The Journal of Sociology & Social Welfare

Volume 6
Issue 1 *January*

Article 7

January 1979

Elements of the Perpetuation of Dependency in a Psychiatric Halfway House

David R. Maines
Yale University

Marilyn A. Markowitz
Upsala College

ELEMENTS OF THE PERPETUATION OF DEPENDENCY IN A PSYCHIATRIC HALFWAY HOUSE

David R. Maines
Yale University

and

Marilyn A. Markowitz
Upsala College

ABSTRACT

Halfway houses are intended as helping institutions for those who are attempting to make the transition from institutionalized mental health facilities to autonomous living in the community. In spite of the manifest goal to produce independence for its residents, however, the halfway house contributes to patterns of dependency. In addition to the network nature of mental health care, we identify three dependency-perpetuating elements: role commitments, language, and mixed messages. These elements are analyzed as both social organizational and social psychological processes, and their implications are discussed.

Our intention in this paper is to identify and examine elements of a psychiatric halfway house which contribute to the perpetuation of patterns of dependency for residents who live there. By dependency, we refer to a passive perspective taken by the person in which decisions concerning his conduct and control of his life organization are taken over by others.[1] This examination is significant because halfway houses, as part of the therapeutic community oriented to helping persons with emotional problems, are designed both in format and philosophy to promote greater autonomy and independence for residents. Moreover, halfway houses themselves are becoming increasingly significant settings (Budson, 1973). The decline in the populations of mental hospitals (Schafer et al., 1975: 68) along with the general therapeutic shift from an emphasis on individual pathology to one based on a systems perspective has led to increases in community based mental health facilities (Gralnick et al., 1975). Our analysis, therefore, pertains to a critical area in the field of mental health, and focuses on those elements and processes in psychiatric organizations which are counterproductive.[2]

The Research Setting

A psychiatric halfway house is designed as a temporary residence for those having experienced some kind of emotional breakdown who are attempting to make the transition from the structured environment of a psychiatric hospital or treatment resource to some type of automous life in the community.[3] White Plains House (WPH), which is the only halfway house in Westchester County, New York serving both men and women, is located in a large apartment building in which half of the space houses nine men and half houses nine women. Each unit contains a living and dining area, a kitchen, three bedrooms for residents, and is managed by a live-in resident manager who has his/her own living facilities. The average age of the residents is about thirty, although slightly higher for the females. The residents, who stay at WPH from nine to twelve months, pay fees ranging from $275-336 per month depending upon ability to pay; and their incomes are derived from savings, earnings, welfare, Supplementary Security Income (SSI), or some combination of sources. These fees cover the costs of room and board as well as the benefits of the program. Basically, the program involves a commitment to a day time activity, such as attending college, working on a paid or volunteer basis, or participating in a day hospital program; outside psychiatric treatment; and attending weekly group and individual counseling sessions at WPH. In addition to the resident managers, the staff consists of a full time social worker who also is the Director of WPH, a part time social worker who is the assistant to the Director, a consulting psychiatrist, and a secretary.

Our data are based primarily on a participant observation study of one halfway house, WPH, although we have also obtained information regarding the operation of other halfway houses in the region. These data include observations of interaction between residents and staff both in everyday life and counseling situations, informal interviews with staff and residents, and cover a time period of approximately one year. Although not directly relevant to our concerns in this paper, the data are supported by portions of a follow-up survey of former WPH residents.

Theoretical Considerations

As an organization, the psychiatric halfway house can be viewed both in structural and processual terms. Structurally, it is part of a network of agencies and treatment resources which variously treat people with emotional problems as well as act upon them. The analytic imagery of how such networks impact upon clients is thoroughly described in Wiseman's (1970) study of how skid row derelicts are processed by public agencies. The critical point to make concerning this structural

perspective is that patterns of activity presuppose and intersect with other patterns of activity which serve to commit persons to certain lines of action (Gerson, 1976). Processually, the halfway house can be seen as an organizational context which presents to those in it certain kinds of situations to which they must respond and as an organizational contingency which structures the relationships between persons whose careers intersect there (Glaser and Strauss, 1968). Thus, the boundaries of the halfway house are defined in terms of interorganizational relationships while its dynamics are defined in terms of interpersonal relationships taking place within it.

Clearly, these two views are closely related, and, in fact, represent in their relationship one of the classical theoretical problems in sociology; namely, the relation between structure and process. It is a problem involving the interaction between the determinative and indeterminative phases of social life, which was central in the work of the early interactionists such as Mead, Dewey, and Park. In their work, society was conceived as a communication matrix which provided the structuring contexts for human activity as well as a mechanism for transforming human conduct. To understand human group life, then, one must understand communication processes and the social mechanisms which give them shape and form.

From the standpoint of symbolic interactionism, there is no social reality independent of communication. It is through such communication that not only interpersonal relationships but social structures are possible (Maines, 1977). Strauss (1959) has emphasized the importance of language, especially naming, as a means of creating and maintaining social order in human relationships. He notes that naming does more than merely indicate; it identifies something as a social object in relation to something else. It is the meaning of names, however, rather than the names themselves which give rise to action. Naming is a directive for action which mobilizes expectations with respect to the object named. The relationship between communication and activity, then, is essential for locating the nature of social roles, which themselves are related to identity (Gross and Stone, 1964). Since identities place the person in some kind of social context and thus confer situated meaning on him, roles become those expectations which are mobilized by announced and situated identities. In interactionist terms, this conceptualization brings us back to the problem of the relationship between structure and process, but expressed at the level of interpersonal relationships. Identities create boundaries. They locate us in social terms by defining who and what we are, and through the act of placement, meaning is established which has the effect of permitting some kinds of behavior while limiting others.

This conceptual framework has been shown to be quite useful in the analysis of widely divergent areas (See Maines, 1977; in press). We also find it eminently useful for understanding the dysfunctional aspects of the psychiatric halfway house. In presenting our data, we shall attempt to convey the sense in which communication processes underly considerations of situated identities, and how these processes contain elements which inadvertently perpetuate identities in such a way that patterns of dependency remain ongoing and to a degree enchecked.

Elements of Dependency Perpetuation

One thing that is recognized by network approach to mental health problems is that more and more public agencies, hospitals, out-patient clinics, rehabilitation centers and other facilities are becoming involved in any given patient's medical biography (Connery, 1968). The psychiatrist, psychoanalyst, and clinical psychologist are now joined by psychiatric nurses, psychiatric social workers, and paraprofessionals as those working in public and private spheres who have a say in the patient's diagnosis and treatment. This increasingly complex system of mental health resources creates a network of dependency in which the patient comes to routinely rely upon these services. The residents at WPH, most of whom have or have had some type of psychotic disorder, reflect this system. All have medical biographies involving institution-alizations, the routine use of prescribed medication, and treatment by a number of therapists. The residents are used to being bureaucratically processed, and in a significant sense they have acquired a perspective of themselves in which they place their own sense of self in a dependent relationship to therapy-oriented organizations. These biographies also frequently involve cycles of movement between hospitals, peer, and home environments, which only broadens the community base of their dependence on others. Hospitals provide therapy, counseling, and medication; public assistance programs provide economic support; families sometimes function to maintain unhealthy dependent relationships; and the association with friends or acquaintances who also have emotional problems creates a perpetuating contact system. The pattern of emotional, social, and medical dependency, therefore, is quite broad based, and operates to keep the person in the mental health network as one who is seen and who sees himself as unable to care for himself (Ferguson, 1975: 406).[4]

It is precisely the function of the psychiatric halfway house to systematically intervene and attempt to break this cycle of dependency by removing the family, when appropriate, as a perceived necessity and by reducing and eventually eliminating the need for therapy, medication, and public assistance. An orientational booklet given to all new residents of WPH entitled Handbook for WPH Residence, for instance, states that:

> The goal of WPH is to prevent readmission to an institution and to give constructive assistance to those who are desirous of becoming selfsustaining citizens; finding employment, enrolling in vocational or academic programs, or resuming responsibilities as homemakers.

The goal, in other words, is to produce autonomous individuals who are capable of creating other biographies which do not involve an unhealthy dependence on family and therapy-oriented relationships. There are certain processes and elements in the organization of WPH, however, which inhibit the attainment of that general goal. We have identified three such elements, some of which intersect with other community resources, which we will consider under the categories of (1) role commitments, (2) language, and (3) mixed messages.

Role Commitments. Participants in any organization typically develop commitments and attachments to their roles within it. The nature of such commitments involves solidifications of meaning in the person's interpretation and enactment of role requirements, and may be thought of as extremely "sticky" insofar as they locate the person in relatively inflexible identities. For a number of reasons, the person's role performance can take on an invariant quality, and to the extent that one attempts to rigidly maintain an organizational identity and its implied role relationships, counter-productive behavior may result (Katz and Kahn, 1966). Several instances of such dysfunctional conduct were observed both among the residents and staff of WPH. Consider the following observations made concerning the residents.

> S (a female having lived at WPH for ten months) was faced with having to leave there. She was reluctant to do so because of what she saw as stressful circumstances facing her in the near furture. She requested that she be allowed to extend her period of residence for an additional five months. Her reasons were considered valid by the staff, and the extension was granted. In a counseling session about a month later, S requested still another extension which, if granted, would have resulted in her staying at WPH for nearly two years. S offered several reasons, seen by the staff as rationalizations, for why this second extension would be legitimate. For example, she felt that moving would be more difficult in the winter, that apartments would be more available in the summer, and that her anticipated additional college course work would produce stress. She also stated that the person she was expecting to move out with wouldn't be ready until then (this was interpreted by the counselor as a projection of her own reluctance to move out).

Although S may have felt that the previous extension legitimated her second request, they clearly reflect her desire to maintain her relationship with WPH. She felt secure and supported in her position there, and variously commented to one of the staff members that she "feared living independently of WPH," that she "dreaded the day that she would move out," and that if she "could live there forever she would." Such instances of self-perpetuating dependency occur rather frequently. Consider the following.

> M (the youngest female resident) raised the issue of her dependency in a group counseling session by indicating that someone in her day activity program had labeled her a "dependent." In a rather helpless and childlike manner, she said to the group, "I don't want to be dependent. What should I do?" This became the group topic for that meeting, with other group members asking M for concrete examples and providing feedback to her. M initiated topics concerning herself in the next three sessions. In another meeting, for instance, she began with her dilemma regarding her eligibility for welfare, and after describing the problem, she looked to the group and said, "I need to stay here to learn how to be independent. What should I do?" This same question "What should I do?", was asked (helplessly) at two subsequent sessions concerning other problems in M's life.

Once again, this observation illustrates how matters of dependency and dependency perpetuation are built into the residents' dialogue and sense of self. Furthermore, this dialogue and perpetuation are usually not a part of the residents' consciousness. It was only after the group leader asked the group to reflect and comment on what had been happening during the four previous sessions that M became aware of how she had transformed the group into a mechanism on which she depended for solutions to her problems.[5]

These examples illustrate the obdurate quality of dependency as well as providing some measure of the extent to which intervention on the part of the psychiatric halfway house is problematic. There exist role commitments among the staff, however, which further serve to foster dependency.

> One of the residents was eating in the living room and had dropped some food crumbs on the floor. She left and didn't clean the floor, which she knew was her responsibility. The resident manager noticed the crumbs, and immediately took out the vacuum cleaner and started to clean the floor. Another resident, observing this, suggested that the person who had dropped the crumbs should be held responsible, and that the resident manager should not do the cleaning. The resident manager responded by saying, "If someone comes in to visit and sees this mess, who gets the bad name? I do."

There are several other instances in which resident managers have taken over the responsibilities of the residents by fulfilling the residents' obligations. These obligations are explicitly built into the WPH program as a mechanism through which residents might acquire certain instrumental skills which would enable them to eventually care for themselves. This process is undermined through the resident managers performing those tasks as a means of keeping themselves in good standing with the organization. This inadvertant support of patterns of dependency occurs also among the professional staff.

> B (the part time social worker at WPH), who also has a private psychotherapy practice,was asked by a resident who was successfully leaving the program if she could see B as a private patient after she left. B consulted with the Director of WPH concerning the propriety of such a relationship. The Director administratively vetoed the proposed treatment, and recommended that the resident either visit B informally at WPH or participate in the only post-resident program available which was a task-oriented group in apartment living.

In many respects, the resident's request represented an embracement of an autonomous life style. She was able to make a treatment commitment which would involve her commuting to New York City and paying a fee. She also brought up the possibility of securing a job in the City. This, indeed, was a mark of health for the resident, and was interpreted as such by B. The Director's suggestions were dependency-fostering, since the resident's contact with B would have taken place at WPH and in terms of WPH policy. Clearly, the Director's role commitment was in maintaining her position of power in the organization, and her responses to B were intended to serve as a mechanism for limiting B's options, which reinforced the power boundaries of the Director's definitions of her role.[6]

To the extent that role commitments result in an ability to adapt to situational demands, organizational goals become at best secondary in importance. This is an especially crucial process insofar as role commitments involve elements of social control. In the case of WPH, these elements feed into ongoing staff identities but at the expense of the organization's goal to provide skills which would enable residents to adopt autonomous life styles.

Language. The organization of language is closely related to and a part of the organization of a community (Hymes, 1974). This, of course, is a fundamental approach in socio-linguistics, and it demands that attention be devoted to how groups talk to and about themselves. One thing that is clear about the psychiatric halfway house as well as the field of mental health in general is that there is a pervasive vocabulary and linguistic

taxonomy in use whose meanings reflect patterns of dependency and in some respects contribute to the maintenance of dependent relationships.[7] Part of the dynamics of this process is that organizational labels are used which place people in classifications which then indicate to the person and to others how they are to be treated. In our examination of language, we make distinctions between these kinds of labels in what we refer to as structural vocabularies and interpersonal vocabularies.

Structural vocabularies refer to conventional terms and labels which are systematically used by public agencies and mental health facilities as a classification system which serve to order the array of emotional problems experienced by people. Given that these vocabularies are systemic in nature, there are many examples. Consider, for instance, the extent to which the term "disabled" is used with reference to people with emotional problems. SSI has "permanently and totally disabled" as one of its eligibility categories into which those with emotional problems fall; there is "disability" insurance; and Westchester County issues cards entitling the holder to fare reductions on public transportation which have printed on them the term "disabled." This card must be shown each time in order for the person to receive benefits. One of the residents of WPH, in addition, had to participate in the Institute for the Crippled and Disabled in order to maintain her sponsorship by the Office of Vocational Rehabilitation.

Szasz, of course, has argued that the entire concept of mental illness is invalid, and that the conventional association of mental illness with physical illnesses such as "syphilis of the brain or delirious conditions... in which persons may manifest certain disorders of thinking and behavior" (1970: 12) is, in fact, dysfunctional for the person with emotional problems. This applies not only to the term "mental patient" but to "mental hospitals," "state institutions," "hostels," and "psychiatric halfway house."[8] What we are pointing out is that public assistance and mental health resources use a conventional vocabulary containing implied identities which are imposed upon their recipients, and that these implied identities can become actual social identities (Goffman, 1963: 2). The relevance of these vocabularies and their implied identities is that in order to receive benefits from these resources, the person must establish "need" (i.e., dependency), and that once established, the person becomes part of the dependency-perpetuating system.

Interpersonal vocabularies refer to those terms which enter the dialogue in the psychiatric halfway house. For the most part, this dialogue is a carryover from the residents being subjected to structural vocabularies, and takes on form and meaning in terms of the incorporation of implied identities. Residents, for example, frequently can repeat the psychiatric diagnostic categories in which they have been placed. The meaning of these diagnoses typically are interpreted in terms of personal deficiency and stigmatization (Goffman, 1963: 7), and serve as a convenient vocabulary of motives legitimizing felt dependency. Reflexively, this vocabulary feeds into ongoing patterns of dependency.

The internalization of these dependency-laden identities, however, should not be seen as inevitable or fixed once and for all. Identities not only can but must be negotiated (Glaser and Strauss, 1964). For certain activities, such as using YMCA or YWCA facilities or shoping at the supermarket, the resident must show a card (a written vocabulary) which establishes an affiliation with WPH. The card, then, contains an identity. Residents frequently refuse to engage in these activities, and candidly state that this refusal represents the rejection of the identity. The critical dimension of such identity negotiation centers around matters of self-interest. In order to receive social security benefits, for instance, the residents must verify residence at WPH, and they willingly admit to the affiliation. It is also useful to affirm that association when attempting to become part of a day hospital program or obtaining a volunteer position. In other occasions, such as applying for a job, renewing a driver's license, or applying for college admission, the resident will use the street address of WPH rather than the name. Thus, the resident will differentially announce "WPH" through manipulating the extent to which he makes public the association of the term "WPH" with himself.

In addition to these processes, certain terms are built into the organization of WPH which are dependency-perpetuating. The distinction between "staff" and "resident," for instance, represents a hierarchy of control in which residents often routinely defer to staff authority. Even the term "resident" itself has dependency connotations. Other terms which have been used to refer to persons utilizing other psychiatric halfway house facilities include "tenants" and "members." Interestingly, these terms also were used in these other halfway houses to refer to the professional staff, thus attempting to eliminate status and role differences.[9] Other value-laden terms include "group leader" which is used in group sessions and which undermines the concept and goal of group autonomy (Riehman and O'Brien, 1973); "house rules," which refers to WPH's expectations of the residents (this term has seen been replaced with the more egalitarian concept of "mutual expectations" which implies a sharing of responsibility); and being "kicked out" of the program for not meeting WPH expectations (this phrase has since been replaced by the concept of "its your choice" which more sharply focuses on the nature of the residents' participation and decision making in the program.

It is important, then to focus on the linguistic nature of mental health resources simply because the vocabularies used there contain meanings which are frequently incorporated into the person's identity which contribute to the self-perpetuating patterns of dependency.

Mixed Messages. A unique feature of the symbolic interactionist approach to interpersonal relations is that they are seen as taking place in and through communication processes (Deutscher, 1969-70), and that constructed realities are seen as never fully completed or unambiguous (Glaser and Strauss, 1964). Human social action is problematic and thus must be handled through interpretive processes (Blumer, 1962) in which persons bring a measure of reality to the interactive situation and then negotiatively construct whatever degree of consensus exists for them at the time. This approach has its complement in the field of mental health in the concept of "mixed messages," which refers to those processes involving different and contradictory, confusing, or incompatible realities communicated between two or more persons (Bateson, et al., 1956). The critical nature of mixed messages is that the incompatible realities put the person in a "double bind" situation in which an appropriate behavioral response is either difficult or impossible. An example of a mixed message was observed in an intake interview in which the applicant and her mother, both living together, were present. The interviewer asked the mother what her feelings were about the daughter's living at WPH. The mother responded by saying, "I want R to do what she feels is best for her. I'll eventually get over the loneliness." There are multiple contradictory realities communicated in her response, all of which can be summed up in "go but don't go."

In order to effectively intervene in cycles of dependency, the psychiatric halfway house must introduce a measure of consistency into the lives of the residents. One way of accomplishing this consistency is through effective communication. The fact is, however, that the reverse is frequently true. There are at least three spheres of activity directly or indirectly involving the halfway house in which we have observed instances of mixed messages contributing to inconsistency.

The first sphere is structural in nature insofar as it pertains to the interaction between public agencies and the person. The following observation concerning work and welfare illustrates one type of double bind which can take place.

> C, who had a consistent work history, went on welfare during her hospitalization. After discharge, she was admitted to WPH where welfare payments covered her fees, and in addition, paid for her psychiatrist's fees through medicaid. Through OVR sponsorship (which is functionally related to welfare), she obtained training as a secretary. Her first position was part time for which welfare reduced her payments in an amount equal to her salary. C was still on medicaid at this point. When she obtained a full time position, however, she was told that she would be dropped by both welfare and medicaid. This circumstance created a dilemma for her. On the one hand, if she continued in her full time work, she would be able to pay WPH fees on her own, but would not be able to afford her

psychiatrist nor would she have any spending money. On the other, if she left her position, she could stay on welfare and consequently would have all these things. C stated that she did not want to remain on welfare, yet she felt compelled to do so, and did.

This case is consistent with the more detailed description by Levitan et al. (1972) concerning problems encountered in the welfare system. What we wish to emphasize, though, is that it raises serious questions with respect to issues of dependency.[10] C's successful efforts at obtaining work skills and a full time job were steps toward independence. It was in both her financial and emotional interests to have that job (see Rothwell and Doniger, 1966, for an analysis generally supporting this kind of interpretation). This potential independence, however, took the form of an unfulfilled promise. The structural components of the relation between work and welfare contributed to her leaving the position and retaining the welfare benefits. In choosing to remain on welfare, she received greater financial reward but at the expense of losing certain gains acquired in her emotional rehabilitation. There is a dual aspect to this form of dependency perpetuation: she (1) lost her financial independence which (2) contributed to a loss of emotional and social independence. The mixed message coming from welfare, therefore, was "work but don't work."

The second sphere pertains to WPH policies and their implementation. All residents are expected to conform to certain universalistic expectations, some of which were described earlier in this paper. Two of them are: no drinking at WPH and no smoking in bed. These policies, however, are not always consistently enforced.

J, a male resident, was well aware of the no drinking rule. He did drink in his room, though, and left empty bottles there, thus announcing his violations. The resident manager knew of this, but did not confront J with the violation. Some time later, one of the social workers became aware of J's drinking and did confront him. J's response was that he understood the policy and that he would stop his drinking at WPH.

This instance of policy violation is not uncommon since some of the residents routinely smoke in bed. The important point, though, concerns the staff's responses to the violations rather than the violations _per se_ (Cf. Gralnick et al., 1975: 20-23). The resident manager's response to J was inconsistent with known policy, and thus the two messages communicated were "you can't drink but you can," and similarily in the case of the no smoking regulation, "you can't smoke but you can."

Mixed messages also occur in interpersonal relationships, the third sphere. The case described earlier concerning the resident manager cleaning up the food crumbs dropped by a resident illustrates not only role commitment but also interpersonal mixed messages. She communicated to the resident "be responsible but don't be responsible." These interpersonal mixed messages occur in many other instances.

> One of the particularistic expectations of one of the residents was that she would consistently hang up her clothes. Because of her emotional deterioration, some of the staff re-assessed her capacity to fulfill this requirement, and it was not enforced. The resident manager, however, was not included in this re-assessment, and continued to demand that the clothes be hung up.

The mixed message here, "hang up your clothes but don't hang up your clothes," was derived from a breakdown in communication among the staff. As with earlier instances with the no drinking policy, the person is faced with inconsistency from the staff.

As Foley (1974: 16) has pointed out, mixed messages of the sort which result in double binds are part of the etiology of schizophrenia. Moreover, these processes occur initially in the family, viewed by some as the primary source of many debilitating emotional problems (Bateson et al., 1956)[11] and then are re-enacted in other institutional contexts. The continued exposure to mixed messages and their multiple realities thus contributes to the perpetuation of the person's emotional problems which put him in a dependent position in the first place.

Discussion

In our analysis, we have attempted to take seriously Becker's (1962) argument that a proper theoretical framework for analyzing aspects of behavioral malfunctioning is one emphasizing man's capacity for symbolization. We contend that such a framework is best expressed sociologically through the symbolic interactionist perspective, which, since its inception in Pragmatist philosophy, has consistently stressed communication processes as the key to understanding human conduct.[12] The substantive problem we have addressed concerns processes which directly or indirectly contribute to patterns of dependency in the halfway house in the face of its manifest purpose to intervene in cycles of dependency and to produce individuals who can live autonomously in the community. We have shown that the perpetuation of dependency involves the elements of role commitment, language, and mixed messages. The importance of these three elements for the effective operation of a psychiatric halfway house has been generally discussed by Jansen, although from the standpoint of the staff.

> The quality of the halfway house program stands or falls on the caliber of staff members, who need a great deal of support and supervision if they are to see the issues and maintain a firm and consistent position, especially when their self-esteem and popularity are at stake. The exercise of responsibility which the patient has given up by virtue of his breakdown, is, not unexpectedly, the very issue over which the main fights well be fought, often by manipulative acts that corner and threaten staff and make life uncomfortable. The challenge to the staff is to treat the individual consistently as a grown-up, with respect for him as a person, and to mobilize the group's resources to recognize and resolve its difficulties (Jansen, 1970: 1501).

Stanton and Schwartz (1954) have earlier discussed the snowballing effect that staff incompetence can have, and point out that rather than always solving patients' problems the staff may in fact add to them. Too many duties performed for residents by staff members, for instance, decreases the residents' degree of participation in the program. Thus, the therapeutic value of that participation is correspondingly reduced.

Our position is that the psychiatric halfway house should be viewed as an activity system much in the same sense that Sullivan (1954) conceptualized the psychiatric interview. Central to this view is the distinction between mutual activity vs one person acting upon another. The dimension underlying this distinction is the degree of responsible participation. By virtue of staff authority and residents' dependency-laden medical biographies, the halfway house staff have a great deal of control. They have the option of structuring situations containing a high or low probability of producing autonomy for residents. Our data suggest that the staff must be aware of such power differentials, must monitor those power relations, and ultimately must decentralize a critical portion of the decision making process. Riehman and O'Brien (1973) have demonstrated the utility of such power shifts in group sessions in which the group leader is transformed from a relatively powerful position to one of greater mutuality. Thus, like the halfway house itself, the group can become its own independence-producing vehicle, or as Schwartz (1970: 20) says, a "mutual aid" system.

These processes, of course, are organizational in nature. Implicit in that organization are matters of communication and transacted meaning. Power relations find their expression in communication processes in which identities are established and transformed. But society, as it were, gets into the halfway house. As we have pointed out, medical biographies are closely related to the collective histories of mental health networks; and in these histories, language, expressed as structural vocabularies, helps in shaping the realities with which the halfway house must deal. The communication processes involved in the organization of the halfway house, therefore, contain

contingencies which only further complicate its primary tasks. Some of these contingencies are largely out of the realm of control, while others are well within reach. Organizational goals, once established, must be kept in the interaction if they are to remain viable. This requires effective communication and an awareness of the identities that are established and transformed in the interaction. It also requires that persons in responsible positions be aware of the implications of their choices. Both staff and residents must understand that some of their choices are contitioned by and feed into dependency-perpetuating patterns. Such recognition and understanding is necessary if the dependency related, unanticipated consequences of otherwise goal-oriented action are to be checked. Therefore, as Mead and Dewey would have argued, it is only through awareness brought about by effective communication and the responsible mobilization of resources that the psychiatric halfway house can intervene in and break cycles of dependency.

FOOTNOTES

1. The concept of dependency is exceedingly complex. Erikson (1968) has discussed dependency in terms of the development of identities, and sociologists in general have long recognized the significance of dependent relationships in matters concerning cooperative human behavior Fenichel expresses a psycho-analytic perspective of dependency in his assertion that "All neurotics tend to regress, and whenever one feels miserable and one's own activities are insufficient, the old longing for external help appears. Phobics become helpless children again; masochistic characteristics exhibit their 'helplessness;' they all want to induce their salvation through a 'magic helper' (1945: 459). Fenichel characterizes psychosis in a similar manner (1945: 523). Our point of view is that dependency is inherent in all life situations, and that in and of itself it is not necessarily pathological. However, there are circumstances under which such dependency inhibits the person's ability to cope with routine, everyday life activities. It is in this sense of the word that we contend that dependency can become a pathogenic process.

2. We do not overlook the fact that psychiatric halfway houses do contain functional elements in their social organization which contribute to the health and growth of their residents. Our approach is purely analytical in nature in which we selectively focus attention on the dysfunctional aspects.

3. Jansen (1970) distinguishes between two types of principles governing the organization of halfway houses: the authoritarian form in which patients are controlled through administrative mechanisms, and the self-governing form in which democratic processes lie at the center of control. WPH contains elements of each of these two endpoints, and, on balance, probably falls somewhere in between.

4. This clearly has many implications concerning the social control of medical care (Clausen, 1959). Haley (1969) vividly expresses the politics of the psychoanalytic relationship in which the patient, by definition, is in a "one down" position. Dependency, therefore, can be seen both in social organizational and interpersonal terms.

5. It is interesting to note that the group had an investment in M's domination of the group topic and focus. It allowed them to maintain a passive relationship in which they became dependent upon M to initiate topics. They did not have to actively contribute to the group from their own experiences. This fact underlines the normative status of the passive, dependent perspective of self adopted by residents.

6. A policy statement was discovered some time after this incident which seemed to support the director's decision. The wording of the statement, however, was highly ambiguous, and could have been interpreted in a way which would allow B to have taken on the resident as a patient. It is unclear whether or not the director knew of the existence of this policy at the time she made her decision, although there is some evidence that she did not. In a very real sense, though, what she knew at the time makes little difference, because the governing body of the halfway house who formulated the policy are themselves implicated in fostering dependency-perpetuating policies. This kind of process is common to organizations. Manning (1977), for instance, shows that the differential interpretation of organizational rules pervades a great number of organizations, and serves largely to allow personnel to justify decisions which "seem" appropriate to persons holding positions of power.

7. The importance of vocabulary as an indicator of meaning and a directive for activity has also been shown by Wieder (1974) who examined processes of "telling the code" in a halfway house for ex-convicts.

8. As implied by the term, however, halfway houses are not total institutions. Thus, the application of Szasz's analysis here depends upon one's perspective. A resident can be seen as still halfway in a mental health facility or halfway out. Obviously, there is a corresponding emphasis on being dependent or independent.

9. Glasscote et al (1969: 110-111) describe a democratically governed and structured mental health program in which language and words were deliberately selected to refer to various persons and roles in the program in such a way to represent and emphasize that egalitarian structure.

10. To underscore the importance of this point, it should be noted that welfare can put individuals in a number of different types of binds which perpetuate dependency. To meet eligibility requirements, for instance, one must liquidate nearly all assets. One resident at WPH owned a car, and, in order to meet this requirement, had to sell it. This created a problem for him because he now had too much money which kept him ineligible and in addition raised his fees at WPH. It wasn't until after he had spent all his money and proved total dependency that he could qualify for benefits. The irony of this situation from our standpoint lies in the incompatibility between a person having certain autonomy-bearing resources and the system's insistence on total dependency. We might add, however, that the welfare system can also be viewed as a mechanism leading to a form of independence. For those who come from schizophrenogenic families in which dependency-perpetuation is inherent, having the option of welfare produces financial circumstances which might create opportunities for becoming independent from that family. It might be argued, of course, that this merely represents a trade-off, but we contend that it probably is the healthier alternative.

11. The characterization of families as harmful is sometimes political in nature, since it allows an institution to justify not having to work with them. Certainly in some cases families can be quite helpful, even when they continue to bind the patient to them. We are grateful to Harris Chaiklin for correctly suggesting this observation.

12. This approach is not unique either to this paper or to sociology. Sullivan (1953) explicitly defines psychiatry as the field of interpersonal relations. Much of the sociologically relevant work utilizing an interpersonal process approach to mental health is reviewed in Clinard (1963: 386-394).

REFERENCES

Bateson, Gregory, Don Jackson, Jay Haley, and John Weakland "Toward a Theory
1956 of Schizophrenia." Behavioral Science 1: 251-264

Becker, Ernest
1962 "Socialization, Command of Performance, and Mental Illness." American Journal of Sociology 67: 494-501

Blumer, Herbert
1962 "Society as Symbolic Interaction." Pp. 179-192 in Arnold M. Rose (ed.) Human Behavior and Social Processes. Boston: Houghton Mifflin
Budson, Richard
1973 "The Psychiatric Halfway House." Psychiatric Annals 3: 64-83
Clausen, John
1959 "The Sociology of Mental Illness." Pp. 485-508 in Robert K. Merton, Leonard Broom, and Leonard S. Cottrell, Jr. (eds.) Sociology Today. New York: Harper and Row
Clinard, Marshall
1963 Sociology of Deviant Behavior. New York: Holt, Rinehart and Winston
Connery, Robert
1968 The Politics of Mental Health. New York: Columbia University Press
Deutscher, Irwin
1969- "Editor's Introduction: Language, Methodology, and the Sociologist"
1970 Sociological Focus 3: 1-12
Erikson, Erik
1968 Identity, Youth, and Crisis. New York: W.W. Norton
Fenichel, Otto
1945 The Psychoanalytic Theory of Neurosis. New York: W.W. Norton
Ferguson, Elizabeth
1975 Social Work. Philadelphia: Lippencott
Foley, Vincent
1974 An Introduction to Family Therapy. New York: Grune and Stratton
Gerson, Elihu
1976 "On 'Quality of Life'" American Sociological Review 41: 793-806
Glasscote, Raymond, Alan Kraft, Sidney Glassman, and William Jepson
1969 Partial Hospitalization for the Mentally Ill. Washington, D.C.: Joint Information Services of the American Psychiatric Association and the National Association for Mental Health
Glaser, Barney and Anselm Strauss
1964 "Awareness Contexts and Social Interaction." American Sociological Review 29: 669-679
1968 Time for Dying. Chicago: Aldine
Goffman, Erving
1963 Stigma. Englewood Cliffs, N.J.: Prentice-Hall
Gralnick, Alexander, et al.
1975 Humanizing the Psychiatric Hospital. New York: Jason Aronson, Inc.
Gross, Edward and Gregory P. Stone
1964 "Embarrassment and the Analysis of Role Requirements." American Journal of Sociology 70: 1-15
Haley, Jay
1969 The Power Tactics of Jesus Christ and Other Essays. New York: Avon Books

Hymes, Dell
1974 Foundations in Sociolinguistics. Philadelphia: University of Pennsylvania Press
Jansen, Elly
1970 "The Role of the Halfway House in Community Mental Health Programs in the United Kingdom and America." American Journal of Psychiatry 126: 1498-1504
Katz, Daniel and Robert Kahn
1966 The Social Psychology of Organizations. New York: John Wiley and Sons
Levitan, Sar, Martin Rein, and David Marwick
1972 Work and Welfare Go Together. Baltimore: The Johns Hopkins University Press
Manning, Peter
1977 "Rules in Organizational Context: Narcotics Law Enforcement in Two Settings." Sociological Quarterly 18: 44-61
Maines, David R.
1977 "Social Organization and Social Structure in Symbolic Interactionist Thought." Annual Review of Sociology 3: 235-259
in press "Recent Developments in Symbolic Interactionism." in Gregory P. Stone and Harvey A. Farberman (eds.) Social Psychology Through Symbolic Interaction. New York: Wiley
Riehman, Lynne and Carolyn O'Brien
1973 "Project in Apartment Group Living." Social Work 18: 36-43
Rothwell, Naomi and Joan Doniger
1966 The Psychiatric Halfway House. Springfield, Illinois: Charles C. Thomas
Schafer, Stephen, Mary Knudten, and Richard Knudten
1975 Social Problems in a Changing Society. Reston, Virginia: Reston Publishing Company
Schwartz, William
1971 "Introduction: On the Use of Groups in Social Work Practice." Pp. 3-24 in William Schwartz and Serapio R. Zalba (eds.) The Practice of Group Work. New York: Columbia University Press
Stanton, A.H. and M.D. Schwartz
1954 The Mental Hospital. New York: Basic Books
Strauss, Anselm
1959 Mirrors and Masks. New York: Free Press
Sullivan, Harry Stack
1953 The Interpersonal Theory of Psychiatry. New York: W.W. Norton
1954 The Psychiatric Interview. New York: W.W. Norton
Szasz, Thomas
1970 Ideology and Insanity. New York: Anchor Books
Wieder, D. Lawrence
1974 "Telling the Code." Pp. 144-172 in Roy Turner (ed.) Ethnomethodology. Baltimore: Penguin Books
Wiseman, Jacqueline
1970 Stations of the Lost. Englewood Cliffs, N.J.: Prentice-Hall