

The chronically disturbed adolescent and the surrogate family model: Observations on two patient populations

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Two preliminary evaluations were conducted by surveying the charts of 15 chronically disturbed adolescents and young adult patients (ages 15 to 30 years) and 23 chronically disturbed adolescents (ages 12 to 18 years) treated in a tertiary surrogate family model hospital. Drug and alcohol use of patients and their parents was assessed in the first patient population. Results indicate that 40% of the patients had at least one parent who formerly used or is still addicted to drugs or alcohol (or both). The second survey examined the Global Assessment Functioning (GAF) scale administered to 23 adolescents on admission and at discharge from the hospital. Scores on the GAF had improved at discharge in 19 of 21 patients whose length of stay ranged from 2 to 12 months.

The information gathered from the retrospective surveys of the medical charts of these two patient populations helps to better understand multigenerational influence as a probable factor in the development of the chronically disturbed adolescent. Also, it shows how small psychiatric hospitals may conduct ongoing outcome studies that could be useful to improve staff morale and produce evidence to case managers and third-party payers that their treatment pro-

grams provide both positive patient care and positive results.

(Key words: Psychiatric hospital, surrogate family model, chronically disturbed adolescent, mental disorders, Global Assessment Functioning scale, drug abuse, alcohol use, dysfunctional family)

The chronically disturbed adolescent can be defined as a young person between the ages of 12 and 19 years who has a variety of symptoms, including social and psychological fragility, transient psychosis, and vulnerability to stress, leading to multiple hospitalizations. Substance abuse, denial of illness, rebelliousness of youth, poor impulse control, and issues of violence often compound problems. These symptoms have also been attributed to the chronically disturbed young adult patient (≥ 20 years).¹⁻⁵

The number of Americans between the ages of 10 and 19 discharged from psychiatric units between 1986 and 1987 increased 43%, even though the population of this age group declined 11%. Among children younger than 18 years, 12%—roughly 8 million—are in need of mental healthcare (*Wall Street Journal*, February 3, 1989; Section A, pp 1, 6). About 31% of these children enter primary care hospital units. Of these patients, 60% are discharged to their communities and continue in outpatient care, family therapy, or day care with supportive medication. The other 40% of these patients remain suicidal, pose a danger to others, or have little self-help skills, and need more care.

The history of having been a victim of sexual abuse is widespread in this population. Many of these disturbed patients, who disdain authority and schooling, run to the streets, most often to continue heavy drug use. Involvement in vio-

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Table 1
Drug and Alcohol Use of Patients and Their Parents —
Inpatients Discharged January 1, 1988 Through May 31, 1989 (N=15)

Case No.	Age, yr	Gender	Patient's drug use history	Father's history			Mother's history		
				Drug use	Alcohol abuse	Marital status*	Drug use	Alcohol abuse	Marital status
1 [†]	15	Male	Multidrug	Yes	...	D	Yes	...	1
2	19	Male	Angel dust	...	...	6	...	...	2
3 [‡]	21	Male	Multidrug	...	...	1	...	...	1
4	16	Male	Multidrug	...	Yes	...	...	...	...
5	20	Female	Not known	...	...	1	...	...	1
6 [§]	19	Male	Not known	...	...	1	...	Yes	1
7	21	Male	Multidrug	Yes	Yes	0	...	...	1
8	21	Male	Not known	...	...	3	...	...	7
9	19	Female	Multidrug	...	Yes	3	...	...	2
10	23	Male	Not known	...	...	1	...	...	1
11	30	Male	Not known	...	...	1	...	...	1
12	26	Male	Multidrug	...	...	1	...	...	1
13	22	Male	Multidrug	...	...	2	...	...	2
14	15	Male	Multidrug	...	...	1	...	...	1
15	17	Male	Multidrug	...	...	1	...	...	1

* Divorced (D) or number of marriages.

[†] Father died of overdose.

[‡] Patient had used drugs since seventh grade.

[§] Mother had bipolar disease.

lent crime is common. More often than not, these young people are faced with little alternative other than the recommended extended hospitalization. Those most fortunate among the chronically disturbed young population are placed in tertiary-care hospitals where they can receive the extended psychiatric care they need.

All mental hospitals are faced with an ever-changing symptom picture. Thus, they grope for a way to diagnose and understand their patient population. Today's mental hospital population does not have deterioration or the residual (negative) symptoms of the chronic, mostly schizophrenic population of the preceding generation. Patients today pride themselves on their perceptual awareness and ability to maintain peer relationships. They seem more "dysfunctional" and less "psychotic," albeit at times, they may be transiently psychotic when the reality testing that they boast of fails.

Chronically disturbed adolescents hate the "mental illness" label, preferring instead to see themselves as part of the street drug/alcohol crowd, or the punk rock (heavy metal) or hip-hop rap culture. They have recognition in "belonging" to such elements of the population, even though such status is considered antisocial or sometimes illegal. These adolescents frequently talk of being tired of "shrinks" and institutions. Moreover, they

refuse or discontinue psychotropic therapy because they dislike the way the medication makes them feel.

Individual uniqueness and stubborn pride mask ego weakness, so chronically disturbed adolescents are more often involved in a sporadic crisis semi-involvement (now you see me, now you don't) with mental health professionals, resisting ongoing affiliation.³ Yet, beneath the symptom picture of today's chronically disturbed adolescents is an unformed personality with a set of values that forces them to remain in a lower stratum of society.

The preliminary chart surveys reported herein were conducted to:

- determine how many of the drug-addicted patients had parents who were addicted to drugs or abused alcohol, and how many parents had multiple marriages; and
- determine what, if any, improvement occurred in chronically disturbed adolescents and young adults during hospitalization.

Treatment program

Short-term-stay hospitals (10 days to 3 months) maximize adaptation and management in the "real world." To accomplish these modest goals, such hospitals tend to rely on medication, and short-term psychotherapy that affirms reality

Table 2
Summaries for Patients Aged 12 to 18 Years Admitted Between June 1990 and February 29, 1992 and Discharged Before March 1, 1992 (N = 23)

Patient No.	Sex	Age at admission, yr	Source of admission*	Length of stay	DSM-III-R/ICD-9-CM diagnosis at discharge†	GAF-A‡	GAF-D
1	M	12	STH	3.5 mo	Bipolar affective disorder, manic	50	55
2	F	13	STH	6.0 mo	Unspecified disturbance of conduct	35	40
3	M	13	STH	5.0 mo	Major depressive disorder, single episode severe without mention of psychotic episode	20	40
4	M	13	STH	8.0 mo	Attention deficit disorder with hyperactivity	20	70
5	M	14	STH	7.0 mo	Major depressive disorder, recurrent episode, severe specified as with psychotic behavior	20	80
6	M	15	STH	2.0 mo	Neurotic depression	40	60
7	M	15	STH	6.0 mo	Unspecified disorder of conduct	40	50
8	M	15	STH	4.0 mo	Neurotic depression	30	40
9	F	15	STH	10.0 mo	Schizophrenic disorder, paranoid type, subchronic	20	50
10	M	15	STH	9.0 mo	Other, mixed, or unspecified drug abuse	30	40
11	M	16	PhysR, PH	5.0 mo	Neurotic depression	15	78
12	M	16	STH	7.0 mo	Socialized conduct disorder	10	60

* STH = short-term hospital; PhysR = physician referral; PH = private home; GH = general hospital; Rehab = rehabilitation center.

† DSM-III-R/ICD-9-CM = *Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Revised)* / *International Classification of Diseases, 9th Revision, 3rd Edition, Clinical Modification*.

‡ GAF-A = Global Assessment of Functioning scores on admission; GAF-D = Global Assessment of Functioning scores at discharge.

testing and support. These hospitals are often affiliated with a general medical hospital, where services are easily interconnected.⁶

Tertiary-care hospitals are most often free-standing institutions designed to effect structural change in the chronically disturbed patient through an open model wherein the hospital milieu manages the entire social system.⁷ Psychotherapy tends to be more expressive. Additionally, these hospitals have a greater tolerance for regression, viewing it as valuable and necessary for the process of growth. Tertiary-care hospitals use Jones⁸ therapeutic community to some degree where the institution's total resources, both staff and patient, are self-consciously pooled in furthering treatment.

The surrogate family model: An alternative tertiary-care hospital

The nonprofit Delaware Valley Mental Health

Foundation was founded in 1962 as an alternative treatment facility for the severely mentally ill.⁹ The inpatient department comprises a series of six cottages around a central courtyard and resembles a small village. A married couple lives around the clock (*loco familias*) in each cottage with seven to eight patients. Two to three family assistants work in the home for an 8-hour shift as helpers to the house parents.

Although the surrogate family model was originally developed primarily for schizophrenics, it has been surprisingly adaptable for the young adolescent with a variety of problems: anti-social and developmental problems, impulse and eating disorders, obsessive compulsive disorders, borderline and schizophrenic psychoses, and victims of sexual abuse. Therapy includes family milieu living, family therapy, education, core life skills programming, and sheltered workshop, various modes of psychotherapy, and medication.

Table 2, continued
Summaries for Patients Aged 12 to 18 Years Admitted Between June 1990 and February 29, 1992 and Discharged Before March 1, 1992 (N = 23)

Patient No.	Sex	Age at admission, yr	Source of admission*	Length of stay	DSM-III-R/ICD-9-CM diagnosis at discharge [†]	GAF-A [‡]	GAF-D
13	M	16	STH	5.0 d	Neurotic depression	41	41
14	M	17	STH	9.0 mo	Unspecified order of conduct	45	65
15	M	17	Rehab	1.0 d	Bipolar affective disorder, depressed	35	35
16	M	17	PhysR, PH	2.0 mo	Depressive disorder, not elsewhere classified	40	45
17	M	17	STH	9.0 mo	Unspecified disturbance of conduct — Delinquency (juvenile)	40	50
18	F	17	STH	5.0 mo	Major depressive disorder, single episode, without mention of psychotic behavior	20	50
19	M	17	STH	4.0 mo	Disturbance of conduct not elsewhere classified	32	32
20	F	17	GH, courts	3.0 mo	Oppositional disorder	50	70
21	F	17	GH	8.0 mo	Major depressive disorder, recurrent episode, severe, without mention of psychotic disorder	20	50
22	M	18	STH	12.0 mo	Intermittent explosive disorder	10	50
23	F	18	STH	6.0 mo	Schizophrenic disorder, paranoid type, subchronic	40	40

*STH = short-term hospital; PhysR = physician referral; PH = private home; GH = general hospital; Rehab = rehabilitation center.

[†]DSM-III-R/ICD-9-CM = *Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Revised)*/*International Classification of Diseases, 9th Revision, 3rd Edition, Clinical Modification*.

[‡]GAF-A = Global Assessment of Functioning scores on admission; GAF-D = Global Assessment of Functioning scores at discharge.

Preliminary chart surveys **Drug/alcohol abuse in patients and their parents**

A graduate study research team from an outside university reviewed charts of all chronically disturbed adolescent and young adult patients discharged during the 16-month period beginning January 1, 1988 through May 31, 1989. From the charts, the team evaluated the patients for their own as well as their parents' history of drug use and alcohol abuse and noted the number of marriages of each parent as well as any special comments (Table 1).

The patients (13 males and 2 females) ranged in age from 15 to 30. Ten (66.7%) of the 15 patients were addicted to drugs; all but 1, used multiple drugs. Seven (23%) of the 30 parents were or are presently addicted to drugs or abused alcohol. Both parents of one 15-year-old boy were or still

are addicted to drugs. Eleven (37%) of the 30 parents have had multiple marriages. One mother had bipolar disease; one father had died of a drug overdose; and one patient had abused drugs since the seventh grade.

Multiple family groups, held once monthly and often including grandparents, parents, and patients, have revealed behavior patterns that have been repeated over three generations. Similar marriage partner choices, divorces, forced marriages after pregnancies, drug and alcohol abuse, and ongoing pathologic family myths were standard. Enough of a pattern of drug and alcohol abuse emerged through two generations of the chronically disturbed adolescent/young adult patient population observed here to warrant further evaluation. Studies directed toward the overuse and abuse of legal prescription drugs for routine treatment of anxiety and stress during

World War II and the postwar period (this patient population's grandparents' generation) might reveal a pattern that has influenced the increased use of street (illegal) drugs in both the parents of the patient population discussed herein and the patients themselves.

Improvement in functioning of chronically disturbed adolescents

The quality assurance medical records department reviewed all charts of all chronically disturbed adolescent patients aged 12 to 18 admitted between June 1, 1990 through February 29, 1992 and discharged before March 1, 1992 (N=23). Data selected for scrutiny were the age at admission, gender, source of admission, length of stay, diagnosis at discharge, Global Assessment Functioning (GAF) score of the admission psychiatric examination, and the discharge summary (Table 2). (The survey also noted home states: New Jersey, 11 patients; New York, 7 patients; Pennsylvania, 3 patients; Delaware, 1 patient; and Massachusetts, 1 patient.)

Twenty-one patients had an improvement (5- to 60-point range) in the GAF score at discharge. Two patients (one, a patient for 1 day) had no change.

The patients' length of stay had greater effect on outcome in terms of GAF improvement than did the diagnosis or the age of the patient. Younger age combined with length of stay was more related to GAF improvement than was the diagnosis.

Discussion

Third-party payers are taking a close look at length of stay at psychiatric hospitals. Some clinicians and hospitals have been outspoken critics of outside intervention in the therapist-patient relationship in the interest of financial prudence at the expense of clinical acumen.¹⁰

Mental hospitals are admitting more and younger adolescents with behavior, impulse, and character disorders. Most of these patients show extreme fluctuation in mood and have a history of illegal drug abuse. Drug dependency in three generations is not unusual. Generational family eruption and inadequate parenting have distorted and confused role modeling, resulting in incomplete emotional development and poor self-identity. Disturbed adolescents are in need of mental health care by the ages of 12 or 13, or earlier, and they are still needing care at ages 15 and 16, by which

time they become labeled "chronically disturbed."

Today, as never before, psychiatric hospitals are increasingly coming under the close scrutiny of managed care companies hired by insurance companies, federal and state agencies, and other accrediting bodies. This surveillance, no doubt, is motivated by a need to improve patient care, but it also has caused a reluctance on the part of third-party payers to reimburse for services that lack measurable evidence of effectiveness.

Well-controlled outcome studies and intense and multiple etiologic reviews—those using randomized assignment, treatment control groups receiving placebo—are not practical for most small hospitals to conduct because they are expensive and time-consuming. Such often-asked questions as, Why did the patient improve—was it the treatment program? or, What part of the program led to improvement? may best be answered by clinical researchers with the time, resources, and professional expertise for such research. This should not stop small psychiatric hospitals from conducting semi-exploratory studies that might help to answer the basic question, Do patients improve during their treatment stay at this facility? Nor should they hesitate to conduct studies that might provide valuable information that might help us understand the background of the patient's illness.

The two surveys reported herein are examples of what is possible. Both were accomplished at relatively low cost and intruded minimally, if at all, into the provision of services or into the patients' lives.

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