

System-Induced Behavioral Decay: A Theoretical Introduction

A White Paper of The Intake Initiative

"What we call non-compliance is often the residue of a system that taught people not to try."

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Abstract

Structured Abstract — System-Induced Behavioral Decay (SIBD)

Background and Problem. Institutional systems established to protect, rehabilitate, and stabilize society's most vulnerable populations — including criminal justice, child welfare, psychiatric hospitalization, and homelessness services — frequently operate in ways that measurably erode the behavioral functioning, coping capacity, and identity coherence of the individuals they are designed to serve. This deterioration is not incidental; it is structural. Yet it is persistently misread by practitioners and policymakers as evidence of pre-existing individual pathology or deliberate non-compliance. The result is a cycle of re-engagement, re-trauma, and progressive functional decline that costs both lives and resources while remaining largely unexamined as a system-generated phenomenon.

The Construct. This white paper introduces **System-Induced Behavioral Decay (SIBD)** — a new theoretical construct defined as the progressive deterioration of an individual's adaptive behaviors, coping capacities, and identity coherence as a direct consequence of prolonged or repeated exposure to dehumanizing, bureaucratically fragmented, or coercively structured institutional systems. SIBD is explicitly distinguished from individual psychopathology, institutionalization effects, learned helplessness, and complex trauma, though it is informed by and builds upon each of these foundational constructs. SIBD locates the primary causal mechanism not within the

individual but within the system, repositioning behavioral deterioration as a rational adaptive response to irrational institutional conditions.

Theoretical Structure. The SIBD framework comprises five domains of behavioral decay — Agentic Collapse, Relational Fracture, Narrative Dissolution, Compliance Mimicry, and Temporal Disorientation — and a three-variable conceptual Decay Gradient measuring severity against duration of system involvement, intensity of coercive contact, and degree of identity invalidation.

The Cinematic Visual Model. A supplementary narrative-stage visual framework — the Cinematic Visual Model of SIBD — is introduced as a non-clinical, community-accessible mode of mapping behavioral decay across five phases of system contact, borrowing structural conventions from screenwriting and film theory to externalize causation and honor storytelling as a tool of sensemaking and advocacy.

Methodology. A three-phase mixed-methods research framework is proposed to validate and operationalize SIBD, culminating in a 36-month longitudinal cohort study using the newly proposed SIBD Behavioral Decay Index (BDI-S).

Implications. Findings have immediate implications for intake reform, practitioner training, cross-system policy architecture, and survivor-centered advocacy. The Intake Initiative invites researchers, clinicians, policymakers, and community advocates to adopt, test, and refine this framework in service of systems that restore — rather than consume — human agency.

Keywords: System-Induced Behavioral Decay, SIBD, institutionalization, intake reform, complex trauma, learned helplessness, coercive systems, agentic collapse, narrative dissolution, participatory research, criminal justice reform, child welfare, behavioral health policy.

1. Background and Problem Statement

1.1 The Paradox of the Helping System

Among the most consequential unresolved tensions in contemporary social policy is what might be called the **helping system paradox**: the institutions society constructs to stabilize, rehabilitate, and protect its most vulnerable members routinely generate the very conditions that produce further harm. Criminal justice systems incarcerate and surveil in the name of public safety while producing documented increases in recidivism, trauma, and social disconnection (Alexander, 2010). Child welfare systems remove children from unsafe environments in the name of protection while simultaneously fracturing kinship networks, destabilizing identity formation, and channeling youth directly into later criminal justice involvement (Roberts, 2022). Psychiatric intake systems hospitalize individuals in crisis while exposing them to coercive procedures — involuntary holds, forced medication, strip searches, and diagnostic labeling — that compound the very dysregulation that prompted hospitalization. Homelessness service systems require people experiencing housing instability to perform elaborate bureaucratic compliance rituals — often while in acute survival mode — that exhaust adaptive resources and deepen learned patterns of helplessness.

This paradox is not the product of malicious intent. Most individual practitioners within these systems are motivated by genuine care. The harm is systemic and structural: it emerges from the accumulated logic of bureaucratic fragmentation, resource scarcity, compliance culture, and institutional self-preservation. The effect, however, is measurable and devastating. Individuals who enter these systems often exit them with demonstrably reduced behavioral functioning — less capable of initiating goal-directed action, less able to sustain trust-based relationships, less coherent in their sense of personal identity and future possibility. We have, as a field, lacked a precise name for this phenomenon. This white paper provides one.

1.2 Related Constructs and the Distinctiveness of SIBD

SIBD is not conceived in a theoretical vacuum. It is informed by and stands in dialogue with several foundational constructs, from each of which it is meaningfully distinct.

Institutionalization, as described by Erving Goffman in his landmark 1961 study *Asylums*, refers to the process by which individuals confined within "total institutions" — environments that regulate every dimension of daily life — progressively conform to the behavioral and psychological demands of the institution, losing autonomous selfhood in the process (Goffman, 1961). Goffman's contribution was radical in naming the institution itself as a shaping force. SIBD extends this insight beyond the walls of total institutions to encompass the diffuse, episodic, and multi-system contact that characterizes modern

social service involvement — contexts that are not total in Goffman's sense but that nonetheless produce analogous decay through cumulative exposure.

Learned helplessness, introduced by Martin Seligman following his experiments on inescapable aversive stimuli, describes the condition in which repeated exposure to uncontrollable negative outcomes produces a generalized deficit in motivation, cognition, and affect, such that individuals fail to act even when action becomes possible (Seligman, 1972; Maier & Seligman, 1976). SIBD is informed by this mechanism but differs in two critical ways: it is specifically located within institutional rather than experimental contexts, and it encompasses dimensions — relational, narrative, and temporal — that lie outside the scope of learned helplessness as originally formulated.

Complex trauma (also termed Developmental Trauma Disorder or Complex PTSD) describes the psychological sequelae of prolonged, repeated exposure to interpersonal trauma, particularly when such exposure occurs in the context of captivity or coercion (Herman, 1992; van der Kolk, 2014; Cook et al., 2005). Complex trauma is a clinically powerful construct, but it remains oriented primarily toward the individual's internal psychological experience and its developmental origins. SIBD, by contrast, is explicitly etiological — it names the system as the proximate cause of behavioral deterioration and insists that this causal attribution carries clinical and political consequences. SIBD symptoms may co-occur with complex trauma sequelae, but their primary driver is the ongoing system environment rather than a prior traumatic history.

System involvement trauma is an emerging practice-level concept that recognizes the inherently traumatizing character of engagement with coercive systems. SIBD builds on this concept by providing it with a specific theoretical architecture — defining the mechanisms, domains, and gradient of behavioral deterioration — and proposing a validated measurement framework.

1.3 The Intake Moment as Critical Inflection Point

Of all the phases of system contact, the initial intake encounter is, in the SIBD framework, the most determinative. It is at the point of first contact that the individual's existing self-narrative, adaptive strategies, and sense of agency first encounter the institutional logic of categorization, risk assessment, and eligibility determination. Intake processes in most publicly funded systems are structured around the institutional need for data — demographic forms, diagnostic screening tools, criminal history verification,

benefit eligibility criteria — rather than around the psychological needs of the person presenting. The individual is immediately repositioned from a person with a story to a case with a status.

This repositioning is not benign. Research on self-determination theory demonstrates that the experience of autonomy, competence, and relatedness are foundational to sustained behavioral engagement and psychological well-being (Deci & Ryan, 2000). Standard intake procedures systematically undermine all three: they remove autonomy through coercive gatekeeping, undermine competence through deficit-focused assessments, and erode relatedness through transactional, procedurally standardized interactions. The intake moment is thus not merely an administrative event — it is an inflection point at which the trajectory toward behavioral decay is often first established.

1.4 The Invisibility Problem and The Intake Initiative's Founding Mission

Perhaps the most pernicious dimension of SIBD is its invisibility. Because the construct has not been named or operationalized, practitioners who observe SIBD symptoms — disengagement, apparent passivity, failure to follow through on service plans, flat or guarded affect, absence of future planning — reliably attribute them to pre-existing disorder, personality characteristics, or willful non-compliance. This misattribution has direct consequences: it triggers punitive rather than supportive responses, escalates coercive intervention, and amplifies the very decay it purports to address. The individual is held responsible for the behavioral effects of the system they are embedded in, and the system is absolved of accountability for what it produces.

The Intake Initiative was founded on precisely this recognition. Our mission is to name, document, and disrupt the processes by which institutional systems produce behavioral harm — beginning at the intake encounter and extending across the full arc of system involvement. This white paper represents the first formal articulation of our theoretical framework and research agenda. We offer it not as a closed system of knowledge but as an open invitation to researchers, practitioners, policymakers, and advocates to join in the work of making visible what has for too long remained unseen.

2. Theoretical Framework: System-Induced Behavioral Decay

2.1 Definition and Core Premise

Formal Definition — System-Induced Behavioral Decay (SIBD)

System-Induced Behavioral Decay (SIBD) is defined as the progressive deterioration of an individual's adaptive behaviors, coping capacities, and identity coherence that occurs as a direct and measurable consequence of prolonged or repeated exposure to institutional systems characterized by dehumanizing documentation requirements, bureaucratic fragmentation, coercive gatekeeping, deficit-oriented assessment, surveillance-heavy relationships, and episodic rather than continuous engagement. SIBD is distinguished from individual psychopathology by its proximate causal attribution: the system, not the person, is the primary agent of deterioration.

The distinction between SIBD and individual psychopathology is not merely semantic — it is clinical, ethical, and political. Individual psychopathology locates the source of dysfunction within the person: in their neurobiological architecture, developmental history, cognitive distortions, or behavioral repertoire. Treatment, accordingly, targets the individual. SIBD locates the source of dysfunction within the institutional environment: in its structural organization, relational quality, procedural logic, and power arrangements. Intervention, accordingly, must target the institution.

This does not mean that SIBD occurs in the absence of pre-existing vulnerabilities. Individuals who enter institutional systems frequently carry histories of adversity, mental health challenges, substance use, trauma exposure, and economic precarity. SIBD is not a denial of this complexity. Rather, it is a precise theoretical claim: that over and above whatever an individual brings to the system, the system itself generates additional, measurable, and preventable behavioral deterioration. The presence of pre-existing vulnerability may amplify SIBD, but it does not cause it. The system does.

The core theoretical premise of SIBD can be stated directly: **behavioral decay is a rational adaptive response to an irrational system**. When an individual's self-efficacy is repeatedly overridden by institutional decision-making, withdrawal from initiative is not pathological passivity — it is logical. When every relationship within a service system is structured by surveillance, reporting obligations, and power asymmetry, the attenuation of trust and emotional investment is not disordered attachment — it is appropriate risk management. When an individual's history, values, and personal narrative are reduced

to a risk score and a diagnostic code, the fragmentation of self-story is not dissociation — it is the predictable consequence of having one's personhood systematically invalidated. The behavior that practitioners label dysfunction is often, in fact, a coherent response to a dysfunctional environment.

2.2 The Five Domains of Behavioral Decay

SIBD manifests across five distinct but interrelated domains. Each domain represents a specific dimension of behavioral and psychological functioning that is progressively eroded through system contact. Together, they constitute a comprehensive map of the human cost of dehumanizing institutional exposure.

Domain 1 — Agentic Collapse

Agentic Collapse refers to the erosion of self-efficacy, initiative, and goal-directed behavior that results from repeated encounters with institutional systems that systematically override individual decision-making. Individuals experiencing agentic collapse are not apathetic by disposition — they have learned, through accumulated evidence, that their decisions do not matter. Service plans are designed without their meaningful input. Housing placements are assigned rather than chosen. Treatment modalities are prescribed rather than negotiated. The cumulative message delivered is that the individual's preferences, judgments, and aspirations are irrelevant to the system's operation. The behavioral outcome — cessation of self-initiated action — is precisely what self-determination theory would predict in the prolonged absence of experienced autonomy (Deci & Ryan, 2000). Agentic Collapse is the most widely observed dimension of SIBD and the most frequently misdiagnosed as depression, personality disorder, or treatment resistance.

Domain 2 — Relational Fracture

Relational Fracture describes the progressive breakdown of trust and the capacity for meaningful interpersonal connection produced by sustained engagement with surveillance-heavy, transactional, or punitive institutional relationships. In most social service systems, the worker-client relationship is structurally adversarial: the worker holds gate-keeping power over resources, is mandated to

report information that may result in punitive consequences, and is embedded in an organizational culture that defines the client primarily through the lens of risk and deficiency. The relational injuries produced by these dynamics are not confined to the system relationship itself — they generalize outward, impairing the individual's capacity to form and sustain trust in non-institutional relationships as well. Relational Fracture is closely related to the attachment disruptions described in the complex trauma literature (Herman, 1992; van der Kolk, 2014) but is distinguished by its specific institutional etiology.

Domain 3 — Narrative Dissolution

Narrative Dissolution refers to the fragmentation of an individual's sense of coherent personal story and continuous identity that occurs when systems reduce personhood to case numbers, risk scores, diagnostic categories, and eligibility statuses. Human beings organize experience and sustain psychological integrity through narrative — the capacity to understand the self as a subject with a past, a present, and a meaningful future (Bruner, 1990; White & Epston, 1990). Institutional systems are structurally hostile to narrative: they require episodic, standardized, deficit-focused self-disclosure; they rarely create conditions for a person to articulate their own account of their situation; and they frequently require individuals to repeat their most painful experiences — abuse histories, criminal records, mental health crises — to multiple workers across multiple systems, severing the narrative from its relational context and reducing it to administrative data. The result is not merely an absence of self-story but an active dismantling of the conditions that make self-story possible.

Domain 4 — Compliance Mimicry

Compliance Mimicry is the development of surface-level behavioral conformity that masks deeper disengagement. Individuals experiencing compliance mimicry have learned — through often painful trial and error — that the performance of system-prescribed behaviors (attending appointments,

signing forms, completing program requirements) is required for access to resources, but that genuine participation, honest disclosure, and personal investment carry significant risks (increased scrutiny, re-traumatization, disappointment) without commensurate benefit. The result is a behavioral stance that mimics engagement while maintaining psychological distance. From the outside, compliance mimicry may look like progress; from the inside, it represents a profound and adaptive withdrawal of self from institutional processes that have proven unsafe or meaningless. Compliance mimicry is one of the reasons that system engagement metrics — program completion rates, attendance records — are such poor proxies for actual well-being outcomes.

Domain 5 — Temporal Disorientation

Temporal Disorientation refers to the loss of future orientation and planning capacity that results from sustained engagement with systems that operate in crisis-only, episodic modes without continuity of care, relationship, or long-term planning. When an individual's institutional life is organized entirely around acute crises — emergency housing placements that last 30 days, psychiatric holds measured in hours, probation check-ins disconnected from any rehabilitative framework — the future ceases to function as a meaningful organizing horizon. Planning for the future requires the experience of a present that is predictable enough to project beyond; institutional episodicity systematically undermines that experience. Temporal disorientation is closely related to the "forestalled future" described in complex trauma literature but is distinguished, again, by its specific causal relationship to institutional structure rather than trauma history alone.

2.3 The SIBD Decay Gradient

Not all system involvement produces equivalent levels of SIBD. The construct's explanatory power is enhanced by a conceptual model — the **SIBD Decay Gradient** — that maps decay severity as a function of three intersecting variables:

- **Variable A: Duration of System Involvement** — The length of time over which an individual has been in contact with one or more institutional systems, including cumulative lifetime exposure across multiple system contacts.
- **Variable B: Intensity of Coercive Contact** — The degree to which system engagement is characterized by compulsion, surveillance, power asymmetry, and punitive contingencies, ranging from voluntary service engagement to involuntary confinement.
- **Variable C: Degree of Identity Invalidation** — The extent to which system processes systematically undermine the individual's sense of personhood, cultural identity, narrative coherence, and self-defined goals — including processes of diagnostic labeling, risk categorization, and dehumanizing documentation.

The following table presents the Decay Gradient as a descriptive typology, mapping combinations of these three variables to predicted SIBD severity levels:

Decay Level	Duration (A)	Coercive Intensity (B)	Identity Invalidation (C)	Predicted SIBD Expression
Level 1 — Incipient	Brief (< 6 months)	Low (voluntary, relational)	Minimal (person-centered intake)	Mild agentic hesitation; mild narrative disruption; recovers rapidly with relational support
Level 2 — Developing	Moderate (6–24 months)	Moderate (mandatory participation, periodic surveillance)	Moderate (categorical assessment, some deficit framing)	Emerging agentic collapse; compliance mimicry developing; beginning relational withdrawal
Level 3 — Established	Extended (2–5 years)	High (coercive, punitive contingencies, multi-system)	Significant (case-number identity, repeated trauma disclosure)	Clear agentic collapse; relational fracture; temporal disorientation; narrative dissolution; compliance mimicry entrenched
Level 4 — Severe	Chronic (> 5 years, lifetime system involvement)	Very high (incarceration, involuntary hospitalization, child removal)	Severe (identity fully colonized by institutional categories; racial dehumanization)	All five domains severely expressed; functional collapse across life domains; recovery requires intensive, long-term relational and narrative intervention

Note on Gradient Interaction Effects

The three Decay Gradient variables are not additive but multiplicative in their effects. A brief period of extremely high coercive intensity (e.g., a short but highly traumatizing psychiatric hold) may produce Decay Gradient outcomes equivalent to a much longer period of moderate coercive contact. Similarly, high identity invalidation amplifies the decay effects of even low-duration system contact. The gradient should be understood as a dynamic, non-linear model rather than a simple scoring instrument.

2.4 Protective and Amplifying Factors

SIBD is not inevitable. The Decay Gradient identifies the conditions under which decay is most likely; equally important is understanding the factors that either protect against SIBD onset or amplify its severity.

Protective Factors

- **Relational continuity with a trusted worker:** Longitudinal engagement with a single, consistent practitioner who demonstrates genuine regard, cultural responsiveness, and power-sharing represents the single most powerful protective factor against SIBD identified in related literature. Continuity disrupts the transactional relational norm and provides a relational context within which narrative restoration becomes possible.
- **Culturally affirming environments:** Systems and service settings that actively affirm, rather than pathologize, cultural identity, language, community connection, and indigenous knowledge protect against the identity invalidation that drives Narrative Dissolution and Agentic Collapse.
- **Peer support infrastructure:** Structured peer support — engagement with individuals who share system-involvement experience and have developed recovery wisdom — provides relational scaffolding outside the power-asymmetric worker-client relationship and models the possibility of agency recovery.
- **Narrative restoration practices:** Structured opportunities for individuals to reclaim and articulate their own stories — through life-story work, community testimony, restorative

dialogue, and creative expression — directly counter Narrative Dissolution and support the reconstruction of identity coherence.

- **Voluntary engagement with clear exit pathways:** Systems that make voluntary participation possible, that communicate transparent pathways to service exit, and that preserve meaningful choice within service structures significantly attenuate agentic collapse.

Amplifying Factors

- **Racial and economic marginalization:** Black, Indigenous, and other communities of color experiencing poverty are both disproportionately represented within coercive institutional systems and subjected to higher degrees of identity invalidation and surveillance within those systems (Alexander, 2010; Roberts, 2022). The amplification of SIBD along racial and economic lines is not incidental — it is structural, reflecting the same inequities that produced disproportionate system contact in the first instance.
- **Polypharmacy:** The prescription of multiple psychotropic medications — common in psychiatric and correctional settings — can compound Temporal Disorientation and Agentic Collapse through direct neurological effects, while simultaneously signaling to the individual that their internal states are chemical problems to be managed rather than meaningful responses to be understood.
- **Housing instability:** The absence of stable, safe, and private housing eliminates the environmental conditions necessary for identity coherence, future planning, and relational investment — all of which protect against SIBD. Housing instability and SIBD co-produce each other in a recursive cycle that is extraordinarily difficult to interrupt without addressing both simultaneously.
- **Cross-system or pipeline involvement:** Individuals simultaneously or sequentially engaged with multiple institutional systems — most notably youth who move from child welfare into juvenile justice and then adult criminal justice — experience compounded exposure to multiple vectors of identity invalidation, coercive contact, and bureaucratic fragmentation. The child welfare-to-justice pipeline represents one of the most severe contexts for SIBD amplification (Dierkhising et al., 2013).

3. The Cinematic Visual Model of SIBD

The theoretical architecture of SIBD, while rigorous, was developed from the outset with a commitment to legibility across audiences. Not all of the people most affected by system-induced behavioral decay are positioned to engage with academic theoretical literature. Advocates, community members, lived-experience experts, and frontline workers require frameworks that can be held in the body and shared in conversation, not only debated in academic journals. The **Cinematic Visual Model of SIBD** was developed to meet this need.

3.1 Rationale for a Cinematic Frame

The dominant representations of behavioral deterioration in clinical literature are internal and individual. They depict what happens *inside* a person — in their neurobiology, their cognitive schemas, their affect regulation systems. This is not without value. But it has a profound political consequence: it renders the environment invisible. The person is the problem. The system is the backdrop.

Cinema works differently. Film situates characters within environments. The camera is always directed outward — toward context, setting, social arrangement, the forces that act upon protagonists rather than merely the internal states of protagonists themselves. The classic protagonist of tragic film narrative does not simply collapse from internal weakness; they are acted upon by forces that exceed their capacity to manage, and the film's function as art is to make those forces visible and emotionally legible to an audience. This is precisely the representational logic that SIBD requires.

The cinematic frame was chosen, further, because storytelling is a mode of sensemaking with deep cultural resonance across the communities most harmed by system exposure. Black and Indigenous communities, communities with oral traditions, communities organized around testimony and witness — these communities do not need the academic paper to know that systems harm people. They need a framework that honors what they already know and provides shared language with which to demand accountability. Cinema offers that shared language.

It bears emphasis that the cinematic frame is not a metaphor deployed for rhetorical elegance. It is a deliberate methodological and political choice. The act of externalizing causation — of moving the camera

from the interior of the individual to the architecture of the system — is, in the SIBD framework, an act of clinical and political resistance.

3.2 The Five-Act Arc of System Encounter

The Cinematic Visual Model maps the arc of behavioral decay across five acts, each corresponding to a phase of system contact and a primary SIBD domain. The five-act structure is borrowed from classical dramatic theory as well as contemporary screenwriting — specifically the model in which a protagonist moves from an established ordinary world through an inciting disruption, a period of escalating pressure, a crisis turning point, a period of consequence, and a final resolution or irresolution (Field, 1979; McKee, 1997).

Act	Cinematic Phase	System Contact Phase	Primary SIBD Domain Activated	Practitioner / System Behavior
Act I	Inciting Incident	First system contact / intake	Narrative Dissolution begins	Deficit-based assessment; identity reduced to eligibility category; story extraction without relational context
Act II	Rising Pressure	Assessment, gatekeeping, categorization	Agentic Collapse deepens	Service plan imposed; decisions made without meaningful participation; repeated proof-of-need demands
Act III	The Turning Point	Compliance demands, coercive intervention	Compliance Mimicry solidifies	Punitive responses to non-engagement; medication compliance enforced; surveillance escalates; trust extinguished
Act IV	Falling Action	Long-term involvement, cyclical re-engagement	Relational Fracture and Temporal Disorientation	Worker turnover breaks continuity; episodic re-intake processes repeat identity invalidation; future planning absent from service relationship
Act V	Denouement	Exit, discharge, or system abandonment	Full decay or recovery inflection point	Abrupt service termination without transition support; or — in the recovery trajectory — encounter with a relational, narrative, and agency-affirming alternative

The five-act model is not a fixed sequence. Individuals may enter at different acts, cycle back through earlier acts upon re-engagement with systems, or experience multiple acts simultaneously when involved with more than one institutional system concurrently. The model is a narrative heuristic, not a deterministic stage theory.

— The Intake Initiative Research Division, 2026

What makes the cinematic frame analytically powerful is its capacity to represent the *momentum* of decay — the way in which each act creates the conditions for the next, not through individual choice but through the structural logic of institutional engagement. Just as a film's narrative is shaped by the forces set in motion at the inciting incident, the trajectory of behavioral decay is shaped by what happens — and what fails to happen — at intake.

3.3 The Role of the Witness

In film theory, the camera is never neutral. It witnesses, frames, and interprets. The perspective from which events are seen determines what can be understood about them. When the camera remains inside the protagonist's subjectivity, what is seen is internal pathology — confusion, grief, disintegration. When the camera pulls back to reveal the environment — the institution, the architecture, the guards, the forms, the waiting rooms — what becomes visible is power, structure, and cause.

In the SIBD Cinematic Model, the practitioner, advocate, researcher, or community member who *names* what they observe — who frames behavioral deterioration as system-caused rather than person-caused — functions as the critical witness. This is not a passive role. The act of naming is itself an intervention. When a social worker says, "I am seeing someone who has learned not to try — and I want to understand what this system has taught them," they have interrupted the default clinical narrative. When an advocate testifies before a city council that "the compliance behaviors we measured were not signs of health; they were signs of a person who had learned to perform survival," they have reframed a policy debate.

The critical witness occupies three simultaneous roles:

1. **The Observational Role:** Documenting behavioral changes across the arc of system contact with sufficient precision to support causal attribution to system factors rather than individual pathology.
2. **The Interpretive Role:** Applying the SIBD framework to make sense of what is observed — naming which domain is expressed, identifying where on the Decay Gradient the individual appears to be located, and distinguishing SIBD from co-occurring but distinct clinical presentations.
3. **The Advocacy Role:** Using the language of SIBD to make the system accountable for what it produces — in supervision conversations, in policy testimony, in community organizing, and in the research literature.

The concept of witness is drawn here not only from film theory but from the trauma literature, in which the therapeutic relationship's function as a witnessing presence is understood as fundamentally reparative (Herman, 1992). Judith Herman's foundational argument — that trauma's healing requires acknowledgment, not only treatment — maps precisely onto the SIBD context. The individual whose behavioral decay has been named, attributed correctly, and witnessed with dignity has already experienced a partial restoration of the conditions that decay destroyed: recognition, story, and the sense that their experience is real and matters.

3.4 Visual Narrative Interventions

The Cinematic Visual Model does more than provide a framework for understanding SIBD — it generates a coherent rationale for a class of interventions that have been undertheorized and underfunded in the social service literature: **visual narrative interventions**.

Photovoice, developed by Caroline Wang and Mary Ann Burris, is a community-based participatory research methodology in which community members use photography to document and reflect on their lived environments, generating evidence and narrative simultaneously (Wang & Burris, 1997). Within the SIBD framework, photovoice functions as both a research tool — generating data about the environmental conditions producing decay — and a recovery modality — restoring narrative agency, cultural expression, and the experience of being a producer of knowledge rather than an object of it.

Life-story work, used extensively in child welfare contexts, provides structured support for individuals to construct, narrate, and integrate a coherent account of their own history. Within the SIBD framework, life-story work directly targets Narrative Dissolution, providing the relational and temporal conditions under which a fragmented self-story can be re-assembled.

Community testimony and **documentary practice** — the creation of community-controlled records of system experience through film, oral history, and public testimony — serve the advocacy function of the critical witness at scale. They make visible, for policy audiences and the broader public, the arc of system-induced harm that the clinical encounter often renders invisible. The Intake Initiative's own documentary research program, currently in development, draws directly on this tradition.

Restorative practice circles, derived from Indigenous justice traditions and adapted for service system contexts, create structured relational spaces in which individuals, practitioners, and community members can collectively examine the conditions that produce harm — an exact enactment of the SIBD Cinematic Model's insistence on externalizing causation.

4. Methodology Proposal: Validating SIBD

The theoretical framework presented in Section 2 requires empirical validation to fulfill its potential as a tool for research, practice, and policy. The following three-phase mixed-methods research design is proposed to validate the SIBD construct, develop a reliable measurement instrument, and generate longitudinal evidence of SIBD's trajectory and determinants across multiple system contexts. Throughout all phases, the design is governed by community-based participatory research (CBPR) principles (Minkler & Wallerstein, 2003).

4.1 Phase One — Construct Validation (Qualitative)

Purpose: To establish the face validity, phenomenological richness, and conceptual boundaries of the SIBD construct through direct engagement with those most qualified to assess it — individuals with lived experience of multi-system involvement, and frontline practitioners who observe SIBD daily.

Design: A community-based phenomenological inquiry drawing on the methodological traditions of interpretive phenomenological analysis (IPA) and grounded theory (Charmaz, 2006).

Component 1 — Phenomenological Interviews: In-depth individual interviews (estimated N=60) with adults and youth who have experienced involvement with at least two of the four target systems: criminal justice, child welfare, psychiatric hospitalization, and homelessness services. Interviews will be semi-structured, narrative-centered, and conducted by trained peer interviewers with shared system-involvement experience. The interview protocol will invite participants to narrate their system contact experiences across time, with particular attention to behavioral and relational changes they attribute to system involvement. Interview data will be analyzed using thematic analysis with attention to domain correspondence and counter-evidence.

Component 2 — Practitioner Focus Groups: Structured focus groups (estimated N=8 groups, 6–8 participants each) with frontline workers across the four target systems. Groups will present SIBD domain descriptions and invite practitioners to assess face validity, offer counter-examples, and identify gaps. Practitioner knowledge is treated as expert knowledge, and practitioner skepticism is treated as data.

Component 3 — Community Advisory Board Co-Design: A standing Community Advisory Board (CAB) comprised of at least 50% lived-experience members will govern all Phase One research decisions, including site selection, interview protocol development, sampling strategy, and interpretation of preliminary findings. The CAB will co-author the Phase One report and hold veto power over representations of community experience that members assess as misrepresentative.

4.2 Phase Two — Instrument Development (Quantitative)

Purpose: To develop a valid, reliable, and psychometrically sound measurement instrument — the **SIBD Behavioral Decay Index (BDI-S)** — capable of measuring each of the five SIBD domains in research and clinical contexts.

Instrument Design: The BDI-S will be a 30-item self-report scale (6 items per domain) using a 5-point Likert response format. Item generation will draw directly from Phase One qualitative findings, ensuring that the language and conceptual content of the instrument reflects community experience rather than clinical convention. Items will be reviewed by the CAB and by an expert panel of researchers with expertise in psychometrics, trauma measurement, and social justice research.

Pilot Testing Populations: The BDI-S will be pilot tested with three populations:

- Justice-involved adults (N=150), recruited through community reentry organizations and public defender partnerships.
- Youth in or recently exited from foster care (N=150), recruited through foster youth advocacy organizations and Independent Living programs.
- Adults experiencing chronic homelessness (N=150), recruited through community-based service organizations using low-barrier outreach protocols.

Psychometric Analysis: Reliability and validity analyses will include:

- Internal consistency reliability (Cronbach's alpha, target $\alpha > 0.80$ per domain subscale).
- Test-retest reliability at two-week interval (target $r > 0.75$).
- Convergent validity assessed against established related measures including the General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995), the Interpersonal Trust Scale, the Posttraumatic Cognitions Inventory (Foa et al., 1999), and the Future Time Perspective Scale.
- Discriminant validity analysis to confirm the BDI-S measures constructs distinct from existing measures of depression, PTSD, and general psychological distress.
- Confirmatory factor analysis (CFA) to assess the five-factor structural model.

4.3 Phase Three — Longitudinal Cohort Study

Purpose: To generate prospective, longitudinal evidence of SIBD onset and trajectory across the arc of system involvement, and to test the effect of relational continuity and narrative affirmation interventions on decay trajectory.

Design: A 36-month longitudinal cohort study enrolling individuals at the point of intake into each of three target systems — criminal justice (community supervision), child welfare (family services engagement), and homelessness services (shelter intake).

Sample: 500 individuals per system (N=1,500 total), demographically stratified to ensure representation across racial, gender, and age groups. Recruitment will occur at intake, with written informed consent and clear communication that participation in the study does not affect service access or decisions.

Measurement Points: BDI-S and supplementary measures will be administered at four time points:

Time Point	System Contact Phase	Primary Research Questions
T1 — Baseline (Intake)	Initial intake encounter	What is the pre-engagement baseline SIBD profile? What intake characteristics predict early decay onset?
T2 — 6 Months	Early engagement	Which domains show earliest change? Do intake quality variables predict T2 decay levels?
T3 — 18 Months	Mid-engagement	What is the trajectory of decay across domains? Are protective factors associated with attenuated decay?
T4 — 36 Months	Extended engagement or exit	What are the full 36-month decay trajectories? Do individuals with relational continuity and narrative affirmation show significantly lower BDI-S scores?

Primary Hypothesis: BDI-S total scores and domain subscale scores will increase significantly over the 36-month study period in the absence of relational continuity and narrative affirmation interventions, controlling for baseline vulnerability, co-occurring disorder, and demographic variables. A secondary hypothesis predicts significant cross-system variation in decay trajectory, with highest decay rates in criminal justice and lowest in homelessness services with low-barrier access protocols.

4.4 Ethical and Participatory Commitments

The ethical framework governing all three phases of SIBD research is grounded in community-based participatory research (CBPR) principles as articulated by Minkler and Wallerstein (2003), and is specifically adapted to the vulnerabilities of research participants with multi-system involvement histories.

- **Community-Based Participatory Research:** All research decisions — from site selection to analysis frameworks to dissemination — are co-governed by community representatives through the Community Advisory Board structure. The research is designed to generate knowledge that is immediately useful to communities, not merely to the academic literature.

- **Lived-Experience Co-Investigators:** Individuals with lived experience of multi-system involvement will hold formal co-investigator roles in all three research phases, with commensurate compensation, authorship rights, and decision-making authority.
 - **Trauma-Informed Data Collection:** All interview and survey protocols are designed to minimize re-traumatization, including opt-out provisions for specific question domains, availability of peer support during and following research participation, and explicit communication that sharing information is always voluntary.
 - **Data Sovereignty:** Formal data sovereignty agreements with participating communities will govern data storage, access, analysis, and publication, ensuring that communities retain meaningful control over how their experiences are represented in research outputs.
 - **Compensation as Ethical Standard:** All research participants will receive fair compensation for their time. This is understood not as a recruitment incentive but as an ethical obligation — an acknowledgment that the knowledge generated by this research rests upon the labor and vulnerability of participants.
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5. Implications for Policy and Practice

The SIBD framework is not an academic end in itself. Its purpose is transformative: to generate the conceptual infrastructure necessary to redesign the systems that produce behavioral harm. The following recommendations are organized across four domains of action. They are offered as immediate, medium-term, and long-term priorities — recognizing that systemic change requires both urgent action and sustained commitment.

5.1 Intake Reform

The intake encounter is the most consequential and most reformable dimension of system-induced behavioral decay. Because it is the point at which the system's logic first meets the individual's humanity, it is also the point at which the greatest harm — and the greatest protective opportunity — is concentrated.

- **Replace deficit-based intake assessments with asset and narrative-centered protocols.** Current intake instruments in criminal justice, child welfare, and behavioral health are overwhelmingly structured around the identification of deficits, risks, and pathologies. The Intake Initiative recommends the development and adoption of intake protocols that open with narrative invitation — "Tell me about yourself and what matters to you" — before proceeding to administrative and clinical assessment. This reordering is not merely aesthetic; it fundamentally repositions the individual as a person with a story rather than a case with a status, counteracting Narrative Dissolution from the first moment of system contact.
- **Require continuity of relationship between intake worker and individual across a minimum 90-day period.** The single most powerful protective factor against SIBD identified in this framework is relational continuity. Policy should mandate that the worker who conducts intake maintains the primary service relationship with the individual for at minimum 90 days, regardless of administrative convenience or caseload pressures. Systems that cannot support this level of relational continuity should receive technical assistance to restructure caseload models accordingly.
- **Eliminate documentation requirements that strip identity or require repeated trauma re-narration.** Individuals should not be required to tell their trauma history to multiple workers across multiple systems. Cross-system data coordination (see 5.3) should reduce redundant disclosure requirements. Within systems, individuals should have the right to designate a single record of their history that is updated with their consent rather than reconstructed repeatedly from scratch.
- **Pilot and evaluate trauma-informed, asset-centered intake models** across at least three system contexts, using the BDI-S as a primary outcome measure to assess SIBD impact of intake design variation.

5.2 Practitioner Training

- **Develop and mandate SIBD-informed training for frontline workers** in criminal justice (probation, parole, corrections), child welfare (caseworkers, foster care coordinators), and behavioral health (intake coordinators, case managers, psychiatric nursing staff). This training

should include: (a) the theoretical foundations of SIBD; (b) domain-by-domain behavioral recognition tools; (c) practice skills for relational continuity and narrative engagement; and (d) organizational advocacy strategies for workers who observe SIBD being produced by their own systems.

- **Restructure supervision to support SIBD recognition and naming.** Clinical supervision in most service settings is organized around case management efficiency and regulatory compliance. The Intake Initiative recommends supplementary reflective supervision structures — adapted from models in infant mental health and trauma-informed practice — in which practitioners can examine their own responses to SIBD symptoms and develop shared language for distinguishing system-caused behavioral change from individual pathology.
- **Deliver implicit bias training centered on the racial and economic dimensions of SIBD amplification.** Because SIBD is disproportionately produced in and borne by Black, Indigenous, and economically marginalized communities, SIBD training must be explicitly anti-racist in its orientation. Practitioners must examine the ways in which their own biases interact with systemic inequities to amplify, rather than attenuate, the behavioral decay they observe.

5.3 Policy Architecture

- **Mandate cross-system data coordination to prevent cyclical re-engagement with multiple dehumanizing systems simultaneously.** Individuals should not be required to navigate the intake requirements of criminal justice, child welfare, and behavioral health simultaneously without coordinated case management support. Cross-system data sharing frameworks — governed by privacy protections and individual consent — should enable information to follow people across system boundaries, reducing redundant documentation, inconsistent service plans, and the identity invalidation of repeated intake.
- **Fund and protect peer support worker roles within intake structures.** Peer support workers — individuals with lived experience of system involvement who are trained to provide relational and navigational support — represent one of the highest-evidence, lowest-cost interventions available for SIBD mitigation. Policy should mandate their inclusion in intake teams across all

four target systems and provide protected funding streams that insulate peer support roles from budget fluctuations.

- **Integrate SIBD screening into quality improvement metrics for publicly funded service systems.** Systems should be held accountable not only for throughput and compliance metrics but for the behavioral outcomes of the people they serve. Incorporating BDI-S scores — measured at intake, mid-engagement, and exit — into quality improvement frameworks creates institutional incentives to reduce, rather than ignore, system-generated behavioral deterioration.

5.4 Survivor-Centered Advocacy

- **Elevate lived experience as expertise in policy design processes.** The most authoritative knowledge about SIBD is held by the people who have experienced it. Policy processes should move beyond the tokenistic inclusion of "consumer representatives" to structural mechanisms for lived-experience leadership: co-authorship of policy proposals, voting representation on oversight boards, and decision-making authority over program design and evaluation.
 - **Fund narrative restoration programs within publicly funded systems.** Storytelling circles, community documentary projects, life-story work programs, photovoice initiatives, and restorative practice circles should be recognized as evidence-based interventions — not discretionary enrichment activities — and funded accordingly within publicly supported service systems. The evidence for their efficacy in addressing Narrative Dissolution and Agentic Collapse is robust and growing (Wang & Burris, 1997; White & Epston, 1990).
 - **Create formal grievance and accountability mechanisms for system-caused behavioral harm.** Just as medical malpractice frameworks create accountability for individual clinical harm, policy should establish structured mechanisms by which individuals can document and seek redress for system-caused behavioral deterioration. These mechanisms should be non-adversarial, accessible without legal representation, and oriented toward systemic learning and reform rather than individual punishment.
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6. Conclusion

The stakes of naming System-Induced Behavioral Decay accurately and urgently cannot be overstated. Every year, millions of individuals in the United States pass through intake encounters, service plans, correctional facilities, psychiatric wards, foster care placements, and homeless shelters — systems designed, in theory, to improve their lives. For a significant proportion of those individuals, the primary outcome of system contact is not improvement but measurable, progressive behavioral deterioration: a diminished capacity to act, to trust, to narrate the self, to inhabit the future, to hope.

As long as this deterioration remains unnamed — as long as it is attributed to individual pathology, pre-existing disorder, or willful non-compliance — it will continue to be treated with more of the same: more coercion, more compliance demands, more documentation, more surveillance. The name matters. When we name what systems produce, we make systems accountable for what they produce. This is the first and most essential move.

The Intake Initiative issues a call to action to each of the audiences this white paper addresses. To **researchers**: test this framework, contest it, refine it, and build the empirical evidence base that can make it irrefutable. To **practitioners**: look at the person in front of you and ask not only "what is wrong with this person?" but "what has this system done to this person?" — and let that question change what you do next. To **policymakers**: redesign intake encounters, mandate relational continuity, fund peer support, and hold systems accountable for the behavioral outcomes they produce. To **advocates**: name what you see, document what you witness, and insist that the language of system-caused harm enter every policy conversation in which the behavior of system-involved people is being discussed.

And to the communities most harmed — the people whose lives are the primary data upon which this framework is built — The Intake Initiative makes a commitment: this knowledge belongs to you first. We will not publish without you, design without you, or advocate without you. The goal of this research is not a better white paper. The goal is a world in which the systems that touch your life are designed to restore your agency rather than consume it.

"What we call non-compliance is often the residue of a system that taught people not to try. Our task — as researchers, as practitioners, as advocates, as human beings — is to change what systems teach."

— The Intake Initiative, 2026

The work of naming, documenting, and disrupting System-Induced Behavioral Decay begins here. It does not end until systems do what they promised.

7. References

Alexander, M. (2010). *The new Jim Crow: Mass incarceration in the age of colorblindness*. The New Press.

Bruner, J. (1990). *Acts of meaning*. Harvard University Press.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. SAGE Publications.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35(5), 390–398. <https://doi.org/10.3928/00485713-20050501-05>

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, 11(4), 227–268. https://doi.org/10.1207/S15327965PLI1104_01

Dierkhising, C. B., Ko, S. J., Woods-Jaeger, B., Briggs, E. C., Lee, R., & Pynoos, R. S. (2013). Trauma histories among justice-involved youth: Findings from the National Child Traumatic Stress Network. *European Journal of Psychotraumatology*, 4(1), 20274. <https://doi.org/10.3402/ejpt.v4i0.20274>

Field, S. (1979). *Screenplay: The foundations of screenwriting*. Delacorte Press.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment*, 11(3), 303–314. <https://doi.org/10.1037/1040-3590.11.3.303>

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Anchor Books.

Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence — from domestic abuse to political terror*. Basic Books.

Maier, S. F., & Seligman, M. E. P. (1976). Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General*, 105(1), 3–46. <https://doi.org/10.1037/0096-3445.105.1.3>

McKee, R. (1997). *Story: Substance, structure, style, and the principles of screenwriting*. ReganBooks.

Minkler, M., & Wallerstein, N. (Eds.). (2003). *Community-based participatory research for health*. Jossey-Bass.

Roberts, D. (2022). *Torn apart: How the child welfare system destroys Black families — and how abolition can build a safer world*. Basic Books.

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston (Eds.), *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp. 35–37). NFER-NELSON.

Seligman, M. E. P. (1972). Learned helplessness. *Annual Review of Medicine*, 23(1), 407–412. <https://doi.org/10.1146/annurev.me.23.020172.002203>

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. SAMHSA.

Travis, J., Western, B., & Redburn, F. S. (Eds.). (2014). *The growth of incarceration in the United States: Exploring causes and consequences*. National Academies Press. <https://doi.org/10.17226/18613>

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, 24(3), 369–387.
<https://doi.org/10.1177/109019819702400309>

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. W. W. Norton & Company.

Wing, J. K., & Brown, G. W. (1970). *Institutionalism and schizophrenia: A comparative study of three mental hospitals, 1960–1968*. Cambridge University Press.

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings. *American Journal of Psychiatry*, 169(8), 790–804.
<https://doi.org/10.1176/appi.ajp.2012.11111616>

Wylie, M. S., & Simon, R. (2016). Rethinking trauma: How a new approach to therapy revealed an epidemic of psychological suffering caused not by childhood wounds but by the systems that were supposed to help. *Psychotherapy Networker*, 40(1), 22–31.