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Resistances to Community Psychiatry

The resistance phenomenon in individual patients—probably the most intractable of all symptoms—has long been studied and techniques have been developed to deal with it.

The author takes up the equally severe problems of resistance to change in "healthy" people and groups. Here, too, techniques must be developed, since our present state of knowledge makes it unthinkable to turn back to the traditional model of large mental hospital.

Resistance in Strange Places

Well meaning as they may have been, our best previous efforts in the treatment of the mentally ill, primarily in the form of custodial care in large mental hospitals, were undoubtedly frequently counterproductive—resulting in the creation of chronicity, deterioration, dehumanization, over-crowding, and a progressive loss of morale and a feeling of helplessness on the part of staff members. The background of this situation was discussed in a previous report. It should be noted that some traditional state hospitals, as well as private psychiatric hospitals, still seem to assume tacitly that a label of "psychosis" automatically calls for inpatient care, and that such care implies locked doors and the use of mechanical restraint "when necessary."

It would be natural to expect that with the advent of a more dynamic therapeutic approach characterized by a more thorough blending of inpatient and community psychiatry (as in the creation of mental health centers, catchment area programs, team approaches to therapy, etc.), there should be an enthusiastic response on the part of all who are interested in the welfare of the patient. Unfortunately, this has not been the case. Instead, various resistances have developed from unexpected sources whenever an expansion of programming was contemplated or instituted. We have long known and studied the phenomenon of "resistance" in individual psychotherapy. We have generally recognized resistance as an unconscious need to resist therapy on

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the part of patients who consciously express a genuine desire for help. We have worked with this phenomenon in individual therapy and frequently have been able to influence it through analytic interpretation and the development of insight on the part of the patient. That we would run into similar, profound, unconscious resistance emanating from sources other than the patient was somewhat unexpected. Yet, with all of our best intentions, we frequently have to struggle against such resistances which threaten our therapeutic efforts.

**Sources of Resistance**

Although additional sources probably exist, the most common types of interference with treatment are the following:

1. Resistance from patients.
2. Resistance from staff members.
3. Resistance stemming from relatives.
4. Resistance originating in the community, including at times the employment of political influence.

**Patient Resistance**

Superficially it would appear that patients would be enthusiastic about being changed from a static, locked and custodial environment to one with a dynamic approach and open doors—a nonpunitive therapeutic community in which they are treated with dignity and offered the possibility of an early return to the community. Paradoxically, in many patients this is not the reaction. Dr. Glass, Acting Director of the Illinois Department of Mental Health, recognized this type of resistance and explains it by the fact that the patient “has become fearful, after prolonged hospitalization, to assume his place in the community.”

Another factor in patient resistance is the masochistic need of some patients. This, of course, we have experienced many times in the past in the traditional mental hospital when patients begged to be put in restraint, to be given shock treatments, to be put in isolation, and to be “protected” from their own impulses. When Hoch Psychiatric Hospital first opened, we assumed responsibility for many long-term patients, some of whom frequently pleaded with us to be returned to their old way of life. Some patients felt threatened by the proximity of the opposite sex and, at first, were under considerable anxiety when the program called for the closeness engendered by the group sessions, dancing, parties, and so forth. Some patients were frightened by the removal of window guards, claiming that they felt protected by the bars on the windows. Some were also threatened by the completely open door environment, using as a rationalization the fear that some undesirable people would come into the building. However, as time passed and with the arrival of new patients who had not previously been involved in a custodial type of environment, these anxieties became less prominent.

Some patients were also threatened by the fact that their efforts at isolation were being interfered with. No