INDIVIDUALIZED NETWORK PLANNING FOR CHRONIC PSYCHIATRIC PATIENTS

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The advantages of social network interventions in the treatment of chronic mental patients are widely documented. Yet the available literature largely fails to take note of the fact that many patients when they are released from inpatient care experience a partial or total lack of network resources. Before they may reap the benefits of social networks, these patients require assistance in gaining access to network resources. In such instances clinicians must step in and assume a positive role in the creation or expansion of social networks for their patients.

However, intervening in the development of social networks presents complex problems for clinicians. Depending on differences in their diagnoses, symptomatology, treatment histories, and prognoses, different patients require different kinds of network interventions. Thus, for example, network developers must take into account a given patient's level of functioning, his or her needs for closeness or distance from others, and the degree of mutuality of which he or she is capable. Interactional factors, such as network members' tolerance for symptomatic behavior and the degree of structure within the network must also be considered.

Generally speaking, social networks for chronic mental patients may be classified into three broad types: institutional, fraternal, and integrated. These network types, which respond differently to the social needs of different kinds of patients, correspond respectively to three groupings of chronic mental patients as they are conceptualized by Sheets and his colleagues. This paper examines these three network styles and discusses for each the characteristics of patients who will benefit, the specific network properties, and the ways in which clinicians might intervene in network development. The observations offered here have been derived from experience with network development at Community Connections, a program begun at Saint Elizabeths Hospitals, and at Community Connections, Inc., a private, non-profit agency providing community-based case management services for deinstitutionalized patients.
The Patient:

By and large system dependent patients are accustomed to their patient roles. Frequently, they have spent many years in institutional settings and are generally acceptant of the services offered to them. Thus, they present few management problems and appear to have come to terms with the severity of their illnesses.

Despite their passivity, however, system dependent patients are often highly symptomatic and remain so whether they are in the hospital or the community. These patients are often diagnosed as schizophrenic and their symptomatic behaviors may vary from mild delusional thinking to more visible manifestations such as bizarre dressing and gesturing.

Interpersonally these patients tend to need a great deal of distance from others. While they may enjoy sharing physical space with other persons, they usually prefer to keep to themselves. They may be aware of others without actively engaging them. In fact, many of these patients experience overtures from others as impingements and respond with a flare-up of symptoms.

Despite their difficulties in forming interpersonal relationships, system dependent patients often form strong attachments to programs and institutions. It is not uncommon to see these patients just sitting in the day rooms of hospitals or psycho-social programs. Sometimes they return to programs even after personnel have changed.

The Network:

The network type that appears best suited to system dependent patients may be termed an “institutional” network; one which allows individuals to share physical space with few demands for mutuality or inter-dependency. In many ways “institutional” networks replicate the living arrangements of large hospital wards, where patients live in proximity to one another but do not assume emotional or instrumental responsibility for each other. These networks in general, have maintenance rather than growth as their primary goal. Moreover, in institutional networks where expectations for performance are relatively low, there is often a high tolerance for symptomatic and aberrant behaviors. Generally, a live-and-let-live philosophy prevails.

Because patient members of institutional networks are generally not expected to progress, these networks are often highly structured. Consequently, although such networks consist primarily of patient members, they are frequently dominated by a mental health professional who imposes the rules for living within the network.

In essence, institutional networks provide what Lamb and Peele and Bachrach have termed asylum care for their members. They shelter their members from the larger community so that individual patients are allowed to exist within a fairly protective milieu.

The Interventions:

In constructing an institutional network for an individual, the mental health clinician involved must be willing to assume responsibility for aggressively managing the individual’s affairs. The clinician selects a group of patients who will be brought together to form a single network. Patients may be grouped together according to age, diagnosis, length of last hospitalization or a combination of factors.