

Social therapy of schizophrenia

By J. K. Wing, M. D., Ph. D., D. P. M., London¹

The term "Social Therapy" will be used in a general sense to cover social treatment, social management and rehabilitation. "Social Treatment" is the manipulation of social forces with the intention of reducing symptoms. "Social rehabilitation" covers the reduction of handicaps due to the illness and attempts to circumvent them by environmental changes. "Social management" is concerned with the maintenance of a minimum level of morbidity. "Primary" prevention, that is, the prevention of first onset, is not covered under any of these headings, but "Secondary" and "Tertiary" prevention — the avoidance or diminution of disabilities — come under the headings "Management and Rehabilitation". The three terms treatment, management and rehabilitation, cover all the social operations directly aimed at symptoms and handicaps, including the creation of therapeutic or sheltered environments at home, in the hospital or in hostels or workshops or rehabilitation units, but not including formal psycho-therapy. Such social milieux can only be maintained at optimum efficiency by good organisation and administration, rationally designed to achieve declared goals which must eventually be measurable in terms of the reduction of morbidity. This is just as true of the organisation of teams of workers who supervise social treatment, rehabilitation and management in the community as it is of the administration of the mental hospital. "Administrative therapy" and "community therapy" are concerned with the maintenance of a social organisation in which good social therapy can take place. They are not themselves so directly concerned with the reduction of morbidity and this paper will therefore not deal with them in detail.

Primary handicaps in schizophrenia

Since we are concerned with the social therapy of schizophrenia, it is important to be clear at the outset how the term is being used. It will not include simple, pseudo-neurotic, or borderline schizophrenia unless specific delusions, hallucinations, incoherence of speech, or catatonic motor phenomena are also present. These basic symptoms may conveniently be divided into positive florid symptoms such as delusions, hallucinations and incoherence of speech and negative symptoms such as flatness of affect, poverty of speech, social withdrawal and lack of initiative. Much psychological investigation has been carried out along these two lines, into overinclusiveness on the one hand and slowness on the other, but little study has been made of the interaction between them. Schizophrenic patients can be categorised not only according to the type of the basic symptom which is predominant, but also according to severity. Table I shows how schizophrenic patients in three mental hospitals are distributed according to type and severity of symptomatology. Roughly half are severely handicapped. They have severe speech disorder, severe impairment of personal relationships, severe impairment of working ability and many other abnormalities on psychological and psycho-physiological testing. The remaining group contains the moderately handicapped patients and the patients who have delusions but express them without speech disorder. Handicaps are seen most clearly when patients in this moderate group are compared with the physically handicapped, for example at an industrial rehabilitation unit. They show lack of initiative, social withdrawal and slowness, in much the same way as the more severely handicapped patients, but in lesser degree. It seems reasonable to suppose that much of this symptomatology has a biological basis although

¹ Director M. R. C. Social Psychiatry Research Unit, Institute of Psychiatry, Maudsley Hospital, London S. E. 5.

this is only a working theory at the moment. It does not mean that primary handicaps such as slowness or overinclusiveness cannot be influenced by social conditions; on the contrary, we shall see that the social environment does exercise an important influence on the severity even of these basic symptoms.

Table one. Distribution of long-stay female schizophrenic patients in three mental hospitals, by type and severity of predominant symptom (1960)

Moderately Ill	%	
No symptoms	11.0	} 44.3
Symptoms of moderate severity only	17.7	
Severe flatness of affect but no other severe florid symptoms	5.3	
Coherently-expressed delusions	10.3	
Severely Ill		
Severe incoherence of speech	15.3	} 55.7
Severe poverty of speech	25.7	
Mute or almost mute	14.7	
	100.0	
	(N=273)	

Secondary handicaps

Any chronic illness carries with it the liability to secondary handicaps. The distinction between primary and secondary is most obvious in physical disease where they can be most easily separated. Hewit (1949) found in a study of unemployed physically disabled men that there was frequently a pathological attitude of resentment, depression and anxiety. The only agreed occupation was walking the streets and there was a marked deterioration in self respect and in personal habits. Hewitt came to the conclusion that "the attitude of mind of the disabled man is the largest single factor in determining the prospects of future employment" Maladaptive attitudes are, in fact, handicaps. This is also true of the attitudes of important others: doctors, nurses, relatives, employers and

so on. For example, Morgan (1966) found a correlation of 0.71 between the numbers of personal possessions owned by men and women in eleven different mental hospitals, although the nursing hierarchies in these hospitals were administratively quite separate. It was clear that there was a common attitude so far as personal possessions were concerned and it was this which influenced the number of possessions owned by patients on the two sides of the hospital. Brown and Wing (1962), in a comparative study of three mental hospitals, found that nurses varied greatly in their estimate of a patient's ability to carry out useful work. Considering the moderately ill only, they found that all the patients in one hospital were thought by the nurses to be able to work, compared with 86 % in a second hospital and only 52 % in a third. Relatives' attitudes were also important. The longer a patient had stayed in hospital, the less likely was he to be visited, or to receive a letter from home, although as Rawsley (1962) showed, relatives are very often available who *could* keep contact with the patient had they been aware how valuable this might be. Such attitudinal factors are just as important in schizophrenic patients in the community. Parents' attitudes are not always healthy (Brown *et al.*, 1962). The frequency of divorce in married schizophrenic patients is three to four times that in the normal population (Brown *et al.*, 1966). Olshansky (1958) has shown how important are the attitudes of employers towards the employability of discharged patients.

All these examples may have their strongest handicapping effect by altering the patient's own self-attitudes, self-esteem and personal habits. The longer a patient stays in hospital the less he expects visits from relatives, the less he is likely to have "town parole", the less he actually travels outside the hospital, the less he is likely to know elementary facts like the price of a postage stamp or a bus ride to the nearest shopping centre, and the more likely he is to be content with his limited hospital existence (Wing, 1962).

Hewitt's unemployed physically disabled men whose main activity was walking around the streets or reading newspapers in public libraries have

their counterpart among schizophrenic patients, both in hospital and in the community. The proportion of waking time that long-stay patients spent doing absolutely nothing in 1960 was 21 %, 26 % and 43 % in three different mental hospitals (Wing and Brown, 1961). The equivalent figure for schizophrenic patients in the community who were either disturbed in behaviour or unemployed was 30 % of their waking time for patients first admitted five years previously. Thus undesirable secondary handicaps of both these kinds gradually accumulate the longer a patient is ill. Everyone who stays for more than two years in a mental hospital is probably affected to some extent by institutionalism. There is no such simple criterion for those who do not stay as long but who develop secondary handicaps in the community. Perhaps degree of employment five years after first admission for psychiatric illness might offer a suitable criterion.

Third category of handicaps

There is a third group of handicaps which are very important when considering social measures of treatment and rehabilitation but which have no necessary connection with the psychiatric illness. This group includes poverty, lack of education, lack of occupational skills, physical disability, and lack of family support. Most of these factors have been suggested as actual causes of schizophrenia but there is still very little evidence on this point. The high frequency of schizophrenics with unskilled manual occupations, for example, is probably consequent upon a decline in occupational level rather than exposure to stressful conditions (Dunham, 1965). The family problems which are so commonly found are not necessarily causal (Brown, 1966).

It is necessary to consider the patterns of handicaps of all these three kinds when prescribing social therapy. The goal is to reduce them or so to change the social environment that the patient can live a useful and enjoyable life in spite of them without causing undue burden on his relatives or on the community. Edwards (1966) has recently given a very similar analysis of the problems of the Skid-Row alcoholic. Such a patient usually has

personality problems to start with, that is, he has handicaps in the third group. To these are added the symptoms and disabilities of the disease of alcohol addiction. These are further complicated by the "institutionalism" of a community of drinkers which has its own peculiar rules and ways of living, which give rise to secondary handicaps. All three types of disability must be taken into account when planning social therapy.

Social therapy in chronic schizophrenia

In the comparative study of three mental hospitals it was found that measurements of the social environment differed considerably. In one hospital the patients owned their own clothing and toilet articles, they were well equipped even with articles such as mirrors and scissors which might conceivably be dangerous, the attitudes of the nurses were favourable, they spent relatively little time unoccupied, and the morbidity as measured terms of social withdrawal or of clinical symptomatology at interview was relatively low. At another hospital the social environment was much more poverty-stricken and the clinical morbidity was very much higher. At the third hospital environmental conditions and morbidity were intermediate between the other two. The survey was first carried out in 1960 but subsequently changes have been introduced, particularly at the hospital with the poor social environment, and surveys made in 1962 and 1964 showed considerable improvement. In 1964, there was no difference in morbidity between the three groups of patients. However, not all the social improvements were correlated with clinical improvement. The most important change appeared to be an increase in activity of patients. An increase in number of personal possessions, for example, was not necessarily correlated with clinical improvement, whereas an increase in the amount of time spent working or in some other constructive activity, was. Secondary handicaps such as an unsatisfactory attitude to discharge, did not change very much. It seems likely that non-specific changes such as an improvement in

personal appearance may take longer to take effect and may need to be supplemented by active rehabilitation designed to change attitudes. The problems of rehabilitation are rather different in the severely ill and moderately ill groups. In the former group the most important thing is to decrease the severity of symptomatology. In the latter group the most important thing is to change attitudes.

Severely disabled patients

Folkard (1960) and Hooper (1962) have shown that a locked *and* restricted environment encourages aggression and that patients react very rapidly when placed in a ward of this kind. Wing and Freudenberg (1961) also showed that an immediate response to the environment was characteristic of primary handicaps and was quite unlike the gradual change with length of stay which seems to be characteristic of secondary disabilities. They found that the introduction of an active form of supervision by an occupational supervisor increased performance and decreased abnormal behaviour very quickly indeed and a reversion to a passive type of supervision produced a relapse in behaviour just as quickly. It is a sound principle of rehabilitation to passively exercise disused functions hoping that active function will return.

These experiments illustrate that properly educated nurses and supervisors can reduce the severity of symptomatology in schizophrenic patients and the problem therefore becomes one of ensuring that staff know what they have to do and can in fact carry it out. This gives specific content to the otherwise rather vague concept of the therapeutic community.

Moderately disabled patients

If the long-stay schizophrenic patient is not so crippled by his basic disabilities as to be incapable of leading an independent existence either occupationally or domestically, the problems of rehabilitation will mainly be concerned with his attitude to work and his attitude to discharge. It has now become abundantly clear in both controlled and descriptive studies of rehabilitation that the attitude

to work can change favourably. If the patient is placed in an environment in which the desired attitude is already being acquired, and some patients already have it, and if he is then given the opportunity to demonstrate to himself and to others his ability to do simple work, there is a good chance that he will come to adopt a realistic attitude (Wing, Bennett and Denham, 1964). It is important to be careful of a recrudescence of florid symptoms which may occur when a long-stay patient is reactivated, although this risk can be minimised by adequate preparation before the patient is sent for industrial rehabilitation. The schizophrenic patient has to walk the tightrope between the dangers of under-stimulation, particularly seen in mental hospitals, which leads to an increase in negative symptoms such as social withdrawal, blunting of affect and lack of initiative, and the dangers of over-stimulation which are more frequently seen in the patient's family after he leaves hospital, and which tend to lead to a recrudescence of florid symptoms such as delusions and hallucinations.

The hospital environment

The adverse social influence of large custodial institutions have been described in detail by Dunham and Weinberg (1960), Belknap (1956), Cumming and Cumming (1956) and Goffman (1961). In particular, Goffman's sociological acumen and literary skill have dramatised the problem. Good administration and a democratic atmosphere will undoubtedly decrease the harm that has been done where a Goffman-type of "total" institution has developed. But they will not do more. It is important not only to decrease the effects of past harm but positively to decrease symptoms and to improve the outcome after discharge. "Freeing communication channels" will not do this automatically. Group techniques can be applied specifically with the aim of changing attitudes, as has already been demonstrated, and the results can be measured (Wing, 1966). Techniques of changing attitudes are just beginning to be scientifically understood and applied and social psychiatrists cannot afford to be ignorant of them.

Social therapy in early schizophrenia

There has been much less detailed investigation of social treatments in early schizophrenia. Mayer-Gross (1932) found that 35 % of schizophrenic patients admitted to the Heidelberg Clinic in 1913 'were socially recovered 16 years later. Harris *et al* (1956) found an equivalent figure of 50 % after five years and Brown *et al* (1966) found 56 % of schizophrenic patients were well five years after first admission in 1956. There is no doubt that the social prognosis of the disease has improved and that far fewer patients now stay in mental hospitals for long periods of time. The decline in mental hospital bed occupancy which has been so marked a feature of British psychiatry since the war is largely due to the early discharge of patients with schizophrenia. However, the clinical outcome in an area with poor community services is not necessarily very much better than it used to be. Wing *et al* (1964) found that schizophrenic patients who were seen shortly before their discharge from London mental hospitals, in sharp distinction to long-stay patients, undoubtedly wanted to leave. They did not regard themselves as ill although they were aware of the meaning of the term "mental illness". They tended to regard the future as rosy and they thought that their relatives would welcome them home. They were quite confident as to their ability to find work. Two-thirds of them were not actively deluded although almost all had florid symptoms at the time of admission to hospital. The relatives seen at the same time were less enthusiastic but on the whole did not refuse to have the patient home. The one year outcome was not very favourable. In 41 % of cases there was a social crisis usually based on delusions which led to readmission to hospital. There was a rather poor employment record but no industrial rehabilitation facilities were made available. Such social work as was carried out dealt mainly with the crises as they arose. There was very little preventive work. Many of the patients did not take their drugs as advised and in these patients the readmission rate was rather higher. A high degree of emotional involvement with a key

relative seemed to have an unfavourable influence on the course of the illness (Brown *et al*, 1962).

A similar series described by Renton *et al*. (1963) gave rather better results. Only 18 % were readmitted, possibly because patients stayed a little longer in hospital and there were much better aftercare facilities available. Thus the goals of aftercare are to reduce the social crises which seem to be such a feature of the course of schizophrenia and therefore to reduce the distress of relatives and the readmission rate; to increase economic and domestic independence; and to improve personal relationships. These goals are similar to those for long-stay patients except that crises do not occur so frequently in hospital.

Models of community care

Several models for community care are available in England, notably those at Nottingham (Macmillan, 1958), Croydon (Wright, 1963; May, 1965) and Plymouth (Pilkington, 1966). In these areas there is a close co-operation between the hospital and local authority services. Another model is that based on the day hospital and the general practitioner (Carse, 1958) and another is based on the general hospital psychiatric unit operating without a mental hospital (Smith, 1965). None of these has clear theoretical advantages in terms of the present analysis and very little evaluative work has yet been carried out. However, the results of a comparative survey of three community services are now available (Brown *et al*, 1966). In this survey 339 schizophrenic patients who were admitted to three mental hospitals in 1956 were followed up five years later. 111 of them were first admissions. One of the hospitals had pioneered the early discharge policy and none of the schizophrenic patients in the series stayed as long as two years in this hospital, the average stay over the whole five year period including readmissions being only 27 weeks; about half that at the other two hospitals. The amount of community care was much greater for this group — 31 % of the final year being covered by various types of community services compared with only five percent at the other two hospitals. There was a tendency for patients to be

readmitted rather more often in the community with the good community care services. Thus there were striking quantitative differences which provided a background against which to look for differences in clinical or social outcome measured more directly in terms of morbidity. However, it was very difficult to discover any difference in behaviour, in employment history, in the problems experienced by relatives or in the clinical course of the disease, between the three series of patients. A cumulative index of handicap which was used to measure outcome gave an identical figure for the three groups. Over the whole series 11 % of patients were inpatients during the last six months of the five year follow-up period, 17 % were severely disturbed during that time although they were in the community, 16 % were unemployed but not severely disturbed, 7 % were moderately handicapped but were working and 49 % were working and had no psychotic symptoms although many had neurotic symptoms of various kinds. That is to say, in terms of the goals mentioned earlier, crises were not entirely prevented, employment was not increased and social relationships were not improved in the area where the community services were best. This is in striking contrast to the comparative study of long-stay schizophrenic inpatients at the same three hospitals in which differences in the social environment were highly correlated with differences in clinical morbidity. The question therefore arises why the better community services did not prevent morbidity. In part, this appeared to be because the most severely handicapped people were not necessarily in touch with the community services. Quite a substantial proportion of patients with severe behaviour disturbances were allowed to fall out of contact either because they were not co-operative or because the staff were unable to keep in close touch. The relatives did not complain, but this lack of complaint is, of course, no justification. Relatives have no consumer association and they did not complain in the old days when patients stayed for long periods of time in mental hospitals. That lack of complaint would not now be regarded as justification for the old system.

Community social therapy

These facts give rise to some difficult problems. It is clear that simply discharging schizophrenic patients from hospital before they become institutionalised does not ensure that they will remain well, nevertheless it is unthinkable that we should return to the old system. However, the lessons learned about the social treatment, rehabilitation and management of long-stay patients may apply also to community therapy in early schizophrenia. These lessons are as follows:

1. Chronic primary handicaps tend to lead to chronic secondary disabilities, particularly perhaps if there are previously existing disadvantages such as poverty or lack of family support. It is therefore necessary to provide a wide range of helping agencies, which can deal with all types and severities of handicap (Early, 1965).
2. There must be no long waits to transfer from one agency to another, no unbridgeable gaps in the level of functioning demanded, and no discontinuity in staff relationships. Basically, social therapy depends on intimate knowledge of the patient, the course of his illness and the ways in which he reacts to social situations. This knowledge is wasted if it is not passed on when a patient changes agencies.
3. Every agency which deals with chronically handicapped patients develops its own type of "institutionalism" which can only be minimised by careful attention to the social milieu.
4. The family is the major social environment of many schizophrenic patients and as much consideration should be given to its problems as to the better-known problems of the hospital ward.
5. In hospital, the patient can be under fairly close supervision, stresses can be minimised and crises anticipated and prevented. In the community, a patient's condition may slowly deteriorate without the knowledge of any of the psychiatric services unless some system for checking progress is set up, regular case-conferences are held, and a

handicapped patient in the community is given similar regular supervision to that he would get in hospital.

6. Finally, it should be emphasized that some schizophrenic patients do not, at the moment, recover from their illnesses. Their disabilities can be reduced but not prevented altogether. These patients have to remain in permanent contact with treatment agencies. They need sheltered work or living arrangements.

The main problems of organisation are geographical (because the patients are widely scattered) and hierarchical (because the staff belong to different professional and institutional groups). One way to overcome them is to have specialist teams in each area consisting of nurse, social worker, psychiatrist and vocational expert who have had long experience of social therapy, who have good services available to them, who know their patients, and who are accorded high status in their professional worlds. A recognition that this is a highly-skilled and most rewarding field of psychiatry is long overdue.

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