the fulfillment of his basic needs. To obtain shelter he has to compete in the market for rental housing. To satisfy his need for friendship and intimacy he has to rely on his family, his spouse, or his friends. To obtain an income he has to work. Instead of hospital staff the people with whom the patient confides most frequently and closely are his spouse, his relatives, his friends and his neighbors. In effect, in terms of location and life-organization, the changes in mental health care had the effect of 'normalizing' the mental patient. To attain a fulfilled and satisfactory life he is dependent on the same community institutions --- marriage, the family, the labor market, the housing market, the neighborhood --- as everybody else.

There is a definite irony in these developments. Through our reform of the large state mental hospital we have finally arrived at inclusion, but it is inclusion by default, inclusion as a result of the legal-administrative obstacles

that society has thrown in the path of exclusionary care in the mental hospital. Instead of the ideal of human, integrated, care of the mental patient in the natural setting of his daily life, the patient's inclusion in the community has come reluctantly, inadvertently. It has arrived as the unforeseen byproduct of society's wish to restore the mental patient, and other marginal groups, into their constitutional rights.

The intricate distribution of inclusion and exclusion which characterizes the contemporary mental health system is the result of a tension between society's altered legal image of the mental patient and its need for control, or, to put it less formally, the tension between the abstract and the concrete image of the mental patient. In everyday interaction mental patients are generally regarded as dangerous, unpredictable, and a nuisance. In many instances the excessive and disruptive behavior of mental patients is a burden for their environment. However, because of the patient's expanded civil rights, blatant exclusion is morally unacceptable and practically difficult. The result has been the emergence of, what could be called, forms of concealed exclusion. For example, instead of confining troublesome, unwanted patients for long periods of time in highly visible mental institutions, we confine them in less conspicuous community institutions such as nursing homes, and board-and-care facilities. Instead of involuntarily committing people to

the mental hospital, we use various forms of persuasion and coercion to get them to sign voluntarily.12 In the same vein, the mental patient's return to the community is a form of concealed exclusion. Because of the unacceptability of overt exclusion, the agents of the state which traditionally dealt with the mental patient have unilaterally transferred the responsibility for his control to the informal institutions of community life, such as the family and the neighborhood. Granted, it constitutes inclusion of the mental patient in the community, but it is inclusion in parenthesis

Thus, both as a matter of fact and as a matter of principle, the community provides the patient's principal environment. The complex series of changes in the legal, fiscal, and administrative structure of psychiatric service delivery that go under the rubric of deinstitutionalization, had the effect of irrevocably altering society's relation to the mental patient. The collective wish to see the mental patient, first, as a citizen with constitutional rights, and, second, as someone afflicted with mental disorder, has brought the patient back in the folds of community life. The implicit message to the formerly hospitalized patient in all this has been that he should, and can, live like everybody else. He should set himself to find a job, a spouse, and a place to

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12 Dan Lewis et. al., "The Negotiation of Involuntary Civil Commitment".

live, and in case his mental illness interferes with this task, he should refer himself to the manifold community services that were specifically designed to provide him with short-term, non-intrusive care

Second Thoughts: Problems with the Patient's Community Tenure.

It is in the context of the changed way in which society regulated its relation to the mental patient that the issue of high rates of readmissions acquired its special meaning.

The transition of the patient from the institution to the community has brought its own set of problems, or alleged problems, both for the patient and the community. In the mid 1970's the number of homeless people on the inner-city streets increased visibly, and led to alarming reports in the national newspapers. It was assumed that many of the homeless were formerly hospitalized mental patients who had been abandoned by the newly erected community mental health facilities.13

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13 References to the mentally ill homeless are abundant in the professional literature. A good example of the usual indignant, although not necessarily careful, style of writing on this subject is Henry Foley & Steven Sharfstein: Madness and Government. Who Cares for the Mentally Ill?, Washington, 1983: 96. Despite the frequent I-told-you-so, rhetoric, remarkably little research had been done to document the claims that scores of formerly hospitalized mental patients were populating our side-walks. Among the few examples of a carefully executed and documented study of the homeless, Freeman and Hall's survey of the homeless in New York City found that only 1 percent of the homeless came directly from mental hospitals. This does not exclude, of course, that many among the current homeless could have been hospitalized under a more liberal commitment regime. The authors estimate that

During the same period the families of mentally ill children became an increasingly vocal pressure group, which time and again pointed to the dislocating effect that current admission procedures had on family life. And, in the professional literature a new category of patients was 'discovered', the "young chronic mental patient", who were thought to be the direct product of the deinstitutionalized system of mental health care. Although clinically they formed a diverse lot, what made them stand out was the frustration and resentment they provoked among providers.14

Looking back it is easy to see that the first critique of the transfer of mental patients from the institution to the community arose precisely among those segments of society that carried the burden of caring for the formerly hospitalized mental patient: the family, the neighborhood, and the clinical

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without deinstitutionalization roughly 14 percent of the current homeless would have been committed to the mental hospital.

Similarly Rossi and Wright, in their study of the homeless in Chicago, found that 23 percent of their sample of homeless people reported to have been admitted to a mental hospital at least once in their lives. This is four times the rate in the general population. Although mental disorder is a common occurrence among the homeless, it is clear from these figures that de- or noninstitutionalization is not one of the major causes of current homelessness in America. (Richard Freeman & Brian Hall, Permanent Homelessness in America?, NBER Working Paper #2013, September 1986: 18-19; Peter H. Rossi & James D. Wright, "The Determinants of Homelessness", Health Affairs, 6, 1, Spring 1987)

14 For example Bert Pepper, Michael Kirshner & Hilary Rygkewicz, "The Young Adult Chronic Patient: Overview of a Population", Hospital and Community Psychiatry, 12, 7,(July 1981): 464

worker in the community mental health facility. Civic virtue collided with clinical, and economic, reality. Those institutions in the community that dealt most directly with the formerly hospitalized mental patient felt least equipped to do so.

Amidst these various indications of mounting tensions within society's newly defined relation to the mental patient, none took on the importance as the statistics that indicated that the proportion of readmissions to first admissions in mental hospitals was rapidly increasing. First of all, the readmission rate provide the statistical evidence --- or so it was thought at least --- that something was wrong with the new system of community care. But, more important, the rising readmission rate tied in with the professional's conceptual understanding of its field of care. Patients kept coming back to mental hospitals, it was believed, because they suffered from a chronic illness. The resources that were available in the community for mental patients were insufficient or inappropriate to deal with chronic mental illness. In their therapeutic optimism the community mental health reformers had forgotten to take chronicity into account.

1.3 Chronic Mental Illness and the Rising Readmission Rate.

To fully grasp the meaning of readmissions to public mental hospitals in the current constellation of psychiatric

service delivery, it is necessary to describe its emergence as a public problem.

First the facts. Between 1969 and 1975, the period in which the complex series of changes in hospitalization practices which are generally summarized by the term deinstitutionalization were fully instituted, the proportion of readmissions to total admissions increased at an alarming speed in most public mental hospitals. Nationally, in these years the number increased from 47.1 percent to 60.1 percent. In many individual states the proportion of readmissions has stabilized at about 70 percent of total admissions.15 Together with another statistic that was seemingly out of control in the early years of deinstitutionalization, the rising number of admissions proper --- between 1955 and 1970 admissions rose from 185,597 to 402,472 per year --- the conviction took hold, with the professional community and the general public, that we were witnessing one of the uglier consequences of the community mental health reform: an abandonment of our national responsibility for the mentally ill, exemplified by an accelerating rate of return to the mental hospital.16 The concern found a label, the "revolving

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15 Abbot S. Weinstein, "The Mythical Readmission Explosion", American Journal of Psychiatry, 140, 3, March 1983; Phil Brown, The Transfer of Care. Psychiatric Deinstitutionalization and its Aftermath, 1985: 76.

16 Phil Brown, The transfer of Care: 51. Between 1970 and 1980 the number of admissions declined again, from over 460,000 annually to 332,920.

door", and a public problem was there that urgently needed amelioration.17

The Emergence of Chronic Mental Illness as a Public Problem.

Political issues, like health fads and heroes of popular culture, tend to ride on the waves of public attention. As Anthony Downs observes, these shifts in public consciousness usually do not follow changes in real conditions as much as they reflect a systematic cycle of heightening and lessening of public interest.18 Public issues, it follows, are not ready-made categories hardwired into social reality, but the product of the concerted efforts of the various participants in the political arena --- politicians, media, professionals, scholars, and the general public --- to grasp and articulate the complexities of their age. Public issues are created in a "common image", the product of the shared cognitions and interactions of the community which reflect members' needs and worries.19

Yet, not everything goes in the public arena. Under the surface of public consciousness potential issues are

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17 Again the literature is abundant, and some of it we will encounter later in this chapter. The phrase "abandonment of responsibility for the mentally ill" is from Ernest Gruenberg & Janet Archer, "Abandonment of Responsibility for the Seriously Mentally Ill", Milbank Memorial Fund Quarterly/Health and Society, 57, 4, 1979.

18 See Anthony Downs, "Up and Down with Ecology --- The 'Issue-Attention Cycle'", The Public Interest, 28, 1972.

19 The phrase is from Murray Edelman.

articulated, and alternatives excluded, according to the insights and interests of, what Gusfield calls the "owners" of an issue, the political or professional groups who have a vested interest in its existence.20 When the time is ripe, the issue jumps into general consciousness, full-fledged, a prepackaged combination of dire problem and authoritative understanding. Part of the rapid spread, among mental health professionals and policy makers, of alarm about the rising readmission rate was no doubt a circumstance of the fact that a convenient, and convincing, explanation was already at hand: the notion of chronic mental illness. Following the aforementioned pattern of political agenda setting, the cognitive-political map of the concept had been drawn in preceding years by the various 'owners' of the problem.

During the 1975 annual meeting of the American Psychiatric Association (APA), the New York County District Branch of the APA issued a so called action paper in which it drew attention to the plight of the chronic mental patient in the decentralized system of mental health services. "The chronic mental patient", the paper states

> "schizophrenic, elderly, or suffering from recurrent affective disorders, has been the concern of a relatively small number of psychiatrists."

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20 Joseph R. Gusfield, The Culture of Public Problems. Drinking-Driving and the Public Order, Chicago, 1981: 14.

The psychiatric profession has preferred the acutely and the non-psychotic

> "leaving state hospitals to provide care for the large group of chronically psychotic patients."

However, because of the advent of the community mental health movement

> "Many of these chronic patients have been discharged from state hospitals to poorly organized or non-existent community programs....Many of these patients drift from emergency room to emergency room, are periodically hospitalized for a limited time, and are discharged to drift in the community once again. There is no follow-up, minimal research into their needs, and little effort to develop programs to alter the course of their illness."21

In the remainder of the paper the authors speak of "the psychiatric community's continued neglect of this group, and urge the APA to provide leadership on the issue of the chronic mental patient. The New York County's call for action resulted in a national conference on the chronic mental patient held in Washington DC in 1978 and sponsored by the APA and the President's Commission on Mental Health. The conference addressed a large number of issues concerning the chronic mental patient, like the epidemiology of chronic mental illness, diagnosis, the needs of chronic patients, legal rights, and economic support.

The conference arrived at conclusions which converged

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21 John A. Talbott (ed), The Chronic Mental Patient. Problems, Solutions, and Recommendations for a Public Policy, Washington D.C., 1978: 223-224.

with a long standing legislative concern over the implementation of the 1963 Community Mental Health Centers Act. In 1972 consumer advocacy groups had forcefully criticized the program for its lack of accountability to consumers and the inability of Community Mental Health centers to provide satisfactory aftercare to patients who were released from state mental hospitals. When in 1974 the CMHC program was on the legislator's agenda, they showed to take this criticism seriously by making the funding of CMHC'S mandatory upon the provision of aftercare to formerly hospitalized mental patients.

In 1977, shortly after his inauguration, President Carter created the President's Commission on Mental Health. The discourse, in circles of professional psychiatry, on the chronic mental patient, informed the Commission's understanding of the problems with the original CMHC Act. The chronic mental patient formed an important element in the Mental Health Systems Act as it was prepared by the President's commission. The general opinion is that the Act acknowledged the plight of this category of patients, but was unable to come up with an effective policy on their behalf, and spoke to their concerns in an insufficient and sometimes conflicting way.22 In 1980, a few months after the Act was passed by the legislature, the Department of Health and Human

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22 Foley & Sharfstein, Madness and Government, chapter 5.

Services issued a comprehensive and ambitious National Plan For The Chronically Mentally Ill.23

By 1980, as a result of the convergence of professional articulation, legislative interest, and public concern the notion of the chronic mental patient had become, what Donald Schon calls, an "idea in good currency". From now on it was firmly entrenched on the political agenda. The problems that patients, families, and providers encountered in the system of community mental health care were attributed to the chronicity of the patient's affliction, or more precisely, the mismatch between the patient's condition and the services that were available to him.24 The altered relation between the mental patient and society as it had emerged in the transition from institutional to community care, was now framed in terms of

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23 U.S. Department of Health and Human Services, Toward a National Plan for the Chronically Mentally Ill, Washington D.C., December 1980.

24 Once again the literature is abundant. The locus classicus on the chronic mental patient is John A. Talbott (ed.), The Chronic Mental Patient. A typical quote concerning the kind of services that are needed for the chronic mental patient is the following: "To treat the chronically mentally ill effectively, a public mental health system must have a comprehensive range of services that is tailored to meet their needs. This tailoring must address issues of cultural relevance, ethnic identity, and age appropriateness. Services must be accessible, not overly restrictive of the patient's freedom, and appropriate to the clinical needs of the patient. In today's economic climate, an important prerequisite is that any service offered be cost-effective (not cheap)." J. R. Elpers, "The Needs of the Chronically Mentally Ill: The Perspective of a Director of a Large Urban Mental Health Program", in Moshen Mirabi (ed.), the Chronically Mentally Ill. Research and Services, 1984: 58.

chronic mental illness.

In this context of problem and action the persistently high rates of readmissions to public mental hospitals were the major empirical basis for the idea of chronicity.25

1.4 Chronic Mental Illness and the Problem of Contextuality: the Realist Conception of Chronic Mental Illness.

The central concepts in public discourse relate knowledge to action. They are drawn in such a way as to combine

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25 As so often in matters of public policy, the measure drives the concern. Various authors have argued that the readmission rate is a misleading indicator for hospital recidivism, or the proportion of patients who return to the hospital after discharge. The readmission rate is a proportion of total admissions, and as such reflects administrative changes in admission policy. When, for example the number of first admissions goes down, with equal readmissions, the readmission rate would nevertheless increase. This, Weinstein argues, is exactly what happened between 1970 and 1980.

To gauge true recidivism rates we need statistics of the number of patients who return to the mental hospital within a specified period of time. Such numbers do not exist on the national level. (Charles A. Kiesler, "Public and Professional Myths about Mental Hospitalization. An Empirical Reassessment of Policy-Related Beliefs", American Psychologist, 37, 12, December 1982: 1332.) However Anthony's famous overview of studies of recidivism showed a recidivism base rate of 40 to 50 percent within one year of discharge. This number had not appreciably changed between 1955 and 1972. (W.A. Anthony, G.J. Buell et.al., "The Efficacy of Psychiatric Rehabilitation", Psychological Bulletin, 78, 1972: 117.)

Although 'true' recidivism, contrary to the readmission rate, has been stable, this does not imply that recidivism is not an issue of concern, of course. Indeed, the number of discharges has increased parallel to the number of admissions between 1950 and 1980. With a stable, 50 percent recidivism rate, this means that in absolute terms, the number of returns to the hospital has increased since 1955.

intellectual understanding, emotional assurance, moral justification, and general prescriptions for action.26 The concept of chronic mental illness is no exception to this. A review of the literature reveals at least eleven dimensions to the notion of chronic mental illness. Chronic mental illness is characterized among other things by "long duration", "frequent recurrence", a "progressive course", "persistence of symptoms", a large number of hospitalizations", and feelings of hopelessness in the provider.

Philosophically speaking, chronicity is currently understood in ontological or realist terms. Chronic mental illness, that is, is thought of as a distinct entity which has an existence apart from the particular individual who exhibits the disease or the particular circumstances which surround it. The disease proceeds along a constant and predetermined

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26 This view of the concepts in policy discourse is drawn from Martin Rein's ideas on the role of "frames" in "value-critical policy analysis". See for example his "Value-Critical Policy Analysis", in Daniel Callahan & Bruce Jennings (eds.), Ethics, The Social Sciences, And Policy Analysis, New York, 1983: 97: "The concept of frame draws philosophically on Dewey and Bentley's work Knowing and the Known, in particular their insistence on the importance of introducing action as an essential part od the knowing, naming, and thinking process. A frame then deals with the perspective by which we see reality and act on it. A frame provides us with a vision in a world of doubt and permits us to see where we are getting with our ideas. Moreover it grounds our interests and permits us to integrate facts and values. A frame provides us with a whole structure by integrating interests, values, actions, theory, and facts. A frame is broader than a theory because it contains the normative action implications of the theory and the interests served by it."

pattern of symptom development.27 From this perspective chronic mental illness is not only considered as generically similar to other 'realist' chronic diseases such as cancer, diabetes, or multiple sclerosis, but in a fundamental sense the disease is independent of its behavioral manifestation. Even if the chronic mental patient acts 'normal', the disease is only thought to be in remission.

Problems in Determining Chronic Mental Illness: an Example from Epidemiology.

The current professional consensus, then, is to define chronic mental illness in absolutist, realist terms. In terms of policy actions and policy planning this conception logically entails the necessity to assess the spread of the disease in the community as the factual basis for the overall planning of required service capacity. Within the contemporary framework of chronicity therefore, there is a need for epidemiological research. As it is stated in a recent Massachusetts policy proposal: "The definition of chronic mental illness is the backbone of any practical

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27 For example, Harding et.al.: "(Kraepelin) classified these diseases according to a concept of linear unfolding sequences of cause, onset, course, and outcome as specific, inflexible natural histories of every disorder." Courtenay M. Harding, Joseph Zubin & John S. Strauss, "Chronicity in Schizophrenia: Fact, Partial Fact, or Artifact?", Hospital and Community Psychiatry, 38, 5, May 1987: 477.

planning process".28

However, despite its alleged realist nature, attempts to assess the prevalence of chronic mental illness in the community have encountered serious problems. Prevalence estimates tend to vary wildly, and the epidemiology of mental illness is associated with intricate methodological problems.29 An example will illustrate this point.

The most influential recent attempt at the identification and classification of the chronically mentally ill is that by Goldman and Taube in the National Plan for the Chronically Mentally Ill.30 Goldman et.al. define chronic mental illness

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28 Mental Health Action Project, Interim Report of the Mental Health Action Project, presented to the Commonwealth of Massachusetts, Boston, April 18, 1985: 10

29 In discussing a number of classic epidemiological studies of the community prevalence of mental disorder, Dohrenwend and Dohrenwend state that these studies have uncovered "a thicket of measurement problems". Underlying all these problems, they argue, is the issue of validity. Their conclusion is that: "Analysis of the measures of psychological disorder used in the community studies of 'true prevalence' indicates that none of these investigations has provided convincing evidence of validity." They recommend that researchers in this field focus their attention on the issue of transiency in mental symptoms, "the extent to which social environmental factors produce transient as against persistent psychological symptoms". Bruce P. Dohrenwend & Barbara Snell Dohrenwend, Social Status and Psychological Disorder: a Causal Inquiry, 1969: 109.

30 U.S. Department of Health and Human Services, Toward a National Plan for the Chronically Mentally Ill. The ideas on the epidemiology of chronic mental illness that are stated in this plan, are further developed in H. Goldman, A. Gattozzi & C. Taube, "Defining and Counting the Chronically Mentally Ill", Hospital and Community Psychiatry, 32, 1, January 1981. Goldman et. al. have been widely cited and emulated, among

along three dimensions: diagnosis, disability, and duration. Each dimension or criterium delineates a slightly different population or set of subjects; where the three sets overlap we find the core population of chronic mental patients. As Goldman et. al. state: "Chronic mental patients suffer severe and persistent mental or emotional disorders that interfere with their functional capacities in relation to such primary aspects of daily life as self-care, interpersonal relationships, and work or schooling, and that often necessitate prolonged hospital care."31 However, despite the authors' assurance that the three criteria are sufficiently precise to accurately delimit the population of chronic mental patients, their actual, practical application suffers from serious, unresolved problems of reliability and circularity.

Diagnosis, the first criterion, is established according to The Diagnostic and Statistical Manual of Mental Disorders (DSM-III).32 Those who belong to the diagnostic categories of schizophrenic disorders, paranoid disorders, and major affective disorders are considered mentally ill. DSM-III is an attempt to increase the objectivity and reliability of

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others in Talbott, 1983, Freedman & Moran, 1983, and Mental health Action Project, 1985. In this chapter we will largely draw upon the more recent ideas in Goldman, Gattozzi and Taube, 1981.

31 Goldman et.al., "Defining and Counting the Chronically Mentally Ill": 23

32 Diagnostic and Statistical Manual of Mental Disorders, 3rd ed., Washington DC, American Psychiatric Association, 1980.

psychiatric diagnosis through general agreement on an authoritative definition of the various psychopathological syndromes. The purpose of ordaining fixed definitions of psychiatric syndromes to the community of mental health practitioners is to reduce as much as possible the subjective, interpretive element in illness designation. Yet, as Jeffrey Coulter has pointed out, this strategy is not likely to work, because it disregards what he calls the "open-textured" nature of such broad, socially defined concepts as mental illness. No taxonomic description of the concept, no matter how explicit, is able to foresee all the necessary recognition rules that an observer needs to identify the conceptual class under all possible practical circumstances.33 In other words, to resolve the inevitable uncertainty that arises in situations of practical judgement, to fill in the conceptual gaps that are left blank by the definition, the observer has to fall back on his subjective judgement, thereby prejudging the very question that the 'objective' definition was supposed to solve. The use of an authoritative diagnostic manual gives no more than an illusion of objectivity and exactness.

Disability, the second dimension, is defined as a "functional limitation" in three or more of the following areas of "major life activity: self-care, receptive and expressive language, learning, mobility, self-direction,

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33 Jeffrey Coulter, "The Metaphysics of mental Illness", in ibid, The Social Construction of Mind, London, 1979: 148

capacity for independent living, economic self-sufficiency". However, as the authors readily concede, "objective measures of these functional limitations are not in widespread use, so in practice we have to rely on a next best operational criterion, which is receipt of SSI". And they continue by asserting that "there is general agreement that approval of SSI eligibility is a measure of chronic disability for non-institutional persons".34

The use of SSI eligibility as a proxy for functional disability due to mental disorder rests on the assumption that there exists perfect identity between disability as a medical category and disability as an administrative category. However, in the actual practice of disability determination, the two are far from identical. Disability in the medical sense refers to a characteristic of the singular individual, the limitations he faces in fulfilling certain expected social roles as a result of some physiological or psychological malfunctioning. Disability in the administrative sense refers to a set of distributive principles which are formulated and applied by agencies of the state. As a general rule, the determination of administrative disability is not only determined by the individual's medical condition, but also by the multitude of social and institutional constraints under which the state's disability administration operates. Mike

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34 Goldman et.al., "Defining and Counting the Chronically Mentally Ill": 22

Lipsky has pointed out, for example, that workers in the state's social service bureaucracies routinely ration services by differentiating between clients. The reasons for this kind of differentiation, he argues, usually have more to do with facilitating the worker's own work, or their subjective judgments of a client's moral worthiness, than the client's legally determined need for the particular service.35 Similarly, the individual's maintenance on the disability roles has often more to do with the economic and sociocultural realities of his life, than his disabling condition.36 Enrollment in disability income support programs is as much determined by the individual's clinical condition as by factors external to the individual's condition, a circumstance which makes SSI-eligibility a misleading approximation of chronic mental disability.

Finally, length of hospitalization, the third criterion for the determination of chronic mental illness, is so contaminated by factors tangential to the mental condition of the individual, like availability of insurance coverage, administrative policies of the hospital, or social policy, that most authors use it either half-heartedly, or refrain

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35 Michael Lipsky, Street-Level Bureaucracy: Dilemmas of the Individual in Public Services, New York, 1980: 105-116.

36 Sue E. Estroff, Making It Crazy. An Ethnography of Psychiatric Clients in an American Community, 1981: 166

from its use altogether.37

We can now readily see that the difficulties with defining and identifying chronic mental illness in the community are not the result of mere practical, operational compromises of an otherwise valid concept --- hopefully, as the implication goes, to be resolved in the future --- but that these difficulties are inherent to the concept itself. What the example demonstrates is that in actual practice, as opposed to theoretical speculation about the concept, the identification of chronic mental illness cannot be seen apart from the social and institutional context in which this affliction occurs. Somehow, it appears, it is difficult to assess the disease entity chronic mental illness outside institutional walls, or more precisely, to identify it independently from the social and institutional adjuncts that are generally thought of as the <u>consequences</u> of mental illness. The social concomitants of chronic mental illness are as much its cause as its consequence.

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37 Goldman et.al. are wary of length of hospitalization as practical criterion for the determination of chronicity; The Mental Health Action Project refrains from it altogether.

1.5 Subject of the Study.

An Earlier Tradition: Chronic Mental Illness as a Socially Situated Phenomenon.

The idea that chronic mental illness is socially situated is hardly new, of course. While in the present climate of realist thinking about mental illness this view represents a minority position, in the 1950's and 1960's the idea that the recognition, expression, and resolution of chronic mental illness was bound up with the context in which it occurred inspired a fruitful and vigorous research tradition. The classic example is Stanton and Schwartz's exemplary study of the mental hospital. In this study the authors showed how aspects of the institutional environment "participated" in the emergence and maintenance of seriously disturbed behavior of hospital inmates.38 Less familiar these days, but of no less interest, is the work of Ludwig and of Gruenberg. Ludwig and associates explored what they called a "code of chronicity", a set of patient-staff interactions that "tends to perpetuate crazy behavior, leads to the acceptance and rationalization of continued hospitalization, and thus effectively eliminates any incentive for change, improvement, and eventual discharge".39

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38 Alfred H. Stanton & Morris S. Schwartz, The Mental Hospital. A Study of Institutional Participation in Psychiatric Illness and Treatment, 1954.

39 A. Ludwig & F. Farrelly, "The Code of Chronicity", Archives of General Psychiatry, 15, 1966: 562-568.

Gruenberg explained the disturbed and disturbing behavior of chronic mental patients by postulating the "Social breakdown Syndrome", a stereotypic pattern of crazy behavior, that is functionally independent of the alleged disease entity, and whose origins are sociogenic, as it is learned and reinforced through the patient's interaction with his environment.40 And, finally, Goffman, in his Asylums, showed how much of the behavior of chronic mental patients made sense as ways of dealing with the peculiar social environment of the mental institution.

Despite differences in emphasis and purpose, what all these approaches had in common is that they conceived of chronic mental illness as a social-psychological phenomenon. Chronic mental illness, its occurrence and its expression, was seen as a "social event", as part of a particular interactive environment, and therefore as determined by the rules, meanings, and purposes that governed that particular environment.41 The fact that some people persisted in acting bizarre or were unable or unwilling to leave the hospital was understood in terms of the components of the institutional context in which this behavior occurred.

It is of course significant that this shared sociological

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40 Ernest M. Gruenberg, "The Social Breakdown Syndrome -- Some Origins", American Journal of Psychiatry, 123, 12, June 1967: 1481-1489.

41 Stanton & Schwartz, The Mental Hospital: 27

understanding of chronicity was itself socially situated. The environment in which the above-mentioned research took place and from which it derived its meaning and purpose, was the large, custodial mental hospital. In the context of the management of a custodial mental hospital the most obvious indicator of psychiatric chronicity was length of stay, whereby it was assumed that length of stay was fully determined by the seriousness of the illness.

The current shared understanding of chronic mental illness is no less socially situated. In the context of the management of a decentralized system of mental health care, the patient's return to the hospital is the prime indicator for the alleged persistence of his mental disorder. But just as elements in the organization and functioning of the large, custodial mental institution contributed to the continuance of the patient's stay in the hospital, there is no reason to assume that the current institutional environment of the mental patient does not also participate in his persistent return to the mental hospital.

Most of what has been said so far in this chapter has been described before in the relevant literature on community mental health, social control, or the history of the mental institution. The "master patterns" have been well documented.42 Yet, despite our understanding of the larger historical and organizational picture in mental health care,

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42 The term is from Stanley Cohen

we know little about how patients and their families have responded to the changed service landscape.43 How do patients succeed in the community? How do they define their relations to such principal institutions of community life as family, work, marriage, or neighborhood? How do patients and their families resolve crises, now that the mental hospital offers only limited care? In short, how does a system of inclusionary control actually work? To provide concrete, detailed answers to these questions is the purpose of this study.

Outline of the Study.

The environment of today's mental patient, as we argued before, is the community. To sustain himself, the patient principally has to rely on the traditional community institutions of marriage, family, the labor market, the housing market, and the neighborhood. I have organized my analysis and presentation of the data around these four

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43 This seems also to be the case in the literature on crime and social control. As Cohen notes: "Textbooks --- those depositories of a discipline's folk wisdom --- still use an older and blander language of social control: how norms are internalized, how consensus is achieved, how social control evolves from pre-industrial to industrial societies. Marxist theories, to be sure, confront the concept in a more critical way. But seldom in these powerful and baroque abstractions about the 'ideological' and 'repressive' state apparatus do we get much sense of what is happening in the apparatus. We learn little about those 'transactions' and 'encroachments' going on in Kafka's 'offices'. For this sense of what the social control apparatus is actually getting up to, the specialized literature is surprisingly unhelpful." Stanley Cohen, Visions of Social Control: 7

principal institutions of community life: marriage, family, housing, and work. This scheme obviously does not include all of the mental patient's relations with community life. Noticeably absent from the analysis are the love and friendship, and neighborhood. Furthermore I only touch tangentially on the patient's relations with the various community mental health facilities. This does not mean that I think that these facilities play an unimportant role in the life of the formerly hospitalized mental patient, or are negligeable in preventing, or contributing to the patient's readmission. Rather to do justice to the complexity of the patient's relation to the wide range of community facilities requires a separate study.

Following Liebow, I think that the principal advantage of such a scheme is that it closely follows the organization of the formerly hospitalized patient's community experience.[44] Marriage, family, housing, and work loomed large in the patient's experiential world. Moreover, maintaining successful relations with these principal institutions of community life is as important to the life-organization of the formerly hospitalized mental patient, as to that of his never hospitalized middle-class counterpart. By organizing our analysis of the patient's community tenure around these principal institutions of community life, we are in a position

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44 Elliot Liebow, Talley's Corner. A Study of Negro Streetcorner Men, 1966: 13.

to relate the mental patient's community experience with that of mainstream society.

Throughout the text, the analysis is guided by the question: To what extent does the patient's experience contribute to his chances of readmission? It will be obvious that certain of the patient's social circumstances, like the loss of an apartment, or strained relations with his family, will influence his decision to return to the mental hospital, or his family's decision to start admission procedures. However, to avoid misunderstanding, this study does not offer a theory of hospital recidivism, far less a sociology of chronic mental illness. Rather it should be seen as a first contribution to an understanding of the place of mental illness in an inclusionary system of care and control, and the role of the mental hospital in it.

1.6 Description of the Study.

1.6.1 Introduction.

The study is a qualitative study of the community experiences and readmission to the mental hospital of 17 formerly hospitalized mental patients. The strategy we followed was to hold in-depth interviews with the patient and everybody who either was actively involved in his or her readmission, or knew about it. This meant that in addition to the patient, we interviewed family members, friends,

landlords, the treatment coordinator in the hospital, and providers in community agencies such as community mental health centers, board-and-care facilities, single-room occupancy hotels, and halfway houses. Organizationally the study is affiliated with the Mental Health Policy Project, at the Center for Urban Affairs and Policy Research, at Northwestern University.

1.6.2 Methods.

The Mental Health Policy Project.

The plan to do a qualitative study of the community tenure and hospital readmissions of a group of recidivist mental patients arose during the initial phase of the Mental Health Policy Project (MHP). As the present study is intimately related to the MHP, both in purpose as in sample, a short description of the larger project is necessary.

The purpose of the MHP was to get an understanding of the demographics and frequency of hospital use of the people who utilize mental health services, as well as of the conditions, circumstances, and motivations which surround patients' commitment, release to the community, and, as happens in many cases, return to the hospital. To this end a panel study of patients was projected. Members of the sample were interviewed just prior to discharge from state hospitals and two times after that at six months intervals.

The sample selected for the MHP is a subset of the total

State of Illinois, Department of Mental Health population residing in Chicago. Four hospitals within the DMH system service Chicago: Tinley Park Mental Health Center, the Illinois State Psychiatric Institute, Chicago Read Mental health Center, and Madden Mental Health Center. The sample, which comprises 313 patients is stratified according to number of prior hospitalizations --- slightly over 37% had experienced no prior admissions, and 31% each had experienced from 1-5, or 6+ prior admissions.

1.6.3 The Present Study: Methods and Background.

The present study is a qualitative study of mental disorder in an inclusionary system of control, organized around the process of readmission to public mental hospitals. The decision to choose hospital recidivism, and hospital recidivists, as the entrance to the wider subject, was based on two arguments. First, hospital recidivism, as we argued earlier, is widely considered a major public problem in the contemporary system of mental health care. Persistently high rates of readmission are interpreted by providers, policy makers, and parents of the mentally ill, as signifying the failure of the community mental health movement.

Secondly, few studies have attempted to study readmissions from the point of view of the readmitted patient. Partly this must be contributed to the organizational and intellectual setting in which research on readmissions usually

takes place. The impetus for much research on readmissions is the concern of professionals and policy makers about the high rates of return to mental hospitals. The public mandate of these groups is to plan and manage, in a cost-effective way, the current mental health service systems. Recidivism is an obstacle to planning and cost-containment, and, naturally, a desire arises to intervene in the system in such a way as to reduce the rate of readmissions. This goal, logically calls for insight in the predictors of readmission, and points to quantitative, regression-analytic research designs in its study.

On a practical level the direct observation and interviewing of patients and families in their community settings is a neglected task because it is fraught with practical difficulties. This population of usually poor, and often troublesome people is mobile, and notoriously difficult to reach. Outside the clinical setting it takes more effort from the researcher to persuade people to cooperate. The research is time-consuming, often frustrating, and sometimes dangerous.45

Yet there is a great deal to be gained from naturalistic observation of the readmission process. The results from quantitative studies of readmissions have been generally disappointing. Numerous studies have assessed the extent to

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45 Lewis & Hugi, "Therapeutic Stations and the Chronically Treated Mentally Ill", Social Service Review, June 1981: 208.

which variables such as the availability of aftercare services, diagnosis, treatment modalities, family setting, and demographic characteristics predict readmission. However none of these variables proved to be very robust as "(f)or every positive finding linking a given independent variable with readmission another study produced a negative finding"46 In fact, in an overview of studies on readmission, Rosenblath and Mayer conclude that the only consistent predictor of rehospitalizations is the number of previous rehospitalizations.47 A first, and as we will see later, not the last instance of the recursive nature of many of the variables involved in the readmission process.

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46 Elaine M. Neuringh et.al., as quoted in Lewis & Hugi, "Therapeutic Stations and the Chronically Mentally Ill": 207.

47 Aaron Rosenblath & John E. Mayer, "The Recidivism of Mental Patients: a Review of Past Studies", American Journal of Orthopsychiatry, 44, 5, October 1974: 697-706. This finding was confirmed in a particularly careful study by ten Horn in the Netherlands. With the use of a case register, ten Horn followed the treatment careers of a whole population of mental patients in one mental health catchment area. In her analysis she tried to find predictors for rehospitalization. However, only the rank order of the patient's admission showed a significant relation with rehospitalization. That is, 50 percent of those who had been admitted twice or more were readmitted within one year after discharge, whereas of those who had been admitted only once, 29 percent was readmitted within one year. Sineke ten Horn, Nazorg Geeft Kopzorg. Een Onderzoek met een Register voor de Geestelijke Volksgezondheid, ("Worries About Aftercare. A Study Using a Mental Health Case Register"), Rijksuniversiteit Groningen, December 1982.

Understanding the Patient's Tenure in the Community: In-Depth Interviews.

To record the readmission process, in-depth interviews were held with each of the participants in a patient's rehospitalization. Qualitative in-depth interviewing is directed at "understanding informants' perspectives on their lives, experiences, or situations as expressed in their own words".48 The interview was semi-structured in that it sought to cover the same topics with each participant. The topics discussed with each informant were: work, income, housing, family, marriage, medication, aftercare, the events preceding the admission, the actual admission itself, admission history, and the patient's self-definition of his troubles. In the interviews with those who were involved with the patient's readmission the emphasis was on the admission process, patient's admission history, family relations, the type of treatment the patient received, and the informant's definition of the patient's trouble. In actual practice very few informants followed the preordained sequence of topics. Most people choose to tell their story in their own way, structuring it as they saw fit. The task of the interviewer was to make sure that each topic was discussed with each informant.

The site of the patient interviews was the mental

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48 Steven J. Taylor & Robert Bogdan, Introduction to Qualitative Research Methods. The Search for Meaning, 1984: 77

hospital. To prevent loss of data through memory lapses or a diminished interest in the readmission because it was superseded by other events in the patient's life, each patient was interviewed as soon as possible after his or her readmission. In practice this meant that usually two to three days went by between the admission and the interview. At the start of the interview the purpose of the study was explained to the patient. He or she was then asked to participate and grant permission to contact those people who were involved or who knew about his admission. The patient then provided us with the names of those people who were involved. At the outset we were unsure how many patients would refuse to give their permission to interview 'others'. In practice only one of the 17 refused to grant us permission to contact his parents, although he did allow us to interview his treatment coordinator. After the patients were interviewed, the 'others' were approached. If they consented to be interviewed, the interview took place in the informants' setting of choice. This usually meant home in the case of family members or friends, and office in the case of mental health providers. Patients and family members were paid $10.- for the interview.

1.6.4 The Sample.

The sample for the present study is a subset of the of the sample of the Mental Health Policy Project. The method

for selecting informants was as follows. In an ten-week period from March through May 1986, those informants from the MHP sample who were readmitted in two of the four Chicago state mental hospitals were approached by the interviewer. The hospitals were selected to permit the interviewing of a broad range of informants. The two hospitals were Chicago Read Mental Health Center and Madden Mental Health Center. Together both hospitals account for 68 percent of admissions in the Chicago area. Due to their respective catchment areas Madden serves a predominantly black and Read a predominantly white population. Both hospitals had an age distribution that was closer to that of the total population of Chicago admissions than those in the other two hospitals.

During the interview period the medical records office at Madden and Read contacted the interviewer as soon as a patient of the MHP sample was admitted. During the interview period 36 patients from the MHP sample were readmitted in the two target hospitals; 17 of these were interviewed for the present study. Of the other 19 patients, 9 were discharged, 4 were transferred to one of the non-target hospitals, and 3 went on unauthorized leave of absence before they could be approached, 1 patient was deflected, and 2 patients were approached but refused to participate.

The sample is self-selected and does not pretend to be random. The purpose of this study is not to make generalizations, but to obtain an in-depth understanding of

the community tenure of this group of formerly hospitalized mental patient, and the circumstances of their readmission. The power of the argument rests on plausibility and recognizability. However, to provide an indication of the extent to which the present sample is commensurate with the total population of admissions in the Chicago area, we have compared it on a number of common demographic characteristics with (1) the sample of 313 patients of the MHP, and (2) a population of 10,068 separate admissions to the Chicago area state hospitals in the period July 1, 1983 - December 31, 1984. (Table 3)

Table 3: Comparing the readmission Sample with the MHP sample and a Population of Mental Patients.

	Readmission Sample (N=17)	MHP Sample (N=313)	Patient Population (N=10,068)
Sex			
male	76.5%	63.3%	60.7%
female	23.5%	36.7%	39.3%
Race			
black	58.8%	55.3%	58.9%
white	41.2%	34.8%	33.1%
other	-	10.0%	5.0%
Age			
18-34	58.8%	66.7%	61.4%
35-49	35.3%	23.0%	26.6%
50-65	5.9%	10.2%	12.0%

(Source: Dan A. Lewis et.al., State Hospital Utilization in Chicago: People, Problems and Policy, Mental health Policy Project, Center for Urban Affairs and Policy Research, Northwestern University, Evanston, Ill., draft, 2/23/87.)

As table 3 shows, the sample does not differ significantly from either the MHP sample or the population of mental patients.

With regard to the 'Others': parents proved to be very cooperative. On only one occasion did the mother of one participant refused to be interviewed, but in that case the patient's younger brother agreed to answer the questions. In fact, most parents expressed gratitude to the interviewer that he took the trouble and time to come to their houses and listen to their story.

Hospital personnel also proved to be very cooperative. Part of the reason was no doubt that they were a 'captive' group; they realized that the interviewer had the full cooperation of the director of the hospital. But more important was that they were asked to participate in various stages of the study and in that way came to know both the study and the interviewer. For example, as a matter of principle treatment coordinators were approached before one of their patients was to be interviewed. After a while many treatment coordinators inquired about the progress of the study, and provided the interviewer, spontaneously or on request, with information on hospital procedures, particular patients, helped the interviewer to get in touch with other hospital personnel, and so on.

The group that was hardest to reach were the providers in

the various community facilities. An interesting division existed here. Members of the 'lower' professions, social work, clinical workers, generally agreed to be interviewed about one of their patents; members of the 'higher' professions, psychologists, psychiatrists, almost as a rule, refused. We can only conjecture an explanation for this phenomenon. Defensiveness is obviously an important factor. In several cases the provider did everything possible to avoid to be interviewed, employing such techniques as consistently refusing to return calls, repeatedly cancelling interviews at the last moment, giving the interviewer the run-around. But what was the source of the defensiveness is unclear, and worth a study by itself.

Taken together we have interviewed 57 people; Appendix 1 provides an overview of the way the interviews are distributed over the various categories of 'Others". In this way each patient's account of his readmission was supplemented by at least one, and sometimes as many as four, different perspectives on the same event. The purpose of this approach was to reconstruct, as detailed as possible, the pathway that each patient took to the mental hospital.

In the following chapter we will give short vignettes of each of the 17 patients in the sample. Naturally names have been changed to prevent recognition.

2. THE PATIENTS.

Clarence. Clarence is a 49 year old, heavy-set, black man of about 5' 11'. My first encounter with Clarence was rather disconcerting. In looking for an empty room to write some notes, I am startled by a loud noise that comes from the end of the corridor. In a small room, its door open, a man strapped to a bed, wriggles and squirms vehemently while incessantly hurling obscenities into the air. Two days later, when a nurse introduces me to Clarence, the man in restraints turns out be him. The difference couldn't have been more striking. Clarence is a friendly, kind-hearted, somewhat gruff, man. He looks at least ten years older than his age. He doesn't seem to remember much from the incident in the small room.

Clarence's first admission to the mental hospital occurred in 1963. According to his sister, in whose household he lives, a few years before that, Clarence's wife had been admitted to the mental hospital. Clarence became exceedingly depressed, and at some point was also hospitalized. According to the sister he was devoted to his wife, and was "just a heart-broken man". Since then he has been admitted 22 more times, the last few years with increasing frequency. He suffers from a plethora of medical ailments --- diabetes, hypertension, and cardiac problems of an unspecified nature. According to his treatment coordinator he belongs in a nursing

home. However Clarence's sister is adamantly opposed to the idea of a nursing home because she feels he has suffered enough in his life, and should spent his last years with his family. The treatment coordinator thinks the sister is opposed to a nursing home because the family needs Clarence's disability allowance.

Rosa. Rosa is a 47 year old black woman of slight build. She has closely cropped hair, with touches of grey in it. When a nurse lets her into the room where I wait for her to be interviewed, she at first approaches me with considerable reserve and suspicion, but soon she lights a cigarette and settles into the conversation. During this first meeting --- I will see her a number of times --- her answers are often hard to follow and confused, although not without humor. She often looks at me as if to gauge the effect her words have on me. Around her lips plays an ironic smile at such moments.

She claims to have a Ph.D. in psychology and education from the University of Chicago, and to be have worked as a teacher. There was no way to check this, but the sophistication of her language indeed reveals some form of higher education. Rosa's first hospitalization in the Illinois state system took place in 1966, and she has been admitted a total of 31 times. According to Rosa, her main problem is that she no place to live. A social worker at Catholic Charities, who

regularly offer Rosa shelter, agrees that this is one of her main problems, although acknowledging that she is extremely confused at times. Several weeks later I meet Rosa again in Madden to which she has been transferred in the mean time. She is in good spirits, and clear and alert this time. She would like to be discharged, but she refuses the board-and-care facilities that her treatment coordinator wants to refer her to. She objects to the rules in these places, that don't even allow her to smoke in the dining room. "I want independent living", she says. And, laughing, adds: "Give me a pot of tea, a good book, and all the cigarettes in the world, and I don't want anything else."

Fred. Fred is the archetypical deinstitutionalized mental patient. Anyone who would meet him on the street, in his ill-assorted clothes, his restless look, his arms swinging wildly as he walks, would immediately recognize him as a mental patient. Fred seems isolated. When I had set up an appointment over the phone, he kept calling me every day to make sure that I would really come. When I finally arrive at his hotel for the interview, he has been nervously pacing up and down the lobby for at least half an hour according to the proprietor.

When we sit down in his room, and talk, a kind, sensitive man appears from under the nervous mannerisms. He has a history of alcoholism, and expresses a lot of guilt and shame

about his earlier life. His first hospitalization took place in 1966, and since then he has been admitted 42 times, with the bulk of those admissions taking place in the last five years. He apologizes about the disorder in his room; he says, he has just moved in. He seems happy to have a place of his own. At the end of the interview he shows me his drawings. He dreams of being employed in an advertizing agency. On the basis of his drawings he certainly would cut a good figure in any advertizing agency; they clearly show talent. But one look at the man tells you that he wouldn't stand a chance. A little later, when he pensively returns his drawings in a folder, one senses that Fred realizes this too.

Dorothy. Dorothy is the most enigmatic of the people in our sample. With 52 she is the oldest of our informants. She is attractive-looking and dresses with taste --- a white blouse, and a long brown skirt with a bright red belt. When I make her a compliment, she laughs somewhat self-consciously, and says, that it is the best she could do, as these are all clothes that the hospital gave her. The details of her life, as she relates them to me, are amazing. She came to the United States from Trinidad in the mid-sixties. She got married, and worked as a beautician. In 1973 she finds out that her husband has a child with another woman. She moves out of the house, and according to her, her downfall began. She loses her job, for reasons that I cannot trace down, and

doesn't find another job, because, according to Dorothy, "they are all in the suburbs and I didn't have transportation". She says that she has basically lived on the streets from 1974 to the early 1980's, first in Chicago, then in Miami. However, in her medical records there are references to a befriended couple with whom she lived for a while.

In 1982 she applies for a job as a house-keeper with a family in the suburbs. Although she doesn't fit the criteria. the family feels sorry for her, and offer her the job. The next two years are good years for Dorothy. The family likes her, she starts taking care of herself. She has quaint habits, like reading the bible incessantly, running the dishwasher with only a few articles in it, endlessly washing one cup under the faucet, but her employer is tolerant of this behavior, because, he says, "she is a good woman".

It is this same combination of agreeableness and quaintness that she presents in the interview. During the conversation, she is reason personified, yet, in the same voice she asserts earnestly that she is the "Virgin of Chicago". She adds though that she realizes that this statement might strike people as odd, but that she happens to believe in it as part of her religion. She is very cooperative, yet she adamantly refuses to sign a release of information form, not because of the contents of the form, but because she rather not sign anything. Her main problem she says is that she can't find a job. Later I make it point to

visit her and inquire about her well-being whenever I am in the hospital. Her mood is generally depressed, and one senses that she feels abandoned by the whole world. During our last meeting she startles me by asking if I want to employ her as a housekeeper. I wouldn't have to pay her much, and she is a good worker, she says. She takes my refusal silently, with a look in her eyes as if she hadn't expected otherwise.

Chip. Chip is a thirty-nine year old, black male of about 5' 8". During our conversation he is ebullient and outgoing, and, contrary to most of our informants, he has a keen interest in the person he talks with. He laughs frequently and heartily, every time displaying, somewhat disconcertingly to the observer, an enormous gap in his teeth where two front teeth are missing. He would definitely be an engaging man, were it not, that there is something pressured about his abundant talk. One cannot escape the impression that there is a manic quality to his conduct, that his behavior has a hollow ring to it.

Chip's career had a promising start. He graduated from college, and through mediation of his father, acquired a job at the Ford Motor Company. He complains that he was discriminated against at Ford, but nevertheless he moves from a blue-collar into a, better paid, more prestigious, white collar job. What goes wrong is not entirely clear. He is

temporarily laid off or demoted in 1975, but simultaneously starts to drink, and as a result is not hired back. This is also the year of his first hospitalization; in the ensuing years 35 more admissions will follow.

There exists a curious parallel to Chip's undoing and that of the family as a whole. Chip's mother has been admitted to a mental hospital several times. His brother, who was a skilled laborer in the plumbing business, has also lost his job. Both brothers express their life problems through completely unrestrained behavior, which includes heavy drinking and drug use, fighting, and destruction of furniture. The house looks indeed as if it has been recently hit by a tornado. Whatever is Chip's problem, he holds a peculiar relation towards certain common ethical norms. Interrupted by great gusts of laughter , Chip tells, for example, how he stole his father's brand new car with the intention to sell it. Chip is hated by the hospital staff who consider him a sociopathic personality who should be in jail instead of in the hospital. But Chip's grandmother, in whose house he regularly finds refuge, thinks he is "lovely, agreeable, and kind". She attributes all his problems to his father's intransigent personality.

Wayne. Wayne is a 40 year old, lank, white man of about 6'. He has a straggly beard and long unkempt hair. He often speaks with vehemence, and at such moments he looks at you

intensely as if to underscore his words. He is a sympathetic man, but with a bristly, petulant character. There is little in his world with which he agrees, and he feels easily slighted or wronged.

Wayne is a veteran patient. His first hospitalization occurred in 1969 after he and his wife divorced, allegedly after she had been unfaithful to him. Wayne does not forget easily. While he recalls the episode his voice still trembles with anger and he laces the conversation with invectives addressed at his ex-wife. Although he had begun to drink, he finds a job, and is able to regain his balance. In the summer of 1979 he is admitted again because of increasing depression, and from then on he incurs 28 hospitalizations in rapid succession. He is able to hold on to his job for another two years, but eventually has to give up.

He now lives in board-and-care facilities when he is not in the hospital, but because of his suspicious, querulous attitude he is not well liked by the other residents. He is regularly visited by his brother and his wife, but Wayne has nothing but criticism for them. According to Wayne, the two have stolen money from him on several occasions. He is lonesome and isolated. He still sees himself as a working man who, through adversity, has lost his job. He is fiercely independent, and for this reason he has a hard time accepting the rules of the facility. He says that he is often despondent and contemplates suicide.

Henry. Henry, with Michael, come closest to the text-book description of a schizophrenic patient. Both men were, as far as can be reconstructed, symptom-free until their early adulthood, at which time an inexplicable, but decisive character change sat in. Their symptoms include both the so called primary symptoms of active hallucinations and delusions, as, in Henry's case, the secondary symptoms of withdrawal and general numbing of emotion.

Henry's symptoms began when he was 19. He is a black man of medium build. He is now 28 and lives with his mother, two brothers and a sister in a cramped apartment on Chicago's North side. According to his younger brother Henry's problem's began in the job corps. Before he went to the job corps, he was talkative and well liked. He always had a joke for everybody. During that year in the job corps, his brother recalls, you could see the change. And when he was discharged, and lived home again, "he just started acting strange".

His first hospitalization occurred in July 1978, and is described in his records as an "acute schizophrenic episode". According to his brother the family was watching television that day. Henry walked around the house restlessly. When his mother asked him if he wanted anything, he answered: "Yes, I want sex", jumped on her, and tried to hit her. When the police arrived, they took him to the mental hospital. Since then, Henry has been hospitalized 11 times. Almost every

hospitalization was preceded by an outburst of violence on Henry's part, often while he was under the influence of alcohol or drugs. On numerous occasions he has threatened the family. The family is desperate and his older brother asks me if Henry cannot be hospitalized for a long period of time. During the interview he is aloof and indifferent. On most questions he answers with: "I couldn't say".

Michael. Michael is a sturdy, 23 year old black male of about 5' 9". He has a friendly, courteous manner, with a trace of distance towards the interviewer. He seems to occupy a central place in the social organization of the hospital ward; while we chat preceding the interview he is repeatedly approached by fellow patients with requests to intervene in some dispute, to give them a cigarette, and so on. His treatment coordinator later confirms his constructive engagement with life on the ward.

His life history stands in contrast with his easy and authoritative demeanor in the hospital ward. If we look at some of the incidents of his adolescent years they add up to a disturbing theme of self-destruction. He is a high school drop out. Except for a summer job he held for three months when he was 15, he has never worked. He says there were no jobs for him out there. He has a four year old son who lives with his girlfriend, but he has been separated from his girlfriend for more than three years now.

Michael is hospitalized because he hears voices. They are girls' voices he says, who tell him that nobody likes him and that everybody is out to kill him. His mother says that when he hears his voices he no longer sleeps and becomes verbally aggressive towards people in the neighborhood. He usually drinks when he hears voices. Michael claims that it doesn't affect the voices, but his treatment coordinator is not so sure. He was a heavy drinker as a 14 year old, so much so in fact, (He claims that he drank three-fifth of whiskey a day) that he developed a severe case of ulcers. He now thinks, although he wasn't aware of it at the time, that his drinking served to keep the voices at bay.

His parents, usually call the police when Michael becomes threatening and aggressive. The police, who know him by now, bring Michael to the hospital. What has scared his parents and his therapists most is that at one such occasion, when the police entered his basement room in his parents' house, he stabbed himself in the stomach with a kitchen knife. Presently, the hospital functions for Michael as an external control on his hallucinations. He has an agreement with his treatment coordinator to check himself in whenever he feels that they get out of control. His first hospitalization took place in February 1982. Since then he has been admitted 13 more times.

Jessie. Jessie, with 19 years old, is the youngest member of our sample. She is a stocky woman of 5' 3" who, with her angry expression and penetrating gaze, at first makes a tough, unyielding impression. However, as soon as one sits down with her the tough facade gives way to the opposite impression of utter helplessness and vulnerability. She is often on the brink of crying, and, her voice is plaintive, almost pleading when she recounts the events that make up her life. Yet, at the same time, it is hard to escape the notion that there is something seductive about her behavior too, as if sexuality at some point in her life has become confused with emotional shelter.

Jessie's mother is a homeless mental patient. Six years ago she separated from her husband. When, a few months later, she and her youngest son went to visit him, they found him on the floor of his house, dead, and already decomposed. After that, according to Jessie's grandfather, mother gave up. "She threw up both hands." During the separation Jessie, who was 13 at the time, developed behavioral problems. She ran away from home several times. She disliked her stepfather and threw boiling water at him. She ran in with the wrong friends. During a fight she chased a friend with a knife; he swung at her with a baseball bat and broke her elbow.

Grandfather intervened by renting and furnishing an apartment and moving in with his daughter and her children, including Jessie. But Jessie became increasingly

unmanageable. She destroyed furniture, ran through the building naked, shaved off her hair, ordered meals in restaurants without paying for them. In April 1983, at age 16, she was admitted to Chicago Read for a period of three months. Several hospitalizations followed often for periods of several months. In December 1985 grandfather moved out of the apartment; within a month mother and her children were evicted. Mother became homeless and began to live in shelters. Jessie's sister and brother were taken in by their grandfather from father's side. Jessie, with her history of behavioral problems, took to the street. Sometimes she lives with her mother in a shelter, sometimes she sleeps on the streets, sometimes she stays with friends.

Jessie's educational background is abominable. She quit school in the eighth grade. Her treatment coordinator has arranged for her to go to school, but Jessie is unable to fit in any program hat is offered to her. She eagerly begins (She showed me proudly a writing pad with tables of multiplication), but she usually quits within a few days. She has recently been arrested for prostitution and had to appear before court. She is fiercely attached to her mother. When the hospital refused her to let her visit her mother on the latter's birthday, Jessie became so enraged, that she ended up in restraints. All in all, at age 19, Jessie has been hospitalized 13 times.

Renee. Renee is a 21 year old white woman. She is about 5' 6", and overweight. Her hair hangs down in greasy peaks, and she has pale, unhealthy complexion. She is withdrawn and sullen, and often one senses an underlying anger close under the surface. She answers my questions in short, uninformative phrases, and usually after a considerable delay. Most of the time I have to prod her to give me more information. She is almost totally without expression. Everything about her is dull and flat. It is clear that she is depressed.

Despite her young age, Renee has a long history of living in institutions. Renee is the oldest of three children. Her father is a physician. According to the parents,Renee was diagnosed at age 8 as a learning disabled. At age 15 she was hospitalized on the psychiatric unit of a general hospital for depression. At school she was placed in a less stressful program. After two days she became violent, and could no longer be maintained at school. The school suggested that she needed a residential treatment program. It was at this point that her odyssey along an endless series of boarding schools, group homes, intermediate care facilities, halfway houses, and finally the mental hospital, began. In between placements she spend short periods at home during which, according to her parents, she destroyed furniture and verbally and physically abused members of the family.

In 1983 the family has exhausted its insurance and Renee enters the state system. She is first hospitalized in Elgin

Mental Health Center, after she had tried to set a fire in the halfway house where she lived. She stays at Elgin for five months because the hospital cannot persuade any residential facility to accept Renee after the fire setting. After her first hospitalization in the state system, she is admitted four more times. One of these hospitalizations lasted for more than a year. During that year she is in a behavioral modification program, an approach which only intensifies her already defiant stance. During that year she is raped by a staff member of the hospital.

She cannot escape her reputation as troublesome and violent patient anymore. The circumstances of her latest admission testify to that. After a home visit her mother calls the halfway house that a gun is missing and that Renee might have it. The director of the facility has her, upon entering the facility, sent to the mental hospital under a false pretext, and with the assurance that she can return in a few days. Once she has been admitted he informs the hospital that he doesn't want her back. When I last see her, four months after the interview, she is still in the hospital. So far, no one has been willing to accept her. The gun, it turned out, had been misplaced. It had never left the house.

Eric. Eric is a 32 year old short, muscular man. He is bald, and has a black moustache. He has lively, attentive eyes. He is better dressed than any of the other patients in the

sample. He wears a tweed sports jacket, a white shirt, open at the collar, and tan slacks. He looks much older than his age. His hands are bruised at the knuckles. He says that preceding his admission he got into a fight with the security guards at the emergency room of Northwestern Hospital.

Eric's problem is alcohol. He drinks since age 15 he says; seven years ago he became an alcoholic. There didn't seem to be any particular reason at the time to succumb to drinking. According to his account, he subsequently lost his job in the Australian government, separated from his wife and children and ended up as a bum living in flophouses. He is usually able to stay away from alcohol for periods of several months. However then he starts drinking, he gets distraught and checks himself into the mental hospital. In this way he has been hospitalized 11 times since December 1983, never for more than two or three days. In telling his life story, he is articulate, affable, and shows good insight in the dynamics of alcoholism. It is not difficult to sympathize with this agreeable man and struggle against alcohol.

However, gradually, over time, this image of Eric is eroded by disturbing, inexplicable pieces of information. He told me that his wife and children lived in Australia; he conveys to his treatment coordinator that all of them died in a car accident. He told me he had fought in Vietnam in '68; that, it occurred to me later, would make him a 15 year old soldier.

After our first meeting in the hospital, I interview him three more times. We meet at a MacDonald's near his hotel. The first time he didn't show up. He called up three hours later, demure, apologetic. The second time, he broke off the interview after 15 minutes. He had to meet a friend of his, a police woman, with whom he was going to live together. He didn't know her very long, but he was sure it would turn around his life. The third appointment he didn't show up. I didn't expect to hear from him anymore, but he called up three days later. We agree to meet one more time. When we have finished the interview and I have paid him the his ten dollars, he asks for thirty dollars. When I refuse to give him these, he shrugs his shoulders. We part on awkward note.

Paul. Paul is a 37 year old white man of medium build and height. He has reddish hair and an open, lively face with pale blue eyes. He wears a large woolen pullover with traces of paint on it. He is a sculptor. Many months after my interview with Paul I have a chance to see some of his sculptures. They are carefully crafted, richly detailed, metal constructions, many of which are inspired by the female body. What unites his sculptures is their relation to the earth's surface. They all seem to want to break away from the confines of gravity, to explore common three-dimensional space in hitherto unexpected ways.

Paul has been diagnosed as manic. During the interview his attention darts off in every direction. He is often teasing. One moment he speaks admiringly about the shape of my hands, the next he suggests to empty a glass of water over my notes. Most of this is good-natured, but one sense that his pranks can easily take a more aggressive turn. Preceding admissions he has been known to threaten his friends and brother, to create fires in his apartment, and to have caused an accident by reckless driving. He has been admitted by a friend this time, an attorney familiar with commitment procedures. From a conversation with the friend one comes away with the impression that Paul is well-liked among his friends, and that the hospitalization was instigated to protect Paul from the dangerous consequences of his unsettled behavior. All in all Paul has been admitted 4 times in the Chicago state system.

Darell. Darell is a tall, 25 year old black man. He has the physique of an athlete or a football player. In the hospital Darell is regarded as a dangerous patient. It is widely known that he has badly beaten his mother, and was hospitalized against his will. The staff treats him with a certain apprehension.

During my first interview with him he is initially withdrawn and taciturn. He is silent about the assault on his mother and dismisses the incident with "family problems".

Rather he is absorbed by the fact that he feels under pressure from friends and family, that his girlfriend had a baby this month and that he doesn't have a job, that his friends treat him like an alien. His expression is dark and worried. It is clear that he regards his admission as one more addition to his worries.

Halfway during the interview he tells that he was involved in an accident as a teenager. He was hit by a train. His legs were badly hurt and partly deformed. He admits that since then he has always felt self-conscious. He never swims or wears shorts. He feels that employers don't accept him because of the accident. They think he is a "bad risk". The CTA paid him a considerable sum in damages. His mother used the money to buy the house in which the family now lives. Darell resents this. He regards the money as his, and feels that his mother has taken it from him. His first admission took place in the summer of 1984. According to his mother it was because he "started acting up after the use of drugs". Darell vehemently denies that he uses drugs. Six more admissions followed, usually after Darell became violent. Darell has an older brother who has also been admitted to Madden several times, according to mother for similar reasons. At some point, both brothers were in the same hospital at the same time.

After the assault, his mother refuses to let Darell live in the house any longer. He is admitted for several weeks in

a Community Mental Health Center, where he is under constant surveillance. I lose sight of him after he is released. He is admitted to the mental hospital once again. From his medical records I learn that he shared an apartment for several months with some other men. They were evicted and Darell ended up on the streets. He slept in an abandoned car in his mother's backyard. he is admitted when one day at 4.00 a.m. he showed up at his mother's doorsteps "shaking and drooling".

Lewis. Lewis is a 35 year old black man of medium height and build. He is friendly. He is slow, listless, seemingly unmoved by outside stimuli. He speaks in an almost inaudible voice. He says that he was in Vietnam from 1967 to 1969. He came back "fatigued and shell-shocked", and addicted to heroin. He took a job, stacking magazines at $2.90 per hour, but quit after three days. As he says: "I couldn't do much of anything". In 1983 he receives SSI. Until then he says he "hustled a bit. Get people sandwiches, empty garbage cans. Stuff like that." He also reports to have spent time in jail. His medical records report "many hospitalizations", and a "history of schizophrenia", although according to his Summary Index, which registers all of the patient's previous admissions in the Chicago state system, his first admission occurred in 1984. Seven hospitalizations have followed after that.

The most conspicuous thing about Lewis is that we know so

little about him. His records are devoid of any specifics about his personal history, and keep repeating the most eye-catching details of his delusions. When he arrives at the hospital he is psychotic and is unable to provide clear information. When he is discharged he drops out of sight, disappearing in a shadow world of poverty, drug addiction and petty crime. He lives with his brother who is also a drug addict. He visits his sister, but she tells him in no mean terms that he is not welcome. According to his treatment coordinator the hospital staff constitute the most stable relations in his life. Whenever things grow over his head, he goes to the police to have himself admitted to the mental hospital. As he has hospital insurance he is first admitted to a general hospital. When his insurance runs out after 21 days, he is transferred to a state hospital.

Jack. Jack is 34 year old white man. He is poorly dressed in ragged pants and badly worn shoes. He has almost completely grey hair that has been rudely cut. He walks in stoop, and, most conspicuously, he squints severely. Jack has diabetes since age 10, and since a few years the disease has begun to affect his eyesight. He has already lost his sight in the left eye, and the right eye deteriorates rapidly. His demeanor is gruff, but not unfriendly. His language is littered with expletives.

His mother recounts that Jack took his illness very

badly. He felt singled out, refused to accept the seriousness of his condition, and became increasingly hostile and withdrawn. A week before his graduation from high school, according to mother, he got into a fight at school and was expelled, without a diploma. He became more and more violent in the house, and age 19 mother tries to have him admitted, but without success. Shortly thereafter the parents separate, and Jack moves in with his father. Both parents were alcoholics. Mother recovered, but father persisted in drinking. According to mother the situation went from bad to worse. Jack fiercely resents his father. Mother recalls that he would become so mad during these days that he would wrap his hand in towel and start pounding the wall. It is also during this period Jack began to report hearing voices.

Still, in those years Jack worked continuously. First in the mail room of the firm where his mother worked, and then as a night watchman. He lost the job in the mail room after he got into an argument with his boss.

Jack's first admission took place in November 1984. In a rage he had thrown the television through the window, after which his father called the police. He was admitted for a total of 9 months. At the hospital Jack is assigned to a particularly dedicated therapist. Over the months his condition improves considerably and when she finds him a place in a residential treatment program for the visually handicapped, all parties have good hopes.

However, the treatment center is closed during the Labor Day weekend. Jack has no place to go, and his therapist at the hospital arranges for him to stay at the hospital for the weekend. When he arrives she is there to receive him. They go through a perfunctory intake procedure. The intake officer asks Jack's therapist what she should put down for a diagnosis. The latter shrugs and suggests on the top of her head: intermittent explosive disorder. Jack takes it personally. He thinks that he is declared mentally ill and explodes with anger. He hits the therapist and has to be restrained by the security guards. His therapist ruefully says that Jack felt that she betrayed him. From now on a pattern of distrust of mental health providers and explosive outbursts his been set. He is admitted six more times, usually after he destroyed property in a residential facility.

Frank. Frank's situation is perhaps best summarized by the following excerpt from his medical records: "Born in this area, his parents divorced when he was three. Mother remarried Victor Cressey, 'who's been really nice to me", he said. He has a sister, age 11. At age 13 he began to use drugs and has used them at various times, usually daily --- according to money available. He dropped out of high school in his junior year. He has used everything known to drug users including PCP. The longest period he has gone without has been 'one week'. Last year he was hospitalized twice in

Chicago Read MHC and twice in private hospitals. This is his second admission to Madden. In all cases he felt suicidal and each time it was after drugs. He has never held a job because he was always on drugs. He believes he can stop using drugs because he is 'strong' and had never before decided to stop. He only went to the private clinic to please his mother. he is aware his abuse is causing sorrow to his family." The records go on to describe Frank as "boyish ...clean and appropriately dressed". He is "cooperative and pleasant", and "alert and fully oriented". However, the assessment closes on a decidedly pessimistic note: "Prognosis: poor".

The most disturbing thing about Frank is that he freely admits to everything that is said above. His world is one of drugs, guns, and hard rock music. He is not an insensitive or unfeeling boy. (The records are right about the boyish look. He is 19 at the time of the interview. They are also right about the pleasant, attentive appearance.) The suicidal thoughts stem from genuine despondency over his drug use or his girlfriend who ran away from him. Yet, there is not the slightest inclination that he is willing to change his self-defeating habits. On the contrary. His behavior is firmly rooted in a rebellious, defiant stance against mainstream society, its dress codes and its work attitudes. There is nothing in adult society with which he feels he can identify. It is for this reason that providers have little hope for Frank. Their frustration derives not from the usual

contradiction between good intentions and abominable social conditions, but from the contradiction of a pleasant, intelligent young man who is resolved to persist on a course of self-destruction.

Frank's first hospitalization in the state system took place in the Spring of 1985. Since then he has been admitted six more times in a state hospital, and an equal number of times in private hospitals. In many ways, Frank's problem are not that different from those of a generation of adolescents who are charting out their own moral course in life. The tragedy is that the way he goes about this task is outright dangerous. Locked into a pattern of habitual drug use and regular readmissions to mental hospitals, he runs a genuine risk of overdosing, either intentionally or unintentionally (In the past he has ended up in the hospital after using nearly lethal combinations of drugs, prescribed medicine, and alcohol.) Yet, one day, he might have outgrown his adolescent rebellion and begin to put his life in order.

Ralph. Ralph is 24 years old, black male. He is light skinned, and has regular, attractive features. He seems absentminded and regularly claims forgetfulness during the interview. He looks young for his age. He is the father of two children with two different women. Ralph comes from a middle class background. His father is a small building contractor, and the family lives in a pleasant house on the

far south side of Chicago. Ralph's oldest sister goes to college, and two younger sisters are in high school.

According to his mother Ralph was a good student until his junior year in high school. After that his grades deteriorated and finally he dropped out. He always managed to find work --- he says he likes working --- but he contends himself with drifting from dead-end job to another. He is drawn to women, and the attraction seems mutual. The only time he snaps out of his usual lethargic style, and becomes alert and lively, is when he introduces me to his newest girlfriend. At age 19 his then girlfriend gets pregnant, and the couple decides to get married. After six months the marriage is disbanded.

According to his mother his problems began after the divorce, but from statements by his sisters one gets the impression that he was confused, and maybe even psychotic at an earlier age. After the divorce, Ralph begins to "act strange" at times. In addition he starts using PCP. His first admission occurred in September 1985. Two more hospitalizations follow, both times after the use of PCP. His parents want him to enroll in a drug program, but they don't know where to find one.

PART II: GETTING OUT: THE SOCIAL SITUATION OF THE MENTAL PATIENT IN THE COMMUNITY.

3. MARRIAGE AND FAMILY.

3.1 Marriage.

None of our informants was married at the time of their readmission. This statement suggests more homogeneity than actually exists in the conjugal situation of our informants. Seven informants had been married previously but were now divorced; five of them had children. Of the remaining ten, two had fathered children and had attempted, unsuccessfully, to set up a household with the mother of their child. One informant had lived together with his girlfriend for a considerable period of time before breaking up. Seven informants had never held a long-term relationship with someone.

The absence of marital ties among these formerly hospitalized mental patients is no surprise.1 The literature on psychiatric epidemiology has consistently shown mental illness to be more common among the non-married. One explanation is to attribute this statistical fact to the patient's illness. Either the illness makes him into an unattractive marital candidate, thus preventing marriage altogether, or in those cases where the patient is married, the strains and stresses that the illness puts on the marriage eventually result in its dissolution. Thus the comparatively low marriage rates among the mentally ill are the result of a

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1 Although unmarried people are overrepresented in our sample.

process of adverse selection.2

Our material lends support to this explanation. Some of our informants have enjoyed stable, long-lasting relationships, and although we cannot with precision determine the exact circumstances of the break-up, it seems that at least in some cases, the troublesome behavior of our informants was a decisive factor. Paul, for example, admits that his girlfriend left him because of his manic behavior:

> "What did your problem do to you? How did it affect your relations? I lost my wife because of my mannerisms."

Eric, provides another example. When asked to list the chief problems that his drinking has caused him, he answers:

> "It cost me my marriage, my child, my relations with my family, my self-respect, and my self-esteem.....I lost my ambition. I mean, I wasn't a poor black kid from the projects that never had any opportunity. I had every opportunity that's available in the free world to make it."

Wayne claims that his marriage broke up because of his wife's unfaithfulness, and that, as a result of that, he began to drink:

> "I was divorced and was hurt. I was in love with my wife and discovered that cheated on me. My brother had me hospitalized in Chicago State, in Dunning. They were still open in 1969. The paddy wagon brought me there. I believe I had a nervous breakdown. I turned into a chronic alcoholic after we were divorced."

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2 Walter R. Gove, "The Relationship Between Sex Roles, Marital Status, and Mental Illness", Social Forces, 51, 1, (September 1972): 39.

Yet he also agrees with his wife that his suspicions might have been exaggerated:

> "My ex-wife says I'm paranoid. I think my ex-wife was right, that I was paranoid. When I'm by myself I like it so much that when I am with other people I get, not nervous, but I don't get along so well with everybody else. I don't get involved in conversations."

So for these informants the break-up of their marriage seems to be the result of the damage that their symptoms inflicted on their relationship. For some of our younger informants the pattern of marriage and break-up took a different course. While our older informants had enjoyed relatively long, stable marriages, in the case of our younger members the marriage usually crumbled within a year. Ralph provides an example. As his mother recounts:

> "Was he officially married? Mother: Yes. Robbie (Ralph's sister): They stayed together for six months. He was 19. We were there at the reception. Was it a surprise to you all that he wanted to marry? Mother: She was expecting. He asked my opinion and I said: You love her, you got her pregnant, so I think you should get married. That's what he decided to do. Why did the marriage last for only six months? They would fight constantly. I don't know why. She left him and never came back.

Although Darell was never officially married, the course of his relationship with the mother of his child resembles that of Ralph. Darell's mother, gives the following account:

> "Darell knows her from age 16. He has a one year old child with her. I wanted to keep them apart. They

> was getting along so bad. I tried to talk to them, but you couldn't talk to them. I figured that was no solution, always fighting, cursing, and cussing. And to be honest with you, I think Darell was the problem. I love my son but I have to be honest. He would go over to her, but he would get violent. So the mother said: don't come her anymore. She's about 23. They haven't had no contact since he's been in the hospital.

Similar stories are told by Michael and Henry. A few patterns seem to emerge from these observations. These young, and predominantly black, men, married young, often in their teens. The decision to marry was not so much based on the mutual and time-proven recognition of affinity or trust between the partners. Instead the marriage or relationship was rushed, forced upon the partners because of the impending birth of a child. In addition the marriage did not signify the final phase in the man's separation from the parental home, and his transition into adulthood. Rather it was carried out within the confines of the parent-child relationship, with the parents from both sides usually closely managing the realization of the marriage. In contrast to our older informants these men never held stable relationships with their partners. The mothers' stories suggest that the partners didn't get along with each other from the start. Instead of a failed marriage it is probably better to say that the relationship didn't have a chance from the beginning.

The mothers' stories suggest that the unstable behavior of their sons contributed significantly to the break-up of their marriage or relationship. We did not interview the

partners of these men to corroborate this observation. Yet, an unexpected incident gives a clue to the man's position in these failed relationships. One of the patients I interviewed for the Mental Health Policy Project was an 18 year old black woman in her final month of pregnancy. When I asked her if the father had any intention to marry her, I elicited a scornful reaction:

> "Hah, marry me! Yes, he wants to marry me. But I don't want to marry him. Then I would have two children to look after."

This woman formulates what, today, is a common fact of life for young, poor, black women. The men who are available for marriage are emotionally immature, and unattractive as a partner. In the literature on poverty this immaturity has been related to the marginal economic position of these men. Due to the instability of their job situation, these men do not have the means for the sustained support of a family.3 Nor,

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3 The problem is of course as much a problem for the women as the men. In their overview of research on poverty and family structure, Wilson and Neckerman show, among other things that the proportion of black women who are married and live with their husbands has declined appreciably since 1960. The most important factor behind this decline is the rise in never married black women between the ages of 14 to 44. Black women in this age category are more likely to delay marriage and less likely to remarry. As the most important cause for this development, the authors see the high unemployment rates among young black men. As they conclude: "(W)e argue that both the black delay in marriage and the lower rate of remarriage, both of which are associated with large percentages of out-of-wedlock births and female headed households, can be directly tied to the labor market status of black males. As we have documented, black women, especially young black women, are facing a shrinking pool of

as we will show in the next section, to move out of the elderly home, and live independently. The result is that these men are hampered in their development. They do not have the opportunity to set up an independent household, and have the kind of experience that add up to the establishment of an adult identity. In fact, our data seem to suggest that the fathering of a child, and the start of a marital relationship should itself be understood as an attempt to gain the sense of manhood that he lacks in other areas of life. However, the attempt is liable to back-fire. His short-lived attempt to take up the role of father and/or husband merely emphasizes his failure as a provider, and, through his inability to shoulder the responsibilities and obligations that are attendant to fatherhood, as a man.

Thus the marital position of our older and younger informants is fundamentally different. The marriages of our older informants failed, because they failed their marriages. Their symptoms made it impossible for their spouses to continue the relationship. While this is to some extent true for our younger informants, their economic position adds a different dimension to their marital break-ups. Their mental symptoms take a back-seat to the diminished opportunity

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the proportion of "marriageable", that is economically stable, black men." William Julius Wilson & Katherine M. Neckerman, "Poverty and Family Structure: the Widening Gap Between Evidence and Public Policy Issues", Paper prepared for the presentation at the conference on "Poverty and Policy: Retrospects and Prospects", December 6-8, Williamsburg, Virginia.

structure in which the relationship came to being. Quite apart from possible psychiatric problems that the man brought to the relationship, his ability to function adequately as father and husband was seriously curtailed by his economic marginality. While our older informants usually stood alone after their marriage failed, our younger informants generally returned to the parental family. In fact, because marriage did not function as a viable resource for these younger informants, the burden of supporting these men fell on the family. What this implied for the family and the patient is the subject of the remainder of this chapter.

3.2 Family.

3.2.1 Introduction.

Ten of our informants lived with their relatives at the time of their readmission. As a general rule, our younger informants, those between 18 and 30 years of age, lived with their parents, usually in a household that included one or more of their siblings. Darell, for example, lived with his mother, Ralph and Michael lived with both parents, and Frank, alternately lived with his father or his mother. Those informants who were of an older generation, like Lewis and Clarence, lived with other relatives. Lewis for example, shared an apartment with his brother, and Clarence lived in the household of his older sister. Although quite a few of

our informants had children of their own, none of them lived in their own household with a spouse at the time of admission.

Except for the absence of marital ties in our sample, these findings are in accordance with the literature on the post-hospital experience of mental patients. In the deinstitutionalized system of psychiatric service delivery, the family has, de facto, become the single most important source of support for the discharged patient during his tenure in the community. As we saw in chapter 1, Goldman estimates that 65 percent of the approximately 1.5 million patients who are discharged annually, return to their families.4 In other words, in the current constellation of psychiatric service delivery society has in effect thrust upon the family the primary responsibility for control of the mental patient and providing him with the basic means for survival. How families and their formerly hospitalized children respond to this task will be the subject of this chapter.

3.2.2 Adolescent by Default: the Formerly Hospitalized Mental Patient in his Family.

Those who lived with their parents had not always done so continuously. Darell and Michael, to be sure, had never left their parental home, but Ralph had moved out of his parents' house when he got married, to set up an independent household

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4 Howard H. Goldman, "Mental Illness and Family Burden": 558.

with his wife and child. When his marriage failed he had returned to his parent's house. And Chip, because of incessant fighting with his brother and father, lived at home for brief periods only, relying on his grandmother, other relatives, or the mental hospital, to provide him with shelter when he was refused entrance to his parental home.

For some of our informants, who no longer lived with their parents, the parental home was nevertheless still the emotional center of their lives. Renee, for example, has lived in institutions since age 15. Because of her exceedingly violent behavior, short periods at home to bridge the transition from one residential facility to another were experienced by the parents as extremely taxing. She now goes on home visits every third or fourth weekend. Yet there exists no doubt with Renee and her parents that Renee, if given a choice, would prefer to live at home. Similarly, Jack's mother refuses to let Jack live with her because of his violent behavior. Jack, from his side, indicates that he feels deserted by his family because they refuse to take him in:

> "I can't live with my mother. I can't live with my brother. I can't live with my sister. I have nowhere to go".

Despite this, he frequently speaks with his mother over the phone, an occasion which, according to both parties, is usually spent with trading arguments and accusations. And,

finally, Jessie lives separated from her mother most of the time. Jessie's mother is homeless and cannot or will not take care of her daughter. Yet when the mental hospital where Jessie resided at the time refused to let Jessie visit her mother on the latter's birthday, Jessie flew into such a rage that she spend the day in restraints.

Authority and Conflict in the Patient's Family.

The turmoil and vehemence that speaks from these examples indicates the particular emotional quality of the relationship between the parent and the formerly hospitalized child. At the surface, both parties seem to understand the decision to have the child live at home as a tacit extension of the traditional parent-child relationship. Similar to the conventional pattern, the parents provide the individual with shelter and food, look after his physical and emotional well-being, and in general, provide an environment of affection and support. Yet, despite its outward resemblance to the traditional parent-child relationship, in reality this living arrangement differs from the traditional pattern on a number of important points. First, and most important, most of our informants who still lived with their parents, were well beyond the age at which children leave home and become independent. Ralph, for example was 24, Henry 28, Darell 25, and Chip 39. In other words, in terms of chronological age these men were adults who in different circumstances would

have set out to establish their own household.

Secondly, the adult status of our informants had the effect of distorting the authority structure of the family. In the traditional family situation the age differential between parent and child is an important factor in the establishment of a recognized distribution of governance among members of a family. The age advantage of the parent confirms a concomitant superiority in skills, experience, resources, and, ultimately, power, both of a legal and physical nature, which is the foundation of the parent's effective influence over the child.

When the child reaches adulthood, at least in terms of calender age, he will make a claim to an enhancement of his status and influence vis a vis the parent. In normal circumstances this signals the beginning of a reconstitution of the parent-child relation towards a more equal distribution of prestige and a mutual recognition of each others' worth. This redefinition of the relationship is typically established by a process of negotiation between parent and child. In these negotiations the argument of the younger member is primarily based on his ability to convince the elder that he is capable of handling the demands of adulthood. Much of this negotiation proceeds by way of demonstration; the child by venturing out in the various arenas of adult socialization --- school, work, marriage, child-rearing, community involvement --- brings home to the senior member the adequacy of his

performance in these areas.

In the living arrangement of our informants this negotiation process is seriously curtailed. For reasons to be discussed later, the child is both unable and unwilling to venture out into the recognized arenas of adult socialization. This robs him of his main argument in his effort to attain the competence and autonomy that are the vestments of adulthood. The child, in terms of demonstrated experience, remains a child, yet, on authority of his advancing calender age, he does not refrain from asserting adult sovereignty. The net effect of this hampered development is a high potential for conflicts of authority within the family of the ex-hospitalized patient. Our material confirmed this.

Many of our informants who still lived at home reported frequent conflicts over a range of usually insignificant issues. Frank says for example that he regularly fights with his father over the loudness of the music that he listens to:

> "My father kicked me out a couple of times....Why? For different reasons. Because I played my music too loud. Things like that, small stuff."

And Darell complains that his mother objects to his going out and meeting certain of his friends:

> "I just felt that I would do something wrong if I went out again. She's old fashioned. It's kind of hard to relate to each other. She always objects with me being with certain people. She thought they would get me into trouble."

In many instances however the areas of dispute are far from trivial, as they concern issues that are directly related to the aforementioned process of adult socialization. Some of our informants for example came into conflict with their parents over the issue of work. Chip recognizes that his unemployment is a bone of contention to his parents:

> "In what way has your underemployment affected your relationship with your family? It's been detrimental. They can't understand why someone that has so much talent is not working. They feel that I'm wasting away my life and they have told me on many occasions in the past. And I agree with them."

Chip describes a tension within the family between two conflicting sets of expectations: the parents' expectation that an adult male should be engaged in employment and earn his own living, and the child's expectation that he can count on the unconditional material and emotional support from his parents. The fact that both sets of expectations concern core domains of the organization of social life, gives disputes in this area the potential for bitter emotions and uncompromising conflict. Darell, for example, deeply resented his mother for her refusal to let his pregnant girlfriend move into the family home, after the girl was evicted. And Ralph, like Chip, came into conflict with his parents because he refused to go to work. As his mother describes:

> "He was working with my husband. One morning he started acting strange. He didn't want to go out of bed and work. So my husband said: if he can work and he can't get out of bed, then he can't live

here....Did Ralph and your husband generally get along well? Yes. So why did he tell Ralph to leave? My husband begged him to come to work. He needed him. But he wouldn't. My husband didn't want him to leave. He said: you talk to him. I did, but it didn't help. He had never acted that way before. He said he didn't want to work anymore Maybe because the day before my husband had to leave and when he came back the boys hadn't done as much work as he thought they would. He was displeased with that. Maybe this brought it on. My husband suggested that he should go and live with someone else. He said: if you're not gonna work, how are you gonna live?"

In all three examples the conflict should be regarded as a confrontation between the child's assertion of his adult rights with the parents' expectation of continued control over him. The vehemence of the conflict derives from the circumstance that its outcome determines the mutually recognized distribution of adult authority and autonomy within the family. In Darell's case, for example, the parents' exclusive right to determine who lives in the family house collided with Darell's expectation that he had gained a certain decision power in that matter. And whatever the reasons for Ralph's refusal to go to work, it straightforwardly pitted his assertion to determine when he likes to work and when not, an assertion rooted in his perception of himself as an independently functioning adult, with his parents' conviction that they still exert authority over their child to the extent that they can order him to do something against his will.

Thirdly, the continued residence of our informants in their parental home is experienced by all parties as

involuntary, as a situation which, through force of circumstance, is imposed upon them. Most parents feel that their child's distressing behavioral problems and economic marginality leaves them with little alternative but to resign to his continued dependency on their care. Without their continued support he or she would be unable to survive in the community. Jack's mother expresses this when she says:

> "He can't live by himself He eats the wrong foods. He sits up at night because he's afraid somebody will break in. He's so paranoid, so afraid to....just afraid to be himself I guess. He thinks he can do everything by himself. He says: I can live on my own in my own apartment, but he can't. It's bad enough to have to learn these things, but with his sight, it has to be overwhelming. How will he do it?"

The Moral Dilemma of the Family.

For many families the decision to have their formerly hospitalized child live with them created a particularly ambiguous moral and emotional situation. On the one hand the child's continued residence in the parental household entails a life of incessant fear and worry for the rest of the family. In many cases this concerns fear for the family's own safety. The families we interviewed told of numerous instances of verbal and physical abuse of family members, excessive consumption of alcohol or drugs, fire setting, and the destruction of furniture by their child. Renee's parents, for example, recount how Renee at one point had held a knife at her father's throat. Chip regularly engages in fierce fights

with his brother which land them both in the hospital or the police station. Sometimes the child's threats and bizarre behavior necessitate a constant vigilance on the part of the family out of fear that he might act out his threats. Both Ralph and Henry's kin, for example, told how at times their fear for bodily harm became so acute that they hid the kitchen knives from their disturbed son. And Michael's mother, when asked if she ever feared for the family's safety, answers:

> "Sometimes I do. One time I tried to talk to him and he said he would bust my head. So sometimes I wonder would he really do it. He threatened his father once, more than once, that he would kill him. Do you take that seriously? We won't trust him. You have to watch him. Because when he missed that medication he was hearing voices and he might try to kill his father." 5

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5 In some cases the family's fear extends to the safety of other people as well. Henry's medical records contained the following internal memorandum from Henry's treatment coordinator, the content of which speaks for itself:

> "Call from Edgewater Uptown MHC --- John Johnson liaison person called. Henry H. this day set two fires in his mother's apartment and took three butcher knifes (sic) and attempted to kill the whole family. He threatened the lives of his mother, two sisters and three children. John was wanting to know why we ignored their requests not to send him back to his mother. I told him that he had been in control for thirty days and that it was a matter of Henry's abusing substance in particular marihuana. Henry's mother states that Henry never left the house and he was not abusing anything. So now Henry's mother is terrified. She has locked up the apartment and fled the city. Henry is in the streets with butcher knifes (sic) and in a rage. Edgewater is hoping the police will catch him before he harms someone. I advised him to tell Henry's mother to sign an assault complaint so he would be treated as an attempted murder." (sic)

Often the parent's fear concerns their child's own safety. Since Michael at one time, during a psychotic episode, stabbed himself, his mother lives in constant fear that he might repeat the act. And Ralph's mother vividly recalls her agony during the night that preceded her son's latest admission:

> "He left the house and went to the bus stop. We followed the bus with our car. He got out at the 95th El-station. My husband and me didn't know what to do. He said: Why don't you go out and ask him to come back with us. Even if we have to stay up all night and watch him. We didn't want him on the streets. I got out and I called him. He was in line to buy a ticket. But he said: I don't go back to that place. (Ralph responds to his parents' suggestion to have himself readmitted to the mental hospital. HW.) He went through the turnstile. I felt terrible. I didn't know what could happen to him, that he might jump the El-track. I was very sick. I walked the floor.

On the other hand, many parents continue to feel strong bonds of loyalty to their child. Through the outward appearance of a disturbed and troublesome mental patient they continue to see the image of the child they always knew. Despite the hardship that the latter has imposed upon them, and the many instances of bizarre or violent behavior, the parent is unable to relinquish his responsibility for his offspring, and feels compelled to help him where possible. Ralph, for example, lived with his uncle after a conflict with his father over work, but when he experienced a PCP-induced psychotic breakdown at his uncle's house, his parents didn't hesitate to take him back home. When I ask Ralph's mother in the course of the interview if she ever felt embarrassed about

Ralph's bizarre behavior, she answers:

> "I had no time to think about embarrassment. I always thought about pity. He's a likable person. He's always been free-hearted and respectful. He's very thoughtful. He called me from the hospital to say that he was sorry that he missed my birthday."

Chip's parents, despite Chip's destructive and violent behavior, have often taken him back home after he was released from the mental hospital. And, only a year ago, his father tried to secure him a job at the Ford Motor Company, an effort which failed after Chip began to call his future supervisor in the middle of the night. Nonetheless father interprets Chip's erratic behavior as the result of his unchecked ambition and his inability to wait patiently for the application procedure to unfold. Talking about Chip's ambition to succeed, father reflects:

> "It affects me. I try to let him know it. Maybe he will do better then."

And Darell's mother, after she had been assaulted by Darell, afterwards expresses relief about the fact that her other two sons were not home at the time of the incident. If they had been, she fears, they might have attacked Darell, and:

> "....that night would have ended in a disaster. I fear that they might snap when they see me being misused by Darell. I don't want them to get hurt. Neither do I want Darell to get hurt. If anyone gets hurt it better be me.

The parents' continued responsibility for their formerly hospitalized child, confronts them with a profound moral dilemma. They find themselves torn between their continued loyalty to their disturbed or troublesome child and their need to guarantee some meaningful life options for themselves and the other members of the family.6 For most parents this dilemma presents them with a no-win situation. When they decide to cope with the situation, and tolerate the child's bizarre or violent behavior, they expose the family to continued abuse, destruction of property, and possible physical harm either of their child or the other members of the family. When they finally bend to the pressure and initiate action to have their child removed from the family environment, they are likely to experience strong feelings of guilt. Jack's mother expresses this when she talks about her failed attempts to have Jack admitted to the mental hospital, and her subsequent decision to separate from her husband:

> "He (Jack) developed this inner rage. At age 19 he threw his brother through a living room window. I took several days off then and went to court to try to get him committed. But he was over 18 then and the court system doesn't allow for that. The judge told me that he could be admitted voluntarily. But Jack wouldn't hear of that and threatened to kill me. I

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6 See also Henry Grunebaum, "Comments on Terkelsen's 'Schizophrenia and the Family: II. Adverse Effects of Family Therapy'", Family Process, 23, (September 1984): 421: "In addition to these and other typical clinical issues a therapist faces in work with families of the mentally ill, I am impressed that the dilemma they confront is at the heart an ethical and existential one --- what does one owe one's children and how is one to lead a meaningful life."

> really lived in fear and I couldn't take it no longer. I had lived with an immature husband and a belligerent son. I left. I guess that's the coward's way out, but I decided to leave then."

Moreover, even when the parents, usually after much soul-searching, finally initiated action to have the child removed from the household, he is not thereby removed from their hearts and minds. Renee's parents express this when they say about their hospitalized daughter:

> "Listen, we are all upset and she is always in the back of our minds."

When the child is admitted to a mental hospital or a residential treatment center, and family life has regained its normalcy, the parents are left with unabated feelings of uncertainty, guilt, or simply sadness about the fate of their child. Some parents, almost against better knowledge, keep wondering if their child is mentally disordered because of anything they have done wrong in the past. Michael's mother expresses the wrenching feelings of the parent who stays behind when she says:

> "We asked ourselves what went wrong or why he is like that. I didn't know. I wondered what I had done wrong. I wondered if God was punishing me. I talked to the lady next door who also has a son who had been in a mental hospital. I asked her what I had done wrong. I couldn't think of anything. I'm a good person, but she said: No, it's just life. That helped a little, but even now I still wonder why sometimes. I have never seen a mental patient and now I have one."

Whether inside or outside the mental hospital, the disturbed child casts a long shadow over the family. Almost all parents realize that they will never be able to lead a normal life as long as their child is dependent on them. They have had to scale down whatever hopes or ambitions they might have had for their children or themselves. The best they can hope for is that they are able at times to strike a compromise between the relentless pressure of their child's condition and their own needs. Jack's mother, for example, describes how she was able to regain her self-respect, and to reconcile herself somewhat with the knowledge that it is beyond her power to turn Jack's life around, when she says:

> "In the beginning you do a lot of crying and soul-searching. But now when he calls, I can at least take it without bursting in tears or have my blood-pressure go sky-high. It's not that you're immune to it, but you can't change it."

However, this fragile equilibrium is constantly threatened by the stark realization of their child's fate. The parents are aware that they are his only, and often last life-link, and consequently cannot help but wonder what will become of their disturbed child when they are no longer around to take care of him or her. As Renee's mother says:

> "<u>What do you fear most about Renee's problem?</u> I fear most that she's gonna....that without independent living skills, when we are not here to take care of her, that she will be a street person. That's what I fear."

The Moral Hazard of the Child.

For the formerly hospitalized patient his continued abode in the parental home is no less wrought with ambiguities. On the one hand, our informants deeply resented the influence their parents kept exerting over their life. Both Ralph and Darell, for example, frequently expressed that, had it not been for a lack of money, they would have left their parents' house long ago. And Darell bitterly complained that his mother "just will run my life".

This anger and resentment about what they perceived as undue parental control was at the roots of the kind of bizarre or inexplicable violent behavior that so often resulted in our informants' readmission to the mental hospital. Despite the apparent unintelligibility of Henry's resolve to wear a winter coat in the heat of the Chicago summer, or to walk around in the court yard of his mother's house in his underwear, one cannot escape the impression that this behavior contains a deliberate element of provocation, a taunting of his mother's wishes. Ralph explained that anger towards his parents motivated him to overturn a coffee table at their house, an act that triggered the chain of events that returned him to the mental hospital:

> "That was because they put me out. I'm tired of them putting me out. I've been put out five times. Always the same reason."

And Darell's mother recounts how in the middle of Darell's

violent assault on her that preceded his latest readmission, he expressed the motivation for an act that was regarded by the police and intake staff at the hospital as inexplicable:

> " He beat me while he choked me. He stopped. I said: Darell, what is it? Do you want money? Do you want me to call your father? He was kind of foaming at the mouth and breathing heavily. He said: No, I don't want anything. You put me in the hospital. You are the cause that I don't have a family. I think he meant this...."

Yet on the other hand, our informants often demonstrated an outright complacency, a tendency to take their present situation of continued dependency and relative comfort for granted. Any suggestion or initiative by the parents that so much as hinted at the individual's departure from the family home, was received with unabated fury. Both Ralph and Henry, for example, interpreted their parents' efforts to find support for their son's troubles as straightforward attempts to evict them from the family home, and reacted to this likewise.

Risks and Tensions in the Families of Mental Patients.

For all parties involved, the involuntary residence of the formerly hospitalized patient in the parental home, carries a number of manifest risks. From the point of view of the family, it is fair to say, that the forced continuance of the child's dependency upon his parents wreaks havoc with the life-cycle of the family. The natural economies of dependence

and independence, support and control, that are characteristic of evolving family life, are seriously distorted by the child's inability to move from one life-phase into another.

For the family the net result is that is it subjected to unexpected demands for which it is ill prepared. Instead of the expected diminishing of parental responsibilities by the child's departure from the family home, many of these parents see the claims upon their continued attention and support increased by the prolonged presence of a troubled, and troublesome, adult. For many families this added task simply goes beyond their capacities. No family can very well be expected to fulfill the mutually incompatible roles of loving parent, impartial therapist, and stern policeman.7

Not surprisingly, effective family interaction regularly breaks down into acute crisis under these insurmountable and contradictory role demands. To be able to continue its functioning in such circumstances, the family often rests nothing but to call upon outside support to resolve these recurring crises. Depending upon their particular circumstances families made use of a variety of resources. Calling upon the assistance of other families is one such resource. After Chip had assaulted his brother, his

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7 Terkelsen, in a reply to Grunebaum's aforementioned comments (see note 3) speaks of "the sheer impossibility of the family's position when confronted with the conflicting needs of a chronic patient and healthy members". Kenneth Terkelsen, "Response by Kenneth Terkelsen", Family Process, 23, (September 1984): 427.

grandmother offered to take him in. When Ralph refused to go to work, his parents arranged for him to move in with an uncle.

When other family is unavailable, or their support exhausted, or the severity or urgency of the crisis is such that it goes beyond the capacity of private individuals to abate it, the family has to rely on professional help. In some cases the family can persuade the troublesome individual to accompany them to the emergency room of a nearby hospital or to the local mental health center. In the majority of cases however the antagonism between family members preclude such reasonable solution and the family has to resort to calling the police. The police in such instances serves as an auxiliary problem solver to the family, in some cases resolving the dispute at the spot through added argument and authority, in some cases diminishing the tensions by temporarily removing the individual from the scene altogether. For those informants who lived at home the police was a common pathway to the hospital.

For the child his inability to move out of the parental home and his continued dependency on his parents, in effect meant a deferral of his personal development. By remaining in the parental home after reaching adulthood the individual unwittingly continued the relational arrangements with his parents that were characteristic of his childhood and

adolescence. Many of our informants, in their fixation on alleged parental injustices, the plaintive tone of their criticism, and their inability to take a more relative perspective on their situation, betrayed an unqualified element of immaturity to their outlook on life. There often existed a clear incongruity between the content of our informants' discourse and their age appearance. An example is provided by Darell's assessment of his mother:

> "I tried to talk to my mother. She don't understand me. That causes problems. She's in the olden days. I'm in the modern days. We don't seem to get together on things. She don't like the change. She's living in the past. It's 1986. I feel you should live one day at the time."

The relationship between those informants that live at home and their kin take on the appearance of a prolonged adolescence. The child has been unable to take part in those socializing experiences, like finishing an education, getting a job, securing a place of his own, founding a family, that mark him as an adult member of society. In effect, the child is unable to make the expected transition from adolescence into adulthood. Forced, through a lack of resources, to remain at home, the individual gets caught in a complex psychological space. On the one hand the individual is aware of his hampered development, and acutely experiences the accompanying sense of defeat and frustration. Unable, because of a lack of the necessary material and psychological resources, to moderate these feelings through constructive

engagement with the world, and confined to the narrow space of the parental environment, the individual's parents become prime candidates for the assignment of blame. It probably testifies to the urgency and intensity of the individual's frustration that so often his ill directed anger takes the form of physical altercations. In line with these sentiments, on many occasions our informants expressed a strong desire to move out of the parental home.

On the other hand, their prolonged residence in the parental home entailed a kind of moral hazard for the patient. Well aware that, if left to fend for his own, he would be unable to support himself, the child becomes dependent upon the parents. Many patients who still lived at home gave the impression that they more or less exploited their parents, and that they had given up trying to attain adult autonomy.

To sum up, family relations are, for those of our informants who still lived at home, a two-edged sword. Although his residence in the parental home shelters him from direct exposure to homelessness, hunger, and social isolation, the psychological and relational complexities that result from the individual's continued dependence upon his parents, turns this resource into a moral and psychological liability. The price that the individual pays is the loss of the incentive to gain adult autonomy and to step into the mainstream of society. On their part, families are not equipped to handle the demands of living with a mentally disordered young adult,

and sooner or later have to turn to outside sources of support to handle the inevitable breakdown of family interaction that would occur. For a considerable proportion of our informants their rehospitalization was preceded by a crisis in the family.

4. HOUSING.

Of all elements in the life of the formerly hospitalized mental patient, his housing situation is probably most directly related to his chances of being readmitted to the mental hospital. In some cases, like those of Jessie, Rosa, or Jack, the immediate cause of their rehospitalization was the individual's lack of stable, adequate shelter. Jack, for example, was readmitted twice, once on Columbus Day and once on Thanksgiving, when the residential facility where he lived at the time closed its doors during these holiday weekends. In other cases the contribution of the individual's housing situation to his or her readmission was less direct, but certainly not negligeable. Wayne, for example, referred himself to the hospital out of anger and disappointment with conditions in the residential facility where he lived. And the train of events that led to Dorothy's readmission was initiated by her loss of shelter.

Lack of adequate housing not only determined the person's admission to the hospital, but also his or her release from it. Renee spend more than five months in the hospital during her last admission because the hospital staff was unable to find a community facility that was willing to accept her. Her reputation as a violent patient, prone to fire setting, had effectively closed all doors to her. In many cases finding the person a suitable place to live came to predominate his or her treatment plan. Housing, in short, was one of the most

direct and potent influences on the frequency and duration of the individual's tenure in the mental hospital.

As a rule, the individuals in our sample lived independently in welfare or single room occupancy hotels, as residents in one of the various community-type institutions, or had moved in with friends or relatives. Only one of our informants had secured his own apartment in the rental market, and had managed, despite several admissions to the mental hospital, to hold on to it. Three of our informants were homeless.

Those of our informants who lived independently without exception inhabited housing of vastly inferior quality. In fact, the middle-class sensibility of this interviewer was most rudely shocked by the sight of the living quarters of some of our informants. Fred's room was a dark, hollow cavern, with a view of a brick wall. His furniture consisted of a small, rickety table with a hot plate, two metal chairs with plastic seats, and a bed. As there were no closets, his clothes were stored in plastic trash bags. I never came to see Eric's room; he indicated that the quality of his lodging was such that he felt too uncomfortable to receive me there.1

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1 Even in squalor there are infinite gradations. Wayne and Eric lived in hotels that were located on the North Side of Chicago. Although these were gloomy, dirty places, they were relatively adequate compared to some of the apartments or SRO hotels on the South Side. Some of the scenes I encountered there, while interviewing formerly hospitalized patients and their families, came straight out of Henry

And Jack reported that he lived in a damp basement room in a neighborhood that was riddled with street crime and drug trade. Those who lived with their families, although they generally enjoyed better housing conditions, did so, as we have seen, force majeure, usually because they could not afford a place of their own. For those who lived in one of the community-type residential facilities, acute lack of shelter at the moment of discharge from the mental hospital, rather than the need for rehabilitative care, often was the decisive factor in their referral to these facilities.

These sundry observations point to one conclusion: judging by the type and quality of housing of our informants, the large majority of them was situated at the very low end of the housing market. Almost without exception they occupied the fringe of this market, a shadowy world of unattractive, substandard dwellings, institutional and semi-institutional environments, and such practices born out of desperation as double or triple occupancy. Now that the mental patient spends most of his time in the community, he is forced to fulfill his need for shelter by competing with other low-income groups for the available housing stock. The sad fact however is, that in this competition the cards are heavily stacked against him. Very few of these formerly hospitalized patients were able to succeed independently in the current

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Mayhew's classic survey of the condition of the London poor.

market for rental housing. This fact, as we will see in chapter 9, had particularly pernicious consequences for their utilization of such services of last resort as the police, the emergency room, or the public mental hospital. Generally speaking, our informants' position in the rental market was determined by their economic and psychological marginality and the inherent structure of the market itself. Before we turn to the former, we insert a brief discussion of the latter.

The Current Market for Low Rent Housing.

Like other low income groups, formerly hospitalized mental patients rely on the market for low rent housing to satisfy their need for shelter. What does the current market offer low income groups? Trends in the incidence of poverty and the availability of low income housing show a disconcerting fact: over the last ten years the gap between the demand for and supply of low rental units has been widening steadily. Between 1974 and 1983 the number of units with a rent of $250.- or less (in 1974 dollars) has decreased with 2 million units from almost 11 million to less than 9 million. During the same period, the number of families in need of such units, that is those living below the official poverty line, increased from 9 million to 12 million. The result is a serious shortage of units in the low end of the rental market, or the emergence of, what Philip Clay calls, a

"crisis of affordability".2

This imbalance between the number of available low rent units and the number of poor persons is the result of several related developments in inner city housing markets. First, as a result of urban redevelopment policies aimed at increasing the economic potential of decayed inner city areas, low-income residential areas, rooming houses, and cheap hotels have been destroyed, to replace them with hotels, commercial buildings, and high-priced housing.3 As a result of the increased attractiveness of the urban environment and the movement of white-collar jobs to the inner city, many cities experienced an accelerating process of gentrification, the movement of higher income groups to decayed inner city areas. This development is usually accompanied by a large scale conversion of low rent units into high priced condominiums. This trend has been encouraged, thirdly, by increased land prices, which made it far less attractive for developers to build low income

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2 The numbers are from Philip L. Clay, "At Risk of Loss: the Endangered Future of Low-Income Rental Housing Resources", Neighborhood Reinvestment Corporation, Washington, D.C., May 1987, chapter 2. See also Richard Freeman & Brian Hall, "Permanent Homelessness in America?", NBER Working Paper #2013, September 1986: 22. Freeman and Hall estimate, something which is particularly relevant to the issue of housing and hospital recidivism, that between 1979 and 1983 the number of unattached adults who live below the poverty line has increased with 21 percent.

3 Rossi and Wright estimate that between 1980 and 1983 single-room occupancy capacity in Chicago has declined by almost 25 percent. Peter H. Rossi & James D. Wright, "The Determinants of Homelessness", Health Affairs, 6, 1, Spring 1987: 29.

housing.4

The most visible and pernicious effect of these developments has been an increase in the number of homeless persons. It has been estimated that in 1984 250,000 - 350,000 persons were homeless.5 Particularly worrisome however is an acceleration in the increase in the number of the homeless between 1983 and 1985, a period of economic recovery. In this period the number of homeless persons increased with 23 to 30 percent, with the biggest increase being registered in the number of homeless families.6 While homelessness is the most visible effect of the dislocations in the rental market described above, a much larger number of people feels the more insidious effects of an imbalanced market by being forced to double up with relatives, by postponing their entrance into the rental market, by being relegated to substandard housing, or by relying on the state to provide them with shelter.

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4 See S. Anna Kondratas, "A Strategy for Helping America's Homeless", The Heritage Foundation, May 6, 1985: 8. See also Freeman & Hall, "Permanent Homelessness in America?": 21. In some cities, particularly those with rent control regulations, anticipated conversions of low rent units to co-ops or condominiums has led to a considerable hidden vacancy rate. The owner's demand is for empty apartments, as these sell for higher prices than occupied dwellings at the time of conversion. (New York Times, July 12, 1987, section 4: 5)

5 U.S. Department of Housing and Urban Development, A Report to the Secretary on the Homeless and Emergency Shelters, Washington, D.C., Office of Policy Development and Research, 1984.

6 Freeman & Hall, "Permanent Homelessness in America?": 8.

In our sample of formerly hospitalized mental patients these various consequences of the dislocation in the low rental market are clearly observable. Three of our informants were homeless, seeking occasional refuge in city-run shelters. Five of our informants either lived in run-down, decrepit hotels, or relied on state-financed residence in community-type institutions. And the remainder had postponed their entrance on the rental market by continuing to live with their parents. Many of our informants indicated that they were unable to find affordable housing. Ralph for example, when asked if he had emotional problems in the weeks preceding his latest admission, answers instead:

> "I couldn't find a place to stay. I didn't have enough money."

Darell, when asked, to whom he turned when he had money problems, answered:

> "I went to SSI. How did SSI help you solve your problems? It didn't. It made me feel a little better that I had some money coming. But it's so little that I can't afford my own apartment."

And Dorothy, Jessie, Jack, Renee, and Rosa all indicated that they considered their inability to find a place to live their greatest problem.

Thus, because of the widening gap between the demand and supply of low rental housing units, these formerly hospitalized mental patients, like so many low income families

with them, find it more and more difficult to secure affordable housing. However finding a place to live is only one side of the problem, holding on to it proved at least as difficult for many of our informants. In this respect our informants' relation to the housing market resembled their equally problematic relation to the labor market, to be discussed in the next chapter. In both instances they find themselves locked into an environment of exchange relations that fails to provide them with the necessary means for survival. In both cases their position in the market makes them extremely vulnerable to the effects of life's adversities. On the other hand, in many instances our informants displayed a carelessness with regard to their job or their lodging that stood in sharp contrast to the latter's importance for their economic and psychological well-being. The result of this interaction of their tenuous relation to the market with their generally low functioning was an incessant instability and turnover of jobs or housing. It is to this vulnerability, capriciousness, and the concomitant inconstancy in our informants' housing situation that we turn in the next section.

Instability in the Housing of the Discharged Mental Patient.

One of the most striking aspects of the housing situation of our informants is its extreme discontinuity. Including hospitalizations most of the patients in our sample had

changed their place of residence 3 or more times in the year that preceded their readmission. (Table 1). For many of these

Table 1: NUMBER OF TIMES MOVED WITHIN THE 12 MONTHS PRECEDING LAST READMISSION. (N=17)

0	-	-
1	-	-
2	2	12%
3	3	18%
4	4	24%
5	2	12%
6	2	12%
7	2	12%
8	-	-
9	1	6%
10+	1	6%

people work, income, personal stability, and housing form a close but highly unstable nexus of resources; instability in one or more of the first three elements immediately translates into forced changes in the fourth. As a consequence the individual's life often takes on the quality of an incessant, never-ending journey along welfare hotels, shelters for the homeless, board-and-care facilities, the homes of friends or relatives, and somewhere down the line, the public mental hospital. Eric, provides a good example of the transient quality of the lives of our informants:

> "I get a job and a place to stay and within a month I lose the job and the place to stay. I stay in hotels. The longest I stayed somewhere was three months. With all that moving all I lost was four suits. A lot of people lose everything they own. They move out without paying the rent and leave behind all their clothes. I try to

keep my things together. Wherever I live is my home to me."

Similarly in the course of one year Chip moves between the house of his parents, that of his grandmother, the YMCA, and the homes of various friends. Jessie moved from an apartment that she shared with her mother to the streets and into and out of various shelters for the homeless. And in between admissions to the mental hospital, Jack moved from a residential institution for the visually handicapped, to a run-down apartment of his own, to a board-and-care facility.

The three most common reasons for our informants to lose their home are financial troubles, family discord, and mental instability. Chip, provides an example of the first. He lost his apartment after he was laid off from his job as quality inspector at Ford. As his father recounts:

"When Chip junior started, he and I were both working at Ford Motor Company. First they had a high work roster. Then they had a bad model that didn't sell. That was in 1972. They laid off salary personnel. Chip was on salary in production control. He had worked for Ford on an hourly basis, he was backed up on an hourly basis....(H)e had a good job. He got in a high rise building, looked out on the lake.....He lost his job and everything."

Dorothy lost her apartment because of a crisis in her marriage and the subsequent loss of her job:

"Ever since I separated from my husband, this has been happening to me. He had a child with someone else, and I left. I had a job then and my own apartment. I still

have my rent receipts and the lease for my apartment. One day in 1973 the owner of the beauty shop said that he didn't require my services anymore. And I haven't worked ever since in a beauty shop. All the jobs that were available were in the suburbs. But I didn't drive. I had no transportation to get there.... This is what keeps happening. I have no stationary address. I get no assistance. It is going on and on and I have no idea why this is happening."

Dorothy's account of her husband's deceit, her divorce, and subsequent hard times is familiar enough. Yet, on close inspection, it is difficult to be completely convinced by her story. The listener is left with too many unanswered questions to be fully swayed by this reconstruction of her life history? Why exactly was she laid off? Was it really that hard to find transportation? Why doesn't she receive general assistance? Does she really have no idea of what constitutes her troubles? Although Dorothy's trouble is real enough, her particular rendering of it demonstrates that there is more to it than this rather matter of fact account of marital and economic problems. Although we have no information to independently confirm our misgivings, it is hard to escape the impression that, wittingly or unwittingly, Dorothy has construed a life-story that conveniently leaves out her personal contribution to her present situation.

With Chip we do have the possibility to look beyond the "objective" events. Chip's father provided some additional background to the circumstances that preceded Chip's eviction from his apartment. As we recall, Chip could afford a quality apartment after his employer promoted him from hourly wages to

salary. However, as his father recounts:

> "Chip got involved with some people whom he had worked with on hourly. I think they were jealous. His problems started from there. These fellows invited him for drinks. He is kind of an alcoholic....I think his friends juiced him up. Plus the fact that he had a good job. He got in a high-rise building. Looked out on the lake. He could pay for it. They had parties all night. He expected to be hired back, but he wasn't. He was drinking already....(A)fter he lost his job, he fell apart."

What this example shows is that it was not external circumstances alone that resulted in Chip's loss of housing. Many of our responds, like Chip, aggravated the impact of "objectively" difficult conditions , by their aberrant, extreme, or careless behavior. Jessie's case provides a particularly good example of how carelessness exacerbated what was already an extremely difficult situation. After Jessie's mother has separated from her father, she and Jessie find themselves temporarily without housing. Jessie's grandfather finds the two of them an apartment. He moves in with them, furnishes the place, and for a period of three years he pays for rent and utilities. As grandfather explains:

> "I left there in '85. I tried to explain to them to have the gas and light switched in their name. I left and they stayed there. I had told them I went along for 2 or 3 years and after that they had to go for themselves, education-wise, job, anything you know, manage their own home....But they relaxed and thought: he isn't going. I had moved in to get them back on their feet....They moved from there in January. They claimed they couldn't keep up with the rent....They claimed they couldn't get a job. I explained to them it's not what you make, but what you do with what you make. I imagine they went to the shelter. ....She (Jessie's mother) was a beautiful person until her

husband passed....After that she took life as it is. Had your daughter changed after that? Her personality didn't change. She always had that easy-going way. She no longer was trying to better her condition or looking forward you know. She just tried to relax. Together they received three checks, but she always mismanaged it.... What went through your mind when you learned that they were evicted from the apartment? When you try to help a person and all they do is relax, you think: well, that's what they want out of their life. So you let it go and try to help them if necessary."

More often than not, as these examples indicate, it is the interaction of loss of income, family conflict, and mental instability that results in the loss of housing. Darell, for example, had no place to stay, when his mother refused him entrance after he had assaulted her. Eric's loss of his job, and the subsequent loss of his room, usually followed his periodic drinking binges. While these indigent, formerly hospitalized patients, compared to their never-hospitalized, middle-class counterparts, had a clear disadvantage in the housing market, their often aberrant behavior added considerably to their inability to find and hold on to a stable residence. As a result of this interaction of market conditions and individual instability, the individual's position in the housing market was exceedingly vulnerable to the impact of life crises.

This vulnerability seems to be made up of two parts: a greater susceptibility to adversities, and a diminished capacity to rebound from temporary hard times. The frequent small and large crises brought on by the individual's mental instability, like a period of depressed mood, a momentary

relapse from alcohol abstention, or a fight in the family, were often sufficient to seriously jeopardize the individual's housing situation. But even more important, because of the individual's position at the bottom of the housing market, the impact of these adversities was often excessive. Not only did marital crisis, the loss of job, temporary mental or physical disability, discord in the family or irresponsible behavior often result in the loss of housing, but because of the individual's general lack of resources he would find it nearly impossible to bounce back and independently secure himself alternative shelter. As a result the individual had to turn to public sources to find a temporary place to stay.

Loss of Housing and the Experience of Mental Disorder.

Thus, the indigent, formerly hospitalized mental patient holds at best a tenuous relation to the market for rental housing. On account of his personal instability and his lack of material resources, he finds it almost impossible to independently obtain a stable place to live. Subsequently he becomes dependent on others --- family, friends or public resources --- to satisfy his basic need for shelter. Yet his tendency towards unusual or careless behavior will most likely bring him into conflict with those on whom he is dependent for his housing needs. As a result the housing situation of our informants is characterized by extreme discontinuity.
Yet, this formal, sociological account of the dynamic relation

between market conditions, individual predispositions, and rehospitalization, does not fully explain why the loss of one's house is such a potent precipitant to readmission. The careful description and exposition of constituting forces fails to capture the personal quality of the individual's housing experience. It made quite a difference to the individual's experience of his housing situation, for example, if discontinuity meant, like in the case of Clarence or Henry, a frequent moving between the family house and the mental hospital, or, as with Fred, Renee, or Dorothy, the movement from one uncertain address to another. In the first examples the repeated changes of quarter had become more or less integrated into the individual's life pattern, almost to the point of becoming a stable, albeit unpleasant routine. In the second set of examples however each move was accompanied by wrenching uncertainty about where one would end up next, usually with the specter of homelessness in the background.

Uncertainty about the prospects of finding a suitable place to live was the key to the individual's experience of his or her housing situation. Not surprisingly, those informants who said at admission that they did not know where they would live after their discharge, were also the most anxious and worried about their housing situation. Jessie, when asked where she will stay after she leaves the hospital answers:

"I don't know. I worry about it a lot"

And Darell, when I ask him where he will stay after his discharge from the hospital says:

"That's what I'm wondering now. Who do I go to. I really don't know.",

and he adds that he worries a great deal about this.

It is this combination of incessant instability and the uncertainty accompanying each move, that establishes the tenor of these individuals' lives. For many of our informants life had taken on a chaotic, rudderless quality, as if the individual had utterly lost control over the choice of his location. But the lack of structure in the individual's outer world was not without consequences for the organization of his inner world. For many of our informants the chaotic quality of their physical environment seemed reflected in the mental confusion, the tangential relation they held with daily reality, that was characteristic of their psychological world. Dorothy is a case in point:

"From 1974 to now I've been moving constantly. I have no fixed place where I can stay. I was evicted from my apartment in March 1985. I couldn't afford to pay my rent anymore. I stayed in the street until I ended up in Cook County Hospital. For maybe three months I was out in the streets. I had a swollen ankle. I slept anywhere. I sit in doorways in front of a restaurant. Sometimes I would walk all night. I stayed in the hospital for a few hours. There they called human resources and they took me to a place called Tabathe House. (A shelter for homeless women) I stayed there for a couple of days. Then the woman asked me to leave. <u>Why did she ask you to leave?</u> I don't know.

She just had some dislike for me or something. I told her to call the police. I thought the police might take me to a police station to find me a home, but they didn't. Instead they took me to Loretto Hospital. Loretto referred me to Read hospital. I stayed there for three weeks. Then I went to Mehta's house. The Mehta's took me to their home. I called them. I had worked for them a year and six months. I worked for them as a housekeeper."

It is the emotional quality of Dorothy's account that should set the key to our analysis of the relation between the housing situation of the formerly hospitalized mental patient and the likelihood of his readmission. There is an element of disorientation to her story, as if to find oneself without shelter has a dazing, unhinging effect upon the individual. The emotions that surround unemployment, although the loss of one's job may ultimately be more far-reaching in its implications, are, by comparison, moderate, restrained. There is nothing here of the controlled anger or the unconcerned attitude that characterized our informants' reflections upon their employment situation. The loss of home, the uncertainty of shelter is a problem that forces itself upon the individual with an overpowering, almost physical urgency. Rosa, homeless, penniless, is readmitted the same day that she was discharged from the mental hospital, after, according to the medical records, "creating a disturbance at Walgreen's drugstore". Asked to describe the events that led to her readmission, she replies:

"I threw up regurgitated hate. They took me to Northwestern in a car. The owner of a Burger King asked me to leave. <u>What did you do?</u> Nothing. I got sick in

the stomach."

Home, like work and family, is one of the central elements in the organization of our material and emotional life. Because of its close association with physical sanctum and emotional refuge, the loss or absence of home simultaneously creates momentary panic and long-term disarrangement in the organization of private life. Rosa, in her aimless wandering along the semi-public environments of a downtown urban area, confuses Burger King with Walgreen as the site of her emotional crisis. Although her confusion comes out of a momentary anxiety, it speaks to the larger dislocation and disorganization that results from a chronically unstable housing situation. The psychological condition of many of the individuals in our sample rapidly deteriorated when they found themselves without adequate shelter. Acute uncertainty about shelter was closely associated with Rosa's delusions or Jessie's confused nightly wanderings through South Chicago, or the deterioration of Darell's psychological state.

Darell's case provides one of the clearest examples of the close association between the individual's psychological balance and his housing situation. As long as he lived in his mother's home the problem that landed him in the hospital was emotional distress punctuated by episodes of seemingly inexplicable violence directed at family members. After his mother refused to take him back in the house however his

physical and psychological condition deteriorated rapidly. For two months after his discharge from the mental hospital Darell wandered from one friend's house to another. Then he suddenly appeared at his mother's door in the early hours of the morning, "shaking and drooling". According to the hospital records:

> "....Sometime in April she (the mother) saw him wandering in the streets sleeping part of the time in a car in the backyard of her home. He says he had an apartment but the landlord didn't want him and the other man there any more."

These and similar examples indicate the close relation that exists between the intellectual and affective disorientation of some of these patients and the disorganization in their life as a result of a lack of adequate shelter. Our informants lost their domicile for a variety of reasons, some having to do with the individual's exposed position in the housing market, some with their careless, lackadaisical attitude towards their housing situation. But whatever the reason, the loss of shelter inevitably puts the individual on a downward slope. The lack of adequate, stable housing seemed to make it harder for him to cope, emotionally, and in terms of organizational ability, with the demands of daily living, and to put him at a considerably increased risk for psychological instability. It is this subtle nexus between the individual's housing situation and his emotional and intellectual well-being that,

almost unavoidably, set the stage for his return to the mental hospital.

5. WORK.

5.1 Introduction: Contradictions and Complexities in the Career of the Mental Patient.

Halfway during my interview with Chip I pose him the question: What, do you think, has caused your problem? Instantly his face, which so far has mostly expressed glee and merriment, becomes serious, as he answers:

> "Underemployment. I applied for the FBI recently, the computer section. They told me I was overqualified. I speak three languages: English, Spanish, and German, and five computer languages. (Immediately returning to his usual cheerful style, he demonstrates his assumed mastery of German by uttering, in a horrible accent: 'Sprechen Sie Deutsch?', followed by loud pails of laughter.) Why do you think it started when it did? (With a serious expression again.) You mean the first time I got sick? Because I got laid off. Black people have historically been underemployed."

Chip's reply to my question vividly illustrates the complex relationship between work and hospital recidivism. Let's take a closer look at some of the complexities and contradictions in Chip's statement.

Taken as a statement of fact, there is little to dispute with Chip's words. His first admission to the mental hospital indeed followed upon his demotion from assistant government regulations coordinator, a salaried white-collar position, to "sweeping floors" on an hourly wage. It is also true that at the outset of his tenure with Ford Motor Company, he was underemployed, (When he began at Ford he had a masters degree in chemistry), although in his account of his employment

career he downplays the fact that he did move up on the occupational ladder at Ford. And it is highly probable that, as an educated, ambitious, and outspoken young black in a blue-collar environment, he has experienced his share of racist remarks and small discrimination.

Yet, there are some disturbing aspects to Chip's answer that merit closer inspection. We remember from the preceding chapter, that prior to his demotion, Chip already had a drinking problem, and that he reacted to the stress and injury of being laid off, by throwing lavish parties, which eventually resulted in the loss of his apartment. Although he expected to be hired back as a salaried employee, he made little effort to demonstrate to his employer his continued employability. Seen in this light his identification with blacks as an underemployed category seems somewhat self-serving; initially, at least, his own career was an example of the increased opportunities that, during the last two decades, college-educated blacks encountered in the corporate sector.1

Even more disturbing is the quality of Chip's answer itself. It demonstrates, at the very least, a lack of realism to apply at the FBI with a history of thirty plus admissions to the mental hospital. Moreover there were some real opportunities available for Chip to return to a working life. In 1985 he followed a six month training for computer

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1 William Julius Wilson: The Declining Significance of Race. Blacks and Changing American Institutions, 1980: 100.

programmer and systems analyst, under the auspices of the Comprehensive Employment and Training Act (CETA). In addition the program set up a job interview for him at the First National bank in Chicago. However, as Chip tells, he couldn't attend the interview because he was in the mental hospital again. Another job opportunity fell through when Chip withdrew from the application procedure after he received more than $2000 in back payments from Social Security Disability Income.

Yet, it would be a mistake not to take Chip's feelings about his unemployment seriously. Despite his irrational and noncommittal attitude towards the world of work, his frustration and despair about his unemployment are genuine. His lack of work, and its consequences for his feelings of self-worth and his relation with his family, are at the center of his thought. He dreams of being employed and respected again, but somehow he cannot bring himself to summon the discipline, competence, and sense of responsibility that a stable work career requires. In the matter of work, Chip poses a paradox. He is as much victim as perpetrator, as much a casualty of cruel, impersonal institutions, as the engineer of his own demise. To his immediate environment, his father, his grandmother, his therapists at the mental hospital and the community mental health center, his behavior is equally perplexing. Their feelings towards Chip alternate between compassion and exasperation, pity and outrage, without ever

striking a balance.

5.2 Getting In: Jobs and Job Satisfaction.

Chip exemplifies the mental patient's complex, contradictory relationship to the world of work. Let's begin to unravel that relationship by taking a look at the kind of jobs our informants held.

With the exception of Eric and Paul, all of our informants were unemployed at the time of their readmission. Yet, every one of them had a work career. People like Dorothy or Wayne had held semi-skilled jobs for lengthy periods of time. These jobs offered them reasonable pay and satisfactory work conditions. Wayne, for example, had worked for a coffee firm, from 1969 to 1975, where his task was to make coffee blends. His take home salary was $1100 per month. From 1975 until 1979 he worked as a warehouse man for a vending company, where his task was to fill the company's chain of vending machines with coffee or cigarettes. Again, his salary was about $1100 per month.

Dorothy, Clarence, Jack, and Fred had held similar, semi-skilled jobs. These jobs were characterized by adequate pay; through continued full-time work the worker and his family could steer free from the poverty line. The worker's position on the job was largely governed by equity and due process instead of personal relations, although in many of our

informants' stories the good foreman or the bad supervisor plays an important role. Entrance requirements were not particularly stringent: some high school, and sometimes a skill training, like Dorothy's training as a beautician. Usually the work was sufficiently varied and challenging to give the worker a sense of accomplishment upon completion of the task. In addition there were some limited opportunities for advancement --- there was always the prospect that particularly able and committed workers could be promoted to foreman or store manager.

In contrast to this, most of our younger informants, had only worked in low-paying, menial jobs. Ralph provides a good example. Since he left high school at age 18, he has held a string of minor, irregular jobs: carpentry, sand-blasting, roofing, steam-cleaning, housekeeping in a hotel. The job he held the longest, for a period of one year, was salesperson in a record store. The most he ever earned was $177 a week. Just before he was hospitalized he worked for his father, a small building contractor:

> "Roofing, for a week, this April. And tuckpointing, for three days."

Michael, Jessie, Darell, Renee, and Henry have similar careers. The only jobs that Henry ever held were three months as a cook at college in Evanston and one week as a stock clerk at a corner grocery store. Renee has worked as a waitress at Wendy's for a couple of weeks. Michael's only work experience

consists of supervising and cleaning a playground during the summer months. And Eric's current job, although he claims to have held well-paying white collar positions in the past, was cook in a deli.

All of these jobs were menial, often dirty, with irregular hours, while, at a maximum, they paid the worker the minimum wage. Even with a forty hours work-week the worker's income was insufficient to lift him out of poverty. These jobs offered the worker little or no protection or opportunity for advancement. Eric lost his job as a cook when he failed to show up on time after he had been hospitalized over the weekend. Many of these jobs, like Ralph's construction job or Michael's summer job, were either seasonal or offered the worker only intermittent employment. As a rule, the worker's position in the work place is not governed by equity and due process, but by highly personalized relations between him and his employer, a situation which is conducive to favoritism, arbitrary discipline, and a concomitant lack of occupational perspective on the part of the worker.2 Jessie, for example,

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2 These low-paid, menial jobs belong to what is described in the economic literature as the low-wage sector or secondary labor market. The concept of the secondary labor market arose out of attempts to explain persistent unemployment and high job mobility in urban ghetto's. Secondary labor markets made up of low-paying unattractive jobs were seen as the product of institutional rigidities in the American system of production. Michael Piore, "The Dual Labor Market: Theory and Implications", in David Gordon (ed.), Problems in Political Economy: an Urban Perspective, 1971: 91. Bennet Harrison, Education, Training, and the Urban Ghetto, 1970: 221. Michael Piore, "Notes for a Theory of Labor Market Stratification", in Richard Edwards, Michael

was fired from a job which consisted of stuffing pillows after an argument with the foreman. Maybe the most important characteristic of the low wage job is that it is perceived by the worker as a final station. Not only are there no serious prospects for the individual to advance within a certain employment situation, but he also knows that the his chances of advancing between jobs are equally nil.

Generally our informants, whether they worked in semi-skilled or menial, unskilled jobs, expressed satisfaction with the job they held. Clarence, who worked among other things as a freight loader, a machine operator, and a gas station attendant, says about these jobs:

> " They were good jobs. I made good money to live on. I be there on time, punch in, punch out. I wouldn't have left them if I didn't get sick."

And Fred talks about his job at the door factory in glowing terms:

> " It was paid good. One of the best jobs I ever had. My working hours were 11.00 pm. to 6.30 am. I worked by myself. I only had one foreman, and he wouldn't say nothing. He never bothered me. I was there three months.

Those informants who worked in low-paid, menial jobs generally expressed satisfaction with their work, although in some cases they had a hard time accepting the unfavorable

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Reich & David Gordon (eds.), Labor Market Segmentation, 1975: 126.

conditions of the job. Ralph says that he liked the work that he did. From 1980 to 1981 he worked for a year as a roofer with a firm in Mississippi:

> "I ran away from home. My relatives live in Mississippi. I tried to live on my own. My working hours were from 7.00 to 5.00, and I worked there for one year. I liked it. The way we did different buildings. I got to work on a college. We got to see girls."

Renee, says that she worked for two months in a catalogue house, where she had to do cataloguing. She said that she liked the job because:

> "It was interesting meeting all these people. It was good work. Customers came up and asked to see different things. I got $3.35 per hour."

However she disliked her job as a waitress at Wendy's because of the pace:

> "I worked for a few months while I was 18, waitressing. They gave me $3.35 an hour. I didn't like the waitressing so much. It was too fast a pace."

Eric was most outspoken in his dislike for his job as a cook in a fast food restaurant. He calls the tasks he has to do "unrewarding" and "menial", probably because more than anybody else in our sample, he was in a position to experience the contrast between the working conditions in the white-collar, corporate world with those in the low wage sector.

Our informants' expressed satisfaction with their jobs

presents us with something of a paradox. Repeatedly overall job satisfaction has been shown to be a powerful correlate of job status. The percentage of workers who answer affirmatively to the question "Would you choose this kind of work again?", shows a strong linear relation with the status ranking of the workers occupation.3 Yet, somewhat analogous to the relation between social class and mental illness, while the statistical evidence for an association between the two variables is strong and robust, it is not immediately clear what it represents. It has been suggested that the relation between job status and job satisfaction is largely tautological. The rank ordering of occupations on the status dimension simply reflects the workers' shared understanding of the importance and desirability of a range of different occupations. The correlation of job status and job satisfaction merely reflects the worker's application of this common knowledge to his own occupation.4 There is no reason to assume that those who are engaged in menial work do not share society's general disdain and lack of appreciation for this kind of work.5

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3 Robert L. Kahn, "The Meaning of Work: Interpretation and Proposals for Measurement", in Angus Campbell & Philip E. Converse (eds.), The Human Meaning of Social Change, New York, 1972: 181-182. There are indications that this covariation also holds cross-culturally.

4 Robert Kahn, "The Meaning of Work": 183

5 Compare Elliot Liebow, Talley's Corner: 60: "The man sees middle-class occupations as a primary source of prestige, pride, and self-respect; his own job affords him

Yet, despite their job's inferior status almost none of our informants spoke about their jobs in negative terms. They liked the work, the hours, the pay, the supervisor wasn't on their back all the time, they had a chance to be outdoors, and so on. Does this mean that the relation between job status and job satisfaction no longer hold on the lower extreme of the status scale? Probably not if we take the social context in which our informants express their satisfaction with their jobs into account. They were talking about jobs they held in the past, from a present in which they were without work, and unsure as to when they would work again. For them, the reference point on which they based their assessment of their former job was a situation of no work. So, the mental choice is between menial work with many disagreeable attributes attached and no work, a choice which is easily resolved in favor of the first alternative.6

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none of these. To think about his job is to see himself as others see him, to remind him of just where he stands in this society."

6 Robert Kahn, "The Meaning of Work": 179: "For most workers it is a choice between no work connection (usually with severe attendant economic penalties and a conspicuous lack of meaningful alternative activities) and a work connection burdened with negative qualities (routine, compulsory scheduling, dependency, etc.). In the circumstances, the individual has no difficulty with the choice; he chooses work, pronounces himself moderately satisfied, and tells us more only if the questions become more searching. Then we learn that he can order jobs clearly in terms of their status or desirability, wants his son to be employed differently from himself, and if given a choice, would seek a different occupation."

Our informants' appreciation of their job is colored by their assessment of their socio-economic environment. When asked about it, they will say that they like their job for reasons that make sense in the particular framework of their social world. The job might be dirty and pay the worker poverty wages, but it gets him away from the house, it enables him to socialize with his colleagues, and it provides him with a modicum of status and independence. That doesn't necessarily mean that he likes the job; no more than anybody else would like dirty, tiring, monotonous work, at irregular hours, and for mediocre pay. The job's rewards should be compared with what life without work has to offer. Whenever the worker feels that he can do better or as well without working, he will feel few hesitations to give up the job. Occupational mobility, the movement in and out of jobs, in other words, seems a better indicator of the worker's relation to the world of work than expressed satisfaction. It is to the job mobility of the formerly hospitalized mental patient that we turn in the next section.

5.3 Getting Out: the Occupational Mobility of the Formerly Hospitalized Mental Patient.

With two exceptions, all of our informants were unemployed at the time of their readmission. For some like Fred or Clarence this condition was more or less permanent.

Fred had not held a job since 1970 and made clear during the interview that he felt unable at the moment to tolerate the stress of work. Clarence hadn't worked for seven years, and his physical and mental condition made it unlikely that he ever would work again. For others, like Ralph or Dorothy, their unemployment seemed only temporary, and one felt that they were resilient and persistent enough to secure themselves a job in between their admissions to the mental hospital.

In more general terms: during their tenure as a formerly hospitalized mental patient these men and women had experienced a fair amount of occupational mobility. Some of this mobility was downward, from higher to lower status jobs, most of it horizontal, from one low status job to another, and none of it was upward, from a lower to a higher status job. However, not all of this mobility is necessarily the result of mental instability. Occupational mobility is a common characteristic of a well-functioning labor market. People change jobs for many reasons, and in some occupational categories, like the unskilled or semi-skilled horizontal mobility is a common, and not necessarily negative phenomenon.7 Our informants' mobility is the result of the interaction of common market characteristics and effects of mental disorder. To understand the contribution of each, we have to carefully unravel the varieties of occupational

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7 Ozzy G. Simmons, Work and Mental Illness. Eight Case Studies, 1965: 8-9

mobility in our sample.

A Case of Downward Drift.

The conditions under which our informants changed jobs or lost their jobs altogether were quite diverse, depending among other things on the nature of the job and the age category of the individual. With Chip, Eric presents probably the clearest example of job change as the sole result of mental instability. His is a classic case of what is known in the literature as social drift.8 According to Eric, he completed his college education and took some graduate courses in business administration. He began his career as a Defense Mapper at Honolulu Air Force Base, where he worked from 1979 to 1980. He moved to Sidney Australia, where he met his wife and found a job as a food buyer in the Australian Department of Public Works. In that latter job, which he held from 1980 through 1983, he said, he earned $25,000.- a year before taxes . Eric, who had a history of alcoholism, took to drinking, divorced from his wife, lost his job, and returned to the

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8 Social drift, the downward mobility of a mentally ill individual as a result of the debilitating effects of his illness, is distinguished from social selection, the failure of the mentally ill to advance as much on the occupational hierarchy as their healthy counterparts. See, R. Jay Turner & Morton O. Wagenfeld, "Occupational Mobility and Schizophrenia: an assessment of the Social causation and Social Selection Hypotheses, American Sociological Review, 32, 1, February 1967: 106. On the basis of their careful analysis the authors conclude that the higher prevalence of schizophrenics in the lowest occupational category is largely accounted for by social selection, and only to a limited extent to social drift.

United States. He describes the events in the following words:

> "In 1983 I woke up in the morning, I put on a suit, and I was greeted with: Good morning, Mr. King, can I get you a cup of tea? In 1984 I was begging quarters on the corner to buy a pint of wine."

Eric's loss of his job seems wholly the result of his drinking problem. He had an excellent educational background and, as he claims himself, the right amount of ambition and aspiration to succeed. Moreover, by being employed in a white-collar government job, it is to be expected that, initially at least, his aberrant behavior met with a fair amount of tolerance from his employer. By his own account, he is the cause of his own undoing:

> "When I was 25 they said I was the most ambitious man this company ever met. I lost my ambition. I mean, I wasn't a poor black kid from the projects that never had any opportunity. I had every opportunity that's available in the free world to make it."

Despite his steep downward slide along the occupational ladder, Eric still proved to be employable, albeit in a different sector of the labor market. He still possessed some of the qualities, like interpersonal competence, autonomy, a modicum of self-confidence, resilience in finding a job, and flexibility in adjusting one's ambitions to available options, that enabled him to keep himself employed for most of the time

despite frequent hospitalizations.9 When he was readmitted he worked as a cook in a deli. He lost the job because the hospital didn't discharge him in time to show up at work that day. When I met him again, three days later, he had already found himself another job, this time as a bartender.

The Job Mobility of the Older Patient.

Such clear cases of downward drift among mental patients are relatively rare however.10 In the large majority of cases the individual already finds himself in the lower reaches of the labor market. In this situation the individual's mental disorder can have several effects on the development of his career. He can drop out of the market altogether, or he can never make a proper start. Both of these cases represents a different relationship of the mentally disordered individual to the labor market, and ultimately, has different

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9 The concept of employability is from Simmons, and is defined by him as follows: "The concept of employability is of course frankly evaluative. Maintaining employability calls for realistic perception of one's own assets and liabilities, capacity to overcome failure and to perform under stress, some modicum of interpersonal competence, autonomy, independence, ability to make stable decisions, and to implement them effectively --- in short the possession of the whole range of attributes and properties which are identified with mental health and, conversely, whose absence are identified with mental illness." Ozzy G. Simmons, Work and Mental Illness: 7. For a further elucidation of the concept, see Simmons: 235.

10 For example, Turner & Wagenfeld, " Occupational Mobility and Schizophrenia": These analyses led to the conclusion that social selection accounts, in largest measure,for the downward shift, with social drift making a relatively minor contribution."

implications for the individual's chances of readmission. We will discuss each of these alternatives in turn.

Wayne provides an example of drop out. Wayne has not finished high school. We have no information on the earliest phases of his career. In 1969 he was admitted to a mental hospital for the first time. In that year Wayne and his wife divorced, allegedly because his wife cheated on him. He took it badly, experienced what he describes as a "nervous breakdown", and was hospitalized by his father. He only spend a short period of time in the mental hospital, but, as Wayne says:

> "I turned into a chronic alcoholic after we were divorced."

After he came out of the hospital, Wayne, as we saw, found a job as a maker of coffee blends at a firm called Superior Coffee. He earned about $1100 a month before taxes, which was enough to support himself. About his appreciation of the job he says:

> "I loved it. I just liked to be working and having money in my pocket."

Still he decide to leave after five years. The circumstances that prompted him to look for another position, he describes as follows:

> I worked at Superior Coffee for 3 or 4 years and I wanted to be a supervisor. But it never happened. This one German fellow told me: I usually stay in a place for 5

> years and when there's no promotion, I leave. I never forget what he told me. I figured: you're right. With me it was prejudice. I was to supervise black guys. They thought I was prejudiced, which I was in a sense. These guys didn't do a thing. I was doing all the work."

Wayne left and found a job as warehouseman with a firm called Tri-Ar Vending, which paid him a similar salary.

Wayne's change of job was prompted by his assessment of his chances for promotion. He obviously liked the job and was committed to it. He held the expectation, shared by his colleagues, as is evident from his story, that after five years of competent work performance, he was entitled to a promotion to supervisor. His story suggests that his employer felt that he lacked the interpersonal skills to function effectively in the role of supervisor. When he realized that he would never be promoted he decided to find another job, despite a high level of satisfaction with the current one. Wayne's is a case of horizontal mobility with the purpose of improving his chances in another work environment.

Wayne made one more horizontal change and finally came to work for the City of Chicago as a garbage collector. In terms of salary and fringe benefits, the move was an improvement. He loved being outdoors, and earned $1400.- a month after taxes. The depth of Wayne's commitment to his various jobs can be gauged from his statement that, despite his alcohol problems, he refrained from drinking all those years, but above all, from his persistence to continue working despite increasing depression, drinking, and paranoid thinking. In

the two years he worked as a garbage collector Wayne was hospitalized no less than ten times, usually for periods of three to four days. At the end of 1981 his drinking and depression made it impossible for him to work. He went on sick leave and subsequently received disability insurance. He hasn't worked since 1981 and experienced eighteen additional admissions.

Wayne experienced several changes of jobs during his career, but they all signified his aspiration to improve his position on the job ladder. The length of his tenure in each position, and his ability to perform adequately despite his alcohol problem, depression, and later, admissions to the mental hospital, testify to the importance that work held for Wayne, and his dedication to his job. Work was an important resource for Wayne, which provided him, as we will see later, with the material and psychological means to sustain himself through life. In the last two years of his work career he seemed to have continued working against all odds, and only when his mental problems became unbearable did he resign. Now that Wayne is unemployed, work still occupies a central place in his life. He is desperate to work again, and blames most of his current problems to the fact that he is unemployed. Without work he is lost. When you don't work you are not a real man, he says.

The careers of Clarence, Dorothy, Jack, and to a certain extent Fred, follow the pattern of Wayne's. Horizontal

mobility was a common feature of these individuals' careers. They all claimed to like their job, usually held a job for several years before changing to another job. None of them were unemployed between job changes. All of them lost their job because of their mental disorder. Clarence became periodically depressed and psychotic, Fred became depressed and started drinking, and Jack became increasingly belligerent towards his superiors. Now that they no longer work, work still is in the forefront of their thoughts, they still define themselves in terms of work, and most of them expect to return to the job market in the near future. Dorothy even managed to find work as a live-in housekeeper. The fact that she was able to locate the job, get herself hired, and hold it for almost two years, shows that despite many years of mental hospitalization and unemployment, she still possessed a certain amount of employability.

The Job Mobility of the Younger Patient.

As we saw earlier, our younger informants were overwhelmingly employed in unskilled, low-paying jobs. On the surface these workers, like their semi-skilled counterparts, seem to have experienced a fair amount of horizontal mobility. But closer inspection reveals important differences between the employment patterns of both groups. Ralph provides a good example of the typical career pattern of the young, unskilled worker. As we saw before in a span of three years he held an

assortment of jobs. All of these jobs were unschooled, paid low wages, and offered no fringe benefits or prospects for advancement. His tenure on the job ranged from a few days to a few months, with the exception of his year as a roofer in the employment of his uncle. In between jobs he experienced periods of unemployment of varying length, during which he received General Assistance. People like Michael, Henry, Jessie, Renee, and Darell showed similar employment and income patterns.

This pattern of persistent and rapid job turnover seems to be largely the result of a lack of commitment to the job. Very few of our younger informants held on to a job for more than a few months. Asked why they had relinquished a particular job, they usually answered that they "just quit". Henry, for example, explained that the last job he had was cook in a college in Evanston. He held the job for five months. Asked what happened at the end of those five months, he answered:

"I just got tired and quitted."

And Fred, whose career contains elements of both types of mobility patterns described so far, explains how he once left a good job on an impulse:

"I worked in the door factory for a year. I got married there. I made $100 a week....I left that job to go to the pickle factory. That was crazy. It was the best job I ever had. But I was young. you have to learn....It was an easy job. I had a lot of friends there....They begged

me to stay. But I quit. But it was a good job.

In many ways these young workers did not fit the usual criteria of employability. Many of them were high school drop outs, and had no interest in or ability for continued education. Many of them held attitudes and displayed habits that formed insurmountable obstacles towards stable employment. Frank provides an example. During the interview he is dressed in jeans and a T-shirt from which the sleeves are cut off. His hair is unkempt, and he has a pale, unhealthy complexion. The observer's gaze is irresistibly drawn to a number of large tattoos that cover his bare arms. On the left upper arm is depicted a large black-and-yellow snake which is coiled around a black rose. The lower right arm shows a unicorn standing under a rainbow and surrounded by pink clouds and yellow stars. When I ask him what the last job was that he held, he answers:

> "I never had a job. I have applied for jobs in the fast food sector. I have filled out at least a dozen applications. And nobody called back....<u>Why do you think that nobody calls you back?</u> They just don't like my kind. I'm young. I've tattoos. People look at my tattoos and they think right away: trash. <u>Do you go like this when you apply for jobs.?</u> Yeah. I figure, when they don't want me the way I am, fuck 'm. I figure, I'm not here at this earth to please people. I'm here to do my own thing, and I'm not here to please people."

Many of these young, unskilled workers had little idea of the kind of work they would like to do. They lacked any perspective on their career. When I ask Henry, for example,

what kind of work he intends to do in the future, he answers with a yawn:

"I couldn't say."

And Ralph answers to the same question:

"I don't know yet. What are your ideals with regard to work? I don't know. And what are your aspirations? I don't know. Whatever I like the best of everything I do in life."

What is the reason for these workers' lack of career perspective and commitment to their jobs? First, as we have seen, the job has little to offer to the worker. These were unattractive, menial jobs, that paid at or below the minimum wage. In addition, the worker is well aware that, no matter how hard he works or how committed he is to the job, he will never advance to a better-paid, more attractive position. The jobs are dead-end jobs.11

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11 Michael Piori, "The Dual Labor Market" :91. See also Elliot Liebow, Tally's Corner: 63: "Furthermore, the man does not have any reasonable expectation that, however bad it is, his job will lead to better things. Menial jobs are not, by and large, the starting point of a track system which leads to even better jobs for those who are able and willing to do them. The busboy or dishwasher in a restaurant is not on a job track which, if negotiated skillfully, leads to chef or manager of the restaurant. The busboy or dishwasher who works hard becomes, simply, a hard-working busboy or dishwasher. Neither hard work nor perseverance can conceivably carry the janitor to a sit-down job in the office building he cleans up. And it is the apprentice who becomes the journeyman electrician, plumber, steam fitter or bricklayer, not the common unskilled Negro laborer. Thus the job is not a stepping stone to something better. It is a

Secondly, the workers' lack of investment in his job should be seen in the context of the social environment of the low-wage sector. The structural characteristics of this sector have the effect of mitigating the impact of the relinquishing or loss of a job upon the worker's economic position. For example, the low-wage sector usually offers an ample supply of similar low paying jobs. Those who are satisfied with a menial job usually had no trouble finding one. But more importantly, the depressed wage level in the low-wage sector closes the gap between income derived from work and income derived from other sources. The worker in the low wage sector has a number of alternative sources of income available to him which promise to pay him as much, and sometimes more, than work. The most important of these are state and federal income support programs, like welfare, food stamps, and Supplemental Security Income. In addition many workers in the low wage sector resort to borrowing or semi-legal activities like hustling, selling drugs, or working in the underground economy.

To sum up, the nature of the low wage job and the

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dead end. It promises to deliver no more tomorrow, next month or next year than it does today."

But see Wachter, who states: "The evidence on the mobility issue clearly refutes a literal interpretation of the dualist model. The recent micro studies that dichotomize the job structure of the economy in the manner outlined by the dual literature suggests a significant amount of mobility between the two sectors." Michael Wachter, "Primary and Secondary Labor Markets: a Critique of the Dual Approach", Brookings Papers on Economic Activity, 3, 1974: 659.

worker's attitude towards the job interact to produce a particular kind of horizontal job mobility in this sector. On the one hand low pay and bad work conditions provide the worker with little incentive to hang on to his job, while on the other hand the combination of erratic work habits and the rigid enforcement of disciplinary standards increases the likelihood of involuntary dismissal. The result is a pattern of job instability in which workers frequently drift between jobs and in and out of employment.

So far, mental hospitalization has played a minor role in explaining the job mobility of our low wage informants. Their attitude towards the world of work is primarily couched in terms of the structural characteristics of the low wage sector of the economy. From our description of the low wage job it will be evident however that these jobs are particularly well suited to the possibilities and career qualifications of the young, formerly hospitalized, mental patient. The easy entrance in and exit from jobs, and the intermittent pattern of employment and unemployment which are characteristic of this sector fit in with the frequent disruption of the worker's life as a result of his recurrent hospitalizations. The availability of alternative sources of income enable the worker to temporarily withdraw from the labor market whenever he is disabled by flagrant symptoms. And, in general, the worker's lack of ties to the low wage job accommodates the

impulsive and often disruptive behavioral style of the young mental patient.

In a direct sense, mental disorder has little impact on the career of the worker in the low wage sector. Indeed, many of our young, unskilled informants regularly held jobs in between hospitalizations. Indirectly, however, the interactive effects of the low wage economy, persistent job instability, and the effects of mental disorder on the lives of the young mental patient are much more far reaching and pernicious. To this we turn in the final section of this chapter.

5.4 Work as Resource and Liability.

The mobility patterns of our older, semi-skilled and younger, unskilled informants signified sharply divergent attitudes towards the world of work. For the older worker the job was one of the central domains of his life. Work provided him with a regular income, friends, self-esteem, and a sense of autonomy. His identity was defined in terms of the kind of work he did. Although horizontal mobility was quite common among this group of workers, job tenures were usually extended and unemployment rare. These workers were invested in their jobs; only when they saw an opportunity to improve their position on the occupational ladder did they exchange their job for another one. Even when the effects of their mental

disorder interfered more and more with an adequate job performance, these workers continued to work, often against all odds.

For this group of informants work is a major resource. Their unemployment was involuntary and most of them had a hard time accepting it. They did not see themselves as mental patients, but as productive members of the economy who, through adverse circumstances, were temporarily forced to stay idle. However when time progressed and the possibilities of ever holding a job and earning their own money became more and more remote, desperation set in. People like Wayne, Jack, Dorothy, and even Chip, were extremely unhappy, and often gave the impression of being psychologically affected by their continued unemployment.12 They had a realistic perspective on their remaining capacity for work. Although their symptoms had decreased their employability, they felt that in a job adjusted to their diminished possibilities, they would be able to be part of the working world again. Indeed as Dorothy proved, when they managed to find such a job, they functioned to the satisfaction of everyone involved. However they were, as a rule, unable to secure such jobs for themselves. For these people work was the means to an accomplished, fulfilled life. Bereft of work their life was, quite simply, bereft of meaning.

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12 In the next chapter we will expand this theme.

The attitude of our younger, unskilled informants towards the world of work was much more ambiguous. On the one hand work, just like for our older informants, was an important resource that provided them with an income, structured their day, brought them friendships, and gave them a sense of self-worth. Yet, despite these recognized benefits, our younger informants held a surprisingly nonchalant attitude towards their jobs. Job tenure was exceedingly short, jobs were left impulsively, on moment's notice, and short periods of employment were interspersed with long periods of unemployment. This noncommittal attitude towards the job was explained as deriving from the particular socio-cultural environment, the particular work-culture, in which these informants resided.

Without exception, our young, unskilled informants were situated in the low-wage sector of the economy. Due to the nature of the job and the availability of alternative sources of income, we argued that the worker has little incentive to invest himself in the job. As a result, in the low wage sector the worker's ties to the labor market are at best tenuous. Because of his personal attitudes and the nature of the job his position in the world of work is exceedingly vulnerable. Unable to develop a continuous career, and never earning more than subsistence wages, he is unable to amass sufficient reserves to sustain himself through adversity. From this perspective, the low wage job was only a limited

resource to the young mental patient.

From a different perspective, however, the low wage job was an asset to the young, unskilled mental patient. Their symptoms and behavioral problems frequently resulted in readmissions to the mental hospital. These same behavioral problems made them decidedly unattractive as an employee. In other words, their mental disorder seriously reduced the employability of this category of patients. Low-wage jobs, with their reduced requirements in terms of education, skills, attitude and appearance, were often the only jobs available to the young mental patient. Unable to compete in the market for skilled or white collar jobs, the dead-end, low-wage job was their only possibility to participate in the world of work. To the young mental patient the low wage job effectively functioned as a shield against complete destitution.

However, the shelter that the low-wage sector offered the young mental patient was not without its costs. Because of his lack of employability, the young mental patient was effectively locked into the low-wage sector. Incessantly switching from one dead-end job to another, or from work to unemployment, he was never able to profit from the cumulative experience of working on one task for an extended period of time. Never amassing sufficient funds to sustain himself, he was unable to found his own family. Never experiencing the accomplishment of bringing a complex task to a successful end, he had little opportunity to develop a sense of competence and

self-worth. And because of the lax behavioral standards of the low-wage environment, he seldom had to reign in his impulses and develop the discipline and judgement that are at the basis of every adult role.

In short, for the unskilled patient the job was both an asset and a liability. Because he was locked into the low-wage sector he was unable to successfully complete the normal, expected process of adult socialization. Lacking a stable adult identity, the patient perpetuated the attitudes and behavioral problems that are characteristic of the adolescent. This however decreased his employability even further, locking him more firmly in the world of dead-end jobs and dependency on family and publicly provided income support. In fact, for the unskilled, young mental patient the low-wage job is a trap. Incapacitated by lack of skills and his disorder he is naturally drawn to the low-wage sector of the economy for employment. Finding that the low-wage job accommodates his problems and particular life-style, he is inclined to remain there. Yet, the toll this takes in terms of a halted adult socialization pushes him even further into dead-end jobs and dependency. The circle is closed and the individual has become dependent, for the fulfillment of his needs, on family and publicly provided services. Among these sources of support the public mental hospital plays a prominent role.

6. THE SOCIAL AND FINANCIAL REWARDS OF WORK.

6.1 Income and Expenditures.

6.1.1 Income Strategies.

In the middle of his angry diatribe against the board-and-care facility where he lived before his readmission, Wayne formulates a simple but powerful truth about the social situation of the formerly hospitalized mental patient:

> "What are the chief problems that your unemployment has caused for you? (with raised voice) ....I don't have any money! I mean, how are you going to live in the United States of America without no money?"

In this terse statement Wayne summarizes two conspicuous facts about the world of the formerly hospitalized mental patient. First, unemployment implies poverty. And, second, how does a poor person maintain himself in a society where every relation of exchange is measured in monetary terms?

Almost without exception, our informants' ties with the world of work were, at best, tenuous. Consequently, for this group work fulfilled its major social function, to provide the worker with a stable and adequate income, only to a limited extent. Indeed, with only one exception, all of our informants reported an annual income below the official poverty line. However, as Table 1 shows, this statement tells only part of the story: 10 of the 13 people who reported to have an annual

TABLE 1: INFORMANTS' ANNUAL REPORTED INCOME, 1985. (N= 17)*

$0	-	$2499	2
$2500	-	$4999	8
$5000	-	$9999	3
$10000	-	$14999	1
missing			3

* extrapolated from reported monthly income

income of less than $10,000, in fact earned less than $5000 a year. Henry, for example, says that he receives $209 a month in SSI, and that his mother gives him an additional $25 each month. And Ralph says that he receives $154 in welfare each month plus $80 worth of food stamps.

Some of our informants, for various reasons, had virtually no income at all. For example, to receive General Assistance or Social Security benefits the recipient needs to have a mailing-address. For some of our homeless informants, this condition proved to be an insurmountable obstacle for obtaining income support. Jessie provides a case in point. Since January 1986, when she and her mother were evicted from their apartment, she has had no fixed address. She alternately lives in institutions, like mental hospitals or shelters for the homeless, or spends the night in the homes of friends or relatives. The last time she received a welfare check, she claims, was in February, two months before her

latest admission. The amount was $122. Since then she has had no income. Dorothy's lack of income is the result of her homelessness and her unwillingness to sign any official-looking document. Several times her treatment coordinator in the mental hospital has tried to persuade her to apply for SSI, but although she would like to receive income support, no one so far has been able to persuade her to sign the necessary documents. She says that all she owns is about $7.

Sources of Income: Income Support Programs.

While for the average middle-class person wages from work are his major, and often only, source of income, this is rarely the case for the formerly hospitalized mental patient. With income from work at below-subsistence levels, or, as in many cases, nonexistent, our informants had to rely on other forms of generating money or goods to maintain themselves. All of our informants derived income from various sources. The most important of these were income maintenance programs, support from family, borrowing money or goods from friends and acquaintances, and various semi-legal ways of generating income like begging, selling drugs, or working in the underground economy.

The large majority of our informants mentioned government aid as their vital means of support. The two main sources of government aid were General Assistance and Social Security. Most informants received medical assistance through such

programs as Medicaid or Medicare. Our informants generally received two forms of Social Security: Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). The average benefits award for SSI recipients in 1986 was $ 336 per month. 1986 General Assistance levels in the state of Illinois were $154 per month; in addition, those informants on welfare received $81 worth of food stamps per month.

Borrowing and Lending.

As the benefits obtained through income maintenance programs were insufficient to support the individual, he had to augment his income by other means. One of the most common ways to supplement a deficient income was to borrow money from friends or family. Fred, for example, says that when he decided to check himself into the Emergency Room of a nearby hospital, he borrowed the money for the bus fare from other residents in his hotel. Wayne's monthly allowance from the board-and-care facility lasted him only until the middle of the month. To buy cigarettes or coffee he had to resort to borrowing money from other residents. According to him he was no exception in the facility. Borrowing money was ubiquitous among the residents. As he says: "They ask you for quarters all the time".1

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1 Only if one spends some time in the world of the indigent mental patient does one get an idea of how widespread the practice of borrowing money is in this world. Literally everybody seems to be engaged in borrowing money from or lending it to someone. The fact of the matter is

Several observers have commented on the importance of borrowing and lending in an environment of severe economic deprivation.2 The practice of borrowing, they observed, is part of a strategy of survival, situated in networks of friends, kin, and acquaintances, in which money and goods are perpetually exchanged. The effectiveness of the strategy rests upon the implicit understanding among the parties involved that the act of borrowing carries an obligation of reciprocity. By borrowing money or goods from a person, the receiving party knows that he accepts an obligation to return the favor at some future date. Similarly the lending party knows that by lending he in effect buys a small piece of economic security for some future period of deprivation. Pearl, Fred's friend, explains how it works:

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that money is a scarce, or rather, ill-distributed, article in the world of the poor, and because of this, as we will see later in this chapter, has acquired value connotations which are quite different from those that the middle class attaches to it. Most inhabitants of that world have out of necessity learned how to spot those who, temporarily or permanently, possess it. One of the people who looked like he might possess this scarce commodity was the interviewer himself of course, and quite regularly informants asked him to buy them a soda or hamburger in a nearby fast-food restaurant, or, in one or two cases, asked him for money outright. The practice of borrowing was often not well distinguished from other ways of acquiring money. Relatives would often give money to help their kin out of a temporary squeeze, or what was initially provided as a loan would later be waived thereby changing its status to a gift. Panhandling should in this context be seen as the art of acquiring gifts from strangers, and, as anybody who walks the downtown streets can testify, is widely practiced.

2 In particular, Carol B. Stack, All Our Kin. Strategies for Survival in a Black Community, 1974: 32-44. See also Sue Estroff, Making It Crazy: 159.

"Where does the money come from to pay the bills? ....Fred helps me once in a while. I help him, he helps me. Back and forth."

The importance that participants in these networks attach to keeping up their implicitly understood obligations is illustrated by Lewis. Lewis was readmitted after he spent his SSI check in one day, and was left without means of support. But what did he spend it on? What was the rationale for this seemingly irrational behavior?

"I got my check that morning. I paid him (brother) $50 for my room. I paid the debts I owe. I paid my sister $150. I paid a friend $200. I had bought drugs from him. I had about $60 or $70 left.

Lewis' action underscores the power of reciprocity. To Lewis, a heroin addict, paying his debts takes precedence over his urge to buy drugs. He only spends the remainder of the money on heroin, and then has himself admitted to the psychiatric unit of a nearby general hospital.

Wayne provides a reverse example of the importance of reciprocity in these informal networks of exchange. Wayne, for unknown reasons, did not return the favor, and although the amounts involved were minuscule, it cost him his position in the social environment of the board-and-care facility.

"I was depressed. I didn't take care of myself. And I was really depressed with Clayton House. I knew I had to get away. That's about it. What happened to make you depressed? I owed a couple of people money. And they told all the other people I didn't pay them back. And my

credit was no good anymore for coffee in the morning and cigarettes...."

Similarly Eric describes how he became a social pariah by exploiting his friend to support his drinking habit:

"How does your drinking affect your relationships with other people? It ruins them. if someone takes me as a friend, I end up using them to support my habit. That's what made me depressed the other night. I owed those people money. Unfortunately people accept you for less than what you are after a while."

Moving in with Family.

A third strategy for securing additional income was to postpone leaving the parental home. or to move back in with family. This arrangement, on which, as we saw, many of our younger informants relied, left these individuals in an economically ambiguous position. In terms of gratification of their basic needs, they were often better off than those who lived independently. By sharing in their family's household economy, they usually had fewer worries than their independent counterparts about such basics as food, housing, and medical care. Yet, strictly speaking, they had attained their relatively favorable economic position, by participating in the benefits of someone else's spending. Their needs were fulfilled, as it where, through vicarious spending. These individuals' well-being was dependent on the continuing generosity of their relatives, an assumption which, because of the moral dilemmas that these families of young mental

patients faced, in most cases was extremely fragile. When the family withdrew its support they were as badly off as those who lived independently.

A Special Case: Income in the Community Residential Facility.

A special case is formed by those individuals who live in community residential facilities like halfway houses or board-and-care homes. Although most of them receive social security, the facility acts as the recipient of the individual's benefits, and uses these to meet the costs for the latter's board and care. As current benefits are not sufficient to fully cover the facility's day rate, in practice this means that the facility appropriates the full allowance and hands out $25 a month to the resident as spending money. Jack, who receives $459 a month in SSDI, explains the system:

> "They (the nursing home) take all of it, but $25 a month. Any nursing home does that. Then you have to buy your own soap and toothpaste. People complain about it."

Those individuals to whom this arrangement applies find themselves, similar to those who live with their families, in a economically ambiguous position. Although all of their basic needs, like food, shelter and medical care, are provided for, they have a hard time thinking of themselves as relatively well off. In fact, most of these people consider this arrangement a bad deal. For example, to Wayne, who says that he receives a total of $900 a month in General Assistance

and disability benefits, it formed a constant source of anger and indignation:

> "It goes to the Clayton now. The whole thing. Plus welfare: $400 (With raised voice) $900 a month to live in this place!"

The reason for this general resentment seems to be twofold. First, with his spending money limited to $25 a month, the individual has a strong <u>feeling</u> of poverty, even though the basic necessities of life are taken care off. The humble size of the pittance seriously restricts the individual in his daily activities, and most find that they cannot possibly make their money last the whole month. To gain at least of modicum of autonomy and freedom of movement, many residents of community facilities rely on their families or fellow-residents to supply them with additional funds. Pearl, Fred's friend, herself a resident of a board-and-care facility, explains the resident's predicament:

> "I have a little job here. (The board-and-care facility) I work at the desk, and I do what I can for Fred. He does the same for me. <u>Can you give me an example?</u> He buys me cigarettes and coffee. Sometimes I buy him a shirt. Nobody has any money. I'm on SSI. <u>And I guess the facility takes most of it?</u> That's what I mean. They only leave you $25 a month. Now what can you do on that? If I didn't work on the desk or my mother didn't help me out, I would be stuck, you know. You see, so many people here get help from their families. Especially when you smoke you have to limit yourself. Then the others, that don't have anybody. That's hard."

Secondly, the practice is experienced as humiliating. The resident is aware as everybody else of the value of money.

He knows that a person's standing in society is to a large extent determined by the size of his income. To receive $25 a month tells him that his worth as a citizen is measured only in single dollars. The meager allowance places him on the lowest rung of the status hierarchy and emphasizes to him how little value society attaches to his person.

Thirdly, the practice is experienced as paternalistic. The individual considers the money as rightfully his. The facility takes it from him against his will. The restriction this puts on his freedom of movement is seen as an integral part off the whole plethora of rules and regulations that govern his life in the institution. By taking away his income, the individual is restricted in what he considers one of his most fundamental rights as a citizen: the right to receive and spend one's money as one wishes.

More than anything else this practice confirms him in his suspicion that he is only a second rate citizen, a warden of the state, someone who, without any means for effective recourse, is subjected to the whims of powerful bureaucracies. This sentiment is expressed by Wayne when he concludes about the facility where he lived:

> "I knew what the future was at the Clayton. I couldn't smoke, I couldn't drink. I'm an American. Where's the freedom here?".3

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3 In Wayne's case this sentiment was intensified because his allowance came from Social Security Disability Insurance. Wayne felt that in a sense he had earned the money in the years that he had worked by paying federal taxes

Semi-Legal Income

Finally, some of our informants reported to derive income from semi-legal sources such as begging, or working in the underground economy. Dorothy, for example, reported to receive no income support at all. When I ask her where she finds the money to buy food, she answers:

> "I beg. I have to ask them. I get $2 from one, $1 from the other....People give it to me.

Others in our sample supplemented the income they received through government aid by working in the underground economy. Ralph every now and then manages to earn $60 a day with unschooled construction work in addition to his SSI allowance. And Eric said that he worked as a cook while he was on welfare, in this way earning an additional $160 a week.

The Meaning of Income and the Idea of an Income Assemblage.

When we observe these diverse ways of generating income, the idea begins to take hold that to the indigent mental patient the notion of income has a meaning that differs considerably from that of his healthy, middle-class

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on his income, and he was careful to distinguish his situation from those who received General Assistance and therefore, by implication, had never worked. The facility, in his experience, took away his hard earned money:

> "I get $569 a month, and they (the nursing home) give me $25 a month! (With raised voice; indignant.) And these people (other residents) are on welfare. They haven't worked a day in their life!

counterpart. Based on a realistic assessment of his options in the labor market, and faced with the dire necessities of survival, he cannot possibly count on income from work as his major source of support. Instead, to make ends meet, the indigent individual has learned to rely on such diverse sources of money and goods as government income support programs, informal borrowing from friend and acquaintances, support from family, begging, and illicit income. For the indigent mental patient these various ways of gathering income do not form alternatives. Rather they compose an assemblage of incomes.

The income assemblage constitute the wages of poverty. Its defining principle is that the individual has to pursue simultaneously all, or most, of various avenues of reward to gather a level of income that is barely sufficient to survive. Taken independently, the benefits from each of these sources are either not sufficient, too uncertain, or both, to be relied on. Each day, the poor person has to obtain, and carefully fit together, incomes from various sources to provide for his daily needs.

However, the discharged patient's reliance on an income assemblage to support himself in the community is not without its economic and moral implications. For example, when work loses its prominence as the major source of income its importance as a social institution tends to suffer with it. For those of our informants who in former jobs had derived

important social and personal benefits from work, work, despite their present unemployment, was still intimately connected to their ideal of the well-ordered life. But for those informants whose work experience was confined to dead-end menial jobs, and who neither derived personal nor financial rewards from work, it is difficult to experience work as an important organizing principle of personal life. For these informants, work had come to occupy a back-seat in the business of survival.

In the concluding chapter we will explore some of the wider implications of the notion of income assemblage, and its significance for our informants' utilization of public mental hospitals. First, to complete our description of our informants' financial situation, we will turn to their expenditures.

6.1.2 Expenditures.

How do our informants spend their income? Eric, who earns $160 a week in his job plus $81 a month in food stamps, says he spends $240 a month on rent for his hotel room, and "a couple of hundred dollars a month" on food. Ralph receives $154 a month from General Assistance and $81 in food stamps. His expenses include $100 a month in rent that he pays his family and some money for the care of his three little children. Clarence receives $475 in SSDI. He lives with his

older sister and contributes $150 in rent each month. Asked to describe his other expenses, he says:

> "I eat and buy clothes and then I have no more money. How much do you spend on eating? I buy enough to last me a month's time. How much do you spend on clothes? I spend about $65 to $75 a month on clothes. You said that you drink beer. How much do you spend on beer each month? I spent about $20 to $25 worth of drinks.

Dorothy, as we saw, had no income at all. When I ask her what her expenses are, she answers with an ironic smile:

> "I have no income and I have no bills. I have no income of anything, and I have no home, so I don't have any bills to pay."

Again, those who live in community-type institutions form a special case. Jack says that he hardly spends anything from his $25 monthly allowance:

> "I buy a can of pop every once and a while"

But Wayne found it difficult to make ends meet with his allowance. Asked to give me an idea of his monthly expenses he says:

> "They give me $25 a month to live on. And by the time it is the middle of the month you haven't got anything at all to live on. You've got no money for cigarettes. No money for a cup of coffee. They give you 5 or 6 cigarettes a day. That's torture."

This pattern of income and expenses is typical for the individuals in our sample. The lion's share of their income is spent on the basics of rent, food, and clothes. Money for

other expenditures was simply not available, and many expenses, such as the purchase of shoes, a winter coat, or the telephone bill, had to be deferred. The most conspicuous example of deferred expenditures concerns children. Those men who had children were only able to provide for them intermittently, whenever they had some money in their pockets. Michael, for example has a 4 year old child. He separated from the mother, his girlfriend, three years ago. He explains that they both take care of the child. What this implies is that the mother bears the responsibility for raising the child, and that each month, when Michael receives his SSI check, the child comes to live with him for a week. Occasionally, as if to assuage a bad conscience, he buys his child an expensive toy.4

The Experience of Poverty.

However, this formal, factual description of our informants' income and expenses does not give an adequate picture of the quality and texture of their economic position. The fact that most of our informants spend all of their income on food, rent, and clothing, does not reveal that most of the time it was not sufficient to adequately provide even for these basics. With only $200 to $250 to spend on rent, the kind of housing that was available to these individuals was

4 Michael recounts how he once bought his baby a $100.- bicycle. The next day his girlfriend called him to tell him that one of its wheels had been stolen.

obviously of poor quality.5 As we already saw in chapter 4, the dwellings that our informants occupied were dreary, decrepit places, situated in the most run-down and crime-ridden parts of the city.

Similarly, with less than $100 a month to spend on food and clothing, one's diet and appearance are likely to suffer. People like Fred, Wayne, Jack, Jessie or Rosa looked pauperized, with an unhealthy, pale complexion, bad teeth, and dressed in an odd assortment of ill-fitting clothes. Those, who had to take care of their own meals like Fred, mainly lived on a diet of hot-dogs and sodas. And even then, judging by the ubiquitousness of lending, in the world of these patients, their money didn't last them through the month.

For many of these individuals their lack of work and concomitant lack of money condemned them to a life devoid of any useful or interesting activity.6 They didn't have a stable job where they were part of a regular community of colleagues and friends. Their lack of work left them with an

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5 In 1985, the average monthly rent in Chicago for single-room occupancy accommodations, which is among the cheapest housing available, was $195. Peter H. Rossi & James D. Wright, "The Determinants of Homelessness": 23.

6 Dan A Lewis & Rob Hugi, "Therapeutic Stations and the Chronically Treated Mentally Ill" : 212: "Whatever may have been the cause or the history of their unemployment, unemployment had two consistent consequences for our respondents. First it gave them an overabundance of 'spare' time. For many this abundance of leisure was a matter of concern.....The other consequence of unemployment was that our respondents had little money with which to divert themselves during their spare time."

abundance of spare time. Such activities of leisure and diversion like going to a movie or taking a friend out to dinner cost money and were therefore, as a rule, not available to them. As a result most of the individuals in our sample had to find ways of killing time, finding ways to divert oneself that didn't require money. The number and variation of such budgetarily neutral activities is of course rather limited, and most of our informants reported to have trouble to find things to do to fill their day. In addition, many of them complained that the constraints on the means to fill their spare time led to social isolation In the next section we will discuss more fully, the intricate relations between unemployment, poverty and an individual's economy of time, and elaborate on some of the psychologically damaging effects of an overabundance of spare time.

The Paradox of Excessive Spending.

Yet, if we take a closer look at the spending behavior of some of our informants, a seeming paradox emerges. Quite a few of our informants engaged in a consumption pattern that, with regard to the amount of money spend and the nature of the expenditures, contrasted sharply with their chronic lack of funds. Michael, as we have seen, bought his child a bicycle that cost him one third of his monthly SSDI allowance. Eric sometimes spend half of his weekly income in one evening drinking in bars. This type of spending behavior was

particularly prominent when, because of administrative rules, a recipient received a number of back payments from his General Assistance or SSI allowance. Instead of budgeting their scarce resources in any rational or responsible way, some of these recipients spend all of their income on luxury items, such as stereo sets or video's, or on alcohol and drugs.7 Lewis, after settling his debts, spends the remainder of his money on heroin, and ends up without enough money to pay for the bus fare to the hospital. Chip, who had not long ago received $700 in SSDI back payments, gave all the money to his girlfriend, a cocaine abuser. When I asked him if he had money problems he answered:

> "In a way yes, because my girlfriend was demanding so much money from me that I couldn't do the things that I wanted to do. But she's worth it. I gave her the $700 SSDI to pay for her rent and light and gas. I gave it all."

The professional literature generally looks unfavorably

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7 As a regular visitor to the mental hospital during the interview period, I came to know a number of inmates who, in the possession of a day pass, spend all of their time in the corridors of the institution. One of these, a friendly, nervous man with an impossible stutter, approached me one day in an elated mood, announcing that he would be discharged the following day and would receive $1600 in back payments from SSI. He then proceeded with a beatific smile, to describe to me how he intended to spend the money: "$1600 bucks man! You know what I'm gonna do. I'm gonna rent me a nice place for about $300 a month. I will put a refrigerator in it, a TV, and a stereo. I will buy a bunch of tapes and stack the fridge with beer. And I will just be lying on my bed, smoking, drinking beer, and watching TV, man." I wanted to ask him how long he thought his money would last this way, but I refrained from it, as I didn't want to spoil his blissful fantasy.

upon this behavior; this reckless and frivolous spending is associated with a tendency in this group of generally young mental patients towards impulsive behavior and a low tolerance for frustration.8 It is hard to decide, on the basis of the available evidence, how to explain this excessive spending. To some extent it might be motivated by a low-income culture that, in its tolerance of generous and spontaneous spending, deviates from a middle class culture of frugality, sobriety, and deferred satisfaction of needs. Much more likely however, the individual's disregard for the consequences of excessive spending stem from his, accurate, perception that money in his world is in short supply and that this condition is not likely to improve in the foreseeable future.

For most of the individuals in our sample the amount of money they handle is insufficient to last them through the month, no matter how hard they try. We remember Dorothy's ironic statement about the absence of expenses given the absence of possessions. Jessie voices a similar sentiment

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8 For example John L. Sheets, James A. Prevost & Jacqueline Reihman, "Young Adult Chronic Patients: Three Hypothesized Subgroups", Hospital and Community Psychiatry, 33, 3, March 1982: 201: Members of this group are not without material aspirations; they often spend their limited funds on TV's, stereos, and tape decks." According to Sheets et. al., this group of "young chronic patients" is characterized by "low frustration tolerance and impulsive behavior". This impulsiveness manifests itself in frequent moving from one address to another, frequent quitting of jobs, reckless spending, and uninhibited sexual behavior. For similar characterizations, see Leona Bachrach, "Young Adult Chronic Patients: an Analytical Review of the Literature". Hospital and Community Psychiatry, 33, 3, March 1982: 191.

when she comments on the support she gets from her social worker at a community mental health center:

> "Do you get help with practical problems also, such as housing or money problems? Yes. He taught me about budget. But I don't know if I even have a budget. I don't know where my next money will come from. Probably from you."

What these and similar statements suggest is that there is probably a minimum level of income below which rational budget practices simply no longer make sense. When one knows that this month's income is in no way sufficient to last one through the month, it might make it simply irrelevant to budget. Rational spending doesn't make a difference anyway. In addition, as some authors have rightly pointed out, rational budgeting relies on a perception of the future in which it is worthwhile to defer present satisfaction for expected larger satisfaction later on.9 A future which, among

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9 See Liebow, Talley's Corner, 64-65: "But from the inside looking out, what appears as a 'present-time' orientation to the outside observer is, to the man experiencing it, as much a future orientation as that of his middle-class counterpart. The difference between the two men lies not so much in their different orientations to time as in their different orientation to future time or, more specifically, to their different futures.

The future orientation of the middle-class person presumes, among other things, a surplus of resources to be invested in the future and a belief that the future will be sufficiently stable both to justify his investment (money in bank, time and effort in job, investment of himself in marriage and family, etc.) and to permit the consumption of his investment at the time, place, and manner of his own choosing and to his greater satisfaction. But the streetcorner man lives in a sea of want. He does not, as a rule, have a surplus of resources, either economic or psychological. Gratification of hunger and the desire for

other things, contains the reasonable expectation of stability, the availability of equal or increasing resources, and adequate circumstances for consumption. However the reality of the world of the indigent mental patient does not allow for such an optimistic future orientation. He knows that his material resources will never expand much beyond their present level whether he is employed or not, that his housing situation will continue to be unstable, and that the possession of money inevitably attracts his equally indigent fellow patients who will either borrow or steal it from him.10

Finally, impulsive spending of large sums of money might serve an important psychological function to some of our informants. Many of them struggled with the psychological effects of being poor and unemployed. Work didn't provide them with the sense of accomplishment of a task well-performed, the respect earned from colleagues, and the social status, that are the ingredients for a stable and enduring self-esteem. Many of the men in our sample regarded

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simple creature comforts cannot be long deferred. Neither can support of one's flagging self-esteem. Living on the edge of both economic and psychological subsistence, the streetcorner man is obliged to expend all his resources on maintaining himself from moment to moment."

10 The complaint of losing one's scarce possessions through stealing was ubiquitous in institutions. Among those who lived outside institutions the incidence of victimization was staggering: 62 percent of the patients interviewed for the Mental Health Policy Project reported to have been robbed at least once in their lives, while nearly half (48 percent) reported to have been physically assaulted on the street.

themselves, and were regarded by their wives or girl-friends, as inadequate in their roles as father and provider. It is in this context that some of the excessive, impulsive spending of these men becomes understandable. As we already saw, Michael's buying of an expensive bicycle for his child probably serves to alleviate his sharp sense of personal failure as husband and father. Chip's spending of his SSI allowance on his girlfriend conveys the message to her and himself, that despite his lack of work and income, he can still keep a woman. And Lewis' spending of hundreds of dollars on heroine is not merely the compulsive behavior of a drug addict, but also demonstrates to himself and others that he rightfully belongs to a world of women, expensive cars, and drug dealing. Lewis gives us a glimpse in the psychological world of the destitute drug-addict when he says, in answer to the question with whom he spends his days:

> "With my brother and a few of his friends. Mostly we talk about girls. How much money a person makes who has the best drugs and the best car. How to finance a car."

Taken together, an excessively low level of economic resources that precludes budgeting, a future orientation that, quite realistically, lacks any perspective of personal improvement, and a social environment that contains a high probability of seeing one's possessions diminished through begging, theft or borrowing, gives rise to a strong presentist orientation with regard to spending and consumption. Saving or

the postponement of need satisfaction is often not only financially impossible, but in those instances where it is viable would, given the social environment in which the indigent mental patient resides, hardly make sense. In addition, a sense of self steeped in guilt and failure provided the psychological motivation to some of the men to indulge in impulsive, excessive, and frivolous spending.

6.2 The Social and Personal Benefits of Work.

In addition to monetary income, work provides the individual with social and personal rewards. Or rather, in the case of our informants, the lack of meaningful work deprived them of these important non-financial benefits of work. Like money these personal and social benefits of work are resources to the individual, the lack of which make it more difficult for him to maintain adequate community relations.

An indication that our informants were well aware of the importance of the non-material rewards of work can be found in their attitude towards their unemployment. Despite their ambivalent relation to the world of work, most of our informants deplored the absence of meaningful work in their life. We asked all those informants who had been out of work in the two months prior to their admission how they felt about their unemployment. With only one exception, they described

their lack of work in decidedly negative terms. Dorothy's reaction is representative:

> "How do you feel about being unemployed? I feel very bad. I feel horrible."

Likewise, Wayne, Jessie, Renee, Fred, and Jack all expressed similar sentiments in answering the same question. As Jack expressed it:

> How do you feel about being unemployed? Not too good. I feel depressed, upset about it."

And, Michael, whose single work experience was a three month job as an overseer at a playground had this to say about his unemployment:

> "I want a job. I feel I should have a job. Instead of getting a check every month."

Peer Relations.

What is it that our informants miss when they so emphatically express their discontent with their unemployment situation? Many of them explained that they liked to work because of the people they met at their job. Fred, for example, said of his job at the door factory:

> "It was an easy job. I had a lot of friends there. A lot of them came to my wedding. They begged me to stay, but I quit"

And among the rewards of Ralph's job as a sales-person in a record store, meeting people ranked high:

> "I liked it. I liked the money. The people were fun. You get to meet new people. You keep up with the music."

As these observations of Ralph and Fred indicate, work is a place where one meets people, where friendships are formed, where one socializes with one's co-workers, and, a function of work that is not to be underestimated, where one has a chance to meet people from the opposite sex. Several of the men in our sample said they liked their job because of the chances it offered them to get in touch with female co-workers. Wayne, for example, refers to this specific benefit of work when he remarks about his job as a warehouse man:

> "The hours were from 5.00 am to 12.30 pm. Which gave me a lot of time to go to the back and see all the girls."

Not working means to our informants that they are deprived of these congenial relationships with their co-workers. As we have seen in preceding sections, many of our informants were isolated people. The number of stable, recurring relationships they held was limited. But, in addition, many felt that the quality of those relationships they did entertain had also suffered from their lack of work. Later in this section we will see that an important function of work is that it functions for the individual as a distraction from his engrossment with personal worries. By

providing him with a set of external goals and challenges, work broadens the life-space, and thereby relativizes the urgency of personal issues. Many of our informants were sharply aware that their lack of work had seriously reduced the range of their concerns and aspirations, and those of their fellow patients. By not working they found themselves locked into a narrow and rather suffocating interactional space. Wayne expresses this clearly when he remarks about his fellow-residents in the board-and-care facility:

> "I get tired of hearing the same people's problems. I'm trying to be a positive thinker. When I talk to them I get depressed."

Social Status and Self-Esteem.

Some of our informants expressed that, by being out of work, they felt rejected or not accepted for what they were by their environment. Wayne, expresses this clearly when, ruminating over a better future, he says:

> "I want to be in a position of being wanted. Being accepted by people."

Wayne's feeling of being rejected refers to an acutely felt loss of status. As long as he worked he could command a certain respect from his environment. His position with the sanitation department of City of Chicago, and the income he generated this way, conferred upon him a social status of which he was proud.

Not surprisingly, the status conferring function of work was experienced particulary acutely by those informants who underwent considerable downward mobility during their history of admissions to the mental hospital. Eric, claims that until 1983 he has always worked in well-paid white collar jobs. Then he started drinking again and was admitted to the mental hospital. Since that time he alternates periods of heavy drinking with periods of soberness during which he does unschooled work in fast food restaurants. The following quote reveals his feelings about this development:

> "I find my life in general difficult, to accept things as they are. For my age, and with my experience and education, I should be a lot better off. I had to take a job that I had when I was 15 years old to make some money.... What do your think that does to your self-esteem?..."

Yet, for those who had not experienced downward mobility, who had always worked in unrewarding, low-paying jobs, the psychological impact of the job's low status was no less potent. Eric's answer indicates how we are to understand this impact: work plays an important role in the formation and maintenance of the individual's self-esteem. On a personal level, our informants experienced their loss of status --- or for those informants who had always held low-wage jobs, their perennially depressed social standing --- first of all as a blow to their self esteem, to their sense of identity. This assault on his self-worth was felt most keenly by the individual who had lost his job altogether. Chip expresses

this when he was asked if his unemployment affected him in any way:

> "Sure. People look at me and wonder why I don't do more with my life. I get embarrassed sometimes. It's denigrating being unemployed."

Chip's feeling of embarrassment is not merely the result of his perceived loss of social status. Work contributes to the formation of an individual's identity in two ways.11 First, in dealing with objects of work, in solving work-related problems, the individual experiences a sense of efficacy and competency. He bases his sense of worth on his internal assessment of the complexity and challenge of the tasks that he masters. He feels that he is up to a certain level. By being unemployed, or by doing unrewarding, unskilled work, the individual is robbed of the opportunity to test his skills and to experience this sense of accomplishment. Eric describes this when he says about his job in the fast food restaurant:

> "I don't like it.(The job) I feel it's unrewarding, menial tasks. I slice meat and make sandwiches."

And Chip, who has a bachelors degree in chemistry , and once was employed in a challenging managerial job, points to the same aspect of work, when he says:

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11 Work in America, Report of a Special Task Force to the Secretary of Health, Education, and Welfare, Cambridge, Mass., 1973: 4

"How do you feel about being unemployed? Well I don't really like it....I'm not working with my potential. For example, my relatives want me to paint their houses."

Chip and Eric experience an unresolvable discrepancy between their self-image and the nature of the work they are presently engaged in. They sense that a deep incongruity exists between their competence, skills and aptitudes on the one hand, and the extent to which their current job allows them to apply these on the other.12 These individuals do no longer experience the satisfaction of overcoming a challenge, of successfully exercising their judgement, of mastering a difficult task and earning the respect from peers and colleagues. The impact of this want of expressive possibilities on the individual's self-appreciation should not be underestimated. Many of our informants, as we will see, coped with a seriously eroded self esteem and strong feelings of alienation. Some seemed to have lost faith in their ability to function adequately in a job altogether. And for some, as we will see later in this section, the effects of loss of self-esteem even escalated into a more generalized loss of mastery and control in personal life.

The second contribution of work to a person's self-esteem derives from his knowledge that what he does is valued

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12 Harold Wilensky, "Work as a Social Problem", in Howard S. Becker (ed), Social Problems: a Modern Approach, 1966: 140

by others. To work means to be recognized by one's peers, one's customers, or one's friends. The job in this way functions as a source of prestige and self-respect to the individual.13 An indication of how important this recognition is to people is the self-evident ease with which they define themselves in terms of their job when they are asked to present themselves. One of the first things that Chip's father mentions, for example, when I ask him to fill me in on the family background, is his 34 year tenure as an electrician at the Ford Motor Company. Similarly, when we ask someone to describe another person to us, it is likely that we will be told what he does for a living. Not to have a job, or to have job that is clearly demeaning, leaves the individual without this sense of pride, and without, as Wayne expressed earlier, a sense of being needed by the world. It is to this that Chip alludes in the following statement:

> "In what way has your underemployment affected your relationship with your family? It's been detrimental. They, my family, can't understand why someone that has so much talent is not working. They feel I'm wasting away my life and they have told me so on many occasions."

Especially for those informants who had long job tenures,

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13 Liebow emphasizes the same point in his Talley's Corner: 60: "To think about his job is to see himself as others see him, to remind him of where he stands in this society. And because society's criteria for placement are generally the same as his own, to talk about his job can trigger a flush of shame and a deep, almost physical ache to change places with someone, almost anyone, else." See also: Work in America: 34-36.

being out of work can mean a serious blow to their self esteem. Chip explicitly says that being out of work has hurt his "pride mostly....my self esteem". And Wayne expresses the importance of work for one's self-worth most clearly when asked what the chief problems were that his unemployment had caused him. He begins by alluding to the economic function of work, but then reveals the importance that work held for him as a source of self-respect:

> "What are the chief problems that your unemployment has caused for you? Mental depression. Not caring for myself. (with raised voice) I don't have any money! I mean, how are you going to live in the United States of America without no money? What do you mean when you say 'mental depression'? Like I said...Not feeling like a man. When you're a man, you should be able to take care of yourself, support yourself, ignore people, be independent."

The loss of work means loss of self esteem --- and vice versa. The obtainment of stable, meaningful work can restore the individual's self-esteem. An example is provided by Dorothy. As we remember from chapter 4, three years before her latest admission, Dorothy found a job as a live-in housekeeper with the Mehta family. When she was hired she was in bad shape. As Mr. Mehta, the employer says:

> "We advertised for a housekeeper....She was one of the applicants. My wife and I felt sorry for her. You could tell she needed help. I called a couple of references, but none said it would work out."

Dorothy's main task was to care for her employer's children. Upon general agreement her rapport with the children was

excellent. Now that she was employed, and experienced others people's appreciation of her work, Dorothy began to care for herself again. Mr. Mehta recounts how Dorothy's confidence and physical appearance improved after she began living with his family:

> "We paid her $100.- a week plus room and board. She left on Friday evening and came back Sunday evening. She took a lot of time in putting up her make-up. She paid attention to her appearance. You could now understand that she had been a beautician. There was a big change in her. She bought new clothes. She got self-confidence."

Most of our informants however never held the kind of job that could provide them with this sense of mastery and recognition by the outside world. These informants had little opportunity therefore to use their job as a means to develop a sense of pride and self-worth. And during periods of unemployment there are no memories of better times to sustain the individual. It seems as if in those cases the individual's feelings of self-rejection are no longer situational, tied to the specific circumstance of unemployment, but have generalized to an extent that they have absorbed the person's whole identity. Let's listen for example to Fred:

> I have a complex. I put myself down over everyone else. Like they're better then I am."

Fred is engulfed by a deep sense of shame. He feels utterly worthless and sometimes his feelings of self-

rejection are so intense that he imagines that people say derogatory things about him. He has lost all confidence that he will ever succeed in a work environment again. His girlfriend Pearl recounts how he once, unsuccessfully, tried to work in a sheltered work place:

> "He tried the workshop, but it didn't work out. Why not? I don't know. Something like he wasn't very good at it, and he didn't like the work. And you have to have car-fare."

Work as a Relief from Personal Problems.

Fred's lack of self-esteem seems directly related to his lack of work, but there is another indirect, and probably more common way in which work, or the lack of it, influences the individual's self-esteem. Darell provides an example. At age 14 he was involved in an accident that deformed his legs. The deformities have left him with an all-absorbing sense of insecurity about his physical appearance:

> "I feel kind of ashamed, self-centered, about it. I can't wear shorts, I don't swim anymore, things like that. I feel like, I don't know, when I go in the pool everybody would run out. I couldn't eat in front of my legs....I can now. It is something that I feel every day, until this very day.

Darell's insecurity and lack of self esteem are not the direct result of his unemployment. Yet one cannot escape the feeling that his absorption with his physical appearance, his inability, with the progression of age, to put some distance

between these feelings and himself, at the very least, has been intensified by his lack of work. To many people work functions as a buffer to personal or family problems.14 By being involved with one's work one has less time and energy to dwell on these. By becoming engrossed in one's task one can, at least temporarily, escape the mulling and anxiety that are associated with problems in one's personal life. In addition, when the individual is burdened with unresolved personal or relational issues, the job provides at least one arena where the individual feels he functions in an adequate way. Work, in this respect, has the effect of relativizing personal problems.

Many of our informants displayed this quality of being utterly absorbed in their problems. The conversation of people like Darell, Chip, Jack, and Ralph unceasingly returned to their problems with their families, and the alleged injustices they had suffered at their hands. And people like Fred and Wayne, as we have seen, had a hard time taking some

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14 This insight into work's ability to neutralize the worry and stress that are associated with personal problems stems from current research on the effect of employment on women's lives. For example G. Baruch et. al. state: "In fact, an exciting new concept of work as a buffer against stress, an escape from tension, is emerging among researchers in many different fields, as they look at how employment affects women and at how employed women compare with homemakers in terms of stress....Having a job seemed to protect the women against the worst effects of difficulties in other areas of life.....(W)ork seems to provide employed women with a buffer and relief, leaving less time and energy to dwell on personal problems." (Grace Baruch, Rosalind Barnett & Caryl Rivers, Lifeprints. New Patterns of Love and Work for Today's Women, New York, 1983: 145, 198.

perspective on their personal problems. One could not escape the impression that part of the intensity of these individuals' experience of their problems was the result of a lack of the kind of relevant distraction that work has to offer. These people found no relief for their problems, no arena where, by engaging in other, rewarding activities they could find compensation for their perceived failure in dealing with their daily problems.

One of the effects of these individuals' absorption with their personal situation is a never ending instability in their life organization. The lives of many of our informants were in continuous turmoil. Not counterbalanced by any meaningful events outside his immediate experience, personal issues, or problems in the family, became larger than life. A slight inconsiderateness by a member of the family, or a sudden change in the individual's mood, often signalled drastic reactions on the part of our informants. When Chip's younger brother damages an old car that Chip owned, it is an occasion for the latter to start a violent fight with his brother and his father, and to destroy furniture in his parents' house. When Fred, in a festive mood, drinks a bottle of port and gets drunk, he experiences this as an unforgivable lapse of his resolve to abstain from alcohol, which plunges him into overwhelming feelings of guilt and remorse. In both cases our informant's reaction landed them in the mental hospital once again.

Work as a Means to Structure Time.

Part of the reason why our informants are so engrossed in their personal situation is that their lack of work leaves them with an abundance of spare time. Work provides the individual with an opportunity to fill his day. The rhythm of work structures his day; events at work function as markers that provide him with a sense of ongoing, meaningful time. Not to work, leaves the individual with long, empty stretches of time that need to be filled. Many of our informants complained about the emptiness of their daily existence and the lack of meaningful activities. Renee, who shortly before her readmission worked in a sheltered workshop, refers explicitly to the time-structuring function of work, when she explains how she feels about being out of work:

> "I don't like it. I like to be working. It's boring. I don't have enough to do with myself during the day."

Filling the day was a chore for our informants, a task that, as we saw in the preceding section, was made even more difficult by their chronic shortage of money. The only activities that were available to our informants were such open-ended, financially "neutral" activities as watching TV, taking a walk, reading a book, or hanging around with other people. We asked each of our informants how they spend their day. The following are some typical answers. Dorothy:

> "I don't do anything with my spare time. I just sit, read a book, or walk."

Fred:

"I do some art work and read the bible. I listen to the radio and watch TV. I go for walks. In the summer I like to go the lake."

Jessie:

"I watch TV, talk to people, play baseball, walk around. Who do you talk to during the day? Whoever I talk to. I do nothing, just let time go by."

Work and the Well-Ordered Life.

Work does not structure the individual's life however by merely functioning as a daily calender. Work is associated with structure and organization in a much more fundamental, even existential, way. Having meaningful work provides the individual with an encompassing sense of order, but, and this is essential, not order that is imposed on him from outside, but that he imposes himself on his life.15 Having work, and in particular challenging, rewarding work, has been shown to be strongly associated with a sense of mastery, with the experience of exerting control over one's life.16 These combined rewards of order and mastery should be regarded as

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15 Work in America: 7

16 Grace Baruch et.al: Lifeprints: 34

the summation of work's social and psychological rewards. A firm, stable sense of self, rooted in a realistic sense of one's capacities and achievements, the knowledge that one's work is being recognized by others, the certainty of belonging to a body of trusted colleagues and friends, and the daily challenge of engaging oneself in meaningful activities, provide the individual with a sense of security, vitality, and being in charge.

Our informants, most of whom did not work, or who throughout their lives had worked exclusively in low-status, dead-end jobs, did not enjoy these important benefits of work. To them the world was a decidedly different place as to the fully-employed, middle class individual. Lacking money and status our informants felt they had little effective control over their world. In addition, as we have seen, many of our informants wrestled with deep-seated feelings of failure, guilt and shame. To them the world was an unsafe place, a place where the individual's wishes and goals rarely prevailed, and where he was never sure, from the next day to the other, that he could hold on to such essentials as housing, friendships, or work.

To sum up, the social and personal rewards of work are just as much resources to the individual as its financial benefits. Like monetary income, friendships, social status, a stable sense of self, and a sense of order are crucial in

shaping the individual's identity and the quality of his relations to his environment. In this respect, work is one of the great organizing principles of social and personal life. But due to our informants' problematic relation to the labor market, work fulfilled this organizing function for them only imperfectly or not at all. Without exception, our informants experienced their lack of work as difficult and demoralizing. More specifically they complained of the lack of meaningful activities, the long, empty hours, and the paucity of stimulating social relations. On the psychological level, our informants complained of the difficulty of maintaining self-respect and a sense of self-worth in the face of their continued failures in the labor market. Our observations confirmed these self-assessments. Most of our informants gave the impression of being insecure, confused, and of being subjected to forces beyond their control. For many their life had a decidedly chaotic quality.

PART III: GETTING IN: THE MENTAL HOSPITAL IN THE LIFE OF THE FORMERLY HOSPITALIZED MENTAL PATIENT.

7. Trouble

7.1 Introduction.

In the preceding chapters we have described what happens to the formerly hospitalized mental patient when he gets out of the mental hospital. Getting out, as we argued in the introduction to this study, has become a regular feature of the mental patient's life in the present, inclusionary system of care for the mentally ill. We have observed how the patient, once in the community, deals with the principal institutions of community life, marriage, family, work, and housing, and concluded that his links to these organized societal domains are at best tenuous. And, conversely, we have described how these informal community institutions, in particular the family, handle the burden of caring for the mentally disordered.

But getting in is as common in the life of the contemporary mental patient as getting out. All of the patients in our sample were regular users of the mental hospital, some of them with histories that included thirty or more admissions. In this and the following chapter we will focus on the circumstances that surround the patient's return to the mental hospital. From our knowledge of the social and economic conditions of his community tenure, we will ask ourselves in these chapters what it takes for the patient to return, or for the family to have the patient returned, to the

mental hospital. In this chapter we will focus on the triggering incidents which turn the ever present risk of rehospitalization into an actuality. In the next chapter we will look at the role that 'experience' plays in the readmission process. Or, in other words, how readmissions contribute to readmissions.

7.2 The Notion of Trouble.

Why, for what reasons, do people return to the mental hospital? Let us approach this complex question by looking at some examples of readmissions. We asked each of the 313 individuals in the sample of the Mental Health Policy Project about the circumstances of their latest admission. The following are some typical answers:

1. "I was having suicidal thoughts and I was starting to entertain them a little. Cook County Hospital and my psychiatrist recommended that I come to ISPI. I agreed with them. They convinced me because I was having suicidal thoughts. I was staying at a shelter at night , and during the day I walked around, looked for a job, slept in my car."

2. "I was sleeping in the hallway. The police got a call from a lady in my cousin's building. They told me to get out of the hallway and go down the street. I told them it was public property and why should I. They took me to jail. They issued an order of detention to come here. I told them I was King James and they couldn't understand that. I told them they weren't my doctor and they didn't have the right to send me here."

3. "I had been here 3 weeks before. I had met a girl here and we got really tight. we talked about everything. We were going to get an apartment and take care of her baby together. But when we got out everything had changed. She acted like a different person. She'd talk down to me like I was a kid. She put her baby up for adoption. When I got out last time there'd been an outstanding warrant for my arrest, so I spend 2 weeks in jail. When I got out she was a different personality. People had warned me, but I didn't see that side of her 'till it was too late. I was depressed and feeling like killing myself, so I came here. I walked."

4. "My brother-in-law came over to watch me because they thought I was acting crazy. We were in front of a beef stand and he had hold of my arm. I told him to let go of my arm or I would throw coke in his face. He didn't, so I did. He beat the shit out of me in front of that beef stand. I ran home and told my mother to call the police. But instead of doing that they called the police and had them bring me here to the nuthouse.

   I had been acting a little strange because of my manic thing. But I could've gotten some other help besides coming here. This is a terrible place. My brother-in-law is very jealous of me. He has propositioned me before. I thought when the police came that they were going to trick Ricky (brother-in-law) into going with them. Instead I was the one who got tricked. I went crazy in the paddy wagon. I started fantasizing that they were tricking me to get married and other bizarre things."

5. My sister brought me in. I couldn't sleep. I thought the baby's head fell off, and I was trying to get it back on. (There was no baby. Interviewer.) Voices were coming through the wall. I didn't sleep for three nights. Her and my daughter took turns staying up. I was nervous and shaky. When I laid down somebody said: I'm going to kill you. I was afraid. I was going from room to room all the time. I knew I needed some kind of help.

What do these different accounts of readmissions to the mental hospital tell us? The first thing to notice is that

each of these individuals, preceding their return to the hospital, experienced some kind of trouble. In all of these examples either the individual or his environment recognized that something was wrong, and that this situation was sufficiently unpleasant or irritating to warrant action of a remedial kind.1

Secondly, the trouble that preceded the readmission of these individuals had a significant social component. In each instance the more familiar manifestations of psychopathological disorder --- hallucinations, delusions, life-threatening mood swings --- were embedded in a rich and dynamic interactive setting. Usually a variety of people in the individual's environment --- family members, friends, fellow patients, physician's, mental health professionals, law enforcement officials, neighbors, strangers --- were in one way or another involved with his troubles. Each of these others brings to the situation triggered by the distressed person's actions, his own interests, perceptions, interpretations, and routines, to produce a situation that ultimately results in the recidivists's return to the mental hospital.

Thirdly, and related to the preceding point, most of these individuals' troubles were complex events. In almost

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1 Compare R. Emerson & S. Messinger, "The Micro-Politics of Trouble", Social Problems, 25, 1977: "Problems originate with the recognition that something is wrong and must be remedied. Trouble, in these terms, involves both definitional and remedial components."

all of these examples the assessment that a situation has arisen that was sufficiently serious to warrant mental hospitalization depended not only on the individual's behavior, but also on chain of circumstantial events. For example, the individual who entertained suicidal thoughts also reported himself to be unemployed and homeless, and to be under the supervision of a mental health practitioner. The young woman who claims to have acted "a little strange" also reports to be sexually pursued by her brother-in-law. Far from being irrelevant to the formation of the individual's trouble and his subsequent readmission, these circumstantial factors contributed substantively to the participants' understanding of the situation as constituting the kind of trouble for which a return to the mental hospital was the logical or preferred solution.

The upshot of the complexity and circumstantial nature of the individuals's trouble is that there exist considerable variation in the kind of situations that eventually result in rehospitalization. Many different paths lead to the mental hospital. The person in example 1 entertained thoughts to kill himself. The one in example 2 ran into trouble with the police because he was thought to trespass onto other people's property. In the other examples we encounter troubled family relations, fights, forsaken love, and various instances of bizarre behavior. In some cases the trouble consists mainly of the individual's personal suffering, while in other cases

the situation is deemed trouble because the individual inflicts grief upon his environment.

To summarize: all of the individuals in our sample returned to the mental hospital because they experienced some kind of trouble in the days or weeks preceding their readmission. In this chapter we will take a closer look at kind of trouble that results in a readmission. For purposes of discussion we will distinguish between trouble of a personal and trouble of an interpersonal kind. Personal trouble begins and is remedied within the individual. Interpersonal trouble originates and is resolved in the context of a recognized relationship.2 While interpersonal trouble can be recognized by either the troubled person or the other, what truly distinguishes it from personal trouble is that any remedial efforts are addressed by the latter to the former.

7.3 Personal Trouble.

Most of the individuals in our sample whose return to the mental hospital was preceded by trouble of a personal nature, reported to have experienced feelings that were both unendurable and overwhelming. Fred, one day, while he was in

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2 With this distinction I follow, and expand, R. Emerson & S. Messinger's distinction between personal and relational trouble. R. Emerson & S. Messinger, "The Micro-Politics of Trouble": 123.

a good mood he bought a bottle of cheap port on the way home, and back in his hotel room drank it in its entirety. Under the influence of the alcohol he experiences a surge of guilt and anxiety:

> "I don't really know everything that happened. All I know was that I was really boozed up. I guess I was hearing voices. I might have killed myself. There was really nobody there to help me you know.....I started getting suicidal feelings, paranoid feelings, like people were talking about me."

Wayne's readmission was also preceded by overwhelming, and intolerable feelings, but in his case they consisted mostly of anger and depression. He explains that he decided to have himself admitted again because he felt that he "got sick":

> "What do you mean when you say that you got sick? I wasn't eating right. Eating became a burden. I had no interest in eating. I was going to bed at 6.30 at night, sleeping. That's when I know that I'm getting sick again, when I go to bed early. I felt terrible. I wasn't talking to no one. I'd sit there by myself and I didn't want to have nothing to do with no one.....How severe is your problem? You mean depression? Oh, terrible. You can't function properly. At 4 in the afternoon I'm emotionally drained from sitting around thinking."

Many of our informants, like Fred, experienced overwhelming feelings after the use of alcohol. Alcohol intoxication generally had the effect of either intensifying or bringing out distressing feelings. Michael provides an example of the first. After he had drunk 6 cans of beer at a party, he couldn't sleep that night and started to hear voices

again. Eric is an example of the second. When after a night of drinking he checks himself in the Emergency Room of a general hospital because he felt "overwhelmed, distraught, depressed a bit", he recognizes that the alcohol intensified his negative feelings:

> "When you're drinking, the thought that nobody cares about me, increases tenfold."

All of these men experienced strong and often intensely painful negative feelings, but what made their experience into trouble, that is, into the kind of problem that cannot be left unattended and requires immediate attention, is that all of them felt that they could no longer control their feelings, and, by implication, their actions. Fred, for example, expresses this clearly when he says:

> "I don't know how to handle myself when I get this way. Not fight but out of control. I don't know how to pull myself together. You might call that embarrassing. I get that way quite often.....I'm scared of myself. Not so much that I will fight or get violent. I just need some help. I don't know how to handle myself. <u>What do you fear most about your problem?</u> I don't know how to control it. That's what scares me.....It changes my whole personality you might say, and then it leaves me frightened."

Eric, observes that the effects of excessive alcohol intake contribute to this experience of having no control over the intensity of one's feelings:

> "I really do not make a scene in public. When I'm depressed I get so overwhelmed I just leave. Only when I'm drunk. I mean, I have bad feelings, when I'm sober,

but I'm in control of them."

As Fred indicates, the sensation of having no control over his emotions, of being swept away in a maelstrom of distressing feelings, is acutely frightening. In some men this took the form of a fear that they would impulsively commit suicide. Fred, as we have seen, reported that he feared that he might kill himself, and Wayne, when asked what he fears most about his depression, answers:

"I think eventually I will commit suicide".

A number of observations with regard to the nature of personal trouble and its importance for readmission are necessary here. At face value, the above examples are relatively clear-cut. All of these men, either under the influence of alcohol or not, became emotionally distraught and acutely suicidal. The danger of suicide constitutes one of the legal grounds for admission, so from the perspective of institutional purpose admission was both justified and necessary.

Yet from the perspective of the individual the troublesome situation is much more complex and diffuse. It is significant to note that all of these men returned to the mental hospital because they themselves took the initiative to seek out help. It was in their own personal life-world that the stimulus to readmission arose. In other words, looking

backwards, after the decision to admit has been made, the trouble that resulted in the readmission looks straightforward enough (suicidal ideation; delusions, hallucinations). Looking forward, however, from the perspective of the individual who feels engulfed by trouble, and who decides whether to seek help or not, the situation is much more ambiguous, and the concept of his trouble is no longer unproblematic. It might be important, in other words, to take a closer look at the actual situation that gave rise to the initial panic of these men. Let's take a closer look at Wayne's situation for example.

Wayne's account of his depression is embedded in a long list of worries, complaints and grievances. His main grievance is the halfway house. When asked who suggested that he go to the hospital for help, he answers:

> "No one. I came myself. I tell you, I've seen a lot of sick people that sit around talking to themselves, hearing voices. And Clayton let's them sit around for 2 weeks without sending them to the hospital. I said to myself: you belong in the hospital, why don't they bring you in? So when I got sick Tuesday-morning I said to myself: I'm gonna go to the hospital. I'm not even going to ask these people."

But it is not only his conviction that he is neglected that angers Wayne, he also objects to the many institutional rules and routines that govern life in the halfway house. For example:

> "<u>Did you have problems with the rules at Clayton?</u> Yeah. You can't stay in your room. Every time you go out you

got to sign out.....I know what the future was at the Clayton. I couldn't smoke, I couldn't drink.... Where's the freedom here.

Often, Wayne directed considerable anger at seemingly minor issues:

"I didn't have the caffeine in the morning. They had me on Alvil to sleep. But I'm so used to living on my own and drink coffee and have a cigarette in the morning. But they have decaf here. I wouldn't wake up. I would just sit there.

As we saw in chapter 6, the sorest point for Wayne was the rule that the halfway house acted as the recipient of his SSDI allowance to pay for board and care, and granted him a monthly allowance of $25. Other grievances in Wayne's life concerned work and family. Being unemployed was particularly hard on his self-esteem, and with regard to his family, he felt abandoned by his children and was convinced that his brother and his brother's girl-friend had cheated him out of money:

"Did you have family problems? I already told you. My brother sold the car and didn't give me the money. And I needed the money for clothes and other things. And like I said: with this girlfriend all the time. Taking my checks when I'm in the hospital. I could've bought clothes for them. Now I'm down to what I wear. It's not good. Especially when you're sick. They're all ganging up on you.

Wayne appears from the interview as an lonesome, suspicious, and deeply isolated man. Several times during the interview he seems to acknowledge this, for example when he says:

"When I'm by myself, I like it so much that when I'm with other people I get, not nervous, but I don't get along so well with everybody else. I don't get involved in conversations."

Wayne's story echoes many themes --- isolation, a sense of powerlessness, the dominating presence of paternalistic, bureaucratic rules, unemployment, poverty, abandonment by family, loss of self-esteem --- that are common in the lives of our informants. Yet, the purpose of Wayne's story is not to provide an inventory of the various, distinct life problems that characterize the life of the formerly hospitalized mental patients, but to present these as they present themselves to Wayne, in a cohesive, textured pattern. From the perspective of Wayne's life-world, his problems form an integrated whole. Both the mundane (worries about coffee and cigarettes) and the vital (unemployment, isolation) combine into a meaningful world of fears, worries, problems, and resentments that constitute for the individual the task of daily living.

Within the closed world of the individual's life-problems the "psychiatric" symptoms do not particularly stand out, or occupy a special place. Wayne's depression, deep-seated suspicion, and suicidal longings are simply other obstacles on his path, not substantively different from his worries about his lack of money or the paternalistic rules of the halfway house. Wayne's story illustrates what could be called a natural ecology of psychopathological symptoms. In the experiential world of the mental patient his symptoms do

not distinguish themselves from the particulars of his life-situation. Rather they are to be regarded as responses to this life-situation and are by and large blended in with the chores of daily living.3

For an understanding of hospital recidivism it is essential to distinguish between the interrelatedness and variability of the patient's problem-world on the one hand and the discrete nosological categories that justify his entrance into the mental hospital on the other hand. From the perspective of the recidivist patient the orderly and standardized diagnostic categories that are established during the intake procedure constitute a retrospective reworking, a simplified organization, of his experience.4 This reworking is guided by the organizational goals of the institution, the legal requirements of the admission process, and the occupational standards of the mental health professions. And, even more important, the substantive content of the official

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3 Compare Erving Goffman, Asylums, 1961: 362.

4 Merton Kahne & Charlotte Schwartz, Negotiating Trouble: the Social Construction and Management of Trouble in a College Psychiatric Context", Social Problems, 25, 5, (June 1978), 462: "Focusing primarily on psychiatrists' retrospective appraisals, we show how these professionals develop accounts which maintain a sense of order, coherence, and continuity in the face of unplanned features of their experience. Characteristically, particulars of time, place, and persons involved are treated as unexpected marginal events, and their importance for the changing nature of trouble is lost. Orderliness and generality are achieved by making situations of rich variability , complexity, and potentiality into oversimplified, general, and stereotypical ones."

nosological scheme reflects a general mandate for action, a collectively agreed upon way of managing the troubles of mental patients. Within the institutional context of the system of psychiatric service delivery the assessment of the recidivist's trouble cannot be seen apart from its resolution. The reasons for readmission as they are established in the hospital records are to a large extent the product of the institutional routines of the mental health system, and do not necessarily reflect the individual's personal reasons for returning to the hospital. The original impetus for readmission in these cases originates in, and is only understandable from, the particulars of the recidivist's life-world.

7.4 Interpersonal Trouble: the Family Context.

Not every readmission was carried out on the initiative of an individual who experienced overwhelming distress. In fact, most of the individuals in our sample returned to the hospital because someone in their environment, family or others, instigated their rehospitalization. In most of these cases the individual had inflicted grief, fear, or worry upon his environment to an extent that his environment felt that his behavior could no longer be tolerated and necessitated immediate action of a remedial kind.

The trouble in these cases was interpersonal in nature.

In the case of interpersonal trouble, both of the constitutive elements of the trouble definition, the aggravating situation and the remedial action, are defined by the terms of a recognized relationship between the troublemaker and others. Interpersonal trouble arises because the troublemaker violates the implicit or explicit rules that govern the relationship. Interpersonal trouble can therefore arise wherever there exists a recognized relationship. Employees can get in trouble with their employers, children with their parents, students with their teachers, inmates with the staff of the institution.

Theoretically speaking, the definition of interpersonal trouble is neutral with regard to the distribution of authority in the relationship. Employers could get in trouble with their employees, parents with their children, teachers with their students, and institutional staff with inmates. In actual practice of course these cases are quite rare, the reason being that the definition of interpersonal trouble strongly depends on the generally accepted distribution of rights and responsibilities in that relationship.5 It is particularly with regard to the remedial aspect of the trouble definition that the particular configuration of authoritative power and duties that characterizes the relationship is

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5 R. Emerson & S. Messinger, "The Micro-Politics of Trouble": 123: "For, unlike efforts to remedy personal troubles, trying to resolve relational troubles raises issues concerning the distribution of rights and responsibilities in that relationship."

important. Some partners in the relationship are inherently in a better position to instigate action of a remedial kind, owing to the circumstance that they occupy that side of the relational nexus which is generally expected to uphold the norms that govern the relation. They are expected both to identify situations that threaten the relationship and to instigate restorative action. To this end they posses, compared to the other half of the relationship, more authority and larger resources to implement that kind of action.

In practice this often means that the identification of the trouble not necessarily occurs with the explicit consent of the troublemaker. Or, where the troublemaker agrees with the definition of the trouble and his designation as the source of it, he still might not agree with the proposed remedial measures. In many cases, as we shall see, a readmission to a mental hospital takes place in a decidedly antagonistic atmosphere. The recidivist individual is not aware or does not acknowledge that he creates trouble for his environment, or if he does, he is not convinced that the trouble is sufficiently serious to justify rehospitalization.

Let's look at some of the ways in which recidivist patients get in trouble with their environment. Some people exasperate those close to them by their seemingly irrational behavior. Dorothy exasperated her employer by what looked like her unwillingness to take care of herself. He gives

several examples of her refusal to provide him with her date of birth, to sign a tax-return form that he prepared for her, or to wear a set of reading-glasses that he had ordered for her. As he concludes:

> "The only thing that I be scared about was a total lack of self-direction. There was absolutely nothing that she would do for herself. She was not crazy, no. I don't think she is crazy. Very slow, yes.

Some of the patients in our sample taxed their environment because of their self-destructive behavior. Lewis' family had given up on him because of his heroin addiction. On the day of his admission, as we have seen, he had cashed his welfare check, spent the larger part of it on the repayment of some debts, and from the remaining money bought heroine. Intoxicated by heroin and alcohol he presented himself at his sister's house where, according to hospital records, he was "verbally and physically abusive, and (..) confronted other people with irrelevant observations". Subsequent attempts by the hospital staff to involve the sister in Lewis' treatment failed. According to Lewis' treatment coordinator the sister:

> "didn't want to have anything to do with him. She was not so controlled when I spoke to her on the phone. In a hostile tone she said: He ain't coming here.

Both Lewis and Dorothy displayed bizarre and unusual behavior. But, although their environment considered their behavior puzzling or troublesome, the unusualness by itself was not considered a threat and was therefore insufficient

reason to spur the environment into initiating a readmission. This pattern has been repeatedly observed in the literature on the families of mental patients. A number of studies have shown that families are willing to tolerate high degrees of bizarre behavior by one of their members.6 Various reasons have been suggested in the relevant literature for explaining families' reluctance to recognize and act upon a member's bizarre and aberrant behavior. The cohesiveness of a family depends upon an intricate and solid network of mutual loyalties and affective bonds; the branding of one member as mentally ill will be understood, at least by the member so designated, as the rescindment of those loyalties and affections, and therefore threaten the existence of the family as an intact and properly functioning unit. Other reasons that have been suggested include the personally threatening aspects of recognizing mental illness in a family member as it brings home the question of possible personal responsibility, and the fluctuating nature of the aberrant member's behavior which makes it possible to interpret that behavior as a momentary deviation. It will be clear that these conclusions are not restricted to family relationships but can be extended to any relationship that is characterized by ties of affect and loyalty.

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6 For family's differential tolerance of the patient's symptoms see James R. Greenley, "Family Symptom Tolerance and Rehospitalization Experiences of Psychiatric Patients", in Roberta G. Simmons (ed), Research in Community Mental health. An Annual Compilation of Research, Volume 1, 1979.

The above conclusions lead to a number of expectations. First, for families to act upon a member's behavior by starting admission procedures requires more than just the unusualness or bizarreness of that behavior. Only when, in addition to the bizarreness, the member's behavior is interpreted as posing a serious threat to the family's standing in the community, for example when the member's behavior is grossly indecent, or to its personal safety, when the member is violent and assaultive, is it expected that swift and decisive remedial action is undertaken.7 Secondly, once a member has been admitted to the mental hospital it will be expected that the threshold to subsequent admissions will have been lowered considerably. Not only have families gained knowledge of and experience with the admission process, but more importantly, the emotional disincentives to admission have become less important after the first occurrence because in a sense the family's cohesiveness has been damaged already. From the point of view of family dynamics, the process of readmission is very different from that of a first admission. Thirdly, it is expected that in those relationships where affective ties are absent, as in institutional and public settings, much less is needed for one member of a relationship

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7 The classic source is M. Yarrow et. al., "The Psychological Meaning of Mental Illness in the Family, The Journal of Social Issues, XI, 4, 1955. The article describes in extensive and convincing detail the almost inexhaustible array of interpretive maneuvers that wives employed to give a rational and comprehensible account of the often increasingly bizarre behavior of their mentally disordered spouses.

to identify a relationship as troublesome and to begin remedial action. The anonymity and emotional neutrality of the relationship make it largely a matter of indifference to those in a position authority if it will be sustained or not. In the remainder of this chapter we will discuss examples of each of the above expectations.

The most common example where a family is spurred to remedial action to contain the behavior of one of its members is when that member resorts to actual violence. In chapter 3 we have described the extent to which the repeated violent behavior of one of the members of a family came to dominate the lives of the other family members. The fear for bodily harm or worse, the constantly recurring turmoil, and in particular the unmanageability of the individual's behavior quite literally makes life impossible for the family.8 Most

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8 Compare Goffman, "The Insanity of Place", in Relations in Public. Microstudies of the Public Order, 1971, 356: "Mental symptoms, then, are neither something in themselves nor whatever is so labelled; mental symptoms are acts by an individual which openly proclaim to others that he must have assumptions about himself which the relevant bit of social organization can neither allow him nor do much about.

It follows that if the patient persists in his symptomatic behavior, then he must create organizational havoc and havoc in the minds of the members. Although the imputation of mental illness is surely a last-ditch attempt to cope with a disrupter who must be, but cannot be, contained, this imputation in itself is not likely to resolve the situation. Havoc will occur even when all the members are convinced that the troublemaker is mad, for this definition does not in itself free them from living in a social system in which he plays a disruptive part

This havoc indicates that medical symptoms and mental symptoms are radically different in their social consequences

relatives of a formerly hospitalized patient who was prone to violent behavior stressed the almost unendurable nature of the situation. As Renee's mother, in discussing her daughters violence towards the family, expressed it: "It was a living hell".

Secondly, most of our informants who were violent also displayed other problems like exaggerated suspicion or confusion, or reports of hearing voices. Yet, as the following quote from Jack's mother shows, in the experiential world of the family the violence tended to overshadow all other problems. Or, to be more precise, the repeated violent behavior of the patient is the strongest stimulus for members of his family to begin remedial action:

> "It turns out,....At that time I was talking to Jack's doctor. I was worried about his hearing voices and his paranoia. He said he was being followed all the time. Jack's doctor thought it was a good idea that he would be admitted to Read. We were all physically afraid of Jack. If you have witnessed his rages, you would have been afraid too."

Initially mother places the admission in the context of Jack's alleged delusions and auditory hallucinations, but then, as if to provide a definitive justification for the suggestion to admit Jack to a mental hospital, she discloses the family's fear for the consequences of Jack's violence.

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and in their character. It is this havoc that the philosophy of containment must deal with. It is this havoc that psychiatrists have dismally failed to examine and that sociologists ignore when they treat mental illness merely as a labelling process. It is this havoc that we must explore.

Yet, although the violent aspects of the individual's behavior tended to dominate the family's experience of his trouble, other aspects were an integral part of the family's understanding of that trouble. For example, Jack's diabetes, the sense of being different that this instilled in him, the anger and hostility that resulted from this, were all part of an explanatory scheme that his mother employed to understand Jack's behavior. The importance of these explanatory schemes is their significance for the kind of solutions that families seek to remedy the member's trouble. Jack's mother perceived his diabetes as the cause of his trouble and sought to address this problem by arranging for adequate medical care. Renee's parents framed their daughter's violence in terms of a developmental disorder and sought help in the form of special schools and behavioral programs. Ralph's parents understood their son's violent behavior as drug-induced and accordingly tried to enter him in a drug-treatment program. Yet, all of these individuals ended up in the mental hospital and kept returning to it. In the next chapter we will describe how the explanatory schemes of patients and families interact with the available options for help, and in the process produce recurring readmissions to the mental hospital.

The crucial distinction between personal and interpersonal trouble is that in the first instance the individual evaluates his own situation and acts upon this

evaluation, while in the second instance the individual is evaluated and acted upon by others. In the second case the nature of the trouble is therefore strongly dependent on the frameworks that others bring to the particular situation.9 This necessarily introduces into the social situation of interpersonal trouble the possibility of disparity, a certain dissociation between the individual's behavior as seen by himself and as seen by others. An example is the case where the readmission is the result not of actual violence but of the threat of violence as perceived by the individual's environment. This was particularly the case when earlier admissions to the mental hospital had been accompanied by violence on the part of the recidivist. Behavior that, on the face of it was rather innocent and inconspicuous, quickly took on an ominous meaning for the recidivist's environment as the first signs of a recurrence of the violent behavior. The following description of the emergence of a manic episode in Paul, that would eventually result in his readmission, illustrates this process of anxiously reading the recidivist's behavior. The story is told by Larry, a public service attorney and close friend of Paul, who was instrumental in having him readmitted to the hospital:

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9 R. Emerson & S. Messinger, "The Micro-Politics of Trouble": 124: "This distinction should not be taken to imply that certain troubles are necessarily or mainly individual, others inherently relational. The difference derives less from the troubles themselves than from the perspective or framework from which they come to be viewed or treated."

> I was fully aware of his prior hospitalizations. He phoned me and said that he wanted to get together for coffee. I said: Come on over. Come the next day. He phoned in the evening. He has done that before. To come to see me before he gets sick. I didn't notice it then, I didn't notice it this time.

Paul comes over to Larry's house, where the two of them discuss Paul's therapy at an experimental program for psycho-affective disorders. Larry continues:

> "When he left he said: Come on over to my house sometime and look at my new paintings. A few days later he phoned and said, this was on a Saturday: Let's have coffee tomorrow morning. I said: Yes. He said: Let's do it at your house. So I said fine, but I began to worry. It was different from the original plan to see his paintings. That phone call, by the way, was at 6.45 in the morning. Five minutes later he phoned again. He said: Carolyn Morse just called. She's got a big job for me to do, so I'll see you at the end of the week, and give my love to your fish. He hang up. At this point I knew he was going downhill fast. <u>What made you think that he was going downhill?</u> Something in the tone of his voice. He sounded manicy, even angry. Plus, saying: give my love to your fish, for Paul, is totally off the wall.
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> Then I learned that he'd shown up to work drunk. He makes a living by doing carpenting, odd jobs. In premorbid days Paul was not a drinker. Occasionally a glass of whiskey or a glass of wine. He smoked a lot of marihuana, but he was not a drinker. Immediately prior to his being incarcerated in jail in Mexico, which was his first psychotic episode, now 7 or 8 years ago, he had consumed a lot of Tequila ....Once he got out of that hospital he would never drink because of his medication. Except prior to his hospitalizations he would drink a lot. Also one day he showed up to work with purple eyebrows. I know when he's sick he gets preoccupied with sex. He sees himself as a superstud. He has been violent in bed with his girlfriend.

Larry's account is typical of that of someone who is witness to the psychotic relapse of a friend or family member. The myriad of behavioral signs are interpreted by the observer

as suggesting a familiar pattern. The gravity of the situation derives not so much from any actual danger inherent to the behavior of the individual -- we could easily think of a situation where similar behavior would be considered perfectly innocent -- but from the memory of earlier instances of the patient's violence, which translates into an expectation that he might resort to violence again. As the following quote by Larry shows, it is this repeated referral to earlier instances of violence that guides the observers' assessment of the situation:

> "Then, a Friday night, and Paul's brother Bill calls me from Phoenix to say that he had spoken to Paul on the phone and so had their parents, and they knew that he was sick again. On two prior occasions Bill had been up here and instrumental in getting Paul hospitalized.....Then he asked me do something about it....Bill laid a guilt-trip on me. Saying: Paul gets drunk and gets into fights in bars. Smashes his car. Starts ritual fires in his house which sometimes leads to burning of furniture. I got mad. I said: I know these problems. We'll do something about it.

As we will see later in this chapter, the dependence of interpersonal trouble on the interpretive actions of others in principle loosens the association between the phenomenology of the individual's behavior and the meaning that is attributed to it. In the case of friendship or family relations one expects that the tendency to interpret the individual's behavior in a negative way is counterbalanced by the observers' affective ties to the individual. Larry's story is representative here. It usually takes a cumulation of

behavioral indicators, all pointing in the same direction, plus some form of corroboration of the initial suspicions (by actual violence, or, as in this case, by similar assessments by others) to initiate remedial action. However in those cases where the relation between the recidivist individual and others is of a less personal and more contractual nature, one expects more precipitous, less well established interpretations of the former's behavior.

7.5 Interpersonal Trouble: the Institutional Context.

Many of our informants, preceding their readmission, resided in one of the proprietary, community-type facilities which provide care and supervision to mental patients in the present deinstitutionalized system of mental health service delivery. This category of facilities, to which we reckon halfway houses, nursing homes, group homes, and board-and-care facilities, have to a large extent taken over, and in a sense augmented, the exclusionary function of the large custodial mental institution. Their role in the spectrum of mental health services goes beyond the mere provision of residence to formerly hospitalized mental patients, in that they provide supervision and/or treatment to a population that is thought to be incapable of self-preservation by reason of mental illness. This, as we saw, has led some to label them as "nontraditional institutions".

As we will see community-type institutional facilities play an important, and so far not very well understood, role in the readmission of formerly hospitalized mental patients. In this section we will begin to explore that role by focussing on the facility's contribution to the emergence of the recidivist's trouble. We will introduce our analysis by returning once more to Dorothy.

Dorothy, after she had to leave her employer and before she was readmitted, spend some time in an Emergency Shelter. The shelter is targeted at people who for various reasons find themselves in a temporary housing crisis; it usually does not accept people with a history of admissions to a mental hospital. Clients are accepted on condition that they find a job within a period of two weeks, and to that end they are required to make three applications a day. Each resident in fact signs a contract/living agreement upon admission to the facility. Within this contractual context Dorothy, whose history of mental hospitalization was known to the shelter staff, was considered an inappropriate client. In reply to the question why Dorothy was considered inappropriate one of the counselors at the shelter explains:

> "Because of the mental illness. She couldn't communicate. She couldn't look for work. She did try. What she did was stopping people on the street and asking then if they needed a housekeeper. She would go on about the Princess of Trinidad. When you talked to her and asked her a straight question she would say: I'm the Princess of Trinidad. We're not qualified to deal with mental illness. Also, people have to make three formal work calls a day. And we call and check on them. If they

don't they get a formal warning and they're only allowed three formal warnings. What happens after that? We usually throw them out. But 95 percent are usually appropriate..."

Let us take a closer look at this rich, complex description of Dorothy's trouble. The origins of Dorothy's trouble in the shelter, the particular state of affairs that causes Dorothy to attract the staff's negative attention, resides in the rule structure of the organization. She was unable or unwilling to abide by the basic rule that residents actively work towards a resumption of their independence.10 This led her to come to occupy a somewhat uncomfortable, adversative, position in the organizational structure of the shelter. She came be regarded by the shelter staff as a difficult case, a "hard one". To the shelter Dorothy constituted first of all a management problem, a threat to the shelter's organizational integrity. Suggestions for remedial action primarily derived from this understanding of Dorothy's trouble. The overriding impulse was to get rid of this bolt thrown in the organizational machinery by transferring her to another service agency. As the counselor explains:

"Dorothy was a hard one. We tried to have her into work, a live-in housekeeper somewhere. She wouldn't do it. She kept thinking her main purpose was to clean here. We try to encourage her to become independent.....She tried

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10 Orange County Emergency Shelter, Resident's Handbook of House Rules, House Rule #11: "To meet with the program director to plan the resolution of your housing crisis and to take responsibility for working toward independent status via the treatment plan mutually agreed upon."

so hard to please everybody, but she couldn't do what we wanted her to do, so she failed here."

Yet, as we saw from the foregoing quotes, the counselor primarily framed Dorothy's trouble in terms of mental illness, with an emphasis in her descriptive presentation of that trouble on various aspects of Dorothy's behavior that allegedly function as signals for the presence of a mental disease process, a disease process moreover which was sufficiently unmanageable to warrant drastic remedial intervention like an admission to the mental hospital. In other words there exists a disparity between the state of affairs that initially was considered difficult or irritating by the organization, and which gave rise to the need for remedial action with regard to Dorothy, and the final, generally-agreed upon definition of that trouble. In the following we will suggest an explanation for this disparity, which illustrates the way that trouble is identified and managed in the context of a public institution.

By way of preliminary remark, we should not lose sight of the fact that Dorothy presented the organization with some reason to attribute mental disorder to her. Some of her behavior was considered bizarre, incomprehensible, or irritating. On various occasions she would refer to herself as the "Virgin of Chicago" or the "Immaculate Conception", and she was reported at times to ignore salutations and to arduously scrub the shelter's floor each day, despite the

presence of a professional cleaning service. Yet, despite these peculiar behaviors, few people were willing to consider Dorothy, who is a friendly, articulate, soft-spoken woman , with a quick intelligence and a mild sense of humor, a mental patient. Even the counselor, reflecting on the fate that overcame Dorothy, expressed surprise at the fact that she was admitted, because:

> "Dorothy...was not a threat. In fact she was not even that bizarre, except for every once in a while. And all the residents liked her."

Given this background we are now in a position to see that the definition of Dorothy's trouble represents a particular structuring or consolidation of the original troublesome situation. In general this structuring process is subject to two kinds of influences. First, certain aspects of the individual's behavior which are considered relatively innocuous or pardonable in the social situation of a private household, easily become offensive and unacceptable in the context of a public institution. Uncushioned by bonds of loyalty and affection even slightly deviant or eccentric behavior tends to meet with little tolerance from the part of the public institution. It is important to note that in Dorothy's case the substance of her behavior has not in any appreciable way changed. The causal agent here is the change in locale. One of the immediate effects of such a shift in one's location from the private sphere of the family to the

public sphere of an institution, is that the standards for the acceptability of one's behavior are sharply raised. Often patients were keenly aware of the contextual dependence that the impact of their actions had . Jack was readmitted from a nursing home after he had verbally threatened the staff and, in rage, threatened to kill himself. As he commented after his arrival in the hospital:

> "They (the nursing home staff) told me I couldn't go back. When you say you're going committing suicide, they take it seriously. You can't kid around with that. When you say it here (in the mental hospital) they laugh you know."

Secondly, the direction that this structuring process takes is guided by the remedial options that are available to the organization. With the criteria for help in the background as it where, the ambiguous situation which gave rise to the initial recognition that all was not well with Dorothy, is organized into a recognized psychiatric problem . As the counselor explains, to transfer Dorothy very few options were available to the shelter . She was turned down by another shelter in one of the suburbs, and the shelters in Chicago were considered too violent, too dangerous to send her to. The only alternative left was to refer her to a nearby psychiatric crisis center. This made it necessary to present Dorothy as someone who was in an acute psychiatric crisis and badly needed a psycho-diagnostic assessment. This is exactly how Dorothy was perceived by the staff-psychiatrist at the

crisis-center. As he describes her:

> "She was confused delusional. She came to us from a shelter where they noticed that she had been very confused. They could not handle her, so they send her here."

To sum up: interpersonal trouble in the context of a public institution is, in more than one sense, socially determined. First, as the example of Dorothy demonstrates, the original difficult, unpleasant situation, that gives rise to the initial experience of trouble and the mobilization of remedial efforts, derives largely from the specific terms of the contractual relationship between the individual and the organization. Secondly, the initial troublesome situation is restructured and modified in the process of finding and implementing a solution to the trouble. Certain aspects of the individual's behavior, not necessarily, or maybe only marginally related to the behavior that triggered the original troublesome situation, are selected, amplified, and organized into a meaningful whole, in such a way as to facilitate the successful application of the available alternatives for help.11 In the determination of trouble the solution precedes

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11 R. Emerson & S. Messinger, "The Micro-Politics of Trouble: 122: " An understanding of the problem's dimensions may only begin to emerge as the troubled person thinks about them, discusses the matter with others, and begins to implement remedial strategies. The effort <u>to find and implement a remedy</u> is critical to the process of organizing, identifying, and consolidating the trouble." (emphasis in original).

There is a certain resemblance between the two-phase theory of trouble that is proposed in this section and the

the definition. The final determination of the trouble represents as much an accommodation of the individual's situation to the organizational possibilities and demands of social service institutions, as it is an accurate assessment of the actual behavior of the individual and its impact upon the environment.

In the final section of this chapter we will discuss the significance this sociological view of the patient's trouble

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distinction between primary and secondary deviance that is the cornerstone of the labelling theory of mental illness. In both cases a fluid and ambiguous initial situation is, under the active influence of a reactive environment, reworked or reorganized, into a patterned and more stable problem definition. (Becker, 1963, Lemert, 1967, Scheff, 1966) However this similarity is only superficial and, for the purpose of understanding the readmission problem, outright misleading. First there is a difference in scope: the labelling theory of mental illness purports to explain mental illness in general. It intends to provide the reader with a sociological ontology of mental illness. My analysis of recidivist's trouble in the context of community-type institutions is much less ambitious. Its purpose is merely to illuminate the kinds of situations that frequently result in a readmission to the mental hospital.

Secondly, and more importantly, there is a crucial difference in the configurations of cause and effect in the respective explanatory schemes of labelling theory and trouble theory. In the first the individual is the dependent variable. Spurred by the problems that the environment's reaction to his primary deviance creates for him, the individual irreversibly modifies his self-awareness and sense of identity, and incorporates the attitudes and behaviors that correspond to the societal label. In the sociological explanation of trouble on the other hand the environment is the dependent variable. Spurred by the awareness of a troublesome situation, and the concomitant need for remedial action, the institution engages in a restructuring of its own perceptions of that situation. In fact, our data indicate, contrary to the predictions of labelling theory, that the troublesome individual, despite the powerful and compelling labels that are attached to him by various institutional actors, are remarkably resilient in retaining their personal definition of their troubles.

has for an understanding of hospital recidivism. We will discuss three relevant implications: the contractual relationship between patient and service institution as a generator of trouble, the disparity between personal and interpersonal definitions of trouble, and the fit between the definition of trouble and the ensuing therapeutic situation.

Institutional Rules and Interpersonal Trouble.

Interpersonal trouble in public institutions often originates in the rule structure that define that institution. The paradigmatic example is the non-traditional residential facility like the halfway house, the shelter, or the board-and-care facility, that serve the formerly hospitalized mentally ill. What these places have in common is that the individual's presence is always transitional and conditional. That is, the individual's presence in such public surroundings is generally understood to be only temporary and to depend upon the consent of someone in a recognized position of authority, like a proprietor, manager, or overseer, who not only identifies those instances where the rules have been violated but is also is in a position to undertake restorative action in those cases.

It is important for our understanding of trouble in public settings to spend a moment on the nature of the rules involved. Generally speaking, the rules that govern the behavior of the users of public institutions tend to be simple

and invasive. With simplicity is meant that the rules and the standards for assessing the application of the rule, are stated in clear, nonambiguous terms. "To smoke only in designated smoking areas." Or, "To have sleeping area tidy daily by 10.00 a.m.".12 Usually the standards that govern rule application are stated in binary terms so that residents' behavior can be neatly divided in two exclusive and non-overlapping categories of 'in accordance with' and 'in violation of' the rules, with no residual category of ambiguous or undecided cases.

Invasiveness refers to the range of application or jurisdiction of the rules. In many residential facilities explicit rule formulation extends to many areas of life which in more private circumstances would be considered as belonging to the personal judgement and discretion of the individual. Most residential facilities have rules governing exit and entry to the facility, access to the living quarters of other residents, the stipulation of a curfew, amount of money allotted for individual spending, sexual conduct, consumption of alcohol, opportunity and location for cigarette smoking and the like. In some instances, when the individual is part of a behavioral modification program, rules are formulated which prescribe in meticulous detail how to behave in various situations and which sanctions are inflicted upon the

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12 From, Orange County Emergency Shelter, Resident's handbook of House Rules, house rules #8 and #9.

individual when he deviates from the rules.

In addition to the substantive content of the organizational rule structure, we should consider how the rules are applied in the contractual relationship between resident and institution. A number of contending forces are important here. First, the relative anonymity and affective indifference of the contractual relationship decreases, as we have seen, the tolerance of the party in authority for unusual, aberrant, or in general, rule-breaking behavior. There is little incentive inherent to the relationship to overlook a rule-infraction, or to give the offender a second chance. This tendency is reinforced by the inevitable asymmetry of the relationship between the resident and the institution. In this respect the institutional relation is the opposite of the familial relation. Where in the latter case the authority figure, the parent was unable to effectively withdraw from the relation, in the case of the former the authority holder can easily renege on his contractual commitment. Not only is the possibility of a voiding of the institute's commitment built into the contract that established its relation to the resident, but in addition economic circumstances work against the latter here. In most urban areas community-type residential facilities are filled to capacity, and can, upon terminating the relation with one party, easily replace him with another. The options of the resident on the other hand are much more limited. While

legally he is free at any moment to continue or discontinue his residency in the facility, in practice his choices are severely restricted. Cut off from the support of family or friends, lacking the resources to obtain adequate shelter, his financial affairs, for the moment at least, interwoven with the facility's administration, he often has no alternative but to take to the streets, or check himself into that means of last resort, the mental hospital, once more.13

Thirdly, we should take into account the resident's value to the facility as an economic entity. This circumstance can work two ways with respect to rule implementation. When the supply of potential residents is abundant -- as it usually is -- the financial incentive to continue the stay of a troublesome resident is small. If however supply for some reason is scarce, and the facility's census is low, the need to hold on to existing clients becomes imperative. Considerations of patient supply immediately translate into tight or relaxed intake criteria and the more or the less liberal enforcement of house rules, which in turn, determine the resident's chances of being readmitted to the mental

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13 This is probably why the untimely termination of a resident's stay in one of these institutional facilities is so often accompanied by grand, violent gesture and emotional abandon by the patient. Uncontrolled screaming, the breaking of windows, the threatening of staff, the barricading of doors seem to express a genuine desperation, a realization by the resident that all bridges have been burned behind him.

hospital.14

Finally, we should note, with regard to the subject of organizational rules, that the relation between resident and institution is characterized by conflict of interest. Most institutional rules make perfect sense from the point of view of organizational functioning. Even the simplest and most mundane of organizational tasks, like getting up, or the timely dispensing of meals requires the precise coordination of the behavior of several hundred residents and staff members. In addition, many rules are inevitable, in the sense that they are the offspring of higher order requirements and obligations to which the institution itself is held subject by various professional, municipal, or state bodies. Most of these higher order rules pertain to licensing criteria or safety standards. For example, the rules, much maligned by residents, that govern smoking are a direct product of professional and municipal procedures that regulate fire-hazards in public buildings. However, although these rules are inevitable or indispensable for the organization, they are usually quite irrelevant, and in some cases even offensive, to the needs of the resident. To the resident who spends most of

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14 By way of illustration of this tendency the following example. Tucked on the wall above a staff-member's desk in a crisis center where I conducted an interview, I noticed the following note:

STAFF

Our census is low. We need to up it. We need increased rate of admissions when screening/doing triage presentations. CP.

his day with nothing much else to do but to socialize in the day room of the facility, restrictions on smoking or on the extent of one's relation to other residents, are easily experienced as unnecessary, aggressive prohibitions of his needs.

Yet our interest is in the contribution that the regulatory climate of public institutions makes to the emergence and identification of trouble, and indirectly to the likelihood of readmission. The upshot of our conclusions about the ubiquitousness of institutional rules and their unyielding application is that they greatly increase the chance that the individual, at some point in his institutional tenure, will collide with the rule structure of the institution. Willingly or unwillingly, he thereby creates a situation that will be interpreted by those in authority as difficult or troublesome, and result in the instigation of remedial action. All the more so of course as these are difficult people to begin with. In other words, the kind of interpersonal trouble that usually results in the resident's exclusion from the facility is grounded in the unique features of the setting, like the rule structure of the organization, its economic position, or its wider regulatory environment.

8. THE READMISSION AS ROUTINE.

8.1 Introduction.

When I ask Pearl, Fred's friend, why, in her opinion, Fred had to return to the hospital, she gives the following answer:

> "I think it was the medicine he was taking that made him do that. It used to work on him in a funny way. He gets disturbed...not disturbed, but melancholy. Then the first thing he thinks of is the hospital, you know....I guess he gets melancholy and he says: I go to the hospital. They always helped him."

Pearl's answer points to what is a crucial, but easily overlooked aspect of the readmission, namely that it is a re-admission. Contrary to a first admission, a readmission occurs in the historical context of earlier admissions, in Fred's case 43 of them. Fred's former admissions comprise a large reservoir of personal experience which, inevitably, will influence his present attitude towards the mental hospital. To Fred the hospital has come to mean support. "They have always helped him", Pearl observes, to such an extent that to a man in Fred's circumstances it becomes the first thing to think of in times of trouble. In fact, history predestines Fred's return to the hospital. The historical presence of his earlier admissions have made his latest admission more likely.

The iterated nature of the readmission is crucial in understanding why formerly hospitalized mental patient return to the mental hospital. Studies of hospital recidivism have

consistently shown that the single best predictor of readmission is the number of previous admissions. Patients with a larger number of previous admissions were more likely to return to the hospital than those with fewer.1 These findings suggest strongly that the patient's experience with the admission process somehow lowers the threshold for hospital utilization. Yet, no studies have shown in what way earlier admissions influences later admissions. What is it that sets the frequently hospitalized patient apart from the newly admitted? What is it that multiple hospitalizations do to the patient, or, for that matter, his family? Exactly what kind of experience do the patient and his family acquire, and how do they apply it to solve their life-problems? And, most important of all, in what way does experience make a return to the hospital more probable? Questions like these point the structure of the patient's personal experience with mental hospitals. It is to this that we turn in this chapter.

8.2 Hospital Preference and Entrance Management.

Each of our informants was closely familiar with the mental hospital and the intricate network of social services in which it is embedded. Many of them, for example, had spent time in different hospitals and, as a result, had outspoken

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1 Rosenblatt & Mayer, "The Recidivism of Mental Patient": 699.

opinions about the differences between hospitals in terms of quality of care, hygiene, or the ease with which such prerogatives as a grounds pass could be obtained. Jessie expresses this when she says:

> "Some hospitals are O.K., some are not. Saint Anne's O.K. That was the best hospital I've ever been in."

And Ralph's mother explicitly prefers Madden Mental Health Center over Tinley Park, because the first, to her opinion,

> "has a better program".

Not only are some hospitals preferred over others, but in some instances the mental hospital is chosen over other service modalities as the alternative of choice. For example, on many occasions the hospital staff has suggested that, given the need for a close monitoring of his physical ailments Clarence should be referred to a nursing home. Clarence's sister, however, vehemently opposes this suggestion and considers the mental hospital, or more specifically, Madden Mental Health Center, the ideal solution to her brother's problems:

> "The doctor asked me do I wanna put him in a home. I said: Hell, no! When he's sick I make sure he gets to the doctor in the hospital. 'Cause that's what the hospital is for: sick people"

And, Fred makes clear that he prefers professional help over the attention of friends or fellow-residents when he suffers

from mood swings:

> "I don't talk to people in the hotel, because I don't want them to know my history. I don't even go to the landlady downstairs. I rather don't tell it to strangers. I just want professional help."

Not surprisingly, because of their preference of one hospital or service modality over another, many of our informants were quite particular about the hospital they wanted to be admitted to. They did not choose a mental hospital in general, but were specific about the particular hospital, and sometimes even the particular ward they wanted to go to. Jack, for example, after he decided that he wanted to return to the hospital, called up his old ward:

> "I was up all night. I came here in the morning. I called up Read first, the C-South unit, to see if there was room. Sometimes they let you wait for three or four hours. But they said: Sure Jack, come on by. We have John Pullman and George Moore here. They're friends here. They have a drinking problem."

Lewis specifically asked the police to bring him to Madden Mental Health Center. Fred, despite the hospital's suggestion that he go to a hospital in his own neighborhood, preferred to go to the emergency room of Ravenswood hospital, where he had been five times before that year. Finally, to illustrate the strength of our informants' preferences, and the persistence with which they pursue them, Frank explains that he went on unauthorized leave of absence while admitted to Madden, when he caught word that he was about to be transferred to Chicago

Read:

> "I escaped from Madden last time because they wanted to sent me to Read. Read is a real hell-hole. People there urinate on themselves, waste on themselves, and nobody cares. There are roaches all over the place."

To attain their goal of gaining entrance to a preferred hospital, our informants put to use their extensive knowledge of the system. Through years of experience our informants had acquired an elaborate practical knowledge of the working of the public mental health service system. Many of them knew, for example, the exact delineation of a hospital's catchment area. They were familiar with the overt and hidden criteria for admission, the intricacies of commitment procedures, the advantages of a voluntary over an involuntary admission, the number of days one could be admitted without losing one's SSI eligibility, and so on.

The application of this knowledge to the advancement of our informant's goals led to various forms of, what could be called, entrance management. For example, one common, and simple technique, which fitted in with the high degree of residential mobility of this group of indigent patients, consisted of adjusting one's stated address to the catchment area of the preferred hospital. Ralph's mother describes how, to gain him entrance to Madden she asserted in the intake office, that her son no longer lived with the family but with his uncle at the West Side:

"After we got to Madden, Ralph had to sign himself in. I knew if I would give my own address they would bring him to Tinley Park. So I told them he didn't live with us at all. I thought Madden had a better program." 2

Another common strategy is based on the individual's knowledge of what constitute compelling criteria for admission. Hospital admission criteria are derived from the legal standard for civil commitment as formulated in the state's commitment statute. This standard is the familiar "likelihood of serious harm by reason of mental illness".3

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2 Hospitals used the same technique to get rid of unwanted patients by transferring them to another hospital. For example, Chip's treatment coordinator spend several days to prove that Chip had lived with relatives outside the catchment area of Chicago Read prior to his admission.

3 For example Massachusetts General Laws, Chapter 123, Section 12 states that any authorized clinician

"who after examining a person has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person and apply for the hospitalization of such person for a ten day period at a public facility or at a private facility authorized for such purposes by the department."

The law defines mental illness in this context as

"a substantial disorder of thought, mood, perception, orientation, or memory which grossly impairs judgement, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, but shall not include alcoholism..."

Likelihood of serious harm is defined as

"(1) a substantial risk of physical harm to the person himself as manifested by evidence of, threats of, or attempts at suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons as

The legal grounds for application for admission have resulted in three practical criteria for voluntary admission: dangerousness to self or others as expressed for example in threats of suicide or homicide; and the inability to take care of self as a result of gross impairment of thought, mood, perception, or judgement.

Most of our informants were well aware of these admission criteria and the way they functioned in the admission procedure. They knew very well, for example, that in case of doubt, the legal-administrative context of the admission procedure, with its attendant risk of litigation, forced the intake worker to err on the side of admitting. Patients, and their families had no reservations in using this knowledge to their advantage.

The most straightforward way of applying this knowledge about admission criteria and procedures is to simply report, upon request, the necessary psychopathological qualifications. To infer impending suicide or the presence of hallucinations the clinician has little recourse to independent behavioral criteria to substantiate the patient's assertions, and has to rely primarily on what the latter tells him. Several of our informants reported to have gained admission by using this form of symptom simulation. Chip, for example, recounts:

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manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them...."

> "I signed myself in, voluntarily. They didn't want me to come in because they thought there was nothing wrong with me. But I convinced them that I had no place to stay. How did you do that? They asked me if I was hearing voices and I said yes. (Laughs) It's not hard to act crazy with all the experience I have...."

Frank gained entrance by stating that he intended to kill himself:

> "I came here, and I knew that if I told them I was a junkie they wouldn't let me in, so I told them I was suicidal. They would have told me to get on a methadon program."

In these examples the patient uses his working knowledge of the admission procedure to structure the interaction with the intake worker in such a way that admission is the inevitable outcome. The patient, by summoning the realities of the hospital's legal-administrative environment, effectively forecloses the intake worker to act on any suspicions the latter might have about the patient's real intentions. The intake worker has no choice but to admit, even if both parties are aware of each other's hidden agendas. The following statement from Fred's intake worker at the emergency room illustrates the complex shadow play that goes on between patient and provider during admission:

> "Did you consider sending Fred home? Yes, we talked about that. I will always ask about possible support systems. He said he had no one. I asked about professionals. He said: I can't get a hold of her. The I asked the usual question: What would happen Fred if we sent you home today? He said: I'd take the pills. That puts us in the

ethical and legal position to certify him. We had no choice. He had given us no choice. He was pleased obviously, because he wanted to be in the hospital. I know I have no choice but to get him in a safe environment for the night. I don't feel he fakes it. He feels worthless or hopeless. I don't know if he would take the pills, but we can't gamble on it."

In most of these examples the individual resorted to outright deceit to have himself admitted. However, as Fred's case illustrates, in certain cases the manipulation of admission criteria took a less blunt, and with respect to the readmission process, probably much more important and ubiquitous form. Despite her awareness of Fred's manipulation, his intake worker is convinced that he does not fake his problems. This gives Fred's complaints a peculiar phenomenological status. Somehow they occupy a middle ground between involuntariness and intentionality. Simultaneously they are symptom and deceit. It is to this that we turn in the next section.

8.3 Symptom Management and Readmission.

According to the medical records Rosa was admitted after "she created a disturbance at a Walgreen drugstore", where allegedly she had drawn the attention of the sales staff by "acting in a confused manner". Upon admission she was still found to be "very confused" with "severe impairment of cognitive functions". In addition "the associations were loose" and the "judgement severely impaired".

If I ask Rosa about the circumstances of her readmission, she does not deny that the police took her from a public place --- according to Rosa it was a Burger King restaurant --- but asserts that she was admitted because she herself decided to return to the hospital. As she says:

> "I needed help, and I thought this (Chicago Read) was the place to come for help, since I've been here through my sickness. I needed help to find me a place to live."

These different perspectives on Rosa's admission present us with a perplexing issue. How do we explain the divergence between the hospital's version of Rosa's hospitalization and her own account? Does Rosa's account represent a denial of her mental disorder, or is she an exceptionally talented actress, who by feigning psychiatric symptoms obtains admission to the mental hospital?

Rosa's treatment coordinator struggles with the same vexing questions. At first he describes his patient as:

> "...extremely delusional. That's why we accepted her. She has very poor judgement. She doesn't have a place to live."

But, he then continues with:

> "I talked with the patient about why she needed to be readmitted. She told me point-blank that she had no place to live. She told me she went from shelter to shelter. She was walking down the street. The police picked her up and brought her here. She denied she acted bizarre for the police to pick her up. I have a feeling she acted such that she knew she would be picked up."

However when I ask him if Rosa behaved in ways that were unusual or embarrassing, he answers:

"My strong feeling is she was. She won't admit it.

Finally, when I ask him about the cause of Rosa's repeated admissions, he answers:

> "My feeling is that it is because she has no stable place to live. Secondly, she does present multiple delusions. While the delusions are not encapsuled, she only uses them for her own benefit. She doesn't get in trouble without her wanting to get in trouble."

The puzzle that Rosa presents to the observer arises from a deep seated assumption about the nature of mental illness: mental illness, or rather its symptomatic manifestations, are essentially involuntary.4 That is, the behaviors that are generally associated with mental disorder --- confused, incomprehensible talk, reports of hallucinations, depressed or agitated affect, unkempt appearance, impairment of judgement and orientation --- are believed to arise from an underlying disease process over which the individual has no

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4 For example Braginsky & Braginsky: "A third belief with which we shall be especially concerned in this book is a derivative of the second: The schizophrenic is regarded as an involuntary victim of his 'illness', over which he has about as much control as he can exercise in the conduct of his personal life, that is, virtually none. Both intrapsychically and in his external affairs, then, the schizophrenic is conceived to be very much a person in whom and to whom <u>things happen</u>; he is, accordingly, almost completely unable to be a causal agent in determining his own fate." (emphasis in original) Benjamin Braginsky, Dorothea Braginsky & Kenneth Ring, <u>Methods of Madness. The Mental Hospital as a Last Resort</u>, 1969: 33.

control. Within the framework of involuntariness the divergent accounts of Rosa's behavior cannot possibly be reconciled. Involuntary behavior cannot at the same time be wilful or aimed at obtaining a premeditated purpose. From the perspective of mental illness as involuntary behavior we are stuck with an unresolvable dilemma. Yet, if we are willing to take a different perspective, and to perceive of psychiatric symptoms as the public expression of certain private experiences, we open up a possibility of reconciling the wilful and involuntary aspects of Rosa's behavior.

The Psychiatric Symptom as Expressed Behavior.

To say that symptoms are expressed behavior is to make a distinction between the individual's private experiences, the fleeting, disturbing, ambiguous sensations of the moment, and his representation of those sensations, in word and gesture, in an interactive context. We assume that what the person experiences in the private world of his preverbalized sensations, feelings, and thoughts is not necessarily the same as what he tells or evinces about these sensations, feelings, and thoughts to another person. In moving from the private, unobservable world of feeling, thought, and sensation to the public, observable world of social interaction, a subtle though profound transformation in the individual's original experience occurs. In expressing his private sensations to another person, the individual, wittingly or unwittingly,

makes a selection from the infinite variety of preverbal sensations, feelings, desires, and motivations. What the other observes is a presentation, an emblem, the representation of the original sensations organized in a way that can be understood or decoded by the other.

It is this emblematic representation that constitutes the primary or 'raw' data for anyone who observes a psychiatric symptom. In principle, only the carrier of the symptom, the individual, has access to the original sensations from which the components of the observable behavior were drawn. And even his access is limited, because once the individual has settled on a recognized representation of the primary sensations, either in words or in gestures, the representation tends to supplant the original. The representation of the experience starts to lead a life of its own and becomes synonymous to the experience.5

Yet, due to a widely held set of assumptions about the nature of symptomatic behavior this distinction goes largely unrecognized in clinical practice. Generally, when someone expresses to us his intention to kill himself, for example, or

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5 This argument draws on Donald Spence, Narrative Truth and Historical Truth. Meaning and Interpretation in Psychoanalysis, 1982: 57: "Once a particular term is chosen to describe an aspect of a memory or dream, this term will arouse its own network of associations and these, if they are sufficiently compelling, will tend to supplant the image. ....(this problem)....is particularly critical in psychoanalysis because the original images are never available for check and comparison, and once they are 'swallowed up' by a particular description, they are probably lost forever."

shows agitated, erratic behavior, we assume that what the individual says or does corresponds exactly to what he himself experiences on a private level. There are two good reasons that we feel safe to assume this. First, we feel that the subject matter of what the person expresses is sufficiently serious or painful to exclude the possibility that he would say something different from what he actually experiences. We assume that when someone says he wants to kill himself he does not say this frivolously or lightheartedly, and, apart from the issue if he would actually put his intentions into effect, must at least have sufficiently compelling reasons to at least harbor the thought. Secondly, as we argued above, symptomatic behavior is generally understood to be involuntary behavior. The behaviors displayed by the individual are so grossly inappropriate or so obviously testify of suffering, that we assume that no one in his right mind would voluntarily engage in them. Moreover, the consequences of exhibiting these behaviors in a public context are so clearly detrimental to the individual --- admission to mental hospital with concomitant stigmatization, loss of personal autonomy, loss of trust of one's friends and family --- that again, no one in his right mind would voluntarily or frivolously engage in them.

In broad terms these assumptions about human motivation and intention are probably correct. No one in his right mind would voluntarily express the pain and fear of a florid

psychotic breakdown or serious endogenic depression. And, while many people voluntarily seek admission to the mental hospital, they usually do this as a measure of last resort, when everything else has failed. However, while these assumptions about the involuntariness and synonymity of symptomatic behavior are generally correct, they are also too crude to completely grasp the subtleties that govern the interaction between what the individual expresses and the context in which he expresses it. Or, to put it differently, the issue is not if something is the matter with the symptomatic individual, but rather if that what we perceive is the matter is the same as that what he experiences and, by implication, is as rigidly determined as we assume. Let's illustrate this assertion with an example.

A Concrete Example: Context and Content in Symptom Expression.

As we will remember, Fred's readmission was inaugurated by an onslaught of overwhelming feelings of loneliness and anxiety after he drank a bottle of port wine. Fred gives the following description of the events:

> "I stepped, on the way back to my place, around 4 - 4.30 p.m., in that grocery store and bought me a bottle of dark port. That is cheap wine, you know. I kept forgetting if I took my medication and I took 5 or 6 of them. And I got suicidal; strung out and suicidal.
>
> In my apartment I drank the bottle, with ice and a glass. I could kill myself, you know. To drink that whole bottle. Jesus! And it's wine. It's not beer, you know. it makes you sick. It took me about an hour and a half to finish that bottle.....I don't really know everything that happened. All I know was that I was

> really boozed up. I guess I was hearing voices. I might have killed myself. There was nobody there to help me, you know. If I called the psychiatrist at Ravenswood I must have known something was wrong."

Both the structure of Fred's narrative account, as his particular use of language are important with regard to the issue of symptom expression. Fred introduces his account of the crisis with a brief, comprehensive description of his actions and the effect it had on him. In the simple past tense he describes that he bought a bottle of wine, drank it, and felt suicidal. He then returns to a more elaborate description of the drinking of the bottle of wine, and proceeds with a second, and more detailed description of his symptoms. This second description is not only more elaborate ("I was boozed up. I was hearing voices"), but it also more varied in its use of verb tenses. In particular there is a significant distinction between his use of the simple past tense to describe the effects of excessive alcohol intake ("I was boozed up") and the use of the conditional perfect tense to describe the psychiatric symptoms ("I might have heard voices. I might have killed myself").

What do these variations in Fred's use of language mean? Fred's account of his crisis should be considered in the context of the research interview. His reply is in response to the interviewers question: "Please tell me Fred how you came to be admitted to the mental hospital the last time?". The question presents Fred's with the task to provide the

interviewer with an accurate and convincing story of the way he moved from a state of relative equilibrium to an admission to the mental hospital. Fred's execution of this task is influenced by two aspects of the interview situation: the fact that his reconstruction of the event is retroactive, and the non-threatening, non-demanding nature of the interview situation.

Fred's account of the events and his reactions is, necessarily, retroactive. We are not actually witnessing the events as they unfold, but are presented by Fred a patterned, well-ordered version of the events. This version, the one he presents to the interviewer, is no doubt influenced by the outcome of the events, the fact that he was rehospitalized. Fred sets out to persuade the interviewer of a story line which logically progresses from the initial event to subsequent outcome. Fred's experience with the admission procedure tells him that a convincing admission story needs a reference to the threat of suicide or the presence of hallucinations. In telling his story he engages in the creation of, what Donald Spence calls, narrative truth: a coherent, convincing account of the events.6

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6 "Narrative truth can be defined as the criterion we use to decide when a certain experience has been captured to our satisfaction; it depends on continuity and closure and the extent to which the fit of the pieces takes on an aesthetic finality. Narrative truth is what we have mind when we say that such and such is a good story, that a given explanation carries conviction, that <u>one</u> solution to a mystery must be true." Donald Spence, <u>Narrative Truth and Historical Truth</u>: 31.

Yet, to provide someone with an account of an event is above all a pragmatic enterprise. The storyteller hopes to create an expected effect, and tailors the story to reach the desired effect. To put the matter differently, the content of the story is influenced by the context. The non-threatening nature of the interview situation puts Fred in a relaxed mood. He knows that his words will have no effect on his obtainment or utilization of services.7 This enables him to talk more freely of the events that surrounded his readmission as he would have in the context of an emergency room or intake office at the mental hospital. He is able to admit that his condition preceding his readmission was more ambiguous, more nonspecific, more open to various interpretation, as the subsequent events would suggest.

No such relaxing conditions prevailed however when Fred presented himself to the emergency room. As we have seen before, for reasons of his own Fred's purported goal was to be

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7 To be sure of this was extremely important to the patients and their families whom I interviewed. In many cases the informant made considerable efforts before agreeing to be interviewed to determine my exact status, by asking if I was a doctor, if I belonged to the hospital, if I came from the welfare office etc. When it was finally determined that I had no ties to any office that played an important role in their lives, the interview could proceed. But even during the interview, when subject matter came up that the informant knew would affect his receiving of services, I had to provide constant assurances that disclosing the information would not hurt them. Usually it would take some time before the informant had decided that I could be trusted. This meant that often in the second half of the interview previously undisclosed information was revealed. All this shows, I think, that the informant is sharply aware of the effects that his words have on his obtainment of services.

admitted, either to the psychiatric ward of the hospital or to the mental hospital. Fred's 'presentation' was carefully organized to attain this end. As the crisis worker at the emergency room recounts:

> "He came in on his own. He signed in the ER. He said he was depressed, he wanted to kill himself and needed to be in the hospital. He has been to our ER. many times....He seemed sad. He said he was depressed. He was tearful. when I met him in the ER he had a bag of pills in his hand. he handed them over to me and said: Here. Take them, or I swallow them all. Did he recognize you? He seemed to. he said: Hi! He certainly is familiar with the crisis staff. He knows the routine....I sat down with him and said: Fred, what can I help you with? He said: I just can't cope any more. I can't take it. He said he hasn't been eating for days, that he was feeling sad and crying, and that he doesn't know why he is feeling sad and crying. He said that he was taking his meds, but that he was feeling lonely and worthless....Because Fred is a consistent user of our services and his presenting problems are similar, there is no need each time to get a detailed or in-depth interview. He comes in six times a year. That's not a lot really. So this time he presented all the right stuff: I feel hopeless, I feel depressed, I want to kill myself, the voices. and he has the means with his pills. Therefore he is a candidate for hospitalization...."

Fred's crisis worker recognizes the genuineness of Fred's problems. By emphasizing his experience with ER procedures, she also shows that she is aware of the expressive aspects of Fred's presenting complaints.

Context and Variation in Symptom Expression.

Fred's example underscores the importance of context in the expression of psychiatric symptoms. Or, more precisely, to distinguish private experience from the public expression

of that experience is to recognize the significance of context in the formation and understanding of behavior. Symptomatic behavior, like all human behavior, occurs in an interpersonal space.8 What this means is that the behavior that we come to recognize and designate as a psychiatric symptom is expressed in the presence of an observer, an audience. The importance of this observation resides in the influence that the audience has on the processes of selection and organization which constitute the transition from private experience to expressed, observable experience. The individual's perception of his audience will, inescapably, influence the way he organizes the raw material of his private sensations. Two observations might help to clarify this general statement.

First, in most cases the individual stands in a recognized relationship to his audience, or the observers of his behavior. For example when someone displays a general lack of vitality or reports the presence of voices he might do this in the presence of his wife, mother, employer, a police

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8 Stanton & Schwartz, The Mental Hospital: 27: "We have assumed throughout the study that all human beings are continually engaged in social activity, that every recognized 'mental phenomenon' is, in fact, treatable as part of this continuous interaction with other people. This applies not only to situations in which one consciously takes another person into account and deliberately or semi-deliberately plans what one is going to say or do with reference to him; it also includes mental activity of the so-called deeper layers of personality, and the defenses. Impulses do not function without relation to the current social situation but can be aroused, satisfied, or altered by one's perception and interpretation of it. All aspects of personality are a part of current interpersonal relations but in ways which are by no means clear."

officer, a social worker at his mental health clinic, or the intake worker at the mental hospital. Depending on who is present, and the relationship he holds to that person, he will, to a greater or lesser extent, adjust his behavior. Darell provides an example.

We remember that Darell, in an explosion of uncontrolled anger and frustration, assaulted his mother. The attack took place when nobody was home but he and his mother. Mother's detailed description of Darell's behavior during the incident, included such details as "he made a real funny noise", "he was kind of foaming at the mouth and breathing heavily". After the attack neighbors called the police. The police arrived when Darell is home alone; mother has been brought to the ER by the neighbors. They decided not to intervene and left again. We do not know what transpired between Darell and the police, but he must have presented some modicum of normal behavior, some appearance of not being a security risk, for the police to leave him alone.

After Darell is attacked by his brother that same evening, the police return and this time he is finally apprehended. The police bring him to ECHO Mental health Center, where he undergoes a psychiatric evaluation. The clinical worker gives the following impression of Darell during the evaluation:

> "He seemed in this deep depression. He didn't seem communicative. I remember that. He seemed to regret the incident, but he seemed overwhelmed by the pressure inside

him....Can you tell me more about that pressure? He was really vague about it. He wasn't talkative about it. He talked in fragments. He was almost tearful."

Finally, that night, Darell is escorted to the mental hospital. On the Intake Evaluation sheet in his medical records his behavior at intake is described as:

"....alert, suspicious, denies any medical problems, smiles inappropriately....claims to have a lot of things on his mind, but unable to elaborate, very vague. "I just snap." Speech --- low monotonous voice, somewhat loose at times, poor concentration....affect flat, unable to give exact date...."

Darell presents decidedly different behavior in different circumstances. Towards his mother, to whom he bears a grudge, he acts violent, uncontrolled, towards the police officer who is called upon the scene, he is more guarded, and towards the social worker and the intake worker, whom he probably resents, but against whom, as he perceives correctly, he is powerless, he is sullen. Darell's behavior is situationally located. That is, the expression of his feelings, impulses, and preverbal stimuli, is dependent upon Darell's perception of the particular interactive situation in which he finds himself.

Secondly, in many cases the relationship in which the symptomatic individual finds himself is long-standing, or in more general terms, the individual has a long experience in maintaining the relationship. This is obvious in the case of

familial and friendship relationships. What distinguishes our informants from uninitiated users of psychiatric services is that they have extensive experience in dealing with police officers and the staff of emergency rooms and mental institutions. In each of these examples the individual has an intimate knowledge of the particular way in which the relationship is defined in terms of authority, mutual expectations, administrative procedures, and rights and responsibilities.

Based on this knowledge and experience, the individual has a pretty accurate idea of the way that his behavior will be perceived by the other party. He will know that he frightens his mother when he reports voices, estranges his boss, get the police officer to take him in, and induce the intake worker to admit him to the mental hospital. The fact that most behavior is expressed in the context of a recognized relationship enables the individual therefore to predict, and to a certain extent manage, the reaction to his behavior. This is especially pertinent when the individual harbors more or less explicit goals. To cite an example from our sample, when the individual wants to get even with his parents, he knows that walking in the courtyard of the apartment building in his underwear will have the desired effect. Or, more relevant to our argument, when he seeks admission to the mental hospital he knows that, in the legal-administrative context of the intake procedure, claiming suicidal intentions

will do the trick.

Symptom Management Is Not Simulating.

For two reasons these examples need to be distinguished from the kind of outright simulation that we encountered before. First, contrary to simulation, these examples of expressed experience arise in genuine personal experience. They are not wholesale fabrications. The person who walks around in his underwear is to all likelihood seriously confused, and the statement of intention to commit suicide arises in undeniable feelings of anxiety and hopelessness. What the context of a recognized relationship does is to shape the way that these primary feelings are expressed. Or, to put this from the perspective of the symptomatic individual, what his knowledge of the particulars of the relation allows him is to shape the public representation of his private experience to attain the intended, and hoped for, effect.

But, secondly, and contrary to simulation, this process of shaping is not completely deliberate on the part of the individual. Yet, as those who have close experience with mentally disordered individuals will testify, it is not completely involuntary either. To the observer this ambiguous quality of the individual's behavior presents itself as a dilemma. While the individual is obviously subjected to painful or grotesque behavior, he also seems to have some control over that very behavior. Paul's friend Larry

expresses this dilemma when, in discussing his friend's repeated psychotic breakdowns, he notices a continuity between Paul's psychotic and prepsychotic behavior:

> "Every time he gets out of the hospital he has fewer friends and less devoted family than before. People who know him perceive when he's sick that it's wilful. I include myself. What makes you think that? Even before his first psychotic break he was fiercely independent, judgmental, sure that he was right, kind and loving with an edge of bitterness to it, critical of the world, which is part of being an artist. I think when he gets sick, all that just gets worse, to the point where he goes beyond disagreeing with people, beyond eccentricity, idiosyncracy."

To sum up, psychiatric symptoms are the expression of private sensations in the context of a recognized relationship. The individual's knowledge of the relationship, which is based on his experience with it, enable him to modify or control the way he expresses the original, private sensations. In particular, it enables to individual to tailor his expressed behavior somewhat to his personal goals. In those cases in which the individual considers the mental hospital a good solution to his troubles, his desire to enter the hospital influences the expression of his symptoms. He will present himself in a way that enables him to be admitted.

Symptomatic behavior, thus, is situationally specific. The expression of private trouble is subjected to the constraints of the individual's social environment. This environment, as we have described in the preceding chapters,

is the world of the indigent mental patient, a world which is structured in ways which make services of last resort the preferred, and often the only, solution to the person's troubles. Thus, in a very real sense, the social and institutional arrangement of the patient's world determines the expression of his troubles. Readmissions, in this way breed, readmissions. The social organization of the patient's world interacts with the institutional structure of psychiatric service delivery. The result is a set of powerful constraints on the individual which channel the presentation of his trouble into the few recognized diagnostic categories which guarantee him admission to the mental hospital.

PART IV: CONCLUSION

9. CONCLUSION: RESOURCES, RISK, AND THE MENTAL HOSPITAL.

9.1 Introduction.

In today's system of mental health care, the individual who suffers from mental disorder spends most of his time in the community. Geographically speaking, he has been included in the community; the boundaries which separated his world from society at large have been razed. The center of his world is no longer the mental institution but the everyday world of work, family, and neighborhood. In terms of location we have to a large extent succeeded in normalizing the mental patient. To sustain himself, to fulfill his daily needs, he, like everybody else, primarily relies on the designated institutions of everyday life. To obtain an income he will have to work, to get shelter he will have to find a house, to experience the intimacy and refuge of human relations he will have to maintain good relations with his family.

The preceding chapters showed that the discharged mental patient meets this task with dubious success. His relation towards these established domains of community life is fraught with complexity, ambivalence, paradox, and ultimately failure. Although he testifies to the importance of work, he is not willing or able to hold on to a job for any length of time. Although he likes to leave the parental home and become an independent adult, his fragile economic position prevents him from doing that. And, when at regular intervals his relations

with the community break down altogether, he has to fall back once more on that alternative of last resort: the mental hospital. To the outside observer --- as much as to himself --- the formerly hospitalized mental patient presents a complex moral picture. Somehow he is both hammer and anvil, both the victim of failing institutions as the architect of his own undoing.

In this concluding chapter we will explore some of the social, economic, and moral implications of the mental patient's problematic relation with the institutions of community life, and the consequences this has for his utilization of the public mental hospital. We will begin by describing the patient's position in the community in a more general, theoretical terms. In this description we are guided by the ethnographic material which we presented in the preceding chapters. We will then describe the risks for the patient that are attached to his problematic position in the community. We will then proceed by describing the special importance of the mental hospital as an alternative for help to this group of individuals. And finally, we will present some reflections on the role and nature of mental disorder in an inclusionary system of care and control of the mentally ill.

9.2 Commitment and the Well-Ordered Life.

To conclude that something fails, we have to recognize when it succeeds. What constitutes a 'good' relation to the aforementioned institutions of community life? The obvious, denotative, answer is: when one lives in peace with one's family, successfully pursues a career, and is able to buy or rent one's own house. The person who has obtained all this, is, to all likelihood, loved by his wife, liked by his friends, and respected by the community. He will possess some economic reserves for hard times, and present an example of good citizenship to his children. Through his actions, values, and attitudes he is firmly anchored in the large organizing domains of social life: work, family, and community. Except in fleeting moments of private fantasy, it will not occur to him to rescind his participation in these arenas of collective action. He will not abandon wife and children, throw his career in the wind, break with his parents, and sell his house to gamble away the money. He will do none of this, and continue, and find fulfillment, in what amounts to a well-ordered life.

What is required for a life to be well-ordered? The central prerequisite to the well-ordered life is stability or continuity. Personal life is constituted by a complex web of social relations, with kin, friends, employers, colleagues, clients, and neighbors. The success of these relations is above all dependent on their continuity. For the individual

to develop a warm, loving relationship with his wife or children, he needs to sustain his involvement with them over long periods of time. To gain the trust of his clients or superior, he needs to have been at their service for equally long periods. Even to obtain a financial loan, it helps if he has been employed with the same firm or has had a bank account at the same financial institution for some period of time. Continuity in human relations is associated with dedication, trustworthiness, and reliability. Too frequent change easily translates into a blot on one's character.

Continuity in the kind of social relations that constitute the institutions of community life hinges on two requirements: ability and commitment. The case of ability is relatively straightforward. The worker would like to maintain his job, but because of a downturn in the economy he is laid off. He would like to continue to pay the mortgage on his home, but without a sufficient salary he is forced to default on his loan. Circumstances outside his control have forced him to disrupt some of his cherished relations with community institutions, and consequently result in the disruption of his life pattern.

The concept of commitment presents us with more complexities. For human relations to be continuous, the participants in these relations need to be committed to them. That is, they need to make the mental decision to persist in this particular relationship for some agreed upon period of

time, and under varying circumstances that both deem acceptable. By being committed they engage in "consistent lines of activity".1 However, to define a concept is a far cry from specifying the social conditions for, or the mechanisms of its functioning. Let us approach the mechanism of commitment by stepping back for one moment and consider the effects or rewards of continuity in human relations.

The Requirements for Commitment: Added Awards.

One consequence of continuity in human relations consists of the accruement of rewards to the participants, both of a direct and indirect nature. For example, by holding on to his job the direct result is of course that the worker draws a salary each week or month for as long as he is employed. More indirectly, after some amount of time on the job has elapsed the worker discovers that he has come to earn a certain respect from his environment, or a sense of accomplishment that comes with increased experience on the job. Continuity on the job has earned him social status and a sense of self-esteem; without his continued decision to remain on the job he would not have been able to acquire these indirect rewards. In effect, by staying in the same job for a sufficient period of time, the job has come to function for him as a resource of money, prestige, and self-esteem.

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1 Howard Becker, "Notes on the Concept of Commitment", in ibid, Sociological Work. Method and Substance, 1970: 262.

The proper metaphor here is that of money in the bank. The individual, by putting his money in the bank and keeping it there for some period of time, first of all creates a financial reserve. At the same time the money begins to accrue interest. However, by keeping the money in the bank for a sufficiently long period the original interest also starts to accrue interest, so that after some time the original deposit begins to grow at an accelerating rate. The compounded interest , and the concomitant accelerated growth of his original deposit, are an added award for the individual's resolve to leave his money untouched. By sticking to his resolution the individual incurs a windfall. Or, to put it differently, the individual, by putting money in the bank, and continuing to hold it there, makes that money work for him.2

By the same token, continuity in the individual's relation to community institutions makes these institutions work for him. By maintaining his relations with his wife, parents, employer and community, he reaps, after a certain period of time, the added awards of self-esteem, respect, trust, a sense of accomplishment, economic certainty,

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2 For purposes of explanation we have not taken into account the eroding effects of inflation, so that in reality the real value of the original deposit plus interest at time t + n is probably equal to value of the deposit at time t. Also, by investing the original deposit in a successful business venture, one could make the money work even harder. However, these circumstances do not detract from the conclusions we draw from this example. The opposite of putting one's money in the bank, or investing it, is spending or squandering it.

emotional shelter, and a sense of control over his life. The importance of incurring these social and personal windfalls is in their effect on the individual's position in the community. These rewards of continuous dedication to the core relationships of his life, make it increasingly harder for the individual to abnegate his involvement in them. For example, while it is relatively easy for him, and to a certain extent expected, to change employers in the early phases of his career, this becomes much harder when he has been with the firm for twenty years, knows its particular area of enterprise inside out, has acquired vast reservoirs of localized expertise, has become the trusted center of a network of clients and colleagues, and so on. In other words, by staying continuously with the same firm for a considerable period of time, he has become invested in the firm --- economically, socially, emotionally --- to such an extent, that he finds it exceedingly difficult to rescind his involvement.

The Requirements for Commitment: Integration of Interests.

This example points to a second effect of continuous participation in community relations: the gradual coupling or integration, over time, of initially disparate involvements. The mechanism here is that decisions in one domain of human relations tend to have ramifications for another. The clearest example is of course the consequences which quitting a job has for the family's economic position. Initially the

decision to take the job and the decision to marry might have been taken independently from each other, but over time the two become integrated to such an extent that decisions in one domain inevitably affect the other. The individual, after he has held a job, been married, and owned a house for some period of time, will discover that he has become enmeshed in a web of interrelated interests, obligations and commitments.3 Having arrived at this point in his life the individual will find that the very pattern of his interests and obligations forms a powerful impediment to drastic change in one or another of his life's spheres. His interests in one domain of community life form a powerful restraint on his abnegating responsibility in another.

The Recursive Nature of Continuity.

We are now in a position to see that continuity in community relations is a recursive concept. Continuity in social relations is both agent and outcome. For example, for the individual who just begins to work, his initial

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3 Howard Becker calls this "commitment by default", which he describes as "A series of acts no one of which is crucial but which, taken together, constitute for the actor a series of side bets of such magnitude that he finds himself unwilling to lose them.... The ordinary routines of living --- the daily recurrent events of everyday life --- stake increasingly more valuable things on continuing a consistent line of behavior, although the person hardly realizes this is happening. It is only when some events changes the situation so as to endanger those side bets that the person understands what he will lose if he changes his line of activity." Howard Becker, "Notes on the Concept of Commitment": 270.

commitment to his job might rest on no more than the prospect of expected or hoped for rewards. In this phase of his career his resolve to continue in the job is founded on rather abstract, elusive motivations. After continuing in this way for some time however, he discovers that, through the mechanisms of added awards and integration of interests, he has become firmly established in a thick web of commitments to his family, his colleagues, his friends, his church, his neighborhood, and so on. His life, at this point, has taken on a well-ordered quality. Continuity is no longer dependent an abstract resolve, but is built into the structure of commitments that constitutes his life. Continuity has become <u>self-perpetuating</u>.

His, has become a life characterized by stability and continuity. A life in which the community institutions of work, marriage, employment, and family 'work' for the individual and operate as supports. Thanks to his stable position in these core domains of community organization, they have come to function for him as resources of economic rewards, self-esteem, friendship, trust, and emotional shelter. In the well-ordered life the individual is largely in control over the daily aspects of his existence. Even in those instances where through external crises the individual's position is one of the domains of community relations is threatened, the individual's stable position in the other

domains functions as a buffer.4

The Disordered Life.

The concept of the well-ordered life serves as a conceptual tool to make sense of the disparate, confusing community experiences of the formerly hospitalized patient. The overriding quality of the mental patient's tenure in the community is one of discontinuity. His relations with family, spouses, employers, friends, and mental health providers are fragmented and episodic. His relations to these established domains of community organization are highly unstable. As our material demonstrated, the intermittent nature of his community relations is due both to inability and lack of commitment. For example, some of our informants lost their jobs because of the disabling effects of their psychiatric problems. Others were unable to establish an independent household with their spouse, and become independent of their parents, because of their economic and psychological marginality. On the other hand, many of our informants quit their job or mental health program on impulse, or deliberately

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4 To avoid a possible misunderstanding, the particular substance of a person's life is irrelevant to the concept of the well-ordered life. The artist's life can be as well ordered a that of the bank clerk. The concept of the well-ordered life is not a blueprint of complacent, middle-class living. Rather, the concept denotes a structure of commitments in the principal domains of community life. These recognized commitments, in turn, rest on three requirements: the resolve to be committed, the social and economic ability to commit oneself, and a structure of interlocking interests.

sabotaged their relation with their parents.

The same social mechanisms that sustain continuity in the well-ordered life, work against the individual in the case of discontinuous relations. Like continuity, discontinuity in human relations tends to be self-perpetuating. First, because our informants cannot commit themselves to their job, the job will not begin to 'work' for them. That is, they will not experience the added awards of self-esteem, accomplishment, respect, and trust, that come with continued employment with the same employer. This, of course, changes the meaning of work for these informants. The job is not experienced as a multiple resource of financial, social, and personal rewards, but only as one way, and not necessarily a convenient one at that, to make some money. This, in turn, determines the individual's attitude towards the world of work. Given the meager rewards of work, he will find it exceedingly difficult to invest himself into any job, and subsequently experience few restraints on his impulse to quit.

Secondly, because few community institutions function as a resource to our informants, his relations to these institutions will not coalesce into an integrated, mutually supportive network of commitments. For example, because none of our informants are married, any decision to quit a job, give up a house, or leave a treatment program is not constrained by the decision's financial or psychological consequences the decision would have for a spouse. One

wonders, for example, what would have happened if Wayne would have been able to discuss his grievances about the board-and-care facility with his wife or children.

Life, for the formerly hospitalized mental patient, is fundamentally disordered. He cannot make his involvement with community institutions work for him and he subsequently decides that he doesn't want to be involved. As a result he is unable to anchor himself in the community by means of an integrated network of mutually reinforcing commitments. To him life is inherently disintegrated and atomized. He feels that he stands basically alone in facing the task of maintaining himself in society. This makes him resentful and distrustful and puts an even greater burden on his relations in the community.

The disordered life of the formerly hospitalized patient is characterized by perennial disruption. Because of his isolation and lack of commitments, he experiences few restraints on acting out his impulses. As we saw, lacking a family of his own, he can quit a job without having to think about the wider consequences. Or, already maintaining tenuous ties with his relatives, he feels hardly restrained from overreacting to minor discords. Similarly, because of his social isolation, he experiences few constraints on aberrant or bizarre thoughts. As no one is there to correct him he finds himself expressing beliefs or harboring thoughts that place him firmly outside the mainstream of social interaction.

As a result, the disordered life is highly volatile. The lives of many of our informants seemed to consist of a continuous series of crises. Time and again, their impulsive behavior or aberrant thought set them on a collision course with mainstream society. Often our informants expressed the wish to get their life in order, to experience some stability in work or housing, but somehow they seemed unable to reach that goal by themselves. Like the well-ordered life, the disordered life is self-perpetuating. To elaborate this point we will turn to the particular risks that the disordered life carries for the formerly hospitalized patient.

9.3 Risk and Vulnerability.

No Ability to Build Economic Reserves.

The disordered life pattern of our informants had a number of pernicious economic, psychological, and moral consequences for their position in the community. First, the self-perpetuating nature of the lack of continuity in our informants' relation to the labor market effectively locked them into the lowest reaches of the income hierarchy. Two mechanisms are at work here. For the group of older informants their psychiatric symptoms had made it impossible to continue in their job. Although their employability was

diminished, it was by no means completely absent. However, they were unable to secure stable employment for themselves in the competitive environment of the labor market, and they were therefore dependent on various income support programs to provide them with an income.

For a second group of mostly young informants, their lack of commitment to the world of work, and their psychiatric symptoms, effectively locked them in the low wage sector of the economy. For both groups, the result was a fatal inability to improve their economic position. Because of their perennially insufficient income, the were unable to build economic reserves, through savings or the acquisition of equity. A continued adequate income through work enables the middle-class employee to obtain credit from financial institutions, which in turn enables him to acquire equity, for example, by buying a house. The combined possession of savings, credit, and equity then creates economic stability in the individual's life pattern, and acts as a buffer against possible financial adversity. Both because of the depressed level of their income, as its irregular nature, our informants were unable to engage in the formation of financial reserves through these designated routes and in this way shelter themselves against adversity.

Loss of Personal Autonomy.

Secondly, our informants' lack of resources condemned

them to a life of perennial dependency. Unable to secure an income that was sufficient to independently maintain himself in the community, the formerly hospitalized patient has become more and more dependent on his family or the state for the fulfillment of his needs.5 This dependency, as we have seen, has some pernicious moral consequences for the patient's position vis-a-vis his relatives or the labor market. His continued dependency on his family for financial support entailed a kind of moral hazard. Through the continued reliance on his parents he enjoyed a level of economic well-being well above what he would be able to secure independently. As a result, he had little incentive to leave the parental home and set up an independent household. In fact, the decision to venture out on his own, given his doubts about his employability and his former experience with low-wage jobs, contained a considerable financial risk for the patient. When the man failed the job, as would be highly probable, he would find himself without any income at all.

Our informants' dependency on others for financial support had serious consequences for their personal autonomy.

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5 There is a parallel here with the position of the young, black worker in the low-wage sector of the economy: "Frequently unable to gain employment in either the corporate sector or the government sector, unemployed and employed workers of the low-wage industries have become more and more dependent on the government to meet their needs through various welfare programs, including welfare benefits, emergency and general assistance benefits, medicaid and medicare, food stamps and commodity distribution, supplementary education programs, and public housing. William Julius Wilson, The Declining Significance of Race: 102.

We have already seen that the continued reliance of some informants on the parental household brought with it a concomitant psychological dependency. In effect, by remaining in the parental household, these informants prolonged their adolescence. Those who relied on income support programs or community facilities, in effect relinquished a considerable part of the adult's sovereignty to decide about the organization of his personal life. A considerable part of their life was now governed by the administrative or organizational rules of the particular program or facility on which they were dependent.

For other patients their dependency on income support programs became itself a factor in the continuation of their disability. Various authors have argued that the administrative structure of the SSI program in conjunction with the economic realities of the mental patient's life, create powerful incentives for the latter to refrain from working and to continue to see himself as mentally disabled.6 The argument makes intuitive sense. Given the abysmally low income levels of our informants, and their tenuous relations with the labor market, they have little choice but to hold on to their government provided income support to support themselves in the community. Taken together, the loss of

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6 Sue Estroff, Making It Crazy: 167. As Estroff argues: "Thus client's perceptions of health status may be influenced and their ability and motivation to work may be undermined simply by being in the treatment system."

personal autonomy as the result of their dependency on others for the fulfillment of their daily needs became for this group of formerly hospitalized mental patients one more obstacle towards escape from their illness.

Lack of Perspective.

Thirdly, the self-perpetuating character of the disordered life robbed the formerly hospitalized patient of any perspective at improvement of his condition. Many of our informants gave the impression of being utterly demoralized by their present circumstances, of being powerless to bring about any change for the better. Jessie, for example, one of our youngest informants, expresses this sense of defeat in the following exchange:

> "What do you call the problem that you have? Sickening. It's not right. Can you explain to me what you mean by that? That I'm a beautiful woman , and that I'm tired of my heart beating in pain....I would need a place to stay and live there peacefully. With nobody hurting nobody."

And Dorothy, who also defines her problem in terms of lack of housing expresses similar sentiments when she reflects:

> "Well, I just take the day as it comes. I sometimes feel very unhappy inside, but I try to show up a face. And I was hoping after all these years, couldn't the government help me find a home."

Increased Vulnerability.

Finally, the lack of resources, of a firm anchor into the

community, makes these discharged patients especially vulnerable to adversity. This vulnerability is made up of two distinct components. First, living on the material and psychological edge, our informants had virtually no reserves to cushion the impact of relatively small adversities. For example, When Fred gets drunk, he gets overwhelmed with feelings of guilt and anxiety. His psychological instability amplifies into a major personal crisis what in another person would have amounted to a hangover. In addition, because he has few friends, there is no one around to assuage Fred's feelings. As a result, his guilt and anxiety mount to the point where he reports to hear voices and fears that he will kill himself. At this point, Fred sees no alternative but to admit himself to the emergency room of a nearby hospital.

In another example, Dorothy is asked by her employer to find lodging for two weeks, while the family is on vacation. With no known family or friends, and little or no financial reserves, Dorothy does not know where to stay during those two weeks. Her employer, aware of her circumstances, arranges for her to stay in a shelter for the temporarily homeless. Confused by the events, Dorothy's mental condition deteriorates in the shelter to a point where the shelter staff have her psychiatrically assessed in a crisis center. From the crisis center, she is referred to the mental hospital. What would have been a minor problem for someone with money and friends, becomes a major life crisis for Dorothy.

Dorothy's story illustrates the second component of our informants' vulnerability. Their insufficient level of resources had the effect of adversity in one area immediately spilling over into another. Because of her lack of friends and economic resources, Dorothy's problem of temporary loss of shelter turned into a multiple problem including psychiatric symptomatology, lack of housing, and lack of funds. In another example, Richard points to the spill-over effect of our informants' troubles, when he says:

> "I get a job and a place to stay and within a month I lose the job and the place to stay."

For the formerly hospitalized mental patient, problems seldom come alone. The general marginality of this category of patients has the effect of compounding initially singular, and relatively manageable problems. On the experiential level, our informants generally underwent their trouble as a multidimensional whole, as a dynamic, evolving situation where, for example, distorted perception and confused thought were embedded in loneliness, family discord, lack of money, inadequate shelter, and the stress of unemployment. As a general rule common life problems such as illness or divorce, had an uncommonly large impact on the lives of our informants. For many of them adversity, the loss of work, and finding yourself at the bottom once more, had become a grim routine. Dorothy expresses this when she says:

"This has been happening ever since I left my husband. I never had a job, except for the Mehta's, and when I left them, I fell right back on the ground again. It was going on and on and on...and I have no idea why this is happening."

In addition, the inherently expanding dynamics of the situation turned initially manageable situations into particularly acute crisis, in need of immediate remedy. At this point it would no longer do to attend to only one of these patients multiple needs. Quit simply for purposes of survival their troubles had to be attended to immediately and holistically.

9.4 The Disordered Life and Services of Last Resort.

At the end of our conversation, Fred looks back on more than two decades of dependency on public services. As he recounts:

"Before there was SSI, welfare used to help you. They gave you a letter then for an apartment and for food stamps. The landlord had to sign it. They don't do that no more. Now you go to PATH and they take you to the social security office. I've been on welfare and SSI for 20 or 25 years now. Now, at Read, they can't send you to the public aid office. Someone has to come with you. You got to have an address. It takes 3 to 4 weeks to see them. it used to be a couple of days. It changed a lot."

Fred's reflections concern the relation between the specific needs of the formerly hospitalized mental patient and the organization of the social service system. From the vantage point of the user he points to an, in his opinion, growing

incongruity between the bureaucratic complexities of service delivery and the nature of the client's problem. It is to this issue, the relation between the nature of the patient's problems and his utilization of social services that we turn in this section.

The requirements of Service Obtainment and the Nature of the Patient's Trouble.

With regard to the utilization of publicly provided services the indigent, recidivist mental patient poses a special challenge. Most public services are targeted at a specific category of needs, and operate on the assumption that the client's additional needs are taken care off. For example, when the individual receives emergency medical care in a public hospital, it is assumed that the individual, upon recovery, has a home to return to. However, as we observed, many of the recidivist patients in our sample lacked even the most basic resources such as adequate shelter, a minimum of funds, or the support of family or friends. This circumstance makes the needs of these individuals simultaneously more acute and more complex. Any problem that arises to threaten the individual's well-being, let's say an emergency health problem, is immediately compounded by the presence of a host of other unsolved problems, like the lack of adequate housing, adverse family circumstances, or substance abuse. Because of their feeble support systems the problems which the indigent

mental patient experiences in one area almost inevitably spill over into other areas of his life. This compounding of problems increases the impact of, adds an additional bite to, the initial problem that brought the individual to the attention of the service provider. In most cases when the indigent mental patient appears in the offices of a service provider, he has a problem and he needs to have it solved now.

This circumstance robs the service provider from any latitude or respite he might have in other circumstances to attend to the individual's problem. The acute, crisis-like nature of the individual's situation demands immediate and decisive intervention. Yet, it is precisely at this point that the needs of the provider, or the providing organization, collide with those of the individual. Human service organizations have usually installed elaborate organizational procedures to determine the client's need, the establish a problem diagnoses, to decide upon an appropriate intervention, and to implement this intervention. The implementation of these routines requires from the client time, patience, and an array of behaviors that not necessarily bear much relation to his need. It also requires from the client the ability to sustain himself, pending the resolution of the problem that brought him to the service organization. However many of the individuals in our sample, given the compounded, acute nature of their problems, simply do not have the time and resources to await the resolution of one of their specific needs. Let's

illustrate this interaction between the procedural organization of the service organization and the patient's needs with a specific example.

The designated public service agency for the distribution of housing among low income groups in Chicago is the Chicago Housing Authority. Yet, almost no one of our informants turned to the Housing Authority to help them solve their housing problem. There are various reasons for this. The housing problems of most of our informants are particularly acute. An eviction, for example, usually means the threat of having to spend the night on the street. Large service bureaucracies like the housing authority are not equipped to alleviate such problems on the spur of the moment. Ralph, for example, who did turn to the Housing Authority, was asked in what way the agency helped him solve his problem. His answer was:

"They didn't. You have to go through a waiting period"

For other informants the intricacies of the bureaucratic procedures that eventually lead to the obtainment of an apartment were simply unmanageable. For them the procedures were incomprehensible and apparently without logic --- they were unable to 'play the system'. Discouraged they often gave up to deal with the system altogether. Rosa provides an example. She said that at one time she also had turned to the Housing Authority to help her solve her housing situation.

Asked how they had helped her she answered:

> "They say I was supposed to move into Academy Square, but I never did. I think someone else took my room, my little apartment. Someone else took the room. I went to the YMCA instead."

Services of Last Resort: the Fit between Help and Trouble.

What our informants express here is that they do not possess the resources, financially and psychologically, which enable them to successfully complete the agency's service procedures. To be able to benefit from such categorical services as the housing authority or social security, a minimum of resources and personal autonomy is required. In many cases our informants didn't posses this minimum, and, in what is only one of the ironies of the contemporary service system, needed additional, specialized services to help them negotiate their way through the thicket of categorical services.7

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7 It strikes me that this irony is completely overlooked in the literature on the service needs of the chronic mental patient. Much of this literature consists of the exposition of elaborate blueprints of a plethora of specifically targeted services or eloquent pleas for "continuity of care" and "effective case management". Yet, the manageability of such systems from the point of view of the user is usually given short shrift. For examples see: J. R. Elpers, "The Needs of the Chronically Mentally Ill: the Perspective of a Director of a Large Urban Mental Health Program", in Moshen Mirabi, The Chronically Mentally Ill. Research and Services, 1984; Leona Bachrach, "Continuity of Care for Chronic Mental Patients: a Conceptual Analysis", American Journal of Psychiatry, 138, 1981; Ruth Freedman & Ann Moran, "Wanderers in a Promised Land. The Chronically Mentally Ill and Deinstitutionalization", Medical

From the perspective of the indigent mental patient suitability is not necessarily an important criterion in his selection of services. Rather, given the acute, expansive nature of his problems, he searches for availability and the reasonable expectation of immediate intervention. This logically draws him to such services of last resort as the police, the emergency room, or the mental hospital, to help him solve an array of life problems.

In contrast to such categorical services as the welfare office, or the housing authority, services of last resort operate with a broad mandate for intervention. They have a wide discretion both in the determination of the problem and the means for its resolution. These services are geared to providing acute care, sometimes, as in the case of the police, on the spot, without the need for the patient to go through elaborate bureaucratic routines and waiting procedures. And finally the service they offer is broad-band, either, like the mental hospital by providing comprehensive support in-house, or, like the police or the emergency room, by referring the client to the appropriate services.

For many of our informants these agencies of last resort were also the agencies with which they were most familiar. Institutions like the public hospital or the mental hospital loom large in the world of the poor. "Cook County", Chicago's largest public hospital, was a familiar concept in the world

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Care, 22, 12, 1984: chapter 5.

of our informants and their families, and almost everyone had, at some point in his life, visited its emergency room. By definition, every one of our informants knew what the mental hospital had to offer, and, as we saw in the preceding chapter, they had extensive first-hand experience with intake and discharge procedures. And, many of our informants had been involved with the police at some point in their life, particularly in the latter's role as mediator in situations of personal or family crisis.

Moreover, many of our informants and their families felt that they could exert some influence over agencies of last resort. The administrative procedures of the low-level bureaucracies of the emergency room or the intake office of the mental hospital, were more easy to grasp for our informants as the complicated procedures of the housing authority or the social security office. In addition, the relation between user and agency in these services is more personalized than is the case in the large categorical service bureaucracies. The workings of the police or the intake office were amenable to personal interaction. Services of last resort are populated by people one could talk to, plead with, or disagree with.

In analyzing the role that the mental hospital plays in the life of the formerly hospitalized mental patient, it is important to understand <u>how</u> the patient, and his family,

utilize these services of last resort. Jessie referred herself to the police because she had nowhere to go. Eric and Fred checked themselves into the emergency room because they were emotionally distraught. Chip had himself admitted to the mental hospital to escape tumultuous conflict with his family. From these examples two principles of service utilization can be derived.

First, the mental hospital does not occupy an exclusive position in the world of the formerly hospitalized mental patient. It belongs to a small number of services of last resort which distinguish themselves from other sources of help in the patient's life because of their close fit with his particular needs. The patient approaches the mental hospital, the emergency room, and the police as family of comparable services which are in principle mutually exchangeable. From all three he can expect low-threshold, broad-band care in acute circumstances. Which particular service he chooses is not so much dependent on the specialized nature of the care that is provided, but on such factors as familiarity with the service, or the institutional context of the individual's problem

Secondly, as the examples showed, there exists only a loose correspondence between the designated mission of the facility and the reason of the patient's utilization of the service. Yet, it would be misleading to call the patient's use of these facilities inappropriate. Rather, for the

patient, it is a matter of limited alternatives. He uses these services because they are the most easily accessible, free of cost, and promise immediate help. And although he realizes that the service he will receive are not tailor-made for his problems, he has little choice, and at least he knows what he can expect and what not.

9.5 Mental Disorder in an Inclusionary System of Care.

So, what about mental disorder? I have described so far how the mental patient's tenuous relations with the principal institutions of community life, perpetuate his social and economic marginality. I have shown how this makes him particularly vulnerable to adversity. In addition I suggested that the particular compounded nature of his problems made services of last resort, like the police, the emergency room, and the mental hospital, the logical, and often the only, alternative of help for him. But what is the place of mental disorder in this dynamic constellation of social and economic forces? Does the suggestion that hospital recidivism in an inclusionary system of care is to a large extent sustained by the patient's social and economic circumstances not amount to an underestimation of the power of chronicity. Perhaps no system, whether exclusionary or inclusionary, quite knows what to do with people the like of Chip, Renee, Jessie, or Lewis.

This premise is, of course, in accord with the

conventional, professional view of the cause of hospital recidivism. Mental patients return to the mental hospital because they suffer from a chronic and intractable disease which at regular intervals flares up into acute crises, which are unmanageable for the patient or his family. But, for two reasons this view is too simplistic, both as an analysis of the causes of hospital recidivism and system failure, and as a guide towards policy action.

First, these patients' troubles occurred in the context of their particular socio-economic situation. Or, to put it less formally, whatever psychiatric problems these patients had, both the recognition as the resolution of their problems were intimately connected with the particular circumstances of their poverty. We have seen, for example, how poverty influenced the course of these patients' troubles. How against a background of utter lack of resources relatively small adversities, like Dorothy's temporary relocation, or Fred's feelings of distress, inexorably expanded into acute, major, life crises. In these circumstances, we argued, such services of last resort as the police or the mental hospital were the only realistic options available to the formerly hospitalized mental patient.

In these instances, one could argue, the socio-economic circumstances of the patient merely added an extra dimension to his psychiatric problems, thereby constraining any attempt at their resolution. We have reason to believe however that

the patient's chronic lack of resources also influenced the very nature of his psychiatric trouble. For example, we observed the close relation between Rosa's housing situation and her mental instability. We saw how unemployment contributed to Wayne's depression and Fred's feeble self-esteem. How the inability of some of our younger informants to leave the parental home created particularly volatile situations which regularly resulted in family violence. These examples show that the particulars of the individual's socio-economic situation are not marginal to the phenomenology of his mental disorder. Psychiatry and economy are not separate domains in the genesis of these patients' troubles. Their psychiatric symptoms had a meaning that extended beyond the classification categories of a diagnostic manual. In a very real sense Rosa's delusions are as much a statement about her deplorable housing situation as a manifestation of some possible biological risk.

Secondly, these patients' troubles are not only influenced by their socio-economic circumstances, but also by the particular service environment in which they occur. The notion of chronicity conceives of patient's problems in absolute terms, as taking place in a biological space and only marginally influenced by the social and institutional contingencies of the patient's life. Mental illness is a disease category that more or less runs its predetermined

course. From this perspective a logical connection exists between the patient's location (the mental hospital) and the phenomenology of his trouble (chronic mental illness).8

Again we have seen that our material contradicted this view. For two reasons the relation between the patient's trouble and his, or his environment's, decision to seek help is much more qualified than the conventional view of chronicity suggests. First, help seeking was influenced both by the patient's perception of available services, as his experience in obtaining these. Patients had preferences for specific hospitals and used their knowledge of the system to gain entrance to the hospital of choice, even if this necessitated the outright simulation of symptoms. But, secondly, not only help seeking behavior but the manifestation of pathology itself was influenced by the patient's experience with available help. We have seen, contrary to our notion of symptom, that the mental 'symptoms' of people like Fred and Rosa were not rigid, predetermined manifestations of an underlying disease process. Rather they had to be understood as social-psychological events. Not only were they influenced by the particular interactional situation in which the patient found himself, but the patient had influence over the expression of his symptoms. The 'symptom' was amenable to the patient's perception of his goals and of what it took to attain these. People like Fred or Rosa adapted their symptoms

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8 This formulation is suggested by Merton Kahne.

to the demands of the situation, which in their case was to gain admission to the mental hospital.

This study has been an attempt to describe and understand mental disorder in the context of everyday life. Now that the mental patient, out of necessity, spends most of his time in the community, the study of everyday mental disorder has become particularly opportune. Our conception of mental illness is largely based on observations of patients' behavior within the confines of mental institutions. These observations have always been subject to "clinical sampling bias",9 but now that patients largely deal with their mental problems in their daily world, we need more than ever, expand our understanding of mental illness. We don't really know how mental illness emerges, manifests itself, and is resolved in the everyday life of those who experience it. We don't know how persistent or transient the symptoms of mental disorder are. We don't know how people actually cope with delusions, hallucinations, and mood swings in between the tasks and demands of daily living. And we don't know which circumstances facilitate coping and which impede it.

Our conception of mental illness is almost exclusively the product of traditional exclusionary ways of dealing with mental patients. The parallel between the practice of

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9 Courtenay Harding et. al., "Chronicity in Schizophrenia: Fact, Partial Fact, or Artifact?": 481.

segregating mental patients and our conception of them as qualitatively different from the rest of mankind is not accidental. We need to restore the continuum between the everyday world of problems of living and the problems of the mental patient. This is not to suggest that mental disorder is nothing but an ordinary problem of living. Or to deny the fact that people do regularly go over the edge. But it is the recognition that even in those severe cases these people's problems have originated, and continue to be rooted, in their daily world. What we need, in other words, is an ecology of mental disorder.

APPENDIX: Overview of Interviews.

Patient	Parent/ Sibling	Other: Friend/ Grandparent Employer	Hospital Staff	Community Provider
Jack	x		x	x
Renee	x		xx	x
Paul		x	x	
Rosa			x	x
Lewis			x	x
Fred		x	x	x
Darell	x		x	x
Eric			x	
Chip	x	x	x	
Jessie		x	x	
Dorothy		x		x
Michael	x		x	
Wayne			x	x
Ralph	x		x	
Frank			x	
Clarence	x		x	x
Henry	x		x	