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Social Deviance in a Day Hospital

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SUMMARY A search was made of records available for 65 non-psychotic patients referred to a psychiatric day hospital. Assessments were made of whether they had shown various specified types of deviant social conduct, such detailed objective surveys of social conduct being regarded as superior to the use of concepts such as 'psychopathic personality'. The correlational structures of the areas of deviance produced four factors, i.e. deviant family roles, poor social integration, violence, and a more heterogeneous antisocial behaviour factor.

The relationship was examined between areas of deviance and indices of the course and outcome of day hospital admission. The prognostic significance of social deviance was different for men and women; for example, only men showed a correlation between the number of areas of social deviance and the outcome of day hospital admissions. Violence and poor social integration showed no relation to outcome at all. It is suggested that there is no basis for excluding such patients from day hospitals on the assumption that they are less likely to be helped than other non-psychotic patients.

Introduction

Day hospitals vary a great deal in the type of patients they admit. Many tend to exclude patients with antisocial behaviour, i.e. who are violent or are a danger to themselves, or who are addicted to drugs or alcohol (Hogarty *et al*, 1968; Michaux *et al*, 1973), but this is not universal practice. A study at the Fort Logan State Hospital (Kraft, 1964) found no differences between in-patients and day-patients in such variables as being a danger to themselves or others, or having made suicidal attempts or broken the law. However, such patients tend to be difficult to manage in a day hospital. For example, violent and suicidal behaviour is the most common cause of overnight 'boarding' of day patients (Herz *et al*, 1971). It has also been claimed that admitting too many such patients can 'submerge' the more positive attitudes of other patients and occupy too much staff time and attention (Morrice, 1973). Though staff can often tolerate disturbed behaviour when it occurs in the context of a psychotic condition, the value of trying to contain non-psychotic patients with deviant behaviour in a hospital setting is often questioned. There is evidence that the psychiatric services are being used by increasing numbers of patients with rather mild psychiatric problems but considerable social disorganization (Godber, 1971).

The present study is concerned with social deviance presented by non-psychotic patients in a day hospital. Of course, whether there is any value in admitting such patients to day hospitals will ultimately need to be settled by a randomized controlled trial. This study tries to answer a less ambitious question, i.e. whether among non-psychotic day hospital patients the presence of social deviance is associated with the course and outcome of admission.

If there is a tendency for deviant patients to have a poor outcome, it is important to know exactly which kinds of deviance are bad prognostic signs. This in turn depends on having a satisfactory, objective approach to the description and classification of the relevant kinds of

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deviant conduct. There have been very few previous attempts to do this.

For too long the study of deviant conduct in psychiatric patients has been clouded by the concept of the psychopathic personality, which Lewis (1974) has aptly called 'a most elusive category'. Perhaps the most sophisticated empirical approach that has been used in this field so far is that of Robins (1966) in following up into adulthood people who had shown antisocial behaviour as children. She examined nineteen areas of adult social deviance in considering whether or not people should be classified as 'sociopathic personalities'. This was defined as 'a gross repetitive failure to conform to societal norms in many areas of life, in the absence of thought disturbance suggesting psychosis'. Gunn and Robertson (1976) adopted a similar approach in assessing nineteen areas of dysfunction in a group of Grendon prisoners. However, whereas Robins tried to ascertain whether particular types of deviance had occurred at any time in adult life, Gunn and Robertson looked for 'permanent' personality traits, though in retrospect they regarded this as a mistake. Also, whereas Robins had used both records and an interview to collect the data, Gunn and Robertson used only an inteview, though this seems unwise in view of Robins' comments that interviews tended to present a picture of relatively conforming behaviour. In the present work it was decided to follow Robins in regarding deviance as present if it had occurred at any time in adult life. Records were selected as the sole source of information; in most cases medical records going back many years were available on the day hospital patients.

Robins' study set a generally satisfactory standard of objectivity in defining the areas of deviance to be assessed. Of course, what is regarded as 'deviant' depends on the generally prevailing value judgements at the time, but it is important for scientific purposes that whatever standards are used are set out clearly so that the assessment process is objective and reliable. Many of the definitions used by Robins were modified slightly for the present study, but the goals of precision and objectivity were the same. A number of areas of social deviance covered by Robins were omitted from the present survey; these included those that referred to previous stages of development (*school problems*, *reckless youth* and *poor armed services record*).

Several other areas of conduct that had proved rather uncommon in Robins' group of sociopathic personalities were also omitted (*somatic complaints*, *lack of guilt*, *aliases*, *pathological lying*). None of these are the kinds of social deviance that are often used as criteria for excluding patients from day hospitals. *Impulsive behaviour* was omitted because it seemed to cover too heterogenous a group of social problems. The remaining 11 areas (*work history*, *marital history*, *use of drugs*, *alcoholism*, *repeated arrests*, *physical aggression*, *sexual deviance or promiscuity*, *suicide attempts*, *public financial care*, *vagrancy* and *lack of friends*), were retained, though mostly redefined. *Suicide attempts* were subdivided into *self-mutilation* and *self-poisoning*, these being defined in such a way that it was not necessary to decide whether the acts were intended to result in death. A number of new areas were added (*care of children*, *relationship to family of origin*, *gambling*, *eccentric behaviour in public*, *destruction of property*). The resulting 18 areas of social deviance and their definitions are given in the Appendix.

A subsidiary aim of this study was to look at the structure of social deviance, i.e. how various types of social deviance are related to each other. The concept of the sociopathic personality seems to assume that different areas of social deviance will cluster together as a coherent syndrome. However, Gunn and Robertson found that correlations between the areas of deviance they studied in their sample of Grendon prisoners were mostly non-significant, though there was some tendency for variables concerned with interpersonal relationships to be positively correlated. It seemed worthwhile to take the opportunity of examining the structure of social deviance in another sample.

Method

Subjects

The subjects were patients admitted to the Maudsley Day Hospital, excluding those with organic conditions, schizophrenic or affective

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psychosis. Thirty-four male and 31 female admissions were used for the study.

Persons referred to the day hospital are mostly rather chronic psychiatric patients who have responded poorly to conventional methods of treatment. In many cases they are referred in the hope that the day hospital will help them to make a more satisfactory social adjustment. Many of the non-psychotic patients in the day hospital had been given 'personality disorder' as either a primary or secondary diagnosis. They included several patients referred from the Camberwell Reception Centre for homeless men.

Assessment

The two authors each examined the records available on each patient, including notes by doctors, nurses and social workers, and reports from various community agencies. Though the amount of material available was variable, in most cases there were extensive records going back many years. These notes and reports were thought to provide a fairly comprehensive record of social deviance, though it is possible that some types of deviance (e.g. gambling) were less likely to be reported than others.

Each patient's records were screened for any evidence of the 18 areas of social deviance listed in the Appendix. Each area of deviance was rated on a two-point (1 or 0) scale. Where multiple criteria are listed under a single heading (e.g. marital conduct) the patients needed only to show evidence of one (e.g. separation) to order to get a deviant score. Also, it was only necessary for deviance to have occurred at any stage for a deviant score to be given. No attempt was made to assess whether deviance had occurred continuously or repetitively. The main advantage of this approach was to simplify the assessment procedure and to increase its reliability.

Each author made an independent assessment of the patient's records. The assessments were then compared, and differences resolved by discussion. In most cases this was done with little difficulty. The use of two independent assessments provided a check on the reliability of the assessment procedure. It was also felt to result in more accurate assessments than either author working alone would have produced. The percentages of cases on which the two authors agreed in their independent assessments are given in Table I. *Financial dependence* and *dependence on supportive services* were omitted, as it became apparent at an early stage that these could not be assessed at all accurately from the information available. *Employment record* was also omitted. The problem here was how to classify married women who worked as housewives; a distinction seemed to be required between those who would have had remunerative employment if they had been able to sustain it and those who would have been housewives in any case, and this distinction proved impossible to make with any reliability. Very few of the patients examined had had stable remunerative employment, so this variable would in any case have done little to discriminate within the sample. It was felt that the level of agreement for the other areas of deviance represented a satisfactory degree of reliability.

Results

The frequency of each area of social deviance is given, for each sex separately, in Table II. Two areas (*eccentric behaviour* and *gambling*) proved so rare that they were not considered further. Self-poisoning was the most common problem, and had occurred in the history of half the patients. The correlations between the remaining 13 areas of social deviance were

TABLE I

Percentage of cases on which assessments of social deviance agreed

Care of children	94%
Marital conduct	92%
Sexual conduct	86%
Social isolation	92%
Settled life	91%
Relationship to family of origin	85%
Self-mutilation	94%
Self-poisoning	85%
Physical aggression	94%
Destruction of property	94%
Abuse of drugs	91%
Abuse of alcohol	97%
Gambling	100%
Eccentric behaviour in public	95%
Contact with the law	92%

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TABLE II
Number of subjects showing social deviance

	Men (n=34)	Women (n=31)
Care of children	5 (15%)	6 (19%)
Marital conduct	9 (26%)	13 (42%)
Sexual conduct	14 (41%)	9 (29%)
Social isolation	5 (15%)	0
Settled life	9 (26%)	1 (3%)
Relationship to family of origin	12 (35%)	13 (42%)
Self-mutilation	5 (15%)	5 (16%)
Self-poisoning	18 (53%)	14 (45%)
Physical aggression	11 (32%)	5 (16%)
Destruction of property	8 (24%)	4 (13%)
Abuse of drugs	12 (35%)	8 (26%)
Abuse of alcohol	7 (21%)	6 (19%)
Gambling	1 (3%)	0
Eccentric behaviour in public	0	2 (6%)
Contact with the law	18 (53%)	8 (26%)
Average number of areas of social deviance (of those listed in this table)	3.9	2.7

TABLE III
Factor loadings

	Factor 1	Factor 2	Factor 3	Factor 4
Care of children	.83	−.06	.14	−.09
Marital conduct	.80	−.14	.15	.10
Sexual conduct	.71	.26	.09	−.03
Social isolation	−.16	.82	−.04	.06
Settled life	.08	.85	.07	.09
Relationship to family of origin	.23	.46	−.02	.39
Physical aggression	.00	.08	.11	.76
Destruction of property	−.03	.02	.03	.83
Self-mutilation	−.10	−.16	.66	.15
Self-poisoning	.14	−.06	.55	−.06
Abuse of drugs	.09	.04	.66	.07
Abuse of alcohol	.15	.19	.54	−.43
Contact with the law	.22	.21	.58	.10

subjected to factor analysis. Data for men and women were combined for this purpose, as there were too few in each group to permit of separate factor analyses. However, inspection of the data suggested that the correlational structure in men and women was similar. A visual examination of the clustering of correlations in the combined data suggested that there were four factors, and this was confirmed by an examination of the latent roots of the factors, using Cattell's 'scree' test (Cattell, 1966). These four factors together accounted for 56 per cent of the variance, whereas the first factor alone accounted for only 21 per cent of the variance. The first four factors were rotated by the varimax method. The factor loadings are given in Table III.

Most items have a substantial loading on one factor, and relatively trivial loadings on the remaining factors. The first two factors could be described as being concerned respectively with family roles and social integration, and the fourth with violence. The third is a more heterogeneous, antisocial behaviour factor.

The relationship of social deviance to outcome

Four measures of the course and outcome of day hospital admissions were used. (1) The length of stay. (2) Whether discharge was agreed between the staff and the patient or was taken by unilateral action of either party. (3) Satisfactory occupational status following discharge (i.e. discharged either to the vocational resettlement unit or to open employment). (4) Whether the raters considered it likely that the patient had been helped by his or her admission to the day hospital. The criterion here was very lenient. The distinction was between those cases where there was some reason to think that the admission had been helpful and those where the raters felt confident that it had not been. There was thus no attempt to assess whether or not constructive changes made during the period of day hospital admission should be attributed to the effects of the day hospital. The first three criteria were simple and objective. On the fourth criterion, the raters reached 85 per cent agreement, which was regarded as acceptable. Disagreements were usually resolved without difficulty. The outcome measures were all positively intercorrelated, except for length of stay which had no significant correlations with the other criteria. The average length of stay and the number of patients meeting the remaining criteria are given in Table IV. It will be seen that 62 per cent of the patients had mutually agreed discharges, 40 per cent had a change of occupational status, and 49 per cent were

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TABLE IV
Course and outcome of admissions

	Men (n=34)	Women (n=31)
1. Average length of stay (in weeks)	17	20
2. Number of patients whose discharge was mutually agreed	20 (58%)	20 (65%)
3. Number of patients with a change of occupational status	18 (53%)	8 (26%)
4. Number of patients regarded as helped by admission	20 (50%)	12 (39%)

rated as 'helped'. Next, correlations were computed between social deviance and the measures of the course and outcome of admission. These are given in Table V. The correlations involving *marital conduct* and *care of children* were based only on those who were married and had children respectively. Correlations were also computed between the total number of areas of deviance and the four outcome criteria.

The relationships proved rather different in men and women. In women, the areas included in the family roles factor were the most important prognostically. Deviant *care of children* and *marital conduct* were associated with long admissions. Deviant *sexual conduct* was associated with disagreement over discharge. Also, each of these areas of deviance tended to be associated with a poor outcome, though only *care of children* and *sexual conduct* were significantly related to not being helped. The correlations with occupational status were in the same direction, but were not significant. Rather surprisingly, social deviance in three particular areas seemed to be associated with a good outcome. Violence (both *physical aggression* and *destruction of property*) and a poor *relationship with the family of origin* were positively associated with changes of occupational status. *Self-mutilation* was positively associated with ratings of being helped. There was no significant relationship between the total number of areas of deviance and any of the four outcome measures.

In men, none of the areas covered by the family roles factor showed significant correla-

TABLE V
Correlations between areas of social deviance and outcome measures

	Length of stay		Agreed discharge		Change in occupational status		Rated as helped	
	Men	Women	Men	Women	Men	Women	Men	Women
Care of children	.33	.38*	.04	−.19	−.26	−.31	−.26	−.44*
Marital conduct	.15	.34*	.17	−.32	−.07	−.21	−.07	−.28
Sexual conduct	−.05	.15	.12	−.42*	−.14	−.21	.00	−.36*
Social isolation	.05		−.14		−.09		−.14	
Settled life	−.20	.14	−.15	−.25	−.08	−.11	−.15	−.15
Relationship to family of origin	.23	.38*	−.35	−.19	−.26	.40*	−.23	.13
Self-mutilation	−.08	.19	.02	.14	−.42*	.14	−.31*	.37*
Self-poisoning	−.23	−.13	.08	−.14	−.14	−.09	−.15	−.19
Physical aggression	.20	−.01	−.16	−.04	−.08	.34*	−.04	.19
Destruction of property	.53*	−.24	−.22	−.12	−.15	.43*	−.08	.09
Abuse of drugs	−.13	−.06	.14	−.02	−.14	.16	−.10	−.16
Abuse of alcohol	−.30*	−.10	−.14	.02	−.09	−.10	−.14	−.05
Contact with the law	.03	−.16	−.15	−.18	−.26	−.18	−.38*	−.17
Total no. of areas of deviance (of those listed in this table)	−.07	.10	−.22	−.29	−.43*	.04	−.43*	−.20

* $P < 0.05$.

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tions with any of the criterion measures, though there was a non-significant tendency for deviance in *care of children* to be correlated with a poor outcome. Poor outcome in men was associated with two of the areas covered by the third factor (*self-mutilation* and *contact with the law*). Most other areas of deviance showed no significant correlations with the criterion measures, though *abuse of alcohol* was associated with short admissions, *destruction of property* with long ones, and poor *relationships to the family of origin* with disagreement over discharge. There was also a strong correlation between the total number of areas of deviance and outcome (satisfactory occupational status and being rated as helped).

Discussion

The fact that only 21 per cent of the variance found in social deviance can be accounted for by a single factor indicates that a general personality trait of 'sociopathy' is of limited value in understanding the social deviance recorded in this sample. On the other hand, a four-factor structure succeeded in accounting for a majority of the variance, and offers an intuitively plausible classification of social deviance. Two of the factors reflected problems in establishing social roles (factors 1 and 2 covering social interaction and family roles respectively). Most of those who were socially isolated or who led an unsettled life had no family roles, deviant or otherwise. It is thus not surprising that these factors should be relatively independent of each other. Both of these social role factors were in turn independent of the other two dealing with antisocial behaviour. The least expected finding here was that violence (whether to people or property) was independent of the other areas of antisocial behaviour covered by factor 3 (abuse of drugs and alcohol, self-poisoning and self-mutilation and contact with the law). This last factor might be regarded as more 'intrapunitive' than violence.

Gunn and Robertson's data showed some weak evidence for a cluster of variables similar to the present family roles factor (factor 1). However, it is surprising that they did not find positive correlations between alcohol problems, drug abuse and self-destructiveness similar to to those reported here. Whether the discrepancy is due to the different population studied, or to the different method of assessment is not clear. They had no variables in the field of social isolation (except a single item assessing personal relationships) and no variables covering violence, so it is not known whether they might have found groups of variables comparable to factors 2 and 4 in the present study.

The implications of deviant conduct for the outcome of day hospital admission were quite different in men and women. The only areas of deviance to have negative prognostic implications for women were two of the family role variables. This echoes Robins' (1966, p. 132) comment that the problems of sociopathic women were relatively heavily concentrated in sexual and family relationships. Ideas about social deviance seem to be largely based on the behaviour of men. So far, female deviance has attracted relatively little attention. The same is true of female criminal behaviour (Gibbens, 1971). The findings for men fit more closely with prevailing assumptions. Men with widespread social deviance were more difficult to help. However, the correlation between number of areas of deviance and outcome fell far short of unity, and there were cases with up to six areas of social deviance (out of thirteen) who had a good outcome. A policy of excluding male patients with social deviance would therefore risk excluding people who might be helped by day hospital admission.

It is intriguing that a *positive* correlation between a record of violence and a satisfactory occupational status on discharge was found only for women and not for men. This could be partly due to a difference in referral processes for men and for women. A greater readiness to regard violence as deviant in women than in men (Broverman *et al.*, 1970) could result in women with a record of violence being referred to psychiatric care despite the fact that their general capacity for adjustment was otherwise relatively good. Alternatively, the findings might be related to general social pressures on women to show a low level of assertiveness. Women who resisted these pressures might both be more likely to be violent and also be more likely to

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seek paid work rather than housework. However, it would be prudent to see if the finding can be replicated before speculating any further on its significance.

The negative findings of the study are of particular importance. Variables comprising the social integration and violence factors were not significant indicators of a poor outcome in either men or women. If such patients are to be excluded from day hospitals it should therefore only be because they are difficult to manage, not because they are particularly unlikely to benefit. Neither is there any indication in the data on length of stay that such patients could only be tolerated for a short period in the Maudsley Day Hospital. Indeed, men with a record of destruction of property were kept longer than most.

It is felt that the objective method used here to assess the extent of social deviance makes a valuable contribution to the formulation of the clinical problems of the patients concerned. The weaknesses of concepts such as 'psychopathic personality' are well known (Gunn and Robertson, 1976) and often seem to express the clinicians' feelings about the patient rather than summarize any objective facts. Objective checklists of social deviance such as the ones used by Robins and in the present study are more acceptable scientifically and of greater clinical value. They deserve wider use as a routine part of psychiatric assessments.

APPENDIX

Areas of Social Deviance

1. *Care of children*

   Any children (under 16) away from home (with other members of family), in legal custody or in care of local authority.

2. *Marital conduct*

   Divorce, separation, multiple marriage or cohabitation.

3. *Sexual contact*

   Prostitution, illegitimate children, admitted sexual 'deviance'.

4. *Social isolation*

   Lack of any regular, stable social contacts (e.g. less than at least one contact a week) other than social contacts in working hours.

5. *Settled life*

   Sleeping rough or regular moves after 2 months or less in one place.

6. *Employment*

   Unemployment for 2 months or more, dismissal from work or frequent job changing after employment for 2 months or less.

7. *Relationship to family of origin*

   Rejection of family, total lack of contact for periods of 3 months or more, persisting disagreements.

8. *Financial dependence*

   Dependence on social security (over and above entitlements).

9. *Dependence on supportive services*

   Regular contacts at a frequency of more than once a month with social or voluntary services or GP.

10. *Self-mutilation*

    Cutting, pricking, hair pulling, pursuit of surgical operations etc.

11. *Self-poisoning*

    Verifiable acts of self poisoning.

12. *Physical aggression*

    Verifiable fights, wife or child beating etc.

13. *Destruction of property*

    Damage to property by fire or breakage.

14. *Abuse of drugs*

    Dependence on established drugs of addiction (either those that are legally recognized as such or where there is a definite medical opinion of addiction), or use of drugs for non-medical purposes.

15. *Abuse of alcohol*

    Arrests for drunken behaviour, complaints about drinking from work or family, or record of treatment for alcoholism.

16. *Gambling*

    Gambling resulting in debts being incurred.

17. *Eccentric behaviour*

    Displays of eccentric public behaviour.

18. *Contact with the law*

    Either charged in court twice or more or convicted at least once.

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