There continue to be conflicting reports of the effectiveness of community care for the mentally ill. Greenblatt and Budson (1976) have recently summarized the work of Polak and Kirby, Stein and Test, Beigel et al., and Mosher and Menn. All of these investigators have reported generally favorable results using a variety of community-based treatment approaches. On the other hand, Kohen and Paul (1976) have reviewed the work of other investigators in the field whose results have been unfavorable. For example, Chu and Trotter (1974) are quoted as suggesting that the community treatment movement has simply resulted in "more of the same" being given in different locations (Kohen and Paul 1976, p. 576). Koltuv and Neff (1968) similarly warned that without a new technology, the only accomplishment of community treatment will be to move "the locus in which the emotionally disturbed [individual] vegetates and experiences personal misery" (p. 252).

A closer examination of the literature reveals that there are some community programs that are rehabilitative and some that are not. The use of so-called boarding homes without bona fide rehabilitation programs and without a trained professional staff has generally been viewed as disastrous. Reporting on the problems in New York, Reich and Siegel (1973) described proprietary homes with as many as 285 beds that failed to provide any day programs, rehabilitative services, or systematic psychiatric care. Shadoan (1976) addressed this problem, and made suggestions for improving the rehabilitative quality of such homes. Lamb and Goertzel (1971, p. 34), comparing boarding homes to high-expectation halfway houses, concluded that boarding homes are characterized by an assumption that "guests" will "remain regressed and dependent indefinitely," whereas high-expectation halfway houses facilitate a "process of delabeling." Residents in a high-expectation setting "are less segregated, experience more normalization, are less likely to be labeled as deviate, experience less stigmatization, and see themselves as functioning members of the community."

Rog and Raush (1975) reviewed followup studies of 26 halfway houses. Although there was no uniformity of followup intervals or indices, a composite picture emerged of 20 percent hospitalized, 58 percent living independently in the community, and 55 percent employed or in school. The finding in this review of only 20 percent recidivism ought to be considered a favorable result.

On the other hand, Test and Stein (1976, p. 76) have made a general recommendation that "serious consideration" be given to the adoption of "nonsHELTERED facilities." across the board. They expressed concern that "managers of sheltered facilities" would give tacit license to residents to behave in "sick" ways. They further suggested that the direct provision by sheltered facilities of many services would lead to the


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characteristics of the total institution and subsequent atrophy of residents' skills.

The widely quoted work of Murphy, Pennee, and Luchins (1972) was used to support this position. However, Murphy and his associates were quite explicit in excluding halfway houses from their study of foster home care in Canada. The foster homes they studied were located generally in rural areas or small towns not close to rehabilitative services. Run by landlord supervisors, the homes had no daily programs. Separation was maintained between the landlord and residents even during the daily functions of eating and social gathering. The most critical factor was the landlord's attitude that residents were infantile, helpless patients. Thus, these facilities were isolated physically, had no daily programs, approached tenants as patients, and were run by landlords with neither training in nor commitment to rehabilitation. Budson (1973) has previously stated that the entire community residence program should not be condemned because such inferior facilities exist.

From a more general point of view, Maxwell Jones (1975, pp. 97–98) recently identified a need to “examine the social organization of the system in which the patient lives.” He questioned the wisdom of following a medical tradition primarily focused on “pathology, symptoms, and illness.” Should we not, he asked, attach “at least equal importance to a social system that can give its members a feeling of identity and of belonging, along with as active and creative a role in the system as the potentialities will allow?”

There does indeed need to be a new system, and it is being implemented by a variety of clinicians and programs. However, a clear common ideology for the nonmedical component does not yet appear to have emerged. The beginnings of such an ideology can be found in the proposed concept of the extended psychosocial kinship system recently described by Pattison et al. (1975). They suggest that this system rather than the nuclear family alone may be the basic social unit. According to Pattison et al. (p. 1247), the extended kinship system can provide two major resources for individual and family sustenance: (1) “affective support, that is, emotional involvement, personal interest, and psychological support”; and (2) “instrumental support in the form of money, food, clothes, and assistance in living and work tasks.” They see the extended psychosocial kinship system as including more than just the extended kinship system, but also the “psychosocial network of neighbors, friends, and family associates.”

Pattison's group feels that “the affective and instrumental resources of this psychosocial system have been seriously underestimated” (p. 1248). They quote a variety of studies, including that of Kammeyer and Bolton (1968), supporting the view that “sick” families have “fewer memberships in voluntary associations, fewer friendships with relatives, and fewer relatives living in the same community.” They also cite Alissi's (1969) findings of “psychosocial system impoverishment in families applying to group service agencies.”

These investigators have developed an empirical instrument, the Pattison Psychosocial Kinship Inventory, to assess the social system that comprises the individual’s primary social matrix. The inventory has five major dimensions of relationship: (1) The relationship had a high degree of interaction; (2) it had strong emotional intensity; (3) the relationship was generally positive; (4) the person in the relationship could be counted on to provide concrete assistance; (5) the relationship was symmetrically reciprocal (Pattison et al. 1975).

The Pattison Psychosocial Kinship Inventory has been used to study normals, neurotics, and psychotics. A healthy person has 20 to 30 people in his intimate psychosocial network. This would include five to six people in each of the following subgroups: family, relatives, friends, neighbors, co-workers, or social contacts. In the neurotic population there are 10 to 12 people in the psychosocial network. These people tend to relate less to each other—as if the neurotic person is at the hub of the wheel, with individual relationships like spokes that have no interrelationship” (Pattison et al. 1975, p. 1249). The studies describe a pattern found among the psychotic population in which the psychosocial network consists of only four or five people, usually the nuclear family. Interpersonal ratings tend to be
ambivalent and nonreciprocal. In this instance, the social connectedness of the four or five people is very high. As Pattison et al. put it, “The psychotic is caught in an exclusive, small, social matrix that binds him and fails to provide a healthy interpersonal matrix” (p. 1249). Finally, Pattison’s group suggests that an impoverished psychosocial system can be aided by being “repopulated” with additional people, and by resolving negativistic relationships. In the case of the psychotic, for example, “it may be important to open up the totally closed system and to establish interpersonal relationships with other social subsystems so that an effective psychosocial system can be created” (Pattison et al. 1975, p. 1250).

We suggest the common element in the successful community program, whether residential or not, is that the psychosocial kinship system was either introduced where it was not present due to long-term hospitalization (Budson, Grob, and Singer 1977; Greenblatt and Budson 1976), aided and assisted where it was weak (Greenblatt and Budson 1976; Polak and Kirby 1976), or vigorously sustained when the individual came directly from the community with a somewhat intact but shaky system (Greenblatt and Budson 1976; Stein, Test, and Marx 1975).

Note, for example, that in the Stein and Test studies (see Greenblatt and Budson 1976; Stein, Test, and Marx 1975) the staff was “dispersed throughout the community working with the patients in such settings as their homes, their places of work, supermarkets, and recreational facilities” (p. 518)—all of this with an omnipresent 24-hour coverage. Polak and Kirby stated that “evaluation of client problems [took] place on home visits, and a majority of crisis and social systems work [took] place in the real life setting” (p. 15). Both of these examples could be viewed as programs based on the concept of the staff's joining the extended psychosocial kinship system of the patient and his family. We suggest that the staff has in these successful programs made a significant and vital shift. They have moved from conceiving of themselves as remote, professional, singular bestowers of health, treating the stigmatized sick, to aspiring to be skilled, caring people who have entered their clients’ world to assist them in healthy living.

If some patients can be treated successfully in the community, which patients are likely to benefit from more sheltered halfway house programs? We propose that patients who have no psychosocial system or only a very impoverished one fall into this category. These patients are totally isolated either because of living circumstances or pathology. In circumstances where nonresidential therapeutic work aimed at restoring an existing psychosocial network proves impractical, the halfway house can provide two essential services: a core nuclear family system, and an off-premises activity program that contributes to an extended psychosocial family system in the community. The requirement of a daily program off the premises reinforces health, fosters progression, and ultimately provides the resident with an opportunity to enter into a true psychosocial system in which he is sustained.

One type of patient who has lost his psychosocial kinship system is the chronically hospitalized patient; he has often been in the hospital so long that his family and his friends have abandoned him. His particular predicament has been described with care and sensitivity by Lamb et al. (1976).

A second type of patient with a need for a halfway house environment is the young, isolated adult who seems likely to embark on a course of chronic illness. Such a patient has usually led an isolated life during his development. After a brief hospitalization for his first psychotic episode—usually schizophrenic, but perhaps manic-depressive—the patient cannot realistically return home. Home is the place that through the years sustained his isolation and became increasingly noxious to him. If he returns to it, he is likely to regress into a previously held dependent, nonfunctioning position. This young adult needs in his first postpsychotic period a milieu where he can be with peers, as it is a natural time to move out of his parents’ home. In the context of peer living, he can address himself more easily to the task of socialization and all of the tasks of late adolescence. These tasks naturally include a capacity to de-idealize the parents, to separate from the parental home,
develop vocational aims and skills, to establish a comfortable sexual identity, and ultimately to have a healthy heterosexual adjustment.

How does the halfway house bring all of this about? The clinical experience of 7 years' operation of Berkeley House, a psychiatric halfway house affiliated with the McLean Hospital in Belmont, Mass., offers some preliminary answers.

A followup study of 78 ex-residents from the first 3 years of operation has been conducted (Budson, Grob, and Singer 1977). This young adult population had a 15-month prior hospitalization and a median stay in Berkeley House of 7.5 months. That study showed that 91 percent of the ex-residents were living independently in the community; 74 percent were at work or in school, with another 11 percent actively looking for employment between jobs. Social contacts with Berkeley House continued for many of the ex-residents; 78 percent had visited the House some time after leaving, and 33 percent were still visiting at the time of followup. Most significantly, almost 60 percent continued to remain in contact with other ex-residents, even though most of them had left the House over a year previously. Budson, Grob, and Singer (1977, p. 126) indicated that "the social matrix of former Berkeley House residents was established, and continued to survive following a dropping off of direct Berkeley House contact." Recently, Lynch, Busdon, and Jolley (1977) further reported that 72 percent of 182 residents served through 7 years of operation used the Berkeley House ex-resident program. A direct correlation appeared to exist between the establishment of a psychosocial network and successful community tenure.

How is a psychosocial system created? First of all, the halfway house milieu is egalitarian, bringing out the best in each member. It encourages people to get to know and to learn how to relate to one another. Over time, certain residents seek each other out because of affinities of interest and temperament. The speed with which this occurs, and the depth of relationships formed, depends on the size and clientele of the facility. However, in the modal group residence of 15 or so people, it is natural for clusters of three to four to become somewhat closer—especially if the program is designated as transitional and the residents know far in advance that they will need roommates with whom to live on the outside.

After a number of months, caring and knowledgeable house managers, like fellow residents, become significant others for the resident. Ideally, the resident can turn to them if he feels he needs a response of a different quality than can be expected from a fellow resident. A little extra reassurance or advice, or someone to intervene with a difficult outside situation of some sort—these are commonly sought from the house manager whom the resident has grown to trust. After awhile, relief managers come to be similarly regarded, adding to the array of positively held, dependable people available to the resident. There may be, in addition, one professional or another—a psychotherapist, an administrative psychiatrist, a social worker, a rehabilitation counselor—to whom the resident has grown close and trusting.

The requirement of a program outside the halfway house adds further social contacts in a variety of potential roles—fellow workers in a sheltered workshop or competitive employment; companions at a day center or a social club; supervisors at work; or counselors at the day center. All of these are potentially meaningful relationships that the resident may develop while living at a halfway house.

Depending on the openness of the halfway house to the surrounding community, relationships with neighbors are also possible. In some instances, neighboring families are friendly and participate in occasional social functions at the halfway house, with the residents and neighbors ultimately becoming friends. The resident may, in addition, be affiliated with a local church or other community organization and become attached to a particular pastor or priest.

If the resident's family of origin lives in the vicinity, one of the tasks of the halfway house would be to help the resident relate to that significant group more effectively. Often, the resident is able to learn over time to deal with the

1Berkeley House is a townhouse in downtown Boston housing 23 residents.
difficulties that his biological family presents to him. Situations and interactions that in the past may have been extremely disrupting can be “detoxified” through discussion and insight gained in the halfway house milieu. The end result of this process may be that one or two significant family members may become less ambivalently regarded and actually become assets to the resident.

Over the months of stay at the halfway house the milieu maximizes a resident's chances of acquiring a significant psychosocial network through a wealth of relationships. The resident who is prepared to move out should have ongoing relationships with his apartment mates (say, three), two other residents remaining in the community residence, the two house managers, the two relief managers, the psychiatric consultant to the community residence or his therapist if he is in psychotherapy, two friends he has made at work or at school, possibly a neighbor, someone from church or synagogue, and two or more family members with whom he may have developed a better relationship while at the halfway house. Thus, ideally, our model resident will have 16 people he is in a position to call “friend.” If the halfway house nuclear family system has not isolated itself from the community, and has done its job within its own interactional milieu, the resident preparing to move out can do so with the support of a healthy psychosocial network of relationships. This matrix is composed of a variety of people from different settings with whom frequent contact occurs. He can expect instrumental help in a variety of ways—in finding an apartment, securing a proper lease, getting a job, or learning about social security benefits to which he may be entitled. There is a range of reciprocity in these relationships, with the professionals having somewhat less need of the resident than the resident has of them, but otherwise the network of friends potentially approaches symmetrical reciprocity.

The extended psychosocial kinship system that individuals have developed while living at Berkeley House has been sustained during their independent community tenure in four principal ways: (1) through the ex-resident program; (2) through housing arrangements; (3) through work; and (4) through a variety of avocational and social groupings.

The Kinship System Enhanced by the Ex-Resident Program

The Berkeley House ex-resident program provides a structure that enhances the continuity of relationships. It creates rituals that promote the retention of the extended psychosocial kinship system, as occurs in any family system. It provides a range of activities and social contacts supporting the viability and continuity of the psychosocial matrix. The halfway house is home base for the ex-resident as he knows he is welcome to return to visit at any time free of charge. Nothing makes a residence feel like a “treatment” so much as the patient's knowledge that just setting foot in the place causes a cash register to ring. Thus, dropping in informally after work, in the evenings, and on weekends is encouraged, as it would be in conventional nuclear families where a member has recently moved out. By arrangement with the managers or the evening's resident cook, an ex-resident might, for a nominal charge, stay for dinner with former housemates. Through these informal encounters, the ex-resident renews closeness, shares new experiences, and simultaneously provides a model for the current house residents.

Berkeley House also has a separate weekly meeting for ex-residents. This is an important setting where ex-residents, with staff assistance, share in exploring solutions to a wide spectrum of problems of independent community living. Additional meetings with either the psychiatric consultant or the house managers, especially in the beginning months, can also help to head off problems.

Berkeley House always keeps an extra bed so that an ex-resident may stay over for a few days in times of crisis.

A variety of issues may generate a crisis in the ex-resident's life. These include loss of a friendship or a love relationship gone awry. When such a loss temporarily leaves the ex-resident feeling devastated, acute support can be instrumental in preventing hospitalization, es-
especially in the young adult schizophrenic patient. Interpersonal problems in the apartment of the ex-resident can most properly be worked out in the ex-resident group, especially if all members of the apartment are in attendance. Problems at work are also crucial, and the loss of a job, like the loss of a friend, can strike at the ex-resident's fragile self-esteem. Mobilization of the best effort of the halfway house and its ancillary vocational counseling services can prevent relapse in this situation as well.

Other issues that commonly arise in the ex-resident's life are generated by his family of origin. These include, for example, the serious illness of a parent, or the father's sudden loss of a job. If the family has to move to another locale, the ex-resident may be thrown into a real-life crisis. Further, psychological turmoil in the family is a common effect of the resident's marked improvement; that is, the former resident may have served as a "reservoir of pathology" for the whole family. When he improves, someone else (a sibling or one of the parents) may be drafted to fill this role, suddenly becoming sick or dysfunctional. The halfway house staff can help prevent the ex-resident's tendency to slip back into previously held pathological patterns, a tendency reinforced by the family's crisis. Backsliding into old patterns may be seen as the ex-resident's attempt to reestablish the family status quo. By lending support and insight (or just by providing an alternate set of roles and relations), the house staff can help to avert this regression.

Planning vacations carefully can also be important in helping the ex-resident to compensate for his own vulnerabilities. We have found that generally first vacations ought to be with friends, not too far from the home base, with phone calls scheduled at intervals to ensure that alienation and panic do not occur.

Psychotropic medication is another issue to which the halfway house management must be alert in the ex-resident program. The ex-resident should be thoroughly educated about his need for certain medications and the managers should be able to recognize when a hyperactive ex-resident needs a lithium level checked and when an increasingly isolated, paranoid, delu-

sional ex-resident needs a review of phenothi-azine dosage.

The physical health of the ex-resident may also require acute attention. He may have an illness that the managers recognize as requiring expert consultation, and they can help direct the resident to appropriate help. There are times when the ex-resident may need the intense support of the house—including sleeping over for awhile. This may be due to physical necessity, such as a broken leg, in which case the ex-resident is put up on the first floor, next to a door, so he can be tended until the cast comes off. Or the occasion may demand emotional support after a traumatic event, such as an automobile accident or a mugging.

Whereas it is clear that the clinical staff of the community residence is in the most strategic position to become significant members of the social matrix of an ex-resident, so-called nonclinical personnel can also often be very important. We include all nonclinical personnel at the routine house meetings. The secretary to the program, for example, became an integral part of the community.

To give an illustration, Sally, when a resident, was not particularly communicative with the secretary, Carol. After leaving Berkeley House, Sally by chance met Carol at the bookstore at her university. Both realized in this chance encounter that they had an additional common bond since they were taking courses at the same school. Later, Sally made frequent visits to the house for the sole purpose of talking to Carol. Sometimes she chatted for as long as an hour. Carol, in turn, understood that part of her job as secretary was to allow herself to be a meaningful person to residents and ex-residents alike. At times Sally said poignantly that Berkeley House was the only home that she had ever had, and that certain staff were like family to her. Carol sometimes bumped into Sally at school and would ask her how her classes were going. Sally continued to come to the house to see Carol after classes had ended. Conversations included such topics as how her new job was going, the kinds of people she met, how she was doing with her family, her boyfriend, and how she was experiencing the move to her new
Sally came back to the house to see Carol to mourn an ex-resident who had died in an auto accident. The sharing of pain with this staff member, who also knew the deceased, proved crucial in helping Sally to deal with this untimely death. The visits subsequently tailed off to once in every 2 or 3 months.

The Psychosocial System Enhanced Through Housing Arrangements

As Fairweather et al. (1969) found in the VA-connected Lodge experiments, the psychosocial network is sustained through the practice of group movement out of the residence. Clusters of friends formed during the house stay tend to "graduate" together. Moving out with a group of friends has the advantage of ensuring continuity of relationships and mutual support. The moving process requires ex-residents to use newly developed skills and to acquire new knowledge. These include shopping for food and preparing it, and hunting for an appropriately spacious apartment with easy access to transportation and jobs in a relatively secure neighborhood. Negotiating with the landlord—not only about rent, but also about repairs needed before occupancy and about what services and utilities go with it—is an art in itself and is best learned in the company of others who will be taking the consequences.

A special ritual that often develops among residents and ex-residents is a housewarming that the new ex-residents give for current residents and other ex-residents. This is a subtle and pleasant way to counter fears of isolation and loss, since everyone knows where the ex-residents live, how to get there, and how to reach them by phone. It also helps the resident left behind to venture out, in the company of his fellow residents, to the new dwelling of his former housemate. The managers, who have already helped in the selection of the apartment, are naturally invited too.

Different patterns of ex-resident housing occur. Individuals moving out of Berkeley House usually move into apartments together with friends from the halfway house. At other times, individual house residents may move into apartments already established by a group of ex-residents. Later in their community career, individual ex-residents from several apartments will sometimes take a new apartment together, forming a new alliance of apartment mates. This is an example of an adaptive move sustaining existing relationships in the face of potentially disruptive losses through the departure of key roommates. Sometimes individual ex-residents will move into several single apartments in the same or adjacent buildings. The rare ex-resident who insists on living alone is more likely to get an apartment near the house and continue to use it for dinner, social contact, and participation in the ex-resident group meetings. In each of these situations, some of the relationships developed during the halfway house stay are maintained in the subsequent living arrangement.

An example of housing enhancing the psychosocial network and sustaining community tenure is a group of five women all in their early thirties. Their diagnoses were paranoid schizophrenia (2), schizoaffective disorder (1), and manic-depressive disorder (2). The women had moved into Berkeley House over a period of 4 months, from July to October 1974, and moved out of the house into an apartment together in June 1975. This apartment was maintained for more than 2 years and became the focal point for many social network activities.

After the women moved into their apartment, problems arose immediately. Clara and Joan were interested in painting, draperies, and other decorations in addition to furniture. The others were not. Some smoked pot, making it difficult for others to say no; some drank constantly and then wouldn't take part in clean-up, even of their own beer cans and bottles. There were problems with "crashing"—Mary or Norma would bring a friend home without consulting the others and assume that the friend could not only stay for dinner but also spend the night. Dates were a problem; the have paraded through the house and in and out of the bedrooms, while the have-nots objected to the intrusion into their privacy when any visitor was there. In general,
the first weeks were chaotic, and each woman tended to put blame on the others. Ex-resident group meetings and informal as well as formal contact with the house provided a sounding board and opportunity for the issues to be aired. In the ex-resident group, the women would often bemoan their inability to get together within the apartment to work on these problems. But other ex-residents in the group and elsewhere tried to help by listening and suggesting how to resolve some of their differences. Within 6 to 8 weeks the apartment was running more smoothly, and the mode of living the women adopted was reminiscent of that which they had learned at Berkeley House—a schedule of dishwashing, shopping, and meal preparation; weeknight limitations on noise, visits, and parties; a ban on crashing; and a collective decision to be aware of and sensitive to particular individual strengths and weaknesses.

Clearly, living at Berkeley House had prepared the five with a modus vivendi for group living, although it took them some weeks to come to terms with the necessity for some structure in their own new environment. Over a period of 2 to 3 years some members of the group remained in the apartment. It became a social center for ex-residents and residents alike. Problems did recur from time to time. Often, at these troubled times, the apartment mates would come back to the ex-resident group as a collective to do some work on the issues.

This group of peers at certain critical times was able to intervene effectively, largely on its own, to prevent pathological patterns of behavior in their fellow apartment mates. Both of the ex-residents described below had diagnoses of paranoid schizophrenia.

Joan, for example, had lost her job, and, in the face of this, had not organized a daily program of activity. Next, the roommates noted that she began to go out of town on short visits and upon returning appeared to be "high." The group put this information together and confronted her with the suspicion that she was leaving town to obtain "speed." The group was aware that this had been an early behavior pattern before her initial breakdown. Joan acknowledged that she had been unable to cope with the feeling of having lost her job. She saw that this led to her becoming disorganized and resorting to amphetamines as a way of dealing with the painful feelings.

In another situation, the apartment mates began to recognize that Jackie, during times of transition or stress, would write down details of philosophical, religious feelings. In their discussions with her, Jackie would begin to go off on long diatribes about a religious breakthrough experience that was to provide enlightenment. Again, the group knew that this behavior had preceded a frank psychosis in Jackie's past. Her apartment mates were able to engage her in direct discussion about the specific problems in her environment that were upsetting her. She was able to relinquish her increasing religious preoccupation and avoid psychosis.

### The Influence of Job and School Relationships

The extended psychosocial kinship network facilitates finding and sustaining employment. The common experience of employment reciprocally enhances the strength of the network. Former residents routinely alert each other to possible job openings either at their own place of work or in related settings. For example, a number of ex-residents have worked as waiters in a nearby restaurant; others have worked for a small electronics firm as assemblers. In each case, the first ex-resident in the job has encouraged friends to apply. After one ex-resident has been able to establish a reliable work record, he is in a position to give a recommendation to his supervisor for other ex-residents. It is of special interest to note that the three ex-residents who became waiters established a special relationship with each other based on a common work setting. Each of the three lived in different apartment groupings, and knowledge of job availability was communicated at the ex-resident group meeting. Thus we have an example of the ex-resident group meeting facilitating the establishment of ties between apartment groupings through work. Indeed one of the three ultimately moved into a living arrangement with fellow employees of the restaurant who were
not former residents of Berkeley House. Over time, attendance at the ex-resident group meetings diminished. The work relationships, however, continued for over a year with mutual support in the work setting as well as enhancement of a broader social network. We have also observed the work setting providing an opportunity for expansion of the social network to include nonpatients. Thus, work is an example of a reality avenue that helps movement of ex-mental patients into the mainstream of the general population.

Berkeley House ex-residents have alerted friends to positions in nearby universities, hospitals, hotels, and other large firms. They often became aware of these positions before they were advertised in the local papers because the positions available are initially posted within these places of business. In one instance an ex-resident who did exceptionally well was promoted to a supervisory position from which he was able to hire several ex-residents whom he knew were in need of jobs.

Ex-residents who maintain network contacts are an important source of encouragement and support for each other in work-related issues. For instance, a secretary encouraged her friend to take the civil service exam in order to increase her job possibilities. A young man living in the same apartment building with a young woman knew she was having difficulty getting to work at holiday time. He took it upon himself to make sure she got up for work in the morning, during that time of stress.

Surprisingly, some jobs that might at first glance appear to be isolated can lend themselves to the creation of a psychosocial system. Ron, with a longstanding illness and diagnosis of chronic schizophrenia, lived in Berkeley House for 10 months. He was a talented gardener and was able to secure a job as an apprentice in a landscape business shortly before moving out. Working in the business, he learned all about landscaping. He began sporadically to do independent work on his own time. Gradually, he found that he was able to build up a group of regular customers. He now is in independent work full time. All of his clients are regularly serviced. They include the ex-house-manager's home, as well as the halfway house lawn itself. Through this job he has derived an income that supports all his needs and he has a basis for regular contacts with a wide group of people. He has also used the money to visit other ex-residents that he befriended through Berkeley House.

Attending school (high school, college, university, adult education, crafts) is an important way of not only increasing knowledge, but also of structuring time, developing skills, and staying involved with people. Almost all ex-residents have at one time or another been involved in some educational program outside the house. Again, the psychosocial network acts as an important communicative resource, imparting information about available courses, the quality of instructors, costs, and many times providing companionship for attending class, studying, or completing course projects.

Avocational Activity and Problem Intervention

Social interaction in the context of a psychosocial kinship network includes many types of interactions. Some are "fun-social" avocational activities such as parties, trips, outings, or other recreational or entertainment activities. Other important interactions include just being together and sharing experiences or problems in the same way that most of us do with family, friends, or neighbors. As ex-residents are sensitive to and aware of each other's personality needs, they are faced with the problem of how to intervene if they are concerned about a friend. Emotional difficulties of a peer are sometimes directly confronted. At other times they are dealt with by contacting other friends of the subject, or encouraging him to re-contact the house staff, therapist, or significant other professional. The network thus provides a variety of ways in which people can send important messages to each other, and for some, indirectness is best. Ex-residents who keep in touch with each other often clearly know when a friend is in difficulty and are usually able to encourage him to get the kind of attention that he needs. In our experience we have observed...
these social contacts being decisive in averting clinical regression and relapse.

The following case description illustrates the impact of friendship on the long-term rehabilitation of Erik. Erik was 18, the youngest of four siblings in his family of origin, and had just started college when his situation began to deteriorate rapidly and family members got increasingly concerned about the need for immediate psychiatric intervention. His symptoms included disorganization in thinking and behavior, occasional abusive verbal episodes with family and parents, agitation, insomnia, and ultimately, incomprehensible speech. When admitted to the hospital in May 1973, Erik acknowledged visual and auditory hallucinations, and an inability to distinguish people one from the other. Family history indicated a rigid, strict family which had always pushed Erik to live up to their expectations within their time frame rather than his own.

His progress in the hospital seemed strong. He had quickly recompensated on medication. With the support of the hospital’s individual and milieu therapy program, he had reentered a nearby college on a part-time basis. The separation from his family provided by the hospital seemed to have been an important and necessary ingredient in the progress that he had made. Therefore, somewhat against the family’s wishes Erik was supported in his arrangement to move to the halfway house. He moved into the house in March 1974, after a 10-month hospitalization with a diagnosis of chronic paranoid schizophrenia. The goals for him in the house were fairly explicit. He was to live in a stable milieu separate from his family; to work on being close to others in positive ways; to be increasingly less concrete in his thinking and relational patterns; and, most important, to avoid emotional and physical isolation from both peers and adults. Erik lived in the house for 8 months and made a very solid attachment to staff and other residents. He was able to move from a part-time school program to a full-time job and then, in September 1975 (one full semester before he moved out the house), resumed a full-time university schedule. Erik did well in his academic work during the first semester and, at the beginning of the second semester, moved out of the halfway house and into a dorm at school. This living arrangement was not without problems. Each of three roommates had a different set of friends and associates at school; each was interested in different intellectual and social pursuits; and in general they had very little in common. Erik’s positive expectations of dormitory living had not been fulfilled, but some of those needs were clearly being met through his ongoing relationship with the halfway house and the ex-resident group. Erik and Betty had developed a nonsexual dating relationship that has continued until the present time—3–4 years. (At one point both were experimenting in positive ways with a sexual involvement but, because of tremendous difficulties, decided it was better to limit the sexual aspect of the relationship.) Each has been particularly available to the other in times of stress and a useful adjunct to intermittent therapy. A particularly stressful time for Erik was a plan upon college graduation to leave the area for a year of travel. This was discouraged by Erik’s therapist and family. Betty was available, in addition to the ex-resident group, as a forum for helping Erik to understand the concerns that his therapist and family had had about the venture and helping Erik to make an alternative arrangement for his future. In another situation two roommates who had originally been personal friends of Erik’s had become more friendly with each other, excluding Erik, and planned to move out of their joint apartment into one of their own, leaving Erik without roommates and without two friends. The bitterness and jealousy were great, but the special relationship Erik had with Betty was very useful in supporting Erik’s self-esteem. He could work through some of the difficulties of that situation without reinvolved in therapy or the need for rehospitalization. Erik, more than any of the others in this group, has had periods of good functioning without medication or individual therapy. He has also developed a keen capacity to identify his signs and symptoms of decompensation and has learned to reengage his therapist at those times—occasionally for three or four visits, but at least on two other occasions.
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to reinvolve himself with a 6- to 8-month contract to do more prolonged work on a particular issue. He has also learned to make very effective use of the ex-resident group, house staff, and the larger psychosocial kinship network that he has developed outside of the house. With these people too, he may seek social interaction, activity, or fun; he may come back to the group for a period of weeks as a means of renewing those important contacts or of checking out trusted people his own concerns about his reality testing and the reactions to life stress with which he is struggling at the time. Recently, Erik was encouraged by a departing supervisor at work to apply for the supervisor's job in 3 months' time. Nervous but excited, and confused about the issues involved as well as some of his feelings, Erik arranged to talk with Betty and two other members of the ex-resident group about his decision.

Erik has also been a very real recent support to Betty as she has gone through a brief rehospitalization and new planning for a cooperative apartment living situation outside of the hospital.

The Interactional System in Practice

The extended psychosocial matrix occurs in relation to a variety of ex-resident groupings. These represent housing, work, and social activities, which overlap in various combinations. These, of course, are in addition to the common element of the ex-resident program based at the halfway house. Illustrative of this type of pattern is a group of 17 ex-residents who interact (see figure 1). Here in narrative form starting at the upper left corner we observe the following: Frank, who lives with two non-ex-residents, works with Jerry. Jerry, in turn, lives in an apartment with Hank and Matthew. Jerry is dating Betty. Matthew is dating Carol. Matthew is going to school with Paul and Lennie, and Lennie moves into the apartment with Matthew and Jerry when Hank moves out. Betty and Carol are roommates with Shirley. Shirley at some point leaves and Ruth moves in. Carol works with Anne and Sally. Anne lives in an apartment with two non-ex-residents, both of whom work with Anne. Sally is in an apartment with Theresa and Wynne. Sally also dates Erik who is in a college dorm with two non-ex-residents. Wynne works with Sara and Andrea. Sara and Andrea live together in an apartment.

Thus, we have an interactional system where 17 ex-residents interrelate through the medium of six apartment clusters, one college dorm cluster, one school cluster, three work clusters, and two social clusters. (The visual impression is demonstrative of the interactional system.) It should be noted that on the fringes are the beginnings of non-ex-residents joining the social interactional system.

Relationships have been sustained for several years after the stay in the halfway house in spite of ex-residents moving away from the area, others being rehospitalized for brief periods of time, and the marriage of an occasional couple. It is interesting to note that contacts are often maintained by mail, by telephone, or by including on a vacation trip the visiting of a distant friend. Also the special annual rituals such as Thanksgiving at the ex-resident group leader's home or the Christmas reunion at Berkeley House act as special times of gathering together.

While the ex-resident program goes on in the house, the psychosocial network outside the house program also keeps growing. The ex-resident continues to develop new networks of friends outside the halfway house. Ultimately, his life becomes enriched through increasing capacity to sustain meaningful relationships.

Summary

A crucial factor in community program success is the program's capacity to foster and strengthen an extended psychosocial network of neighbors, friends, and associates at work or school, as well as the extended kinship system. The chronically hospitalized patient and the young, isolated, acutely psychotic adult are both in need of an enhanced psychosocial system when entering a community program. The experience of Berkeley House, a psychiatric halfway house, is related as an example of a program that has achieved successful community
FIGURE I.
INTERACTIONS OF 17 EX-RESIDENTS

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tenure for its patients through the creation of an extended psychosocial kinship system. Four principal ways in which the system was sustained through the Berkeley House program are described: (1) through the ex-resident program; (2) through housing arrangements; (3) through work; and (4) through a variety of avocational and social groupings. The extended psychosocial matrix formed by overlapping groups is illustrated.

References


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