A Social Network Approach and the Revolving Door Patient

by Robert C. Morin and
Edward Seidman

Abstract

Traditional psychiatric treatment approaches have not been very successful with the "revolving door patient." A variety of findings suggest that the social network, as opposed to the individual patient, may be a more viable locus for intervention. A conceptual review and analysis of the literature reveals two constructs salient to understanding social networks: flexibility and stability. The networks of revolving door patients are frequently characterized as inflexible and/or unstable. Assessment methods as well as strategies for balancing flexibility and stability are described. Enlarging the network, increasing multiplexity, and/or reducing the negative effects of attitudinal inflexibility encompass the strategies for increasing flexibility, while developing connections between individuals, generating spans between clusters of people in the network, and increasing multiplexity are recommended for increasing stability. The assets and liabilities of each of these strategies are discussed.

Since the advent of deinstitutionalization, a group of patients alternately referred to as new chronics (Caton 1981), young adult chronics (Pepper, Kirshner, and Ryglewicz 1981), or revolving door patients has emerged. Typically, these revolving door patients demonstrate a pattern of short hospitalization and discharge followed by repeated admissions. The most important characteristic of these patients is that they have rarely been treated successfully. Caton (1981) reports a rehospitalization rate of almost 60 percent and almost 30 percent multiple rehospitalizations in the first year after discharge. Most alternative demonstration programs attempting to facilitate community adjustment are characterized by low rehospitalization rates, although 12 to 18 months after these programs are terminated, patients begin to relapse (Test and Stein 1978; Fenton, Tessier, and Struening 1979; Dellario and Anthony 1981; Test 1981; Salem, Seidman, and Rappaport 1984). Of course, the ongoing instrumental and social support that had been created by these experimental programs had effectively disappeared by that point.

A second important characteristic of revolving door patients is that they are notoriously difficult to work with. Though they are characterized by varying diagnoses (primarily schizophrenia and borderline personality disorder) and symptom profiles, they have similar difficulties in social functioning related to "their acute vulnerability to stress, their difficulty in making stable and supportive relationships, their inability to get and keep something in their lives and their repeated failures of judgment" (Pepper, Kirshner, and Ryglewicz 1981, p. 464). Under stress, their reality testing may be severely impaired, their affect extremely labile, and their impulse control almost nonexistent (Greenwood 1981). Furthermore, the pattern of relatively short periods of acute stress, followed by rapid stabilization, often make it difficult for these patients to perceive their need for treatment. As their symptoms abate, they typically lack insight into the circumstances that led to their hospitalization and perceive their problems as being external and resolved. Immediate release from the hospital is demanded. Upon release, they often sever contacts with mental health professionals, both from the

hospital and the community (Harris and Bergman 1981).

Understanding the importance of social networks is of particular relevance in working with the revolving door patient. The networks of these individuals before their first admission are smaller and more conflictual than those of healthy individuals, and the continued loss of network members after multiple admissions reduces even further the resources available to aid the patient returning to the community (Lipton et al. 1981). Early intervention in this process may help patients retain more of their network's original strengths to build on, rather than having to create a totally new network. While network intervention strategies are not new, they have not been addressed for this population nor, in particular, from a coherent conceptual framework. It is hoped that such intervention will break and/or curtail the revolving door pattern.

Before presenting various techniques of network intervention for working with the revolving door patient, it is vital to gain an understanding of a network's critical components and their relationship to the experience of the revolving door patient. First, network variables that appear relevant to working with the revolving door population are examined. Next, it is argued that these variables are interrelated and combine to determine two critical network constructs: flexibility and stability. Finally, the concepts of flexibility and stability are used to guide the clinician in planning network interventions.

Key Network Characteristics

The major structural characteristics of a network are size and the pattern of connections among network members (density and clusters). The salient relational characteristics in terms of the focal person are multiplexity and attitudes held by network members toward the patient.

Structural Characteristics

Size. The size of one's network has been found to be negatively correlated to degree of pathology (Pattison et al. 1975; Cohen and Sokolovsky 1978; Hammer 1980). Patients with higher levels of social contact before hospitalization demonstrate better outcome (Strauss and Carpenter 1977); this, too, suggests the importance of network size. After reviewing a variety of community maintenance studies, Budson and Jolley (1978) concluded that the presence of a strong psychosocial kinship system comprised of friends and neighbors, as well as family, was the crucial factor in determining program success. Smaller network size may be both a predictor of rehospitalization (Cohen and Sokolovsky 1978) and a result of hospitalization (Lipton et al. 1981).

Larger networks may provide a patient with access to a greater number of resources. If one member is unable or unwilling to supply the type of support desired, the patient can simply turn to another member. It is not true, however, that more is always better and that merely increasing network size is always therapeutic. There are many cases of psychiatric patients pulling their lives together only after the loss of a significant network member (e.g., an overinvolved mother) or group of members (Beels 1981). Clinical experience suggests that network size is not consistently related to positive outcome. Many of the larger networks are so fragmented that patients feel pulled in several directions at once.

Density. Density refers to the degree of interconnectedness, usually defined as the ratio of actual links to potential ones. Results interrelating network density, resources, psychopathology, and rehospitalization rates are contradictory.

Two studies have found density to be positively related to pathology and rehospitalization among ex-patients (Hammer 1963-1964; Pattison et al. 1975). This finding is paralleled among nonpsychiatric populations (Hirsch 1979, 1980). Denser networks develop between individuals who share a common set of values and expectations. Because of this commonality, there is often little support or tolerance for behavior that does not conform to the group norms and expectations. For the psychiatric patient, this may mean that the network holds a single perception of what his or her role is and should be. Attempts to change this role, possibly by becoming more independent, may be met with resistance.

Tolsdorf (1976) failed to find a significant relationship between density and the availability of either tangible or intangible resources. He also failed to find significant differences in density between psychiatric and nonpsychiatric medical samples. Similarly, Cohen and Sokolovsky (1978) failed to find a relationship between density and the degree of pathology or rehospitalization rates. In fact, using an additional measure of interconnectedness, these authors concluded that schizophrenics form less intertwined networks.

Clusters. Hirsch (1980, 1981) has found that boundary density (the proportion of interconnections between the nuclear family network and the friend network) is related to greater symptomatology, poorer mood, and lower self-esteem and,

inversely, to measures of social support in samples of college students, recent widows, and mature women returning to full-time under-graduate study. This suggests that a critical issue regarding connections between network members may be the separation between clusters of relationships.

A cluster can be defined as a group of people richly connected to one another. Clusters are usually composed of individuals who share a common role with each other, e.g., family members, lodge brothers, or coworkers. If these clusters are too interconnected, as in having numerous connections between friends and family, the network begins to look like one large cluster. Consequently, an individual cannot withdraw from one cluster during intracluster tension and obtain support from an alternative cluster. The alternative cluster is too enmeshed with the original cluster to be free of its tension or to hold different values and expectations. This is a particular problem for psychiatric patients because—unlike normal people's networks, which are characterized by five or six clusters—the networks of psychotic individuals contain few clusters (Hammer 1981).

Relational Characteristics

Multiplexity. A multiplex relationship is one in which a network member serves or fulfills more than one role or provides several types of exchange (e.g., advice and information, emotional support) that are important to the patient. Multiplex relationships have consistently been found to be beneficial. That is, they decrease with increasing pathology (Tolsdorf 1976); their absence in the patients' local living environment significantly predicts rehospitalization (Cohen and

Sokolovsky 1978); and they relate to overall satisfaction with one's network and with better support and mental health in nonpsychiatric populations (Hirsch 1979, 1980). These findings hold despite the different ways in which authors operationalize the construct.

Multiplex relationships can be advantageous to the patient in two major ways. Each relationship can be satisfying because the patient can derive benefit from any one of several different content areas, and thus can frequently gain satisfaction even if one type of support is not available at a certain time from a network member. For example, a friend who is unable to socialize with the patient at a particular time may, nevertheless, lend the patient money for a movie. Second, there is less chance that any one type of support will be unavailable, since network members overlap in the functions they serve for the patient.

Attitudes Toward the Patient. While no studies have systematically examined the attitudes of all members of an individual's network, examination of familial attitudes suggests this is an important variable. For schizophrenic patients living with key relatives, the level of "expressed emotion" (EE) on the part of family members has been found to be the best predictor of symptomatic relapse (Brown, Birley, and Wing 1972; Vaughn and Leff 1976; Liberman et al. 1979). The EE rating is based on the number of critical or rejecting statements family members make about the patient, as well as any examples of emotional overin-volvement. The relationship between high EE families and high relapse rates is independent of the patient's level of behavioral disturbance or work impairment.

High EE families are more rigid and demanding than low EE families

(Vaughn and Leff 1981). They are highly intrusive, making repeated attempts to establish contact and to dictate the behavior and lifestyle of the patient. They do not perceive the patient as legitimately ill and are intolerant of his or her symptoms. The patient often cannot deal with the overstimulation of this socially intrusive environment. If the patient is unable to withdraw from it, the underlying thought disorder may be manifested in florid symptoms resulting in rehospitalization. Clinical observation reveals that most revolving door patients' families fit this high EE pattern.

Just as with network size, density, cluster presence, and multiplexity, the attitudes of the family are not the sole determinants of success or failure in the community. Patients living with low EE families also relapse, and better than 40 percent of those from high EE families remained in the community (Brown et al. 1972). Further research is needed to determine the effect of nonfamily members holding the high EE attitudes.

In summarizing the network characteristics that are potentially important to the well-being of the revolving door patient, we are left with less than a clear picture. Never-theless, in most cases, large network size, distinct clusters, multiplex relationships, and network members holding tolerant, nonintrusive attitudes toward the patient appear to be independently related to positive outcome.

Emerging Constructs

Flexibility

The difficulty in obtaining consistent findings for any one of the network factors may be a function of their

interrelationships and the fact that they all contribute to network flexibility. One network variable providing flexible support may offset another variable that does not. For example, the negative effect of a high EE family can be reduced by having access to social contacts outside the family. Almost 70 percent of those patients whose network options centered largely on their families (i.e., they spent 35 hours a week in contact with their families) were rehospitalized. Those with outside contacts who spent less than 35 hours a week in family contact had a relapse rate of less than 30 percent (Vaughn and Leff 1976).

Watzlawick, Beavin, and Jackson (1967) have suggested that fixed, rigid patterns of interaction characterize families of patients, while flexible patterns characterize less psychopathological relationships. In a flexible network, the positive functions, e.g., acceptance and support, are available both when symptoms are being experienced and when they are not. A flexible network provides the patient with the opportunity to experiment with other social identities, such as friend, wage earner, club member, spouse. Conflict between the patient and network members, or between network members in general, does not result in the patient's losing all network resources. The patient can temporarily withdraw from an area of conflictual overstimulation and not suffer from social isolation because there are other network members to fall back on. If a key network member becomes unavailable, other network members are available to provide, at least partially, the lost support.

Flexibility is a function both of the number of alternative routes available for gratification and of the "flexible" attitudes of network

members. More network members, more clusters, and more multiplex relationships all add to the number of social arenas in which the patient can experience different roles and obtain different types of support. The increased options decrease dependency on any one network segment, so that if one member or cluster has difficulty accepting the patient's symptoms, he or she can turn to another member or cluster. Similarly, multiplex relationships increase options by increasing the probability of overlap in the type of support the network supplies. Thus, if the person a patient usually turns to for tangible assistance is unavailable, another network member can take over that function.

The accepting, nonintrusive (low EE) attitude of network members provides the same type of flexibility within a specific cluster. Network members with these attitudes do not demand the patient play one role (either "normal" or "sick") but provide support regardless of the patient's current level of functioning. Also, since low EE members do not demand to be involved in all aspects of the patient's life, they are more supportive of the patient's taking advantage of the flexibility the network's structure offers.

The flexibility of a network can be operationalized as the sum of the number of network members, the number of clusters, the degree of multiplexity, and the level of attitudinal acceptance. However, network research beyond its current embryonic stage of development is required to determine how much weight to attach to each of these components.

Case Example. The concept of flexibility may be clarified by examining the network of a revolving door patient and observing how it is

inflexible. Mr. S. was a 26-year-old patient experiencing his eighth psychiatric hospitalization in 6 years. Typically, he was returned to the hospital after having behaved in a threatening and assaultive fashion at home. Increased drug use often preceded readmission.

Mr. S.'s network consisted of three small clusters: a family cluster, a friend cluster, and a hospital cluster. The hospital cluster was unconnected to any members of the other two clusters. There was only minimal contact between the family cluster and the friend cluster. As with many revolving door patients, Mr. S. would typically stabilize within a month and want nothing to do with the hospital. Consequently, the hospital cluster would drop out of his network as soon as he was discharged.

Mr. S.'s family cluster consisted of his mother, with whom he lived, a younger brother with whom he seldom interacted, and an older sister whom he saw twice weekly. His family was clearly of the high EE variety. His mother was overinvolved, intrusive, and demanding; she was constantly concerned with trying to meet all his needs. She was also frustrated by his illness and interpreted his problems as being totally under his control. His sister was hypercritical of him. When Mr. S. returned home, he initially was rewarded for his dependency, but excessive demands were placed on him very quickly. Mr. S.'s friend cluster consisted of three young men in his mother's neighborhood. These men were unemployed, as was the patient. They did little with the patient but socialize, usually around drug use.

Mr. S.'s network was inflexible in that the number of routes he had through which to satisfy his needs were few. Upon discharge, he had

only two small clusters within which to function. His mother was his major multiplex relationship and his primary access to instrumental support. This made him extremely dependent upon her. His friends provided a major source of emotional support. Problems with either of these clusters resulted in loss of the corresponding support. Because neither of these clusters provided access to job or housing information, Mr. S. had no one to turn to for aid in these critical life domains.

The attitudes of these two clusters also made it very difficult for Mr. S. to break out of his role of a revolving door patient. If he spent all his time with his family, their intrusiveness and criticisms would generate sufficient stress to result in decompensation. On the other hand, his friends encouraged his unemployed status and his drug use, which would also result in decompensation. The only roles for which Mr. S. received support were those of an "inadequate, sick son" and a "drug-abusing street person." The limited and rigid structure of these clusters, as well as the intrusiveness of the network actors were the antithesis of the network flexibility needed for improved community adjustment.

Stability

Closely related to the concept of flexibility is that of stability. In a sense, the network must have the flexibility or adaptability to remain the same, to retain the same membership over time, even if the patient is temporarily removed from it because of rehospitalization. Leaving the hospital becomes more difficult if the patient finds the social network decimated each time he or she returns home.

Hammer (1963-1964, 1980, 1981) has demonstrated that, for both psychiatric and normal populations, unsupported connections (network members who are connected only to the focal person and not to other network members) are most likely to be lost over time. It is reasonable to speculate that unsupported connections in the networks of revolving door patients may be lost for two reasons. First, relationships with these patients are often quite stormy and stressful. Unsupported connections cannot receive support from others who know of, and can empathize with, the difficulties of being involved with the patient. Without this support, the network member may become frustrated and burned out and may withdraw from the patient. Second, rehospitalization often means that the unsupported connection must look elsewhere to obtain the gratification that was received from the relationship with the patient. As his or her needs are met elsewhere, the probability decreases that the member will maintain the perseverance and initiative required to reestablish a relationship with the patient.

Just as connections between individual network members increase stability, it can be hypothesized that connections (spans) between clusters increase the likelihood that the clusters will maintain their involvement with the patient. Often the patient will temporarily withdraw from certain clusters, e.g., a work cluster. Such clusters may remain part of the patient's network by virtue of their spans to other clusters. Spans between clusters may also enable clusters to provide support for each other and prevent them from working at cross-purposes. Information not available to one cluster may be provided by another, which may result in a new perspective for

dealing with the patient. Also, in times of crisis, spans may enable a network to activate all its resources quickly and to develop a unified approach to the problem.

The presence of multiplex relationships also contributes to the stability of a network. A relationship based on more than one form of interaction may signify a greater level of involvement for both the network member and the patient. This greater involvement may enable the relationship to weather stormy times or make it possible for interaction to continue even during rehospitalization.

While stability is certainly important, maximum stability would hinder flexibility. Flexibility requires that the network provide a variety of types of relationships. This is promoted by members not being overly interconnected and by the presence of relatively independent clusters. Stability is promoted by connections between members and by spans between clusters. Consequently, a balance must be reached such that members are sufficiently connected to prevent fragmentation and eventual network disintegration but not so connected that the patient is functionally interacting with only one cluster.

Combining the need for both flexibility and stability, a picture of an ideal network emerges. This network would be composed of several distinct clusters. While each cluster must be able to operate as a relatively independent unit, a small number of spans should connect the different clusters. In general, totally unconnected members or clusters not connected to any other clusters should be avoided. The network should be dominated by multiplex relationships rather than uniplex ones. Finally, the attitudes and behavior of network members should

fit the model of the low EE family. Members should accept the fact that the patient has a legitimate problem, allow the patient personal space, and be supportive of his or her efforts to function as a "healthy" individual without demanding this be done at all times. In working with the revolving door patient, the clinician's task is to help transform the patient's inflexible, and frequently unstable, network into one having the preceding characteristics.

Network Intervention

A network meeting provides a critical locus for network intervention (see, for example, Speck and Attneave 1973; Garrison 1974, 1981; Rueveni 1979). Ideally, these meetings should be part of an ongoing treatment approach while having a crisis orientation. New network members are introduced, and all members are helped to discover new ways to interact with the patient and one another. Experience indicates that it is best to meet with 4 to 10 members of the patient's network at a time, rather than with the entire network. Attempting to assemble all members of a network on a regular basis has major logistical problems and may end up generating resistance and resentment among them. Also, frequent meetings of the whole network run the risk of generating too many connections between members and reducing flexibility. Network meetings with subsets of the patient's network reduce both these problems.

Increasing Flexibility

The strategy used to increase network flexibility will, in part, be determined by the ascertained source

of inflexibility: the lack of sufficient supportive alternatives; the negative effect of critical, hostile, or overinvolved (high EE) members; or a combination of the two. The lack of sufficient supportive alternatives can be dealt with either by enlarging the network or increasing the degree of multiplexity in existing relationships. The negative effect of high EE members can be dealt with by reducing contact with those members or by modifying their attitudes (see table 1).

Increasing Network Size by Adding Clusters. Network size can be increased by adding individual members or clusters of members. Adding clusters is particularly useful because it provides the patient with numerous connections at one time; since these connections are also connected to one another, a certain level of stability preexists.

Clusters, as well as individual connections, can be classified as formal or informal (Beels 1981). Formal clusters exist for some reason other than the reciprocal exchange of services among members. They may have scheduled meetings and often have prescribed roles for each member. They tend to be enduring organizations. A vital characteristic is that these clusters will continue to exist with, or without, the input of a specific patient; thus they require little initiative or exchange by the patient in order to maintain membership. Formal clusters with whom the patient typically has contact include the family, the hospital, and human service agencies in the community.

Informal clusters, on the other hand, tend to lack the structure of formal clusters and depend more on the successful initiation, and receipt, of social exchange. With informal clusters, such as friends, the inability to initiate interaction, to interpret

interactions adequately, or to reciprocate support may result in the dissolution of the cluster or the expulsion of that member who cannot participate in the exchange.

Given the difficulties patients have in interacting with others, it is advisable initially to attach them to preexisting formal clusters that will make few demands on them. Another advantage of formal clusters is that since they are not dependent on the patient's involvement, they will continue to exist even if the patient's membership is temporarily curtailed by rehospitalization. The cluster is still present for the patient to return to upon discharge and often welcomes the patient with open arms. Examples of such clusters, to which one might attempt to introduce a patient, are church groups, day and evening programs run by local mental health organizations, and community service organizations such as the Elks Lodge, Lions Club, YMCA, a citizens' group, or neighborhood coalition.

Introducing or reintroducing a patient to a cluster in the community requires a significant amount of work. In attempting to connect a patient to a church, it must be remembered that most pastors have had little contact with severely disturbed people. This is even more true of the congregation. The clinician must pave the way for the patient by meeting with the pastor and relevant church members and educating them about these patients' strengths, as well as their needs, on a regular basis. The church members with whom the patient has routine contact must be seen as part of the patient's network. For example, Mr. S. was referred to a weekly outpatient group that was established in a local church. Initially this group was run largely by hospital staff, but three involved church women

Table 1. Network intervention strategies and tactics

Goal	Source of problem	Strategy	Tactic
Increase flexibility	Lack of sufficient supportive alternatives	Increase size	Add: (1) Clusters (2) Individual members
		Increase multiplexity	Encourage/assist members to: (1) Provide additional types of assistance/aid (2) Take on new roles, re: patient
	Negative impact of high EE network members	Reduce contact with high EE[1] network member	(1) Enlarge patient network (2) Involve patient in daily activity (3) Post-hospitalization placement in a different environment (4) Enlarge network of high EE member
		Modify attitudes of high EE network members	(1) Educate network members re: mental illness (2) Combine high and low EE network members in group as modeling tactic
	Members at high risk of being lost to network	Generating connections	(1) Between unconnected members (2) Between members with similar role/function
Increase stability	Unconnected, vital clusters	Generating spans	(1) Between clusters with similar functions (2) Between clusters in conflict
	Low involvement of network members	Increase multiplexity	Encourage/assist members to: (1) Provide additional types of assistance/aid (2) Take on new roles, re: patient

[1]EE = expressed emotion

eventually took over the meeting. Connections between group members were encouraged by planning parties together, exchanging bus routes, and advising one another on how to deal with community life. Another patient whose network consisted primarily of

his family and mental health professionals was encouraged to attend services at his former synagogue. Now he stays after services and is beginning to use this as a social outlet.

An additional method of adding a

cluster to a patient's network is to move patients into the community in groups. Patients immediately have roommates or neighbors they know. This establishes a reference group that can provide peer support and set up a situation in which patients may

take mutual responsibility for one another's welfare (Fairweather 1980).

Once a cluster of patients is placed in the community, the differences between formal clusters and this informal cluster may become evident. Informal contact, be it with neighbors or even roommates, may remain minimal because neither party feels comfortable generating interaction. Therefore, the clinician must, at least initially, monitor these relationships closely. This usually requires weekly or biweekly meetings with that cluster. To reduce dependency on the hospital further and to generate reintegration into the community, these meetings should take place in the homes of the patients.

Increasing Network Size by Adding Individual Members. Adding individual members to a patient's network is at times more difficult than adding a cluster. Cluster membership often requires maintaining only loose contact with several members of the cluster. Individual relationships tend to require more effort on the part of both parties since they do not have other connections supporting their relationship. Consequently, the clinician may have to monitor and intervene with new relationships even more than with new clusters.

A major source of new network members is past members who have disengaged from the patient's network. Contacting these ex-members and explaining how important they could be in helping the patient and the network, as well as offering the assistance of the treatment team in dealing with any problems that might arise, are often sufficient to get ex-members to come to an initial network meeting. The treatment team may need to do additional work to help the patient and the ex-member work out the

problems that led to the disengagement.

Adding new members to a patient's network often requires that the clinician do some detective work to discover natural helpers in the community, e.g., a bartender who lends poor patrons money and helps regulate their drinking (Collins and Pancoast 1976). These natural helpers must be approached to determine if they might be willing to expand their aid to a specific patient.

Increasing Multiplexity. Another method of dealing with the inflexibility resulting from the lack of sufficient supportive alternatives is to increase the degree of multiplex relationships among current network members. Increasing multiplexity provides the patient with alternative sources of encouragement, advice, tangible assistance, and social companionship. It also tends to add to the total number of exchanges the patient might receive and reduces dependency on any one person for a specific social purpose.

The first step in increasing multiplexity is to determine whether a major deficit exists in a potential area of supportive exchange. The next step in transforming a uniplex relationship into a multiplex one is to encourage that network member to take on a new role during network meetings. For example, the friend who is solely a social companion is helped to provide advice and information by being asked to share how a job was located or a problem with a landlord solved. The friend is helped to translate those experiences into concrete steps the patient can follow. This initial work demonstrates, both to the network member and to the patient, that the member is capable of supplying various exchanges. Through "homework" assignments that call for the new roles to be practiced, these roles

become generalized to interactions outside network meetings.

Initially, network members find it difficult to adjust to additions to their roles. Participants feel awkward in their new behavior and often do not experience the patient as sufficiently reinforcing. Therefore, it is vital that any attempts to fulfill homework assignments be discussed in subsequent meetings. On occasion, to make the transition easier, network members may be paired to learn from each other. A relative who generally offers support and encouragement may be paired with a friend to help the patient find housing or move into a new apartment. This way, network members may learn to work together and provide mutual support.

Reducing Negative Affect Toward the Patient. The greatest source of attitudinal inflexibility in the networks of most revolving door patients tends to be their families. In part, this may be a consequence of the fact that high EE, nonfamily network members can withdraw from the patient's network or the patient from them. It is far more difficult, however, for family members and patients to withdraw from one another.

Overinvolved foster sponsors (supervisors of community residential facilities) are often a major source of attitudinal inflexibility with this population. Most foster sponsors are experienced in working with more severely institutionalized chronic patients; they often control or are involved with almost all aspects of the patients' lives. They do most if not all the cooking, cleaning, and laundry and set rules on when patients go to bed and who they spend time with. Revolving door patients are often more active and independent than chronic patients and may resent foster sponsors' attempts to treat them like children

who must be watched over constantly. Finally, neighbors, friends, coworkers, and even mental health workers may hold some of these attitudes toward the patient.

Reducing Contact. One method of dealing with the effects of attitudinal inflexibility is to reduce the patient's contact with inflexible members. This can be achieved by enlarging the patient's network. If the patient has other social spaces in which to interact, he or she will have less time and less need to interact with those who hold inflexible attitudes. Involving the patient with a daily activity, such as a day treatment program, volunteer work, or a job, will temporarily reduce contact with the family or foster sponsor. A work schedule may be established so that when the patient is asleep the parents are awake, and vice versa. If possible, when the patient is placed in the community after hospitalization, he or she should not be returned to the same critical or overinvolved environment that was home before hospitalization. For example, Mr. S.'s contact with his high EE family was reduced by helping him obtain a job, establishing a schedule for home visits, and reaching an agreement that he would not return to his mother's home to live.

Another tactic for reducing patient contact with a high EE family member is to enlarge that member's network. Parents with low rates of contact with friends and relatives, and single parents with no one else but the patient at home, are more likely to register as high EE (Leff 1976). This suggests that the networks of the families themselves are fairly impoverished, forcing them to interact only with one another to have their needs met. This may also be the case with other overinvolved network members. If the high EE

member's network is made more adequate, that member may have less need to interact with the patient.

Enlarging a member's network is similar to enlarging the patient's network. Also, when selecting which former members of the network to target for reengagement, the clinician may decide to choose an individual who was also previously connected to the high EE member. Thus, both the patient's network and the member's may be enlarged at the same time.

Modifying Attitudes. Another method of dealing with inflexible attitudes is to attempt to alter them. Regardless of how often a patient has been hospitalized, most network members have little understanding of the illness, its etiology, the importance of medication, warning signs of decompensation, and those things of which the patient may or may not be capable. In early network meetings, time must be devoted to explaining the patient's "illness" and dispelling various myths about "mental illness" held by members. As network members learn more about the patient and his or her problems, they may become less intimidated by the symptoms they see. This may increase their ability to respond to the patient more appropriately.

Attitudes and/or resulting behavior may also be modified by placing high EE members in groups with low EE members. This usually involves composing groups from members of different networks. The most common group of this nature is the multiple family group, although the same principles should operate in foster sponsor groups, friends, or neighbors' groups. In all these groups, members can learn by example, seeing how others deal with problems similar to their own.

In practice, it is seldom advisable to deal with attitudinal inflexibility

by either reducing contact or attempting attitude change alone. To obtain the maximum benefit, both approaches are often employed simultaneously. Similarly, since inflexibility seldom stems from only one factor, a variety of techniques for increasing network size, the number of clusters, and the degree of multiplexity—as well as for dealing with attitudinal inflexibility—are typically used at the same time. The specific components addressed should depend on appraisal of the major sources of inflexibility as well as on knowledge of the resources available. Flexibility is a cumulative process. An increase in flexibility of any of the components by definition increases overall flexibility. This, in turn, reduces the potency of any of the other inflexible components. Thus, if the clinician is aware of some strong natural helpers who could easily be added to the patient's network, this addition should probably be attempted first, even though the major sources of inflexibility may be a lack of independent clusters or attitudinal inflexibility.

Increasing Stability

Increasing the flexibility of a patient's network is often only part of the work required. There must be some certainty that the network's positive aspects will endure. The key components creating network stability are connections between individual members, spans between clusters, and a high percentage of multiplex relationships (see table 1). Since methods of increasing multiplexity have already been discussed, they are not reiterated here.

Generating Connections and Spans. The first task is to target which connections and spans should be generated. Since unconnected members (those connected only to

the patient) are at high risk of being lost by the network, connecting them to others is a high priority. Such individuals may be integrated into the network by connecting them with another network member who serves a similar role with the patient. Connections between two friends or two coworkers are encouraged, because such people are more likely to have something in common than a friend and a coworker.

Similarly, spans should be generated between clusters that perform similar functions. Thus, spans should be generated between all mental health clusters so that services are not duplicated or undermined. Clusters that the patient may play off each other, e.g., the treatment staff and the family, should have a couple of spans to reduce this process. Any clusters that are in conflict, by virtue of the conflicting demands they place on the patient, should also be connected. It must be remembered, however, that the various clusters' independence must also be preserved to provide flexibility. For this reason, no more than two or three spans between clusters should purposely be generated.

The network meeting is the major forum for beginning to develop the desired connections and spans. Here individual members or representatives of different clusters may meet each other for the first time. The clinician can facilitate interaction by helping to resolve differences, encouraging future interaction, and helping participants discover common interests. For example, Mr. W.'s network consisted primarily of his foster sponsor, employees at a local topless club, and hospital staff. The foster sponsor disapproved of Mr. W.'s going to the club and attempted to limit his visits. This agitated the patient, and he would

return to the hospital rather than face arguments at home. A network meeting was convened with the manager of the club, the foster sponsor, Mr. W., and the treatment team. During the meeting, specific times were mutually agreed upon for Mr. W. to attend the club, and both relationships were maintained. Later, when Mr. W. was in the new foster home, network meetings included both old and new foster sponsors.

To encourage further interaction, the clinician never takes full responsibility for arranging subsequent network meetings. Connections are stimulated by having several members contact other members or other clusters. During the network meeting, future contact is arranged by establishing that certain members will work together to help the patient deal with a specific problem. Connections are also encouraged by the treatment team's referring a network member or cluster back to other members or clusters. Early in the network process, network members are very dependent on the treatment staff. They call for assistance with any problem that arises. The treatment team facilitates connections by directing members to other members who may be of assistance. For example, to generate spans between the family and other clusters, a parent may be directed to the leader of the patient's church group and a representative of a community agency for help on enlisting the aid of these clusters in finding housing for the patient. As the connections and spans become stronger, individual members and different clusters will turn to one another more and more, and the treatment team can begin to minimize its involvement.

While increasing stability is often easier than increasing flexibility, it is no less important. Most revolving

door patients, particularly early in the networking process, will be rehospitalized periodically. To have their networks decimated each time this occurs, or each time there is network conflict, results in needless suffering for both the patient and the network.

Summary

In the last 10 years it has become evident that the traditional modes of psychiatric treatment are not effective in dealing with revolving door patients. Rehospitalization rates remain high, and many patients who stay in the community continue to lead a marginal existence.

A variety of findings suggest that the focus of intervention should be on the patient's social network, particularly its flexibility and stability. It is important that a patient's network have the flexibility to provide support regardless of the patient's behavior or the social identity being attempted, and regardless of any conflict that may exist within the network. Furthermore, the network must endure over time, i.e., remain stable.

Networking, however, will not solve all the problems that exist for the revolving door patient. Patients may still require occasional short hospitalizations, as do Mr. S. and Mr. W., although the duration and frequency of these hospitalizations may be greatly reduced. In addition, treatment strategies for common deficiencies in social and work skills, as well as for substance abuse, must be specifically designed and incorporated into comprehensive treatment plans. Experience has demonstrated, however, that merely addressing these treatment issues is not sufficient to enable such patients to succeed in the community. The

clinician's major focus must turn toward the patients' networks. Careful assessment of the networks and appropriate interventions that increase flexibility and stability promise to help slow and reduce the revolving door pattern.

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The Authors

Robert Morin, Psy.D., is Staff Psychologist at St. Elizabeths Hospital, Washington, D.C. At the time this manuscript was written, Edward Seidman, Ph.D., was Director of Clinical and Community Psychology Training and Associate Head of the Department of Psychology at the University of Illinois at Urbana-Champaign. Currently, he is Dean of Research and Vice President of Bank Street College of Education, New York, NY.

Announcement

The Family Support Group of the Northeast Ohio Chapter of Alliance for the Mentally Ill is compiling a resource list of all facilities that are available to and provide services for those afflicted with schizophrenia. All information, inquiries, and cooperation are solicited. Please contact:

M. Jaffe
2447 Edgerton Road
Cleveland, OH 44118