DEINSTITUTIONALIZED RESIDENTIAL CARE FOR THE MENTALLY DISORDERED

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The Soteria House Approach

Holly Skodol Wilson, R.N., Ph.D., F.A.A.N.

GRUNE & STRATTON

A Subsidiary of Harcourt Brace Jovanovich, Publishers

New York London
Paris San Diego San Francisco São Paulo
Sydney Tokyo Toronto

Library of Congress Cataloging in Publication Data

Wilson, Holly Skodol.
Deinstitutionalized residential care for the mentally disordered.

Bibliography: p.
Includes index.
1. Mentally ill — Rehabilitation. 2. Halfway houses. 3. Community mental health services. 4. Psychiatric nursing. I. Title. [DNLM: 1. Schizophrenia — Therapy. 2. Residential treatment — Organization — United States. 3. Deinstitutionalization. WM 203 W748d]
RC440.W448 362.2 82-3152
ISBN 0-8089-1427-8 AACR2

Grune & Stratton, Inc.
111 Fifth Avenue
New York, New York 10003

Distributed in the United Kingdom by
Academic Press Inc. (London) Ltd.
24/28 Oval Road, London NW 1

Library of Congress Catalog Number 82-3152
International Standard Book Number 0-8089-1427-8
Printed in the United States of America

To Martin

This one is for you . . .

with my thanks and affection.

1982

Contents

Acknowledgments

So much time has elapsed since my first interests in the sociology of psychiatry began to take shape that to develop a list of those who may properly find some signs of their influence in the pages of this book would almost coincide with a list of my family, friends, and colleagues. However, I must restrict myself to a few that even a less than perfect memory could never entirely suppress.

Many of the ideas and analytic approaches found in this volume were developed during a six-quarter seminar in qualitative analysis led by Professor Barney Glaser of the University of California at San Francisco. I wish to offer my gratitude to him and to my colleagues for their insightful criticism and encouragement.

I am also grateful to the members of my original dissertation committee: Professor Donald Hansen, who allowed me the freedom to set my own course; Professor Shirley Chater, whose high standards and grace were important sources of personal support and motivation; and Professor Leonard Schatzman, who shared his own theoretical sensitivity.

To the professionals, staff, and residents of Soteria House I extend sincerest thanks for allowing me to be an exception.

Discussions with other key people spurred my thoughts throughout the research process. I would like to thank my brother, Dr. Andrew E. Skodol, Dr. Loren Mosher, Dr. Harley Shands, Dr. Anselm Strauss, Dr. Hildegard Peplau, Dr. Shirley Smoyak, Dr. Barbara Tescher, and Dr. Merle Borrowman.

I am grateful to the Division of Nursing, National Institutes of Health (Pre-Doctoral Fellowship SF04-NU-27, 423); the

American Nurses' Foundation (Developmental Grant 442120-40840); Sigma Theta Tau, the National Nurses' Honor Society; and Nurses' Educational Funds for the financial support they provided at various points in the course of my original study.

Foreword

Writing about this book is like writing about one's offspring. They're wonderful, but we remain slightly envious of their ability to tell their story in a way that describes a life history better than their parents can. Such is Holly Wilson's Soteria book. A scene, a time in history, a way of being are set forth in intimate detail. It's nice to have documentation of a true social experiment told in the words of the participants. As conceptualizers of this scene, we are filled with awe and humility to find it so well described. A child observed and commented upon. A locale sketched, analyzed, and conceptualized. A fine piece of work given the circumstances. The halcyon days.

The Soteria model grew out of the savage 60s. It was a time of impatient, often self-righteous criticism of the existing society. It was the time of Kennedy's New Frontier and Johnson's Great Society. We declared war on poverty and promised its eradication in this century. We celebrated man's first landing on the moon and the climax of the golden age of technology. It seemed that science would not only shape man's destiny but also provide the tools for fundamental social change. During those years we were impatient with our sociological traditions; we refused to live with the pragmatisms and ambiguities of the past or the present. We rejected the notion that progress grows by slow iterative processes like the building of a coral reef and believed it was possible to build that coral reef from a volcanic eruption of new ideas and their rapid acceptance and implementation.

This view of rapid and radical change was also apparent in the optimistic unpheavals in mental health during the 60s. The Community Mental Health Center Act of 1963 provided the

possibility of fundamental change in the mental health care delivery system. Crisis theories of emotional disability were refined, new models of schizophrenia postulated, new delivery systems invented, and manpower resources expanded.

The *crisis model* provided a new direction. It gave us hope that serious emotional disability could even be prevented. Coupled with changes in welfare laws, something different could now happen to the thousands of people incarcerated in mental hospitals. Those of us on the line, who had learned our craft in the "cuckoo's nest," began emptying the state hospitals. We knew that the central cities might not be much better than the campuses of state hospitals, but we nevertheless clung to the hope that the situation might improve and worked to make our roles redundant.

As *new models of schizophrenia* were postulated, we began learning of alternatives to a medical model for conceptualizing mental illness. Redefinitions came from the work of the double-bind theorists, Gregory Bateson and Don Jackson, the founder of the MRI, who described mental illness as an understandable, interpersonal familial conflict. Laing and Cooper defined psychosis as an intrafamilial conflict due largely to the increasing nuclearization of the family after the industrial revolution in the West. The definitions of Scheff and Goffman emphasized a labeling and social control process for dealing with a particular form of defiance. Theorists and researchers, following a reminder by Menninger that some patients become "weller than before" after psychosis, began to look more closely at potentially positive consequences of the psychotic experience. Julian Silverman told us that in some cases psychosis helps, Dabrowski described positive disintegration, Laing lauded the blow-out, and John Perry poetically and carefully described the process.

In practice, we could no longer ignore the reality that, despite even good planning, people leaving hospitals often returned there, and we now had the revolving door. While we knew that they seemed better that the lobotomized, overshocked, infantilized clients of the 50s, we questioned whether the over-medicated, zombie-like individuals whom we sent out into the community were really better. Goldstein's work began to give hints that perhaps there were at least some people for whom psychosis was prolonged by having received antipsychotic medications, and in the late 60s, Rappaport and Silverman set out to explore this notion further. Their study at

Agnews State Hospital examined the two groups of young schizophrenics treated in a special ward in which the staff held a growth model concept of psychosis. Half of the patients received antipsychotic medications, the other half received placebos. Those of us who were privileged to participate in the study were able to experience firsthand — to understand experientially — what Menniger, Dabrowski, Silverman, and many first-person accounts of psychosis had been trying to tell us didactically. At the same time notable researchers of the decade, such as Fairweather, Pasamanic, and Langsley, were developing new models of service delivery and proving their feasibility and utility.

Concurrently the Great Society was also concerned about technological advances that would eliminate opportunities for unskilled work. People like Pearls and Riessman began seeking answers to this dilemma. The idea of new careers — and the development of new kinds of service-oriented occupations especially for the poor — seemed to be a workable answer to the need for more jobs and the staff shortage in mental health. In an attempt to deal with this manpower shortage, increased numbers of nonprofessionals were being given responsibility for direct services to hospitalized patients.

The Soteria model was born in this social context. It reflected and incorporated many of the notions we just described: the Community Mental Health crisis model, disenchantment with antipsychotic medications, growth from psychosis, new careers, and use of nonprofessionals. Yet even within this milieu, Soteria was a radically different approach. Loren Mosher and Len Goveia conceived of a project to develop and study the long-term outcome of a residential treatment environment for young schizophrenics, using a growth model, minimal antipsychotic medications, and a nonprofessional staff, and in 1970 they applied to the National Institute of Mental Health for funds. The Clinial Research Branch of the National Institute of Mental Health authorized a feasibility study to see if it could be done and awarded the project $75,000 per year for two years.

We planned a setting that would redefine the psychotic process from a degenerative, incurable illness to a developmental crisis, with the nonprofessional staff having positive expectations for those coming for asylum. The labeling and invalidating, the hiding away from the community, the expectations of the magical pills that mask all pain and suffering, the "doing to" people — all this could be mitigated. An egalitarian, fraternal,

and communal residence could be developed in which staff tasks would be defined principally by the needs of individual residents. Helpers could have time to aid the residents in identifying, experiencing, and dealing with life problems. Therapists would not take on the role of expert or fixer. Some of the underlying postulates that we used in developing the critical elements for our work were that: (1) each resident is a unique individual with his or her own valid experience; (2) a person acts as he thinks the other perceives him; (3) the psychotic process is often characterized by a sensory overload; (4) anything that is occurring is the consequence of all the actors in the field, which means that the helper is always responsible for at least a major part of any problematic behavior; (5) behavior that you find unpleasant or threatening is usually a request for your attention; (6) a primary role to "be with" rather than "do something to" the disorganized resident. Our motto was, "Don't do something, stand there." We now have come to see six elements of the Soteria program as critical:

1. Positive expectations of learning from psychosis.
2. Flexibility of roles, relationships, and responses.
3. Sufficient time in residence for imitation and identification with staff.
4. Acceptance of the psychotic person's experience of himself as valid.
5. Great tolerance for unusual "crazy" behavior without anxiety or a need to control it.
6. Normalization of the experience of psychosis.

At the end of the feasibility period, we were able to show that a stable milieu could be developed. It was possible for people to go through the acute phase of their psychosis safely. Staff could be recruited and would be willing to continue to work there without flipping out themselves. Parents and families of the residents would consent to have them remain there. The costs were not exorbitant. The neighbors did not run us out of town.

Thus began a decade of work, the extraction of a long series of personal sacrifices on the part of most persons involved, and grant-seeking — an endless process of supplication to the establishment. How can one deal with the paradox of being anti-institutional and antiestablishment while seeking the support of establishment institutions? How can an existential–phenomenologic study survive in the all-pervasive logical positivist context of so-called "scientific" psychiatry? With the remarriage of psychiatry to medicine over the past decade or so, how can a nonmedical, humanistic, psychosocial approach to madness survive? Basically, it can't. How has it for ten years? The answer is contained in Dr. Wilson's manuscript: limited disclosure. Although Soteria's preliminary results have been published, its therapeutic essence has remained relatively undisclosed until this manuscript. Devoid of establishment support, Soteria can now speak its mind.

This is the first in what we hope will be a series of disclosures of Soteria's methods and implications. They are more radical that we first thought and hence less acceptable to the psychiatric community. It is possible to deal with psychotic persons without neuroleptics; it is possible to understand and relate to madness; we can "be with" persons in an altered state of consciousness; medical degrees are not required to facilitate healing. This contrary-to-popular-zeitgeist list could be continued. To what avail? No much.

Current political and economic realities do not bode well for widespread implementation of Soteria-like facilities. Territorial protectionism is much more likely than innovation when resources are scarce. Defensiveness and rigidity rather than open-mindedness and flexibility are likely to be the order of the day. At least in the short term, Soteria's lessons are likely to be lost in this context, though we hope that Holly Wilson's work will help preserve and make these lessons more widely known. Insofar as this proves to be the case, we can only say bravo.

Alma Z. Menn
Institute for Psychosocial Interaction
555 Middlefield Road
Palo Alto, California 94301

Loren R. Mosher, M.D.
Professor and Associate Chairman
Department of Psychiatry B3072
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, Maryland 20814

Preface

State hospital management and services for the severely and chronically mentally disabled were established in the early 1800s to provide a benign and enlightened alternative to the foul and inhumane conditions found in jails, workhouses, and poorhouses. By midcentury, however, they had become warehouses characterized by rigid regimentation, personal repression, long-term confinement, and overcrowding. Based on the notion that long-term confinement in a mental hospital produces institutionalization and dehumanization, "deinstitutionalization"—a conscious public policy shift to move the locus of treatment and care of the chronically mentally ill from state hospitals to community settings—became the single most important development in contemporary mental health services. By the mid-1950s the numbers of people who would have spent their lives behind state hospital walls began to decline dramatically. The national state hospital population decreased from a high of 558,992 patients in 1955 to a low of 148,533 in 1978. What happened to these discharged mental patients? Some have died or returned to families, but the majority are found to be loosely associated with the community mental health movement, the sequel to America's state mental asylum system. Under the aegis of this movement, large multipurpose, custodially operated state hospitals have been replaced by smaller, decentralized, multipurpose facilities near patients' families and communities.

Regrettably, moving the locus of care and funding arrangements has not solved the problems of the severely and chronically mentally ill in America. Institutionalization of people appears to transcend the setting in which services are given

and to result in processes of care and treatment associated with routine, structure, and control that deny self-care and self-determination. The move from the state hospital system to community mental health care is described by some writers as a "shuffle to despair"—a national disgrace. The community mental health center has replaced the state hospital warehouse with a similarly dehumanizing, bureaucratized, clearinghouse where heavy reliance on neuroleptic drugs, a revolving-door pattern of resource use, and a redistribution of discharged patients in flophouses, welfare hotels, and nursing homes predominate. The reformist zeal originally associated with deinstitutionalization through the community mental health movement clearly has begun to pale, and new definitions and models are needed.

This book has been written to acquaint mental health personnel with Soteria House (from the Greek, meaning sanctuary, saving, safety, deliverance), a setting for treatment of schizophrenics that departs ideologically and operationally from both the custodial approach of the old state hospital and the clearinghouse method of contemporary community mental health centers. Its historical prototype is England's Kingsley Hall, opened in 1965 by the Philadelphia Association, headed by Glasgow-born psychiatrist R. D. Laing, and dedicated to a new existential and phenomenological view of schizophrenia. It is part of a growing network of alternative communities devoted to self-care, self-determination, self-control, and self-healing for schizophrenic patients.

This book is the first full report of a study conceived approximately 10 years ago. At that time I was a doctoral student at the University of California at Berkeley interested in the sociology of psychiatry. The purpose of my research was to generate a conceptual explanation of day-to-day life in the natural setting at Soteria House using methods derived from the fieldwork tradition as well as modes of analysis consistent with the discovery of grounded theory. I observed that at Soteria House conventional psychiatric arrangements for social control were muted and denied. There were no locked doors, medications, or therapies for controlling behavior of the diagnosed schizophrenics who lived there. Similarly, there were no orientation programs, job descripitons, task assignments, or a hierarchy of differentiated roles to provide the nonprofessional staff members with guidelines for their work. Finally, there were no guarded

gates or official regulations to keep Soteria from the control of outside licensing, funding, and social control agencies. In the course of hundreds of hours of participant-observation and intensive interviews over a 6-month period, I developed the concept of infra-control as the core variable or basic social process. It explains how residents, staff members, and outsiders are controlled under conditions of espoused freedom and nonintervention.

Infra-controlling has practical as well as theoretical significance because according to the preliminary outcome study findings published by Mosher and Menn, Soteria's founders, the Soteria House approach works. Mosher and Menn reported that two years after discharge first break, young, diagnosed schizophrenics in need of hospitalization who met the other criteria for inclusion in their research, attained a better psychosocial adjustment after care at Soteria than did the control group of patients who received psychotropic medications and usual hospital treatment in the community mental health system.*

The book conforms generally with the conventions of scientific reporting. In Chapter 1 I present an autobiographical background for my involvement with Soteria House and the setting in which the study was conducted, including its structural, spatial, and temporal features. In Chapter 2 I outline the research problem of developing a grounded-substantive theory about fundamental sociological aspects of the treatment of schizophrenics under nonconventional, nonhospital conditions. The methods associated with fieldwork data collection and the generation of grounded theory through constant comparative analysis also are explained. In Chapter 3, the concept of "presencing" explains how the physical presence of people can act as both a condition and a strategy for controlling resident patients. Chapter 4 examines a system for managing work when both rational bureaucratic methods for division of labor and negotiation among a company of equals have been rejected. The process by which social order emerges and staff work problems are addressed is called "fairing." In this chapter I also consider the conditions, strategies, and consequences for the fairing

*Mosher, L. R., and Menn, A. Community residential treatment for schizophrenia: Two-year follow-up. *Hospital and Community Psychiatry*, 1978, *29* (11), 715–723.

process. Chapter 5 examines the infra-control process as it applies to deflecting and disengaging external control agents from impinging on Soteria's autonomy. I refer to this key construct as "limited intrusion" and discuss strategies such as minimizing aproachability, situational positioning, limiting disclosures, and avoiding incidents. Finally, Chapter 6 reviews the broad implications of the Soteria model, particularly with respect to the concept of deinstitutionalization and the emerging social movement toward alternative, community-based settings for treatment of the severely and chronically mentally ill. This chapter also addresses some health policy considerations related to the efficacy of nonmedical, psychosocial treatment for schizophrenia.

Institutionalization, once believed to be a consequence of living one's life within the requirements of an impersonal, bureaucratic state hospital, has emerged as a quality of mind rather than of location, created by settings that limit self-determination, self-care, and self-control. This book examines the social psychology of an imaginative and viable alternative to conventional psychiatric hospitalization within the community mental health system for persons deemed in need of residential care.

1

The Asylum Redefined

To search in order to find the world's beginning and end is a disease he said to me. The normal person lives, struggles, experiences joy and sorrow, gets married, has children and does not waste his time in asking whence, whither, and why.

(Nikos Kazantzakis, *Report to Greco)*

That the face of madness has haunted the imaginations of men and women since ancient times is evidence by its appearance in both our art and science. The historical literature dealing with attempts to comprehend this human experience portrays madness as divine inspiration associated with special powers and vision, the consequence of a divine curse, errors of common knowledge, socially inappropriate behavior, folly or idleness, and more recently mental disease.*

Among the several scientific disciplines that have taken madness as a subject for study, the most recent is sociology. Early sociological studies of mental illness were couched mainly in terms of finding the social variables associated with psychiatric diagnoses (Hollingshead and Redlich, 1958; Leighton et al., 1959; Srole, 1962). This approach rarely questioned the basic assumptions implicit in the medical model,

*For a complete consideration of the history of insanity and society's altering perception of it, see Michel Foucault's monograph *Madness and Civilization* (1965).

and for the most part its explanations provided a good fit with psychiatric ideologies of mental illness and its management. Some of the most extensive contributions of sociology to the literature on mental illness have been studies of psychiatric hospitals as formal organizations or as microcosms of society (Caudill, 1958; Greenblatt et al., 1957). In the last decade, however, certain sociologists, often those associated with the Chicago school or the Pacific seminar, have turned their attention away from the search for etiological factors in the development of mental illness and from the hospital as a formal organization or small society. They have focused instead on recurring patterns of behavior and interaction among individuals and groups that attempt to deal with persons who have been labeled mad or mentally ill. The manner and circumstances in which such a label is assigned to a person and how the designation influences his or her career as a mental patient have aroused special interest (Rose, 1955; Scheff, 1966; Spitzer and Denzin, 1968). Collective action by the family or community to commit a disturbed person has been related to the social processes involved in identifying a person with or classifying a person into a socially defined role. From the work of Lemert (1951), Perrucci (1969), Goffman (1961), Strauss (1964), and others, we find that the way an individual plays his or her mad role is influenced not only by the persons who initially define the behavior as mental illness, but also by the collective definitions, operations, and ideologies that predominate in the treatment facility. These studies explore and explain sociological problems within the elaborate structure of the mental institution. With the growing social trend away from treatment of mentally ill persons in mental hospitals and the burgeoning of alternative community treatment models, a study of the social contexts of those labeled mentally ill under nonhospital conditions is both timely and relevant.

The purpose of the research presented here was to develop a grounded substantive theory about fundamental sociological aspects of the treatment of schizophrenics under the nonconventional, nonhospital conditions that characterize a setting designed to offer a unique alternative to institutionalization for the severely mentally disordered. By "theory" I mean an adequate explanation of social processes. This study is one of discovery rather than one of verification. Its intended impact is to explain and predict organizational and interactional aspects of the care of schizophrenics and to provide recommendations on the viability of a sanctuarylike treatment model.

This study was directed at the generation of a substantive theory from qualitative data. It was designed to explain a grounded, emergent research problem through the analytical identification of the basic social-psychological and social-structural processes. There are essentially two sequences for finding basic social processes (BSPs). One sequence is to choose a BSP that has been discovered elsewhere and then to decide where to go and whom to study in order to develop the BSP. For example, one might select "crediting" as a BSP to study and then choose settings in which variations in behavior are comprehensible in terms of a crediting process. The second sequence, which was followed in this study, involves choosing a setting and then attempting to discover the BSP that is operating.

The setting for this study was an experimental, community-based, residential treatment facility for diagnosed schizophrenics. An identifiable set of social-structural and social-psychological conditions were present, under which several populations of "actors" interacted face-to-face. In this chapter I describe the physical setting as well as present the conceptual conditions under which the study was formulated. This chapter also offers a brief account of my own association with Soteria House. In order to grasp the philosophical and organizational basis of the setting, a perspective that accounts for movement and flux in a developmental sense is necessary.

HISTORY

In a working-class area of London's East End stood a three-story, 60-year-old, dusty brick building called Kingsley Hall. Nearby this site are dismal rows of modern apartments. The rest of the neighborhood is composed of Victorian homes converted to multiple dwellings (Gordon, 1971). Although there are considerable differences between Kingsley Hall and Soteria House, the London house in effect represents the historical prototype for the setting studied in this research.

In approximately 1913 two wealth spinster sisters with social-work inclinations established Kingsley Hall as a settlement house. When the sisters died, they left the building to a foundation called the Kingsley Hall Association. Over the years the building served as a center for social, religious, and pacifist activities in the East End. In 1965 the building was leased to the Philadelphia Association, a group

of Londoners headed by the Glasgow-born psychiatrist Ronald D. Laing who were dedicated to relieving and investigating mental illness of all descriptions. Although Laing had written his first book, *The Divided Self,* in 1963, it was not until the publication of *The Politics of Experience* in 1967 that his interest in existential psychiatry and the phenomenology of schizophrenia earned him a reputation as a major cultural and social critic. Like Norman O. Brown and Herbert Marcuse, he drew on psychoanalytic insights to make a radical critique of Western society.

Laing's first book can be distinguished from his later works on at least three counts, according to Laingian scholar Peter Sedwick (1971). First, there is no hint of mysticism in it. Second, psychotic patients are not seen as prophets of a supersensory world—pioneers in the exciting endeavor of exploring inner space. And finally, Laing's refusal to use the term "disease" does not imply any reluctance to admit the disturbance, disorder, and profound alienation of the psychotic state. This disturbed state is, at least in large part, an attribute of the individual who represents himself as a patient.

Laing leaped ahead of the theoretical framework of his first work soon after it was published. He began to emphasize the interdependence between a subject's outlook and the perceptions of other people about him. His work at this point was becoming closely associated with that of David Cooper and Aaron Esterson. Laing also was settling into a research program at the Tavistock Clinic dealing with interaction in families. His thinking was influenced from two widely divergent locations, Paris and Palo Alto, California. Engulfment and terror exercised overtly or insidiously by the familiars of the mental patient, were now specified as crucial agents of human derangement both in Sartre's essays in psychoanalysis and in the contributions of the Palo Alto school of schizophrenia research headed by Gregory Bateson. Research groups in the United States headed by Theodore Lidz and Lyman Wynne had reached similar viewpoints on the origins of schizophrenia. The ideological relationship between London and Palo Alto became reciprocal with the inception of Soteria House in 1972.

Up to the mid-1960s, Laing's conceptual journey was from the self to others; it soon turned once again to concentrate on charting individual space rather than social space. From 1964 on, he became associated with an interpretation of schizophrenic experience that is now considered his unique vantage point in the field. He saw schizophrenia not as a psychiatric disability, but as one stage in a natural

psychic healing process containing the possibility of entry into a realm of "hypersanity" as well as the destructive potential of existential death. According to Laing, psychiatric medicine with its emphasis on intervention and symptom control at best offered a mechanistic bungling that would frustrate the natural progression of the potential healing process. What was needed was a "sympathetic initiation ceremonial" through which the person would be guided, with full social sanction and encouragement, into his or her own inner space and time. Laing felt that only through a reevaluation of our socially and institutionally defined ideas about sanity and madness could he arrive at any true therapy for madness. This reevaluation could only proceed in a new setting, where all previous definitions and roles might be called into question. Laing's therapeutic community, Kingsley Hall, was founded in an attempt to provide a sympathetic setting for the schizophrenic's voyage through and out of madness. Based on the experiences of Villa 21, David Cooper's ward within a conventional hospital, the conclusion was reached that if such a setting were to develop, it had to take place outside the confines of an institution. Staff members who worked there had to be "liberated from the hierarchized, paternalistic system of domination by categorization" (Cooper, 1967, p. 121). For Laing and Cooper, an "anti-psychiatric community" necessitated breaking away from the mental hospital. A brochure published by the Philadelphia Association described some of the features of Kingsley Hall and presented some statistics.

> At Kingsley Hall everyone's actions could be challenged by anyone. With no staff and no patients—with the ultimate breakdown of the binary role system of the institution—no resident has been given any tranquilizers or sedatives by any other resident. Experiences and behavior which could not be tolerated in most families or psychiatric institutions made heavy but finally tolerable demands on the community. Members of the household established the structure of their days. They get up or stay in bed as they wish, eat what they want when they want, stay alone or be with others and generally make their own rules. Kingsley Hall accommodated 14 residents and from June 1965–November 1968, 104 people stayed there. About 86% of the residents were between 20 and 40 years old and about 2/3 were men. Sixty-five of the 104 people classified themselves as patients. More than half of them had been previously hospitalized. Three-quarters of the patients who lived there had been diagnosed as "schizophrenic." Only nine of the 65 have been hospitalized since leaving Kingsley Hall and there were no suicides. (Gordon, 1971, p. 57).

In order to appreciate the import of what happened at Kingsley Hall and later at Soteria House, it is useful to be acquainted with some of the more conventional ideas about schizophrenia—the archetype of madness—and its treatment.

CONVENTIONAL PSYCHIATRIC MEANINGS

At all times and in all cultures there have been some people whose behavior was regarded by others as different and unusual. But these people, however deviant or mad, were not always thought to be sick. It is only during the last two centuries in Western Europe and America that the madman or madwoman has no longer been considered to be possessed or saintly, annoying or amusing, but rather has come to be seen as primarily sick. The reasons madness came to be regarded as a disease are complicated. Thomas Szasz (1961), an American psychiatrist, points to the fact that in the industrial era traditional Christian categories of sin and salvation were displaced by scientific, medical ones of disease and health. Advances in pathology in the nineteenth century did show a relationship between some mad behavior and damage to the brain. Neurosyphilis, chronic alcoholism, and arteriosclerosis all cause people to speak and behave in a mad fashion, and all produce identifiable pathological lesions. But the brains of people with the most prevalent and dramatic form of modern madness, schizophrenia, show no pathological lesions, nor at any time has any genetic defect or biochemical abnormality been conclusively demonstrated in their bodies (Gordon, 1971, p. 51). Nevertheless, psychiatrists treat people who act and speak strangely as diseased. The assumption that schizophrenia is a disease provides the rationale for trying to cure it by medical means, including tranquilizers, electroshock therapy, and hospitalization.

In the creation of mental institutions, social fact and medical artifact converged. The French historian of culture, Michel Foucault, points out that with the decline of leprosy at the end of the Middle Ages, madmen took the place of lepers as social scapegoats (1965). During the Renaissance madmen were expelled from their native cities and confined to boats called the "ships of fools." These ships served to isolate and exclude the socially troublesome madmen from their fellow citizens. At present, mental hospitals serve a similar function. Half of all the hospital beds in the United States are in mental

hospitals, and more than half of those beds are occupied by diagnosed schizophrenics (Gordon, 1971, p. 52).

Psychiatric professionals are taught to classify their most bizarre patients according to categories that owe their existence to a late nineteenth-century German psychiatrist, Emil Kraepelin. From his French contemporary Morel, Kraepelin adopted the term *demence precoce* (early insanity) and placed under this rubric the catatonic, hebephrenic, and paranoid psychoses. He emphasized the onset of these conditions in young people and noted that the disease usually resulted in a state of mental deterioration (Kraepelin, 1925).

In 1911 a Swiss psychiatrist, Eugene Bleuler, emphasizing the patient's state of mind rather than the outcome of his disease, coined the term "schizophrenia" (split mind). Bleuler outlined what he called the primary symptoms of schizophrenia, which consist of four "As": distortions of affect, loose associations, ambivalence, and autism. Secondary symptoms are hallucinations, negativism, delusions, and stupor (Arieti, 1959, pp. 455–484).

Freud, who originated psychoanalysis, underscored the necessity for the psychiatrist to understand his or her patient's experience of the world. Freud felt his techniques were not applicable to the treatment of schizophrenics, however, because these patients were too absorbed in the inner workings of their own minds to establish a working relationship with an analyst (Arieti, 1959, p. 456).

In the 1920s, however, a group of American psychiatrists, including William Alanson White and Harry Stack Sullivan, undertook a psychoanalytically oriented treatment of schizophrenic patients (Sullivan, 1962). Sullivan saw his patients' strange speech and behavior not as the signs and symptoms of a disease, but as evidence of difficulties in living. He believed that the schizophrenic could learn to understand these difficulties in the context of a warm interpersonal relationship with a therapist. Both he and his followers, including Frieda Fromm-Reichman, Harold Searles, and Otto Will, have emphasized the two-sidedness of the therapeutic encounter.

The interactional and interpersonal theoretical framework for treating schizophrenia was highlighted in the work of contemporary American research teams on the pathology of family communication. This perspective is usually traced to Gregory Bateson's 1956 paper outlining the "double bind" theory of the origins of schizophrenia. "Double bind" refers to a specific pattern of disturbed communication that is detectable within pathological families. One member

is subjected to a pair of conflicting injunctions or binds, both of them highly traumatic, and a third injunction implicit in the situation prevents him or her from leaving the field in order to avoid the conflict. The unfortunate recipient of these messages tends to opt out of social interaction and lose confidence in the accuracy of his perceptions of other people. Most double bind theorists, however, have refrained from any radical indictment of the treatment of schizophrenia by existing medical and psychotherapeutic means.

Although Kingsley Hall was forced to close in 1968 because the building was condemned and friction arose with neighbors who regarded the residents as being dangerous, a network of similar communities has grown up around London and as far west as California, in the form of this study's setting.

ORIGINS OF SOTERIA HOUSE

In 1966 a California-born psychiatrist named Loren Mosher spent a year in England on a fellowship, where he met and worked with R. D. Laing, who was then just starting Kingsley Hall. Upon his return to the United States, Mosher became head of a new community mental health hospital at Yale University, where he unlocked the doors, eliminated many of the rules and restrictions, and generally earned the unit a reputation as "a good place to go if your head was in trouble." If the people directly involved in the hospital went along with the new philosophy, the Yale psychiatric administration, much like the administration over Villa 21, did not. Mosher left New Haven to start Soteria House on a federal grant of $73,000 in 1970. The project was designed to test a "developmental crisis theory of schizophrenia through a comparative outcome study of two groups of young, first-break schizophrenics" (Mosher and Menn, 1971, 1978). Therapy was to be given by indigenous, nonprofessional personnel who would act as "trip guides" to a group of up to six schizophrenic patients living in a 16-room home in a Bay Area community. The control group would receive the usual psychiatric treatment on inpatient wards of local community mental health centers.

At Soteria House the schizophrenic reaction was viewed as an altered state of consciousness in individuals who were experiencing a crisis in living. In addition to the elements of fragmentation and

disintegration, the psychotic experience was also believed by Mosher to have unique potential for reintegration and reconstitution if it were not prematurely aborted or forced into some straitjacket compromise (Mosher and Menn, 1972). Such ideas about the nature of schizophrenia represented the official and formalized basis for therapeutic attitudes in the house and had obvious links with the ideology of Laing and his colleagues.

Both the control and experimental patients were obtained from a large screening facility that was part of a community mental health center. Patients who met the research criteria (that is, between the ages of 15 and 30; unmarried, divorced, or separated; undergoing a first hospitalization; and diagnosed as schizophrenic) were assigned on a space-available basis to one or the other group. Both groups were assessed on the same battery of tests and were followed at 6-month intervals for 2 years after discharge. Outcome indicators included number and length of subsequent hospitalizations, ability to work, interpersonal functioning, and total treatment costs. Changes in both groups of patients were measured at intervals by means of autobiographical written accounts, standard symptom scales (IMPS), and attitudinal tests, such as the Welsh-Barron Art Scale and Soskis Attitude toward Illness Questionnaire, which were chosen as particularly relevant to the theory and techniques being investigated (Mosher, Menn, and Matthews, 1975). It was of prime importance that, by virtue of its association with the Center for Schizophrenia Studies and its National Institute of Mental Health funding, Soteria House was characterized by a degree of legitimacy in the conventional psychiatric world and by a number of restrictions about day-to-day living.

The context provided by Soteria House, as portrayed in official documents and disclosures, was comprised of the following:

1. A nonauthoritarian, nonhierarchical organization, where all staff members are viewed as equal in overall therapeutic potential. The project director, a psychiatric social worker, acts as research and referral coordinator and "mother hen," but is not viewed as a special therapeutic person. A part-time psychiatrist evaluates each resident, takes care of medical records, and is one of the landlords of the house. There are no job descriptions, formal organizational goals, staff evaluation protocols, or the like.
2. Flexible time and activity schedules. There are no formally scheduled forms or times for anything called "therapy." Staff

members solve their own coverage problems and have never opted for the conventional 8-hour work shift.

3. Sensitivity, supportiveness, and tolerance. There are few prescribed behaviors to which residents and staff are expected to conform. The two rules—no dope and no sex between staff and residents—are aspects of the single injunction to avoid harming other residents or the staff, community, and program. Generally speaking, staff members encourage patients to participate in a variety of activities and yet respect their needs for solitude. A particularly important aspect of the community is said to be a tolerance for regression, but staff is advised not to perpetuate regression unnecessarily. There is, in effect, a professed absence of a shared single ideology, any explicit guidelines for decision making, and a clear authority structure.

CHARACTERISTICS OF THE STAFF

Distinctions between staff and residents (patients) are not observable at first glance. All participants are generally white, young, and dressed in casual, unconventional clothing such as blue jeans and army jackets, with long hair, beards, or no makeup. Staff members at Soteria are relatively untrained in any psychiatric profession. The rationale for using a nonprofessional as the primary therapist is that having no theory of schizophrenia enables the therapist to adopt a phenomenological stance and to be a "real person" with psychotic individuals. Highly trained mental health professionals are said to lose this freedom and spontaneity in favor of a more cognitive, theory-based, learned response which might tend to invalidate the patient's experience (Mosher, Reifman, and Menn, 1973).

The people who chose or were chosen to work at Soteria are characterized as wanting neither to become part of the business world nor to drop out and become part of the hippie scene. They are young (generally under 30), of superior intelligence, and have attended some college but usually without any formal education in psychology. They have led long lives in relatively few years and are tough but tolerant, energetic, witty, and well-integrated. Like many of California's youth, most have experimented with various psychedelic drugs but none have adopted drugs as a life-style. Many came from problem families in which they often played the role of caretaker for a neurotic parent. Despite the difficult situations in which they were raised, none labeled

any of their personal crises as being of psychotic proportions.

Initial selection of the staff was made from a pool of psychiatric technicians and volunteers who had come into contact with the Soteria House project director in an experimental ward at a local state mental hospital. When an announcement was made of the intent to hire individuals to work intensively with unmedicated, acutely psychotic persons, there were 20 applications for 4 full-time positions. The final selection was made on the basis of the applicant's ability to "tune in" to the psychotic person's "space" and to provide a constantly reassuring presence without being intrusive, demanding, or interfering. From the pool of candidates, six were selected, three men and three women, after splitting two of the budgeted positions into four half-time jobs. In the selection process an effort was made not to choose politically radical individuals who might engage in active conflict with "the establishment." The project administrators considered this apolitical characteristic to be important for two reasons. First, the work is so draining that it would be difficult for anyone to deal with psychotics intensively and also actively pursue political activities; and second, because the house is located in the community, it would be destructive to the program for staff members to take an adversarial position. At the close of the data collection for this study, only two of the original staff members remained at the house. The other four staff positions had changed hands at least twice. (Staff replacement and turnover is considered in chapter 5.)

Psychometric test data showed staff to resemble artists (Welsh-Barron Art Scale performance), to report high numbers of paranormal experiences (As Experience Inventory), and to manifest a highly consistent pattern of reliance on intuition, feelings, and perception (Meyers-Briggs type indicator). The tentative conclusion was drawn that Soteria staff members resembled creative persons with a high tolerance for deviance, low practical orientation, low inclinations for order and organization, and low control needs (Mosher, Reifman, and Menn, 1973).

CHARACTERISTICS OF THE RESIDENTS

Participants at Soteria House who would be called patients in a more conventional facility are called residents here. Foremost among the characteristics of this group is the diagnosis of first-break schizophrenia. The melange of theories and ideologies concerning the origins of schizophrenia and its psychodynamics was mentioned earlier in this

chapter. Evidence about the condition is confusing and contradictory, and there seems to be no conclusive single explanation for schizophrenia that prevails among psychiatric professionals. It is possible, however, to identify certain behavioral patterns, called manifest symptomatology, which when displayed by a young adult or adolescent without organic lesions typically lead to a diagnosis of schizophrenia, according to the American Psychiatric Associations' DSM II Manual. According to Arieti, this diagnosis is made when a patient who usually has manifested some unconventional traits for a long period of time comes to a psychiatrist's attention because of a diminished interest in life, obsession with some special problem, or ideas that are not acceptable to his family or community (1959, pp. 459–460). He frequently has started to think that certain events are related to him or have a special meaning in relation to him. These thoughts are called ideas of reference. The patient usually offers some interpretations that are not supported by other people, called false beliefs or delusions. The perceptual functions of the individual may seem altered as well. Frequently he reports perceptions in the absence of any objective stimulus. These experiences are called hallucinations and may involved any or all sensory organs.

In addition to the disorders of thought that are associated with schizophrenia, the individual's behavior may seem odd in many ways. He or she may display mannerisms, grimaces, purposeless acts, stereotyped motions, and impulse gestures. Mood and affect may also be altered: the individual often appears inappropriately angry, highly emotional, suspicious, cynical, or blunted. Finally, speech and language show peculiar characteristics. If questions are asked, the patient may seem evasive. It is frequently difficult to understand what the individual is trying to convey. Sentences consist of words that seem unrelated to one another (word salad), certain words may be used repeatedly (perseveration), or the patient may use words that he has coined (neologism). In many cases the individual may be unable to talk at all (mutism).*

Although all of the residents did not display all of these characteristic behaviors of schizophrenia during my observations, in order to qualify as a Soteria House candidate and member of the experimental group in the NIMH study, each individual needed to demonstrate two or more of the following behaviors on an initial and 3-day follow-up

*Criteria for the diagnosis of schizophrenia have since been revised in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (1980).

evaluation by psychiatric professionals: (1) disturbance of thinking or speech, (2) catatonic motor behavior, (3) paranoid traits, including delusions and ideas of reference, (4) hallucinations, (5) blunted or inappropriate effect, and (6) disturbance of social behavior and interpersonal relationships.*

Having met these criteria, residents were required to be between 15 and 30 years old; unmarried, divorced, or separated; and involved in their first hospital admission with this diagnosis. They had to give informed consent or it had to be obtained for them, and they had to show no organic impairment. Residents at Soteria actually ranged in age from 16 to 23, there were approximately equal numbers of men and women, and they ranged in social class from two to four (Hollingshead-Redlich scale). All had at least some high school, and 45 percent had attended college. On a scale of global psychopathology with a maximum score of 7, Soteria residents had a mean score of 4.8. In short, they were not unlike the first-break schizophrenics usually admitted to conventional hospital facilities (NIMH Grant No. 20123, p. 30).

CHARACTERISTICS OF THE VOLUNTEERS

The third and most fluid group at Soteria was the volunteers. Because of the temporary and changing nature of their association with the house, it is somewhat difficult to describe or characterize them. Those participating during the five months of observation for this study generally fell into three categories: (1) disenchanted, anti-establishment graduate students in psychology, (2) ex-residents who continued to maintain an informal affiliation with the house, and (3) a variety of seekers for whom Soteria was a stopping place while they searched for something in their personal lives or experimented with alternative lifestyles.

The major source of recruitment of volunteers was word of mouth. Although a volunteer program was originally structured to require five hours of participation per week for at least six months and some apprenticeship training for recreational and maintenance roles, by the time of this investigation the association of volunteers with the house

*NIMH Grant Application No. 20123, *Community Alternatives for Treatment of Schizophrenia*, p. 40.

had become much more casual and spontaneous. The original design for the volunteers as a source of free manpower, however, has led to their significance as a pool of potential staff replacements and their value as supportive peer consultants for the paid staff.

THE NEIGHBORHOOD AND THE HOUSE

The house is an old, 16-room, two-story, whitish frame building that has seen better days. It was purchased and then rented to Soteria by two local physicians who agreed to assume financial responsibility for any damage done to it because they supported the project. It was completely refurbished inside and out, although roughly, by the landlords. Less than two years later, however, a torn screen door, broken windows, and peeling paint were evident. The house is located only one block from a private hospital which has an emergency service available, and it is on a major artery to the freeway and downtown San Jose, California. This poses a traffic hazard. City ordinances represent a further constraint on the site since the house, registered as a "board and care home," can be licensed for only six paying guests at a time. The neighborhood is a transitional one in which older private homes have been converted into flats and rooming houses. Just around the corner are gaudy drive-in restaurants, gasoline stations, and a variety of shabby stores. Immediately next door is a home for the elderly. Other neighbors are primarily a heterogeneous collection of hippies, transients, and members of ethnic minority groups.

Contact with the neighbors and community has been limited. At the initiation of the project there was a deliberate attempt to keep a low profile and publicity was minimized. There have been no lasting relationships with neighbors. Three incidents involving local police were quickly resolved.

Although there is a professed interest in making the program known among psychiatric professionals, actual firsthand knowledge has been denied to most visitors. Instead, a "distinguished visitors committee" was composed of representatives from various psychiatric professions, and the members were invited to visit the house briefly. Psychiatric professionals subsequently expressing interest were referred to the committee members for information about the setting and the program. A number of professional papers and meeting presentations have been produced by the house research group.

Structural and Spatial Dimensions

Once inside the torn screen door and unlocked front door of the house, one enters a small hall with an old staircase leading to the second floor. Opening a door kept closed but unlocked from the hall, one enters a large, musty living room. It is furnished with gloomy overstuffed furniture, a television set, a phonograph, several Goodwill coffee tables, and some lamps. A wood-burning fireplace dominates one end of the room with a mantle that serves as a bookshelf. Adjoining the living room is a large, cluttered kitchen, the center of which is a wooden picnic table and benches. Off the kitchen is a pantry which can be locked with one set of keys that circulates among the staff. The pantry contains scissors, over-the-counter medicines, and foodstuffs. A shiny beige pay phone hangs on the kitchen wall in place of an unobtrusive black residential phone that has recently been removed. The dishware, glasses, plates, and cups are breakable, and the kitchen drawers contain sharp knives and other cooking utensils. Somewhat incongruously, the refrigerator and freezer are adorned with heavy padlocks which were installed because "one resident was eating up the whole week's food supply." They are left unlocked now, because the problem no longer persists. Several broken windows in the kitchen are covered with plastic, suggesting a house history of window breaking. The kitchen is the center of collective life during daylight hours, with some shift in the evening to the living room or upstairs.

The rest of the first floor contains two bathrooms, which can be locked from inside, and individual bedrooms. Upstairs are more bedrooms and a second living room, which acts as a meeting place or conference room, with pillows on the floor in lieu of furniture. Here also is the only other locked item in the house—a metal box in which medical records (such as they are) and several bottles of Thorazine are kept. The decor of the individual rooms varies from compulsive neatness to psychedelic posters and strobe lights or overt clutter, disarray, and dirt, reflecting the tastes of the occupants. Many of the participants are interested in organic foods, spiritual and mystical literature, underground music, and an assortment of other health-optimizing and spiritualizing practices, as evidenced by the books, records, and foods in the house.

The layout of the house maximizes possibilities for both privacy and companionship. With very few exceptions, there is a muting or absence of conventional psychiatric structures, such as locked doors, seclusion rooms, nurses' station, and medication room. Finally, the cleanliness and efficiency standards would probably be defined by most observers as relatively low, and the decor perceived as somewhat rough and primitive.

The Temporal Map

A day at Soteria seldom begins before noon, and never before 10 A.M. Staff, volunteers, and occasionally residents begin drifting into the kitchen for coffee, cigarettes, and the newspaper. If individual residents have not helped themselves to eggs or granola, a few may spontaneously team up and put together a breakfast, usually lasting until 1 or 2 P.M., with dishes left on the table or in the sink. Afternoons are spent doing errands, going on an outing, or sitting outside or in one's room. By 6 or 7 P.M., some activity is begun toward preparation of the evening meal, which is typically the first full group activity of the day. With small talk and joking around the table, dinner occupies the evening until 8 or 9. Dishes are washed before and after the meal. Television watching by some and napping by others usually occur from 9 to 11 P.M.. Only from midnight to about 3 or 4 A.M. does anything resembling therapy take place. This usually is done by a staff member and a resident who have indicated their preference for privacy by going into one of the rooms to talk. There are also occasional small-group rap sessions, on subjects such as meditation, nutrition, or drugs, that occur spontaneously around the kitchen table or in an upstairs room. People rarely retire for the night before 4 A.M. There are few scheduled activities or events. During the observations for this study, a yoga teacher was scheduled to come to the house every Monday morning and a weekly staff meeting was set for each Friday morning. Both of these activities failed to take place almost as often as they were held according to plan. Generally the pace of the house was extremely slow and low-key. Substantial blocks of time were undifferentiated except in the grossest sense.

CONCEPTUAL CONDITIONS

The setting for this study presented a set of identifiable conditions under which the analytical web was generated and applied. Fundamentally, Soteria House is set up both structurally and ideologically as a noncontrol system that, despite the muting and denial of conventional psychiatric controls, must solve control problems posed by a population of unmedicated, diagnosed schizophrenic residents in face-to-face interaction with an equal number of nonprofessional paid staff with anti-establishment inclinations. While espousing a

radical critique of medical-model psychiatric treatment, Soteria is supported as an organization by an elaborately designed psychiatric research study funded by NIMH and the Mental Research Institute collaboratively. Staff members lack a homogeneous educational background as well as any single theoretical position or organizational rule to provide guidelines for action. Decisions are emergent, atheoretical, intuitive, pragmatic, and rooted in the here-and-now rather than being the results of long-term planning.

BACKGROUND OF THE STUDY PROJECT

The issues addressed in this book stem from areas that have been of concern to me for approximately 21 years, although this particular study was formulated only several years ago. I conceived the general idea for the research in the spring of 1972 after reading a newspaper article entitled "Laboratory for Schizophrenics" by a graduate student in journalism (Johnston, 1972). It reported an interview with Dr. Loren Mosher, then Chief of Schizophrenia Studies at the National Institute of Mental Health, in which he described Soteria House, an experiment in radical psychiatry, where "the role model for staff people is something like an LSD trip guide; they lead patients through their psychosis, letting them go where it takes them and trying to make it less frightening...rather than trying to quell it with drugs" (p. 12). "Soteria" means deliverance or resurrection and is suggestive of the program's espoused ideology concerning the nature of schizophrenia.

The literature of a seedling movement within psychiatry labeled by some as "anti-psychiatry" was intriguing, although it did seem that the only attempts to put this emergent ideology into practice were in London. With the discovery of Soteria House in San Jose, it became feasible to study the care of schizophrenics in this setting.

FORMULATING THE STUDY

The initial problem was to contact the appropriate individuals and obtain their permission and cooperation for an as yet undesigned study. Relying on a sense of comradeship with the graduate student in journalism who had written the newspaper article, I phoned her for information on the whereabouts of Dr. Mosher and for advice about the

most effective approach to take. She was a willing and helpful informant who led me to Dr. Mosher in Maryland by phone. I arranged to meet with him on his next visit to the West Coast. Fortuitously he indicated that the people involved with Soteria House had been struggling with the difficulty of conceptualizing the nature of day-to-day interaction there. Their own intimacy and subjective involvement with the house resulted in an analytical myopia. Dr. Mosher's comment gave me the idea of what I could offer the house as a meaningful inducement for study. A systematic sociological analysis was negotiated in exchange for authorized permission to enter the setting and make it the subject of study. This negotiated exchange was mutually satisfactory and provided the basis for proceeding.

The next problem was to establish my qualifications and competence—in short, my credibility—as an essential condition for obtaining full cooperation. This was achieved both through a presentation that emphasized the seriousness of my scholarly interests and through the articulation of a sound and interesting research proposal. The latter strategy was extremely difficult because relatively little information about the setting was available, short of its presumed resemblance to Laing's Kingsley Hall in London, on which to base relevant researchable problems. A symbolic interactionist perspective and methodological interests in generating grounded theory guided me initially to propose a field study of social processes with a qualitative, humanistic orientation as opposed to a quantified test of a few preconceived (and quite possibly irrelevant) hypotheses. The study was presented as a process of learning about what was happening at Soteria House in the participants' own terms. In Lofland's words, "I sought to find out what is fundamental or central to the people under observation" (1971, p. 2). The open-endedness and aptness of the study proposal earned the approval of both of Soteria's gatekeepers, Dr. Mosher and Ms. Alma Menn, a psychiatric social worker and the official project director. My credentials and experience as a psychiatric nurse contributed to the perceived legitimacy of the study proposal.

FUNDING

Selection of the setting for the field study was tempered by the realization that the work would be expensive in terms of both time and money if not done in connection with a larger funded project. It would

entail, for example, participant observation over a period of many months, transcription of notes and interviews, and long-distance phone calls. Thus, a second condition for the feasibility of my research was to obtain financial support for its expenses. This was achieved through submission of small grant proposals to the American Nurses Foundation and to Sigma Theta Tau, the National Nurses' Honor Society. A predoctoral fellowship from the National Institutes of Health covered a small allowance as well. This consortium funding provided financial coverage.

ACCEPTANCE BY THE RESIDENTS OF SOTERIA HOUSE

Although I had obtained authorized consent for my study from the psychiatric professionals associated with the administration of Soteria House, it was granted on condition that the nonprofessional staff and patients find me and my work acceptable. The problem of enhancing my acceptability took on a different aspect with these individuals, ultimately depending more on cultivating and modifying my personal appearance and behavior than on any claim to professional or academic status. In the first day's field notes (January 29, 1973) I made the following observation.

> T., one of the female staff members, jokingly comments that I "got all dressed up." (I wore a plaid wool skirt and a cotton blouse.) All of the staff and residents (patients) are in blue jeans, black turtleneck jerseys, army jackets, hiking boots, etc. I feel intimidated and straight and decide to contour my appearance to blend more easily into the situation. T. goes on to ask me what I'm supposed to be doing and I describe my process-oriented field study in straightforward, common-sense terms, sensing that academic or sociological rhetoric would be counterproductive to my goal of cultivating her acceptance of me.

The distinction between studying social rather than personal patterns was important to the residents and staff members, and I confirmed it repeatedly. I also gave assurances of the confidentiality of my notes.

The fact that I had spent extended periods of time with severely disturbed and psychotic patients during my experience as a psychiatric nurse clinician helped to minimize any fear, discomfort, or awkwardness that a novice fieldworker might have experienced on entering a situation with few conventional structural controls for dealing with a

group of often blatantly psychotic residents. My ease in responding to the patients very likely facilitated acceptance of my presence.

The nature and extent of my actual participation in the setting varied somewhat throughout the research process. I initially attempted to engage in minimal, clarifying interaction so that I would not set myself apart from the participants. My effort to blend into the situation, however, did not extend to engaging in any form of therapy with the residents. My comments in the flow of interaction were confined to asking for clarification of ongoing events. Later I became more active in directing interaction along lines that were designed to produce particular data. I avoided a fully participatory role in order to maintain a distinction between my actions as an investigator and those of a volunteer available to do the chores of the house. These decisions enabled me to maintain my identity as a sociological researcher studying the process of day-to-day life. Furthermore, as Polsky (1969) advises, "so long as the investigator is honest about his role as social scientist, he can reasonably observe 'intimate' events without developing personally intimate relationships with actors in the setting" (1969, p. 119). Finally, I consistently attempted to communicate empathy for the participants' mode of life in order to develop their trust and thereby avoid being cut off from important events, information, and documents.

2

Studying Techniques for Maintaining Social Order Under Conditions of Espoused Freedom

. . . that we should set aside all previous habits of thought, see through and break down the mental barriers which these habits have set along the horizons of our thinking and in full . . . freedom, proceed and lay hold of those genuine problems still awaiting completely fresh formulation which the liberated horizons on all sides disclose to us. These are hard demands, yet nothing less is required.

(Edmund Husserl, *Ideas*)

THE STUDY PROBLEM: SOCIAL CONTROL UNDER CONDITIONS OF FREEDOM

The salient problem of this research emerged in the process of examining the organizational conditions and unfolding interaction that represent the basic social-psychological and social-structural processes in an experimental community for the treatment of schizophrenia. If this had been a study of the social processes of treatment for schizophrenics under conventional hospital conditions, framing the relevant questions to guide the research from its outset would have been less problematic. Enough is known about such settings to enable an investigator to make certain assumptions at least about the structural conditions. For example, it is known that individuals in hospital settings are divided into two groups, patients and staff, and that the latter group is

further subdivided according to professional or occupational roles. It might reasonably be assumed that the staff members share certain relatively homogeneous educational experiences, their work is scheduled according to some codified system, and specified psychiatric treatment practices are likely to be employed in the care of patients. Although there is some range of differences on these points, there is a general homogeneity in the way hospitals are run. Assumptions could also be made about the organization's hierarchical authority structure, its communication channels, its informal culture, and other properties that have been reported in the sociological and psychiatric literature.

In this study, however, it was not possible to make such preliminary assumptions and thereby preconceive a research problem or set of questions that would be meaningful in the setting. Rather a considerable period of time had to be spent in the field, first mapping out its relevant dimensions and later discovering a researchable problem, the explanation of which would account for most of the variation in the behavior that occurred. Thus, the problem explained in this analysis earned its way into the study by virtue of being grounded in the data and thereby being meaningful and salient to the setting under investigation. Although the initial observations were not guided by a single preconceived theoretical framework, sensitizing concepts from the sociology of work, negotiation, careers, identity, and language provided a beginning foothold on the data collection. These concepts were gradually supplanted with grounded ones.

Soteria House has a noncontrol system, as contrasted with the conventional control system in mental hospitals. There is a conscious attempt to mute and deny elaborate control structures, such as formalized authority lines, hierarchical division of labor, formalized organizational goals or ideologies, schedules, therapies, medications, locked doors, and uniforms. An ethic that emphasizes freedom, spontaneity, and individuality and that opposes established psychiatric practices predominates. In doing away with elaborate structural controls, however, the problems of social control are not eliminated. The community consists of up to six diagnosed schizophrenics under the care of an equal number of nonprofessional staff, residing together most of the time. According to Goffman (1967), psychotic behavior such as that characteristic of schizophrenia runs counter to what might be thought of as public order. "Much psychotic behavior is, in the first instance a failure to abide by rules established for the conduct of face-to-face interaction . . . . Psychotic behavior is, in many instances, what might be called situational impropriety" (p. 137).

The specific problem that emerged in this research was that *in the absence of conventional, elaborate, psychiatric control structures, how are problems of social control solved?* This problem is explained using an *infra-control concept* and its implementing processes. Infra-control constituted the core, or central variable and basic social process, in the study setting. My analysis describes how social conditions, problems, strategies, and consequences are woven into a dense theoretical scheme in relation to the different participants at Soteria House are analyzed. Among the implementing processes developed in the substantive theory of this investigation are *presencing,* a process for control of residents; *fairing,* a process for control of staff; and *limiting intrusion,* a process for control of outsiders. Rather than searching for the frequency and distribution of the problems and processes addressed, the theory attempts to delineate the conditions under which certain processes occurred, the conditions under which they varied, and the consequences of variations. The properties defined as core properties of the social experience under examination are the focus of inquiry rather than verification of preconceived hypotheses. Among the questions that can be addressed using the analysis of infra-control are:

1. In a situation where an officially espoused goal is being with rather than intervening in a person's journey through madness, how do staff avoid being accused of negligence, whether by themselves or by others? Under what conditions do some take action to control others, and with what consequences? What tactics are employed?
2. Staff have little if any formal structure for the management of work. How are tasks assigned and labor divided? What happens when there is a conflict concerning the equitable management of work? What effects do conditions in the setting have on staff composure?
3. Since psychotropic drugs and other control measures such as locked doors are absent for the most part, what strategies are used in dealing with the outside community and external control agencies? How is autonomy preserved, and the community reassured?

These general questions represent only a few of the rather complex array that guided the observations and analysis in this study. My analytical focus in addressing these questions was consistently on behavioral rather than personal patterns. Specific personal patterns were considered only as possible exemplars of broader social patterns.

JUSTIFICATION FOR THE STUDY

"Schizophrenia" is a diagnostic label given to behaviors that constitute our most recalcitrant mental health problem. Its scope is reflected in the low levels of psychosocial functioning achieved by 65 percent to 85 percent of discharged patients, their high readmission rates (about 50 percent in two years), and the large population (more than 200,000 patients) currently hospitalized with this diagnosis (Mosher et al., 1972). These figures serve as powerful justification for continued innovation in the delivery of services to this population as well as for associated research.

Although the bulk of research on schizophrenia has focused almost exclusively on intrapsychic phenomena, a growing body of sociological investigations has pointed to the influence of an individual's social context on the way in which he pursues a career as a mental patient (Clausen and Yarrow, 1955; Lemert, 1951; Scheff, 1963). Such influences operate not only within the family during the prehospital phase of the patient's career, but also throughout the time spent in a treatment facility. Studies of mental hospitals are rich with descriptions of how the course of a mental patient's career becomes interwoven with organizational and interactional processes in the hospital itself, making it difficult to separate role behavior from behavior that is a function of the mental disorder (Goffman, 1961; Caudill, 1958; Scheff, 1963). These findings indicate the importance of studying the interaction that occurs in the social contexts of individuals diagnosed as schizophrenic.

As previously stated, research on the social contexts of the mentally ill has occurred primarily under conditions found in conventional hospital settings. With the burgeoning of a community mental health movement, the locus of care has shifted away from large, often distant, state hospitals to smaller, community-based facilities. Yet moving the locus of care and funding arrangements have failed to yield care and treatment that are genuinely deinstitutionalizing for the severely mentally disordered. Community residences such as Soteria House might logically become a more successful approach. Public confidence and professional endorsement for such a model rely heavily on public trust in the control capabilities of this system.

SOCIOLOGICAL PERSPECTIVE

Although this research was not directed by a preconceived theoretical framework, several converging lines of theory provided an overall philosophical perspective. The work of George Herbert Mead, John Dewey, and Alfred Schutz offered a conception of persons and society that is reflected in many of the methodological and design decisions that were made. The view of society developed by these authors differs substantially from the positivist view of Emile Durkheim (1951) and the structural functionalism of Talcott Parsons (1964). The former writers see actions constructed by interactants as the basic premise of the study of society, and the latter believe that society inculcates and enforces a set of rules and behaviors on the individual. The decision to inquire into an aspect of social life within its natural context grew from my orientation to society as situated process rather than structures that perform functions. This perspective is derived in part from the general philosophical position known as pragmatism. Later conceptualizations were referred to by sociologists as symbolic interactionism. In accord with this perspective, the substance of this study was viewed as emergent rather than as preexisting and merely waiting to be located and measured. Such an orientation required methodological strategies that could account for change over time. Another criterion for selecting data-collection methods was that they symbolically address interaction in situations. Finally, the act of engaging in social research was itself viewed as a process of symbolic interactions.*

ASSESSMENT OF SOCIAL CONTROL LITERATURE

Although the concept of social control has never been defined to the full satisfaction of most sociologists, it has been widely studied. Robert E. Park (1967) goes so far as to say that "all social problems turn out finally to be problems of social control" (p. 209), and that it can be studied under categories of (1) administration, (2) policy and polity, and (3) social forces and human nature. Generally speaking,

*See Denzin (1970) for an explanation of the rationale behind this approach.

however, the concept of social control has either pointed to folkways, mores, and laws as the predominant means of achieving social control, or social control has been viewed as having more to do with developing social integration. Lemert (1967) has referred to the former as passive and to the latter as active social control. He distinguishes between passive control as an aspect of conformity to traditional norms and active control as a process for the implementation of goals and values: "active social control is a continuous process by which values are consciously examined, decisions made as to the dominance of those values, and collective action taken to that end" (p. 53).

Strauss et al. (1964), in his discussion of the negotiated character of rules, underscores a view of the orderly character of hospital activity that is closely aligned with active social control. He notes that "most rules can be stretched, negotiated, argued, ignored or applied at convenient moments," because rules are not disembodied standards; like other negotiable products, they are human arrangements (p. 314).

Numerous theorists have attempted to define social control within sociology, but there is still no clear-cut consensus on the precise definition. Mannheim (1957) proposes that "social control is the sum of those methods by which a society or a group of people tries to influence human behavior to maintain a given order." He distinguishes one facet of the concept which he terms "mutual controls." These are instances in which control is not transferred to an acknowledged agency that exercises control on behalf of the group. Mannheim frequently links mutual controls to a system of sanctions associated more with custom than with official legal punishment. Despite his emphasis on social controls as the objective aspects of authority, he acknowledges that authority is always exercised by people and that social control methods, sources, and consequences vary with time and with the structure of society (1957, p. 29).

Park (1967) considers social control by taking a developmental approach from elementary, spontaneous forms in ceremony, prestige, and taboo, to more explicit forms in public opinion, and finally to the most formal organization in law, dogma, and political institutions. He proposes that social control "has its origin in conflict, assumes definite forms in the process of accommodation, [is] consolidated and become[s] fixed in assimilation" (p. 210). After describing this highly specific evolution, however, he adds, "certain definite and quite spontaneous forms of social control are developed" (p. 210), which he categorizes as tradition, custom, folkways, ceremony, myth, and belief, thus acknowledging (as Mannheim did) the restrictions of viewing social

control exclusively as institutionalized social products.

Douglas (1971) offers another dimension to sociological work in the area of social control by suggesting that most studies have reflected the implicit assumption that moral rules, whether they are formally codified or simple folkways, and other meanings in society are absolute. The properties of this assumption follow:

1. Meanings are assumed to be completely homogeneous for everyone.
2. Meanings are assumed to be unproblematic, so that everyone can be assumed to know without question or uncertainty what is right or wrong at all times and for all situations.
3. Meanings are assumed to be external to the individual.
4. Meanings are assumed to be necessary in the sense that there is no escaping them or choosing not to invoke them.
5. Meanings are assumed to be timeless or eternal; they do not change or go into abeyance (p. 16).

Douglas's identification of these properties offers a key to the problematic nature of defining the concept of social control without grounding it specifically in the natural social conditions of the participants. Most efforts to date have borrowed the concept from grand sociological theory and forced data to fit. This methodological and theoretical pattern is most obvious in the area of deviance sociology, where social control has always been of special interest.

Since 1940 a sizable portion of phenomena traditionally labeled social problems—for example, crime, delinquency, drug addiction, mental illness, and physical handicaps—has been categorized as deviance and studied as such. Ideas in sociology generated to study deviance differ considerably, although there are some areas of minimal agreement. One group of prominent sociologists following in the steps of Durkheim, Parsons, and Merton has been concerned with the etiology of deviance as a reality and with its different rates of occurrence within societies. They have sought to locate the sources of deviation in the discontinuities, anomie, or strain of the structure of society, which is more or less assumed to be an integrated system.* This structural conception of deviation, as developed primarily by Merton, rests on reified ideas of culture and social control. A more empirically tenable perspective (and

*For the theoretical basis of this category of research, see Robert K. Merton's essay "Social Structure and Anomie" in his book, *Social Theory and Social Structure* (1968).

the one reflected in the present study) is that human beings regulate and control the behavior of other human beings. The task of this research is to explain how and with what consequences this activity occurs under a specified set of conditions.

The theoretical perspective in this study on the sociology of deviance and social control is considerably distant from theories concerned with structural sources of deviance and the assumption of absolute meanings. Sociologists associated with the point of view adopted here assign much greater importance to symbolic interaction and social contexts in understanding and analyzing deviance. Among the prominent contributions to this perspective are Lemert's *Social Pathology* (1951), Kitsuse's paper on "Societal Reaction to Deviant Behavior" (1962), Goffman's *Asylums* (1969), Erikson's "Notes on the Sociology of Deviance" (1962), and Becker's *Outsiders* (1963). This group of sociologists focus on the consequences of moral order and social control and seek to show how categories of deviance are invoked and applied to individuals and groups. They have generated concepts such as moral careers, deviance careers, contingency, drift, turning points, and secondary deviance.

A great deal of research on deviance has been characterized by a mood and tone that discloses a strongly fixed, critical stance toward the ideology, values, and methods of state-dominated agencies of social control. Much deviance sociology seems more social criticism than science and therefore offers little to facilitate and foster the kinds of decisions and controls actually necessary to balance freedom and order. Lemert calls for the sociology of deviance to become a science: "it must be made an integral part of a science of social control broadly conceived to discover things necessary to do as well as things not to do" (1967, p. 25).

SOCIAL CONTROL AND PSYCHIATRY

Internal disorder and the breakdown of social control in mental institutions have provided sociologists with excellent opportunities for analyzing stability and change in social systems. Some major studies maintaining this focus have been concerned with collective disturbances. This term indicates that the phenomenon is not an aggregate of individual disturbances, but is a disturbance with a contagious element that is transmitted in an interpersonal way. In seeking to locate the elements involved in a collective disturbance on a psychiatric ward,

Stanton and Schwartz (1954) focused primarily on covert staff disagreements and disruptions of normal communication channels. Caudill (1958) similarly examined the strains created by an imbalance between affective and cognitive communication among staff members. Perrucci (1969) posited an explanation of collective disturbance as a condition in which aspects of the structure of a social system are likely to produce a breakdown of social control. His study of a hospital psychiatric ward placed analytical emphasis on Durkheim's concept of anomie. His findings indicated that the collective disturbance investigated was the result of a breakdown in the "release ideology" surrounding the means for obtaining a hospital release. The ideology was badly constructed, in that the means perceived by patients were not related to the indicators used by staff to establish a release prognosis.

Some sociological work in the substantive field of medicine has delineated dimensions of the work and careers of health professionals. In a study of self-regulating behavior among professionals, Friedson and Rhea (1963) note that the preferred form of work control is a self-regulating process among a company of equals rather than the rational-legal control of Weberian bureaucracy. Such a company of equals was originated by Talcott Parsons and later defined by Barber (1962) as "a social group in which each member is roughly equal in authority, pursuing his work under the morality which he shares with his colleagues" (p. 195). Prominently featured in this notion is the individual's respect for the moral judgment of his peers. Friedson and Rhea conclude that since "so little is known about how the company of equals works, it is by no means self-evident that bureaucratic devices are so dangerous to professional work as professionals claim" (p. 186). In another study of a company of equals, Friedson describes the control processes among physicians in a clinic and also emphasizes the need for additional study of this topic. His findings suggest that the extent to which self-regulating control processes work effectively pivots around (1) recruitment of highly socialized professionals, (2) the observability of their work, and (3) the prevailing value system concerning the rightness of controlling others (1963, pp. 198–199).

Strauss et al. (1964) have studied control over work among professionals and nonprofessionals in two psychiatric institutions. Among the former, the division of labor was negotiated rather than being dictated by formal authority. Negotiations were both explicit and implicit. The latter were called "understandings" (p. 311). Lay personnel were observed to organize their work according to a perspective and logic for

helping patients that was built around maintaining or enhancing the shape and integrity of the hospital unit (p. 356).

Goffman (1961) provides an analysis of life in institutions with special attention devoted to mental hospitals. In his discussion of self-mortification and secondary adjustments, he illuminates aspects of social control of mental patients under conditions termed the "total institution."

> The central feature of total institutions can be described as a breakdown of the barriers ordinarily separating the different spheres of life. First of all, aspects of life are conducted in the same place and under the same authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same things together. Third, all phases of the day's activity are tightly scheduled . . . . Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfill the official aims of the institution (p. 6).

The characteristics of a total institution as identified by Goffman represent the conditions under which social control has been studied in settings for the treatment of mental patients. There is clearly a paucity of research designed to explain psychiatric social control of patients and staff under noninstitutional, nonhierarchical, nonmedical conditions of espoused freedom.

This dearth of research may be traced to a rather widespread belief within psychiatry that therapeutic activities are politically neutral and therefore quite remote from the subject of social control. Halleck (1971), in a monograph describing the political and social control polemic within psychotherapeutic practice, notes that a number of therapists question the morality of behavior modification because of its potential power to control patients. These critics allege that behavior modification has a dehumanizing effect. However, Halleck argues that traditional therapy, especially when practiced under a medical model, can exert as much or more influence in shaping a patient's values.

Without entering into the moral fray concerning the relative evils of one therapy over another, one can entertain Halleck's basic premise: "insofar as politics is defined as the science of how power is sought, distributed and exercised within social systems, all psychiatric intervention must be viewed as having political consequences" (p. xiv).

A plethora of research exists to support the idea that most agents and agencies of social control do more to perpetuate deviance than to

eliminate it. This body of sociological work has generally been carried out under conventional institutional conditions. The present study de-emphasizes the political aspects of this topic and generates instead an abstract theoretical explanation of how problems of control are solved under conditions that mute and deny conventional psychiatric structures and control processes.

STUDY DESIGN

This investigation was designed as a field study. The major portion of data collection was carried out using research strategies that involved direct contact with individuals in the setting under natural living conditions. Although field research has been sternly criticized over the years by many social and behavioral scientists as being unreliable, a growing number of social scientists have argued its merits, especially for conducting descriptive and theory-generating research. Polsky (1969) speaks out strongly against what he calls "scientism" and the lack of good observational skills among criminologists.

> Successful field research depends upon the investigator's trained abilities to look at people, listen to them, think and feel with them. It does not depend fundamentally on some impersonal apparatus . . . that is imposed between the investigator and the investigated. Robert Park's concern that sociologists become first of all good reporters meant that . . . the sociologist should train himself in such human capacities and use them to their utmost in direct observation of people he wants to learn something about (p. 119).

It is not my intention to review in detail the pros and cons of this debate but rather to indicate that sending investigators into the field to observe communities, special groups, and institutions has a long history in both anthropology and sociology and has proved to be well-suited for the study of ongoing processes in social situations. Among the classic and major modern works that exemplify its use are Anderson, *The Hobo* (1961); Whyte, *Street Corner Society* (1955); Becker et al., *Boys in White* (1977); Cavan, *Liquor License* (1966); Roth, *Timetables* (1963); Lynd, *Middletown* (1959); Thrasher, *The Gang* (1963); and Vidich and Bensman, *Small Town in Mass Society* (1958); to name only a few.

Central to the logic of the study design is a distinction between "unit" and "process" sociology. Sociological units exist at both macro- and micro-levels and are bound to finite times, places, and people.

Conventional examples include social class, sex, status, aggregate, group, race, and organization. Process sociology, on the other hand, deals with the movement of social life through time, transcending the specific identities of particular units. Glaser calls two basic types of processes "social-psychological" and "social-structural."* Examples of the former include socialization, becoming, health-optimizing, and normalizing; a classic example of the latter is bureaucratization, and codification, decentralization, and formalization are others. Process sociology may fruitfully be considered to be a sociology of gerunds and unit sociology as a sociology of nouns.

Within any unit of social life, certain identifiable social-psychological and social-structural processes may legitimately be regarded as basic. Basic social processes account for most of the variations in behavior in the situation under investigation. The work of Glaser and Strauss (1968) on terminal care provided a model for this study's design. These authors found that much of the variation in behavior that occurs in the care of dying patients can conceptually be accounted for in terms of stages of an "awareness context" (the fact of dying is known differently by the patient, the family members, and the staff members) and stages in a "dying trajectory" (the shape and duration of the time it takes to die).

This study therefore was designed neither to test a few specific hypotheses deduced from a preexisting theory nor merely to describe a single organizational unit, but rather to investigate the organizational conditions and unfolding interactions that were thought to be the basic social-psychological and social-structural processes in the setting.

Since this study was designed to generate rather than to test or verify theory, data collection and analysis depart from a conventional linear model, in which they are viewed as separate and consecutive steps. Rather, collection of data using strategies generically termed "field methods" and analysis according to the "constant comparative method" elaborated by Glaser and Strauss occurred simultaneously. Concepts, variables, and propositions emerged from the data and then served to direct subsequent data collection. For the sake of clarity and parsimony of presentation here, however, discussion of the methodology is divided into the two conventional parts.

*I owe this conceptualization to the seminars on qualitative analysis taught by Barney Glaser in the sociology program at the University of California, San Francisco, in which I participated from 1972 to 1974.

DATA COLLECTION

Sources

The bulk of the analysis was based on approximately 200 hours of field observation, 11 in-depth interviews with eight staff members, all available documents related to the setting (grant proposals, journal publications, results of psychometric tests of staff and residents, medication records, "nursing notes," correspondence, and "The Manual," a 100-page offical portrayal of interaction in the house), a 15-minute documentary film entitled "Soterialand," attendance at four formal meetings at which official versions of the character of Soteria House were presented to an audience of professionals, and finally self-examination of my own experiences and interactions. This multifaceted accumulation of data was purposefully sought in order to provide different vantage points from which to understand a category and develop its properties as part of the analytical process. Glaser and Strauss refer to such an approach as acquiring different "slices of data." They point out that the resulting variety of data "would be bewildering if we wished to evaluate them as accurate evidence for verification. However, for generating theory this variety is highly beneficial because it yields more information on categories than any one mode of knowing" (1967, p. 66).

Timing and Focus of Observation

The 200 hours of participant observation took place over a period of five months, from January to June 1973. For approximately 50 hours, decisions about what to observe were guided by the desire to see what could be seen. I attempted to record everything within my line of vision. The first 50 hours were devoted to mapping out a working conception of the relevant dimensions of the setting. These dimensions then provided a basis for future sampling of situations and groups. After learning that house meetings were held every Friday at around 10 A.M., for example, I made a methodological note to attend some of them. The schedule of observation that yielded the data on which the analysis is based includes all periods of the day and night and all days and nights of a month. I was present at all types of meals, at special occasions such as birthday parties, on field trips, at meetings, when visitors arrived, and so on. Single, multiple, and mobile positioning, as presented by Schatzman and Strauss (1973, p. 41), were all employed while observing.

As the core explanatory category and its dimensions began to emerge from the ongoing analysis of the data, my observations were guided by the following questions concerning the basic social-psychological and social-structural processes:

1. What is going on?
2. What are its properties?
3. Under what conditions and with what consequences does it work?
4. How did it come to be?
5. What is it becoming?

This active, purposeful approach to the collection of data is directed toward developing a theory and is called theoretical sampling. Denzin (1970, p. 44) views theoretical sampling as a reconceptualization of the traditional sampling standards in order to address interactive research questions. He underscores Glaser and Strauss's point that theoretical samples are judged by the quality of the theory, whereas statistical samples are judged by the extent to which they conform to rigorous rules of statistical sampling theory (Glaser and Strauss, 1967, p. 45).

Recording of Field Notes

The recording of field notes was systematized according to Schatzman and Strauss's scheme of observational notes (ONs), theoretical notes (TNs), methodological notes (MNs), and personal notes (PNs) (1973, p. 99). ONs and MNs were recorded in the ongoing situation on a small, relatively inconspicuous note tablet. TNs and PNs were added as soon as possible after leaving the setting. Problems with recording were interpersonal much more than technical. The decision to record and take notes in full view of the individuals being observed was in part a consequence of the structure of the setting and in part a consequence of my attempt to avoid the social-psychological risks of secretive behavior. Unlike a hospital, a 16-room house full of people offered little opportunity for slipping off to a cafeteria or restroom periodically to record from memory. Long stretches of time usually spent at the house (an average of 8 hours each visit), combined with the 2-hour drive home afterward, increased the risks of recording from memory. In the early days of my note taking, dealing with the participants' concerns

constituted much of my clarifying interaction. I explained that anyone was welcome to read the notes I was writing because they were merely descriptions of what was going on. Every staff member availed himself of this offer once and responded jokingly with comments such as, "well, it's accurate but boring as hell!" This on-the-scene note-taking strategy in conjunction with continuous observations provided me with the rationale for adding TNs and PNs only after leaving the situation, when the copious written in shorthand notes were typed, dated, duplicated, and stored in files. TNs and PNs were not seen by staff or residents in the setting.

The Interviews

The interviews in this study were conceived as open-ended. They allowed the interviewees to express the details of their experiences as they perceived them, but also had to be focused enough to probe the dominant patterns emerging in the analysis. I originally intended to design and conduct them myself. However, the project director for the house called my attention to the fact that she had recently conducted lengthy in-depth interviews that were minimally structured and directed toward discovery of "central interpersonal patterns and problems at Soteria." She was trained as a psychiatric social worker with considerable expertise in interviewing techniques. These interviews were offered to me on tape. On review, their availability and relevance to my analysis led me to decide to avoid repeating the lengthy and expensive task of formally interviewing the staff firsthand. In making such a decision it was necessary to give up a degree of control over the information yielded by the interviews; however, the existing interviews proved to be a rich source of variation for the analytic scheme that was already emerging in the analysis of the field notes. Typescripts of the 11 2-hour interviews with eight staff members were made, and these were subjected to an analytical procedure described in the section on data analysis. It bears noting that a limitation of the interviews was their exclusive perspective of the staff. The labeled schizophrenics who constituted the patient population were judged to be too troubled to warrant their participation in such interviews, or they communicated primarily in private and symbolic forms that were not accessible or applicable to the purpose of the study.

Self-Examination and Introspection

Self-examination of my own experience and interaction relates to what Gold and others have called "role taking" in field research.

> While playing a field work role and attempting to take the role of an informant, the field observer often attempts to master hitherto strange or only generally understood universes of discourse relating to many attitudes and behaviors . . . . He continually introspects, raising endless questions about the informant and the developing relationships. (Gold, 1969, p. 31)

Such notions follow the tradition of Alfred Schutz in acknowledging that the human observer registers not objective fact, but rather intersubjectivity (Natason, 1962). Studies such as my own that accept this point of view value the Weberian concept of *verstehen*, or subjective interpretation. McCall and Simmons (1969) point out that there is an elaborate and longstanding debate on this subject. It is sufficient here to comment that both the nature of my research interests and my special training in empathy as a nurse played parts in the position I knowingly took on this polemic. Such a decision served me in ways similar to those reported by Chafetz (1973) in her study of the counter-junk culture. Most of the residents in the study setting were linked by special, deviant inner worlds in which particular unconventional meanings were attached to everyday language and private understandings were shared. An observer lacking the capacity to register subjective understanding would be unlikely to discover the rich meanings that were exchanged.

In some instances careful examination of my own interaction gave some verification of the traction my emerging analysis was bringing to the situation. For example, as the process of joking became established as one major strategy of control and influence among staff, I took the opportunity to employ it in order to influence staff members toward signing my Human Subjects Consent Forms.* Instead of soberly promising confidentiality and protection of personal privacy, I jokingly engaged in small talk about promising to make them famous and, in the case of young males, considering their proposition that I indeed should invade their personal privacy. Presenting the consent forms in the context of humor and informality effectively transformed a potential obstacle into a relaxed minor formality.

*In accordance with regulations concerning protection of the rights of human subjects, all investigators doing research involving human subjects must obtain signed consent forms from the respondents.

Documents

The complete list of documents that illuminated this study's analysis is reported in the References. The specific items were obtained primarily through the cooperation of the Soteria House project director and her secretary. To my knowledge, this list represents the entire universe of this type of data available on the subject during the investigation period.

DATA ANALYSIS

The constant comparative method was the fundamental mode of qualitative analysis in this research. According to Glaser and Strauss (1967, pp. 33–35), its purpose is the generation of conceptual categories and their properties from the data in order to build grounded theory. This study focused on producing substantive theory. Substantive theory, as contrasted with formal theory, helps to elucidate a specific empirical area of social inquiry rather than a conceptual area. In this study the substantive area is psychiatric care of schizophrenics under conditions of structural freedom. According to the constant comparative method, basic properties of a category are brought out by comparing similar groups, so that the boundaries of applicability of the theory can be established or its conceptual categories modified and broadened to increase its explanatory power. Among the comparative groups in this study were patients versus staff, long-time staff versus newcomers, spaced-out patients versus patients who were just trying to get attention, and patients who were violent versus those who were merely bizarre. Comparisons that maximize differences and variation are most appropriate at the later stages of analysis.

The elements of theory toward which this study was directed are (1) conceptual categories and their properties, and (2) general relations among the categories and their properties. As the categories were identified and developed, their accumulating interrelationships made it possible to identify the core analytical framework of the emerging theory. The core variable or process became a guide to further collection and analysis of data. The final stage of theory building consisted of an integration of the fullest possible diversity of categories and properties.

Generating Categories and Their Properties

The initial step in the analysis began at the time of the data collection and continued throughout the investigation. It was accomplished through a process of open coding, whereby both substantive and theoretical codes are developed and data are both taken apart and put back together. Substantive codes are in vivo words pulled out of the data. They are usually words used by the individuals in the setting, and they contain considerable imagery. The process of substantive coding is not unlike the explication of the text performed by a literary scholar or the theme abstraction undertaken in interaction process analysis (Wilson and Rank, 1971, p. 8).* Among the long list of substantive codes were "being with," "burning out," "bumming out," "spacing out," "joking," "fairing," and "insulating." Substantive coding of incidents in the data made it possible to develop constructs that combined sociological knowledge with what was grounded in the data. The core varible of infra-control is such a construct. Concepts and their dimensions were generated by constantly reading and rereading the data, asking "What are these data an indicator of?" Thus indicators of concepts in this analysis are actual episodes or events in the field data, not indicators derived logically from some grand sociological theory. Concepts earn their way into the theory by virtue of being grounded in the data. In fact, the open codes were written in the margins of the field notes beside their indicators in the data.

Theoretical codes are the ways in which substantive codes and the data they represent are interrelated. There are innumerable families of theoretical codes, including causes, contexts, contingencies, consequences, covariances, conditions, mutual effects, cutting points, degrees, and types. All are ways of relating variables theoretically. I attempted to discover multiple relationships among concepts rather than prove a linear causal hypothesis between two concepts. Such an approach is designed to yield molecular rather than linear theoretical models and is in essence what Glaser and Strauss mean by a "dense" theoretical scheme (1967, p. 118).

Since theoretical codes are the relationships among substantive codes, they were frequently elaborated and diagrammed in the analysis. Each incident in the data was coded into as many categories as possible.

*The IPR is a verbatim recording of verbal and nonverbal communication that takes place between the nurse and the patient. In addition to the actual dialogue, it includes an attempt to analyze the themes in the conversation (Wilson and Rank, 1971).

As an incident was being coded for a category, it was compared with incidents already in the same category in order to discover the properties of that category. This process is based on the notion of the interchangeability of indicators. Under some conditions, for example, behavior substantively coded as "tuning in" is a condition for a particular control strategy, such as "monitoring"; in other instances "tuning in" may be a consequence of a control strategy or may be a control strategy itself.

Saturation of Categories

When new categories stopped appearing in the data, it can be said that the categories became saturated. In other words, saturation occurred when the major recurring interactional patterns had emerged. Saturation of identified codes was accomplished through the process of theoretical sampling. I logically elaborated the varying conditions and comparative situations that might help to develop the categories and then set out to look for them. The determination of saturation is fundamentally an empirical question that is less difficult to answer if the analyst can clearly distinguish between new descriptive events and genuinely new conceptual dimensions. Determination of saturation on this basis fundamentally became the point at which to stop. This feeling of completion, however, does not preclude an entirely different order of analysis involving different categories and frameworks for perceiving the data.

Collecting and Storing Ideas

Memo writing is a strategy directed toward collecting and storing analytical ideas as they occur to the researcher. In this study, memos were written on 5 × 8-inch index cards headed with the relevant code or category. They also contained references to excerpts in the data that were indicators of the idea or its dimensions. Memos were written during data collection and coding. They provided an effective means of proceeding on an ideational level, because they freed me from many of the usual constraints of writing good prose. Working from memos forced me to rework the ideas in the analysis continually. In this sense, the memos verify the quality of the theory. They provided a fund of ideas that could be reworked, they allowed for integration of the accumulated ideas, and when finally sorted they provided the structure and context of the final manuscript.

Emergence of the Core Category

The core variable in this study was discovered by comparing each category and its properties with all others. As it emerged from the data and seemed to pick up most of the variation in the social-psychological problem raised, infra-control became part of the theory, and eventually it offered the most complete explanation of how problems of control are solved under conditions of structural freedom. Once infra-control was discovered, its facets were developed by reviewing the data for patterns and relationships. A deliberate attempt was made to avoid premature closure on either the specific analytic concepts or the overall integrative scheme. Numerous colleagues were asked to read randomly selected portions of the data and informally discuss the tractability of the infra-control idea. Without exception, these professionals perceived themes in the data to correlate with the structure of the analytic scheme.

Selective Coding

In working with the memos and reading and rereading the data, it became apparent that many of the substantive codes were not separate categories, but were rather facets, conditions, strategies, and consequences of a few higher-level concepts. For example, "monitoring" initially appeared in my notes as a separate substantive code, but as I compared all the indicators for "monitoring" it became obvious that it was a subcode of "presencing." With the operation of selective coding it was possible to delimit the theory to a smaller set of higher-level concepts. The aim of selective coding is to achieve theoretical completeness; that is, to explain the variation in the problem with as few variables as possible, thus achieving for the theory both scope and parsimony.

Writing the Theory

The written exposition of the theory was based on hundreds of pages of coded data, approximately 300 sorted analytic memos, and diagrams of the core analytic framework. The findings and analysis were structured according to the carry-forward notion of theory writing: as soon as a concept is first mentioned, imagery from the data is provided to develop the concept and its dimensions to the reader. Subsequently a one-word concept is used to represent the described

indicators. It was the intent of the analysis to provide a dense conceptual explanation without excessive formulations.

Effective Use of Time and Energy

Because this study was intended to generate theory through contemporaneous collection, coding, and analysis of data, the temporal aspects of the research were different from those characteristic of studies in which separate time periods are designated for each step. This study required that all three procedures proceed simultaneously and to the fullest extent possible. It was of prime importance to avoid using up all available time in the fieldwork activities, which included 4 hours of driving, usually 6 to 10 hours of participant observation, and several hours of typing field notes immediately afterward. The demands of this type of data collection can be detrimental to the development of ongoing analysis. Therefore I struggled to code rather than to collect more data, to write memos rather than to continue coding, and finally to maximize my own enthusiasm and productivity. These pacing decisions resulted in a two-month extension of the original data-collection period, but they also prevented the loss of emergent ideas and provided momentum for the unfolding analysis.

Credibility of Qualitative Research

A discussion of credibility necessarily begins with acknowledgment of a general position among sociologists that the only way to do systematic work is to apply the canons of quantitative analysis to sampling, coding, reliability, validity, construction of hypotheses, and presentation of evidence. These sociologists emphasize the rigorous testing of deduced hypotheses and deemphasize the discovery of concepts and hypotheses that are relevant or salient for the substantive area being researched. Glaser and Strauss (1966) have raised doubts about the applicability of the canons of quantitative research for judging the credibility of qualitative research and analysis. They argue that the criteria of judgment should be based instead on the generic elements of qualitative research.

Although I acknowledge that the analysis developed here is not necessarily the only one that might plausibly have been based on the Soteria House data, my own trust in the credibility of qualitative analysis is a result of both the real-life character of fieldwork and the

systematic effort invested in the analysis of data. Biases brought into the field were acknowledged and carefully checked out so that the hypotheses that emerged arose exclusively from the data rather than being imported or borrowed from logico-deductive theory. In the words of Glaser and Strauss:

> It is the field worker himself who knows what he knows and has lived through. He knows it not only because he has been there in the field and because of the careful verification of his ideas, but also he feels the worth of his hard-won analysis in his bones. He has been living with partial analyses for many months, testing them every step of the way . . . not only by observation and interview but also in daily livable fact. (1966, p. 58)

In the chapters that follow I attempt to perform the two fundamental tasks essential to conveying the credibility of the analysis: (1) to enable the reader to understand the analytic framework, and (2) to describe the social world studied so vividly that the reader can almost see and hear it—in relation to the framework. It is incumbent on the credible theorist to provide the reader with adequate information about how conclusions have been reached. The researcher must communicate the range of data on which the analysis was made, so that both researcher and reader can make meaningful judgments about the value of the analysis in accurately representing the prominent features of the social environment being studied.

3

Social Control of Residents

Much Madness is divinest Sense—
To a discerning Eye—
Much Sense—the starkest Madness—
'Tis the Majority
In this, as All, prevail—
Assent—and you are sane—
Demur—you're straightaway dangerous—
And handled with a Chain—
(Emily Dickinson)

The dynamics of social control touch the lives of all persons who are attempting to participate in group endeavors. Sensitivity to this fact of social life is not the exclusive domain of the poet's, hero's, or madman's "discerning Eye." At Soteria House conventional formal arrangements for social control are muted, denied, and discarded. Under the espoused freedom characterizing Soteria, a tacit infra-controlling process has emerged in place of elaborate, formal control structures to deal with problems of social control. Infra-control is comprised of three implementing processes, each of which addresses problems presented by a corresponding population of resident patients, staff, and external control agencies. These implementing processes are *presencing, fairing,* and *limiting intrusion.* Presencing refers

to ways in which the physical presence of other people is used to influence and modify residents' behavior (Kneisl and Wilson, 1976). Fairing refers to the management and distribution of work according to tacit, implicit understandings among staff members about what is fair (Kneisl and Wilson, 1976). Limiting intrusion refers to the process by which Soteria restricts the potential control that might be exercised on its operation by external agents (Wilson, 1977). The definition in the Oxford English Dictionary of the term *infra-* is "denoting below or beneath in respect to condition or status as in infra-red." The term infra-control in this study refers to a control process that is largely emergent, intuitive, tacit, and improvised. The formulation of infra-control organizes many events that superficially appeared to be disconnected or paradoxical. Furthermore, it enables major patterns of interaction to be discerned, despite the tendency of persons involved in the setting to discount patterned events in favor of the uniqueness of each situation. This chapter analyzes presencing as it is utilized in the control of residents. Fairing and limiting intrustion are included only as they aid in explaining the phenomenon of presencing.

GENERAL PROPERTIES OF INFRA-CONTROL

Several features of infra-control at Soteria House contrast sharply with the formalized control structures inherent in many psychiatric settings for the treatment of schizophrenics. Unlike structured controls, infra-control has as its social context a community ethic of nonintervention and espoused freedom. The belief that psychosis can be a self-healing experience with a potential for psychological growth and special insights supplants the conventional notion of psychosis as an illness to be cured by intervention from an external agent. The community is oriented toward anti-authoritarian and anti-structural values. It challenges the legitimacy of imposing one's viewpoint or value system on somebody else by requiring conformity to any given set of norms concerning mental health. Although this ethic is generally an area of common understanding at Soteria, in its implementation it presents different problems to the staff. One staff member who subsequently resigned, expressed the following in an interview with me.

> We try to allow the individual in his altered state of consciousness as much expression of anger as possible. We have a high tolerance for property damage; property is considered expendable. We try to tune in to a person's feelings of aggression rather than repressing them. Still, it's a big source of frustration—trying to follow the idea of not interfering and just letting people go through their spaces without rushing in. You never really know how much of our trip we're laying on them. It's hard not to do something when someone is going through really heavy space. (Field notes, visit 4, p. 4)

A second staff person found it somewhat easier.

> I think the most important thing we do here is nontherapy. Our "letting be" process is really beautiful! (Female staff interview, S., p. 13)

Despite advocacy of the freedom ethic, infra controlling operations are largely atheoretical. In short, staff, volunteers, and residents do not all stand in relation to a single articulated theoretical framework that guides decision making and action. Consequently, concrete problems are solved on an *infra* basis, that is, on an emergent, improvised, and intuitive basis. In one interview a staff member was asked about some of his typical techniques or styles of dealing with residents. He responded

> I don't think that can be found out by talking into a tape. A lot of it just seems natural at the time. I'm naive. The fascinating part for me is to know that there's something going on but not to know what it is. (Male staff interview, H., p. 10)

When another staff person was asked directly, "What is the theory for Soteria?" he responded, "You'll get a different answer from everybody you ask. I think some of it is supposed to come from Laing. Nobody's ever made much of the theory part." A third staff member commented

> If I can keep my concept of what I am doing away from what I am actually doing, I can do fine. I know it's worthwhile because I feel good about it. (Male staff interview, G., p. 3)

Staff members occasionally come to Soteria with a single, well integrated personal ideology, such as mysticism or health-optimization, which is reflected in their interpretations of events. When asked how specific situations were handled, a staff member told me, "How people handle things is different every time. People decide what to do as situations come up."

A corollary to the atheoretical property of infra-control is that unlike more formalized, theory-based psychiatric practices, strategies of infra-control are uncodified and therefore not learned through

training and educational programs. They must instead by discovered through experience, picked up from others on an informal basis. Some of Soteria's original staff had worked with unmedicated schizophrenics at a state mental hospital where a technique called a vigil was developed. The vigil involved a set of structural arrangements that enabled a designated staff person to provide continuous attention to a severely disturbed patient over a period of days. Such structural arrangements included the designation of "vigil rooms," official redistribution of workloads to relieve the staff member of customary duties, and scheduling for coverage based on 4- to 8-hour shifts (*Manual*, p. 10). Although the continuous attention aspects of the vigil were well suited to the Soteria staff's ideology, an attempt to import the formalized structures and techniques of the vigil into Soteria through a specified "vigil training" ultimately was unsatisfactory and met with failure. Staff accounted for this failure by emphasizing the necessity for experiential, heuristic learning in their work

> It's something you can only learn by doing—something that's an experience you experience. It doesn't have much meaning unless you actually participated yourself. You couldn't explain it. You couldn't have a classroom situation telling about it. (Male staff interview, W., p. 74)

The extent to which the uncodified infra-processes at Soteria may eventually result in formalization is discussed in chapter 6.

In most hospitals, elaborate formal structures such as locked doors, seclusion rooms, medications, and therapies determine control of patients, and other structures such as job descriptions. orientation programs, work shifts, uniforms, and task assignments determine management of staff work. Under the infra-control system by contrast, structures are simplified and denied.

> Hospital rituals aren't part of Soteria because we believe that they usually just work to keep staff from being with patients. We don't even have the usual equipment to stop a violent resident—no drugs or locked doors. The only kind of restraint is other people. One guy wanted to go to Bangla Desh and ran into the street. I grabbed him and held him down for 45 minutes until he calmed down. (Field notes, visit 19, p. 5.)

Infra-control relies heavily on face-to-face interaction to yield emergent self-regulating patterns rather than external, preestablished rules as the basis for social order. In mental institutions, control generally is imposed externally. Overall expectations are that staff as well as patients cannot be responsble for their own self-control: patients

need established rules and a privilege system (Goffman, 1961, pp. 51-60), staff need asssignments, supervision, and formal evaluations. At Soteria, however, infra-control is characterized by the enhancement and promotion of self-control in all participants. Control does not simply imply conforming behavior, but rather behavior that is within the tolerance capacity of others. Infra-control relies on individual tolerance ranges instead of agreed upon norms.

Infra-control is reciprocal in that the controller as well as the person being controlled is subject to its consequences. For example, when a resident evidences behavior defined by the staff as attention getting, a staff member frequently will engage the resident in a conversation urging self-control. Such "therapy talk" usually modifies the resident's behavior at least temporarily. The staff member is also controlled by the resident, however, who in effect has used the infra-control process to schedule his or her own therapy. This exchange goes on most frequently at 3 or 4 A.M.

> For a long time I'd spend my whole shift Monday to Wednesday with her. She went through periods where she didn't sleep at all at night; like we'd watch the sun come up every morning, talking. She was an all nighter—one of the most famous all nighters! (*Manual*, p. 11)

PRESENCING: A SUBPROCESS OF INFRA-CONTROL

> It all started about four years ago when I first tried grass. I started getting afraid of getting caught and afraid I'd go crazy. I couldn't concentrate and thought I'd end up in a straitjacket for life. Soteria gave me people to be with so I wouldn't be so afraid of going crazy. When I was alone, I'd be afraid of blowing up. I'm not afraid at the house, because there's always someone right next to me. (Interview with resident, visit 12, p. 6)

In casting out formal structures and philosophies of conventional psychiatric control, actors at Soteria rely on one of the most fundamental forms of social control, that is, being in the presence of other people. Presencing as a process may be delineated into three phases: mere presencing, monitoring, and intervention. Mere presencing is the initial stage in which the physical presence of people acts as the basic control condition. The second phase, monitoring, involves at least a minimal focusing of attention on someone by other people. Monitoring is an

ongoing requirement for intervention, because it addresses the problem of when and with whom intervention is appropriate. Intervention usually but not always takes place after staff have engaged in monitoring, and it encompasses a number of active and passive strategies for dealing with resident control problems by using other people as control agents. Crucial to this last phase of the presencing process is the decision of how to intervene once it has been decided to do so. In this phase, staff and other helpers must also legitimate their mode of intervention in the face of antithetical community values.

The First Phase: Mere Presencing

It is an unnoticed, unappreciated, and too often assumed condition at Soteria, that the mere physical presence of others is fundamental to the control of residents. Both common-sense understanding and small-group theory indicate that social visibility enhances behavior that adheres to norms. At Soteria this finding persists, even though there is a broad range of interpretations as to what the norms are.

Mere presence is possible at Soteria because, unlike the mental hospital where a large number of inmates must be managed by a small staff, there is an exceptionally high ratio of staff members to residents. The number of staff members, volunteers, and other helpers customarily exceeds or at least equals the number of residents at any given time. Minimum coverage is assured by a convention that requires one male and one female staff person to be in the house at all times. The details of coverage are discussed in chapter 4.

As Goffman (1961, pp. 6–7) has pointed out, many psychiatric practices and structures are consequences of efforts to manage the daily activity of a large number of persons in a restricted space with few resources. In effect, when people are not present to manage patients, structural arrangements such as locked doors, routines, rules, and medications act as substitute control measures. When asked about the feasibility of handling unmedicated schizophrenics at Soteria, one staff member said, "I think the fact that there's always plenty of people around has something to do with it." The community's value commitments and the adequate supply of resources in the form of people being present make presencing a common state of affairs at Soteria.

An important characteristic of mere presencing is its potential for prevention. For a resident who is experiencing an impending loss of control, the presence of someone who can exercise control conveys

prevention potential. Some degree of composure frequently results from knowing that dangerous, out-of-control behavior will not go unnoticed or without a response. This characteristic constitutes a subtle paradox when viewed in light of the nonintervention ethic at Soteria. As Shands points out in his monograph on structure and transcendence, however, the paradox that structure not only imprisons but also liberates has been familiar to members of many different cultures: "in any condition of expanded consciousness, taken here to be the affective component of a discovery of new patterns of experience, it is important that the person be in an externally or internally disciplined context (1971, pp. 70–73). Mere presencing at Soteria provides such a context. It is the structural condition for a control process relying primarily on face-to-face interaction rather than on preestablished rules.

Another noteworthy property of mere presencing at Soteria is that it can generate control problems of its own. Examples are recurring problems related to crushes and sexual advances. The physical and psychological intimacy that results when people are constantly in close proximity in an informal, homelike setting, along with the common age range of residents and staff (exclusively adolescent to young adult), fosters crushes and sexual advances among residents. Sexual involvement between staff and residents is viewed with particular concern, and a self-initiated regulation against such involvement has been established. Physical contact between residents and staff must be modified into some acceptable form, such as massage. Staff members must determine whether or not the offer of a massage by a resident is sexual in intent. The criteria for this determination are usually circumstances in which the massage is given and the exclusiveness of the activity. Also crucial in differentiating between touching that is sexual and touching that is acceptable between residents and staff is the staff's assessment of how acutely disturbed a resident is. A resident genuinely out of touch with reality is not considered to be capable of making a serious sexual advance. In order to avoid defining an offer of a massage as a sexual advance, staff members carefully limit its privacy and exclusiveness, as evidenced in the following female staff member's explanation:

> One night C. (a male resident) came into my room and asked if I wanted a massage. I said, "Well, why don't you give me a short one and one to U. (a female resident)." It's not a problem for me as long as it's not exclusive. (Female staff interview, K., p. 27)

Another staff member offered a rather succinct summary of this topic, when she responded:

> I've never thought too much about crushes because everybody gets them on various staff members. It's just something to expect. I don't worry about it because it's a perfectly natural thing. The only big difference is that we (staff) don't fuck the residents. (Female staff interview, T., p. 1)

The Second Phase: Monitoring

The next stage of the presencing process is based on the control condition of mere presencing. Monitoring can itself serve as a passive intervention strategy when the focused attention of staff members on residents is sufficient to modify or control their behavior. It is differentiated from close supervision in that the latter is a highly purposeful activity and a consequence of a hierarchical structure, while monitoring is an emergent, interactional process without structural dimensions.

Monitoring also operates as a setup for the intervention phase: staff pay attention to residents, watch for signals and cues of impending loss of control, and determine when to intervene and for whom.

> He was lying on the couch in the living room and started to crawl sort of into the couch. I was just sitting there but at that point I started to watch him closely. He started to head off the couch, and we just let him keep crawling. I thought for a second of stopping him, but I didn't. He crawled all the way upstairs and into the back bedroom. Then he started out the window because he wanted to see the sunlight. We stopped him finally at that point. (Female staff interview, S., p. 23)

Central to the monitoring phase are problems of defining the situation.* The community ethic that emphasizes tolerating the intolerable relies on the staff's ability to differentiate bizarre behavior that is acceptable, intolerably deviant, and attention getting. This defining process acts as a social-psychological intervening variable throughout the monitoring phase. Staff rely on cut-off points that divide a continuum of behavior into tolerable and untolerably deviant ranges. Any specific symptom or behaviorial index may be defined differently at different points in time

*Definition of the situation is an old concept in sociology usually credited to W. I. Thomas. It refers to the process in which an individual explores the behavior possibilities in a situation to form an attitude toward the situation. It is also used to denote certain products (agreed upon definitions) of group life that are left as residues of the definitions of many situations. (Waller, 1961).

or according to various residents' histories. A biographical cut-off point is redefined according to its presumed meaning in the life of a particular individual. The same behavioral cue may be interpreted differently for different individuals. In conventional psychiatric institutions where cut-off points for unacceptable behavior are normative, such distinctions at Soteria might be called biased or arbitrary; but within the infra-control process, they are valued as being individualized. The interpersonal familiarity and relative intimacy that characterize relationships at Soteria provide a basis for understanding the signals and behavior that are typical for each resident.

> U. (a resident) played the Rolling Stones when she was angry. When the Stones album came on, you got to know that she was going to come out and stomp around and maybe break a window or something. She'd turn it up full blast, and everyone would know she was angry. Then somebody would go to her room to be with her. (Female staff interview, T., p. 12)

Such familiarity and presumed understanding are achieved because of the comparatively small number of people involved in the setting, the amount of time they spend in each other's company, and the relatively long stays of all the participants. In short, biographical cut-off points are possible because everyone knows everyone else. As one staff member put it, "Knowing D. helps you not to be afraid when he gets violent. It's not like strangers that you meet on the street." Interpreting signals and making such cut-off points regarding deviant behavior are particularly problematic at Soteria, since considerable deviation from convention is tolerated and some forms of bizarre behavior are accepted and at times even encouraged. Staff repeatedly described their initial uncertainty in this regard and the eventual necessity of defining situations for themselves.

> Well, the first time, I didn't know what to do. I didn't stop her from smearing it all over the walls, floor, and kitchen ceiling. I just watched to make sure she wasn't going to hurt herself. (Female staff interview, K., p. 31)

This specific resident presented the novice staff member with a great deal of uncertainty about the legitimacy of intervening, because the staff member had not yet learned the tolerance range for resident behavior that makes extra work for the staff. A second staff member who was attuned to the fair distribution and management of work in the house was quicker and more certain about interrupting the resident.

When staff members are uncertain about the point at which to intervene, there is a greater likelihood that active intervention will be avoided.

> There were several times when M. (a resident) was going to cut her wrists and she would say, I have a right to do this. The question for me is, where do I draw the line? When do I say, "you have a right to do this but not that"? It's a very hard thing. (Male staff interview, G., p. 3)

Definition of a particular resident's behavior as attention getting, genuinely out of touch with reality, or unacceptably deviant and concomitant control measures also are influenced by the tolerance ranges and limits of individual staff members, and vary according to their personal histories. Burned-out staff members whose tolerance and energy resources are depleted are more likely to control attention-getting resident behavior and to require more dramatic psychotic signals to conclude that a resident's behavior is of a sort that should be allowed to go on uninterrupted. How much staff members know about the history of each resident's behavior also influences their tolerance and the point at which they institute control measures. For example, old-timers with a lot of data about a resident are more likely to view a particular behavior as being typical in view of what they know about the resident's history in the house. Certain residents earn reputations as attention getters and are barely tolerated by staff members who have a long-range perspective of them. In these instances staff members are quick to intervene, particularly when such a resident uses shams and other attention-getting devices. The intervention takes the form of active strategies to set limits directly or to urge self-control.

> U. (a resident) comes into the kitchen and gets the scissors from the pantry. T. (a staff member) follows her in and tells her to get out. U. threatens to cut her hair with the scissors. She says she cuts her hair when she's "pissed" so staff better hide the scissors. Another staff member hears the conversation and says: "You don't have to do it. You want to do it, and then you do a number on yourself and try to play games with us because you tell us it's our fault for leaving the scissors around." (Field notes, visit 2, p. 4)

Similar behavior on the part of a new resident whose typical behavior patterns were not yet known or the same situation confronting volunteers or new staff members not knowledgeable about the resident's reputation as an attention getter would produce different management of the control problem. Tolerance of the behavior of residents who are

not yet well known by the staff is higher, and staff members are more willing to engage in constant monitoring despite its drain on their energy and time.

> Incontinence is a little hard for me to handle. It tests my patience, depending on the degree I feel the person is spaced out. When N. (a new resident) spit food all over me I wasn't bothered. I let her do it. Other times when D.T. (a long-term resident) did it I'd get pissed and make her clean it up. (Male staff interview, H., p. 11)

In sum, each resident's history of behavior at Soteria influences the cutoff point at which the staff will intervene in his actions; likewise, each staff member has his or her own range of tolerance for such behavior before deciding to intervene.

Definitions of behavioral cues also rely on the occurrence of dramatically psychotic behavior that acts as a backdrop of accumulated experiences against which newly encountered behavior is evaluated. Experience with deeply psychotic residents offers important reference points for people at Soteria when they define behavior.

According to Erikson (1970), who discussed this notion in his study of the Puritans, each time the group recognizes some act of deviation, it redefines where relevant boundaries are located. Self-mutilation is one specific form of resident deviance about which there is considerable consensus among Soteria participants. It exemplifies behavior that goes beyond the tolerable limits of deviance, without being treated as an annoying, attention-getting device.

> Most of her thing is really self-destruction—not to kill herself but to ruin herself. She did really bizarre things to screw up her body. She would insert things into her vagina, cut herself, tattoo herself, stick pins into herself, and set her hair on fire till it was all in icy clumps of ashes. I always get a twinge of fear when I think of all that kind of stuff. (Female staff interview, T., p. 8)

Erikson concludes that deviance, instead of being a behavior that disrupts stability in a society, may be an important condition for preserving stability. At Soteria the occurrence of psychotic behavior from time to time provides imagery that assists in making distinctions between attention-getting, genuinely psychotic, and intolerably deviant behavior. Deviance informs the groups what shapes madness can take.

Erikson additionally proposes that group cohesiveness can be enhanced by the sense of unity that accrues from recognizing distinctions

in types of behavior on the behavioral continuum. Soteria also supported this.

> At one point the investigator discussed an idea about contagiousness of some forms of resident behavior, such as talking about fears or nightmares. A staff person modified the idea by commenting that in a real crisis, when one person is in very heavy space, everyone rallies to help out, including other residents. (Field notes, visit 9, p. 11)

Highlighting unusual resident behavior in a show-and-tell format takes place in meetings that only staff members attend and reaffirms the differentiation between staff and residents, despite official efforts to mute such distinctions. The following response was given by a staff member when asked in a meeting what had been going on at the house.

> Jealousy is the word for the week. T. (a male resident) is jealous of D. (a female resident) and her vamping with male staff members—all of whom she's asked to go to bed with her. E. (a male resident) is jealous of T.'s sexual relationship with D. and has started imitating T.'s mannerisms. U. (another female resident) is jealous of D. because she went to bed with T. once and now is upset because he is sleeping with D. (Field notes, visit 5, p. 2)

Staff solidarity and their separateness from residents is reaffirmed in the knowledge that they do not engage in such complex sexual involvements with the residents. This highlighting in the form of storytelling also provides a cognitive array of discrete events as indicators that later indicate when a tolerance limit is reached. Essentially, the infra-control process has an alerting system.

Implied in the preceding analysis of definitional problems is the fact that monitoring occurs under highly variable resident control conditions. Control problems take many specific forms, such as physical violence, verbal abusiveness, general bizarreness, and regression.

> I've had N. (a resident) urinate in my lap, I've had food wiped on me and rubbed in my hair. I've stood and watched them break windows or use food to draw on the walls. (Female staff interview, S., p. 16)

In addition to individual variation, the overall condition of the house also varies. One indicator of the house condition is the intensity of psychotic experiences and the concomitant drain on the staff's control resources. A second indicator is the number of actively psychotic residents in the house at one time. This variability underscores the importance of staff astuteness and sensitivity in becoming aware of signals

and reading them accurately. When asked what was most important in the functioning of the house, the staff member who had been there longest replied:

> I personally think the big thing is really being aware—knowing how much to give and how much not to give. Really understanding a resident as much as possible. (Male staff interview, W., p. 109)

The pace of monitoring varies from constant to intermittent, usually depending on whether it occurs as a result of controlling dangerous behavior, that is, behavior that poses a safety risk, or in maintaining the viable life of the house. The overall pace of life in the house also influences the pace of monitoring.

> When she was in really heavy space we'd just stick with her, follow her around. The only time she ever did damage was when she was left alone. When someone is in really crazy space, they need constant watching to protect them and us. With her I was absolutely convinced she would kill herself if I took my eyes off her and didn't watch her every second. (Female staff interview, S., p. 6)

Monitoring dangerous out-of-control behavior is likely to be constant, as in the example just cited. Constant monitoring generally is the mode of choice when the house has a large proportion of troubled residents, and then it also serves as a take-off point for active intervention strategies.

> As the evening went on, he started to kick and move around restlessly. It became a matter of making sure he didn't kick his foot through a window. Through that whole period we were there watching so that he wouldn't hurt himself. With us there, he couldn't break windows. Having people there watching and ready to stop him is what did it. (Male staff interview, K., p. 7)

Monitoring the viable life of the house usually involves relatively casual, intermittent watching by staff to preserve a minimal degree of order for basic needs. This kind of monitoring takes place during relatively peaceful times and seems essential for some social order, since the individual residents frequently do not have the ability to control their own behavior in a family situation.

> E. (a resident) says he is hungry and goes to the refrigerator prepared to eat a bag of bean sprouts. T. (a staff member) suggests that he have something else because the bean sprouts were purchased specifically for the group's meal that evening. (Field notes, visit 1, p. 3)

In summary, monitoring provides the cues and definitions for deciding when and with whom to intervene. Despite a shared value commitment to spontaneous and individualized management of resident problems and against intervention in general, limits do exist that set the conditions for intervention when they are exceeded.

Furthermore, although interventions are structurally deemphasized, they are less than completely spontaneous and unique, especially when members of the resident population have been monitored by staff for some time and are dealt with in a characteristic manner. Thus, some strategies reflect an accumulated repertoire used in similar situations in the past. A repertoire is likely to be utilized by staff members who have a comparatively long history in the setting or by newcomers who have been socialized by old-timers.

> Q. (a resident) has been standing in the doorway without moving for 8 hours. He stays there all day without eating or going to the bathroom until at least midnight. I ask a well-seasoned staff member if and when anyone will intervene. She tells me that if he goes without eating for three days or so she'll actively try to get him to take something. She will probably try approaches that have worked with other wigged-out residents who wouldn't eat. Q. hasn't taken a bath in the month that he's been at Soteria. The staff person tells me, "he shits and pees in his pants and really smells." When this happens, the staff cleans him up. She tells me, "although we usually do intervene, we let things go beyond the usual limits before we do." (Field notes, visit 12, p. 5)

Intervention Strategies

The crucial questions for the monitoring phase of presencing are definitional: when and with whom to intervene. The questions for the intervention phase are how to intervene and how to legitimize the strategy. Intervention relates to monitoring through the defining process and takes two major forms, passive and active strategies. The fundamental conditions for active intervention are the defined intensity and imminence of safety problems presented by a resident's behavior.

The Third Phase: Intervention

Passive Intervention

The defining process itself can act as a form of passive intervention. When staff members can define a particular episode of bizarre behavior as acceptable, they reduce the need for active intervention strategies.

> In a staff meeting, the psychiatrist says that a new resident will have to go on Thorazine. When staff members ask why, he tells them that she's been "listening to the audience" and having other symptoms all her life, and chronic schizophrenics like her don't change. A new staff member challenges that explanation by arguing that maybe what D. (the resident) is experiencing aren't symptoms but rather growth-producing experiences. For example, feeling that there are thousands of butterflies inside her could be a lot of good energy. (Field notes, visit 9, pp. 1-2)

This kind of redefining process occurs when residents' behavior can be synchronized with the ideologies and behavior of the staff members. In the previous case, a feeling of butterflies inside oneself contained positive imagery for the pastoral ideology of several staff members. The tendency of staff members to adapt their thinking regarding resident behavior to fit acceptable forms, such as those associated with mystical, drug culture, or growth-oriented ideologies, is facilitated by the similarity of age ranges between staff and residents.

Bizarre resident behavior that is markedly dissonant with staff ideologies and fails to adapt over time impedes the redefining and reductionist processes and increases the likelihood of direct active intervention. One staff member reinforced the idea that residents whose behavior enhanced the viability of staff ideologies best fit the Soteria setting.

> Soteria is definitely better suited for some rather than other people. It's best for people who would be locked up otherwise—people who are openly crazy. We had one older woman who was just having boyfriend and post-operation problems. She tried to be hip, wore cutoffs, and said that she and her 17-year-old daughter were pals. She wasn't crazy at all. She was just a manipulator and didn't belong at Soteria. (Field notes, visit 14, p. 3)

In addition to raising the tolerance levels of staff members and diminishing their need to employ active intervention strategies, redefin-

ing resident behavior so that it synchronizes with staff ideologies also is capable of modifying resident behavior. Redefining a symptom previously labeled psychotic as good energy has important consequences for a resident's view of himself. A resident who comes to Soteria with the diagnosis of schizophrenia has been functioning in a world of social expectations that fit the general understanding of that label.* He has most likely learned that because he is schizophrenic he is sick and unable to assume responsibility for self-control. At Soteria he encounters a new perspective that may contribute to reengineering his identity through a conversion process.

A language system that normalizes or spiritualizes many aspects of life at Soteria is supportive of the conversion process. The setting itself is referred to as a board-and-care home or simply as a place to live, rather than as a residential treatment facility. A hip jargon supplants psychiatric and medical terminology: residents are described as being "in heavy space," "wigged out," or "freaked out" rather than as psychotic or mentally ill. Instead of conventional psychiatric treatment practices such as group or individual therapy, time at the house is spent listening to records, dancing, doing yoga, meditating, going to the beach or health food store, and engaging in the activities of normal everyday life, such as cooking, washing one's hair, or planting a garden. Under the redefining and conversion processes at Soteria, a resident who does not eat for a day or two may be thought of by others as fasting. This conclusion is in marked contrast to the diagnosis of this behavior as "withdrawal" and institution of a program to push the resident to eat with the threat of tube feedings, as is the practice in some mental hospitals.

As residents become converts to the staff ideologies and learn a set of social expectations that require them to demonstrate enough self-control to behave within the tolerance limits of the staff, they begin to adapt accordingly. Conversion to an ideology that expects self-control interacts in an intricate way with each resident's particular psychology. One resident who had been at Soteria for almost a year said, "We're not crazies, we're hippies!"

Although no single theory prevails at Soteria, all of the staff

*Both John I. Kitsuse (1962) and Thomas J. Scheff (1964) have made a case for the importance of societal expectations in the pursuit of a deviant career. They argue that the status of mental patient is often an ascribed status than an achieved status dependent on the patient's own behavior.

ideologies are consistent with a growth optimizing, spiritualized ideology rather than with a medical-psychiatric one. One staff member expressed the belief that "altered states of consciousness are growth." Another commented that "freaking out is a real profitable thing." In discussing his understanding of Soteria's purpose, this second staff member made the following statement:

> Soteria is a place where energy can be withdrawn from outside rules and directed inward. This is what makes getting into new spaces at Soteria possible. Taking reponsibility for your own self and life is a really important part of it. (Field notes, visit 1, p. 3)

The muting of conventional social expectations (such as the outside rules this staff member referred to) often obscures the fact that certain expectations do exist at Soteria. One ex-resident said that she thought of Soteria as a womb where she didn't have to meet anyone's expectations (field notes, visit 11, p. 5). A volunteer felt that, "You don't have to have anything together when you come here. If you want to tell someone to fuck off, you can. Nobody challenges you" (field notes, visit 2, p. 2). These illustrations indicate that a main property of the passive intervention strategy called conversion is its tacit nature.

In summary, redefining a resident's behavior as acceptable and converting him to staff ideologies concerning the reasons for his behavior are crucial forms of passive intervention that reduce the necessity for active intervention strategies and enhance a resident's view of himself as a person capable of self-control.

Active Intervention

Despite conditions that enable staff members to reduce the likelihood of direct, active intervention, circumstances do arise that go beyond the range of redefinition and conversion. In these situations, staff and others decide to intervene and choose strategies from three main areas: verbal limit-setting, physical restraint, and structural manipulation. The determination of how to intervene is made in terms of the intensity, imminence, and visibility of a safety risk, judged on the basis of immediate situational cues, the resident's history in the house, and social conditions. *Verbal limit-setting* is more frequently used with resident behaviors on the lower ends of all three criteria. Two main properties generally characterize this strategy: its understated style and its unstated power. Both properties fit will with the community ethic and the ongoing conversion process. Verbal limit-setting is undertaken in a

flippant, nonauthoritarian, and usually joking tone. The understatement of limits allows staff to legitimize their use to themselves and to the residents.

> C. and D. (two female residents) go out for a walk and come back in a few minutes giggling and flushed. G. (a male staff member) reports to T. (a female staff member) that they've been smoking the evil weed (nonverbal exaggerations undo the word "evil"). He sleuths around the room and asks if T. thinks they should play narco squad. She responds, "Better us than the real narco squad." (Field notes, visit 11, p. 5)

The staff member in this instance did tell the two residents to "be good girls or Auntie T. will spank." In effect she made her point and set the limit. Her joking, playful manner served to modify the intervention into an acceptable form. The staff's playful scolding does not lack clout, however, for a second property of this intervention is that staff members represent power at a distance. Although this fact is unspoken, they are acknowledged by residents to be the liaisons with external control agents such as the police, social workers, and hospital psychiatrists. The staff's prerogative to move beyond the infra-controlling process to outside agents of control invests them with the symbolic presence of these agents and with the associated threat of conventional intervention.

Invoking the image of conventional control agencies constitutes the outer limits of infra-control. An example of this behavior occurred when a resident was given the option of modifying her behavior or returning to juvenile hall. When she refused to comply, she did in fact leave the house, choosing to define herself "as a juvie rather than a crazy." Actual reliance on conventional control, such as administering Thorazine or admitting a resident to the psychiatric hospital, represents movement beyond the infra-process. It occurs only after other intervention strategies are judged to have failed. The complete overruling of the infra-control process by the introduction of community control mechanisms, such as calling the police or taking a resident to the nearby emergency room, are perceived by staff members as last-resort options under the conditions of crisis that they are unable to handle. In one instance when a resident disappeared from the house, the staff member who had been looking for her said:

> Maybe she's in a movie, but she's just not one to do things by herself. She's too scared. I just don't know any more places to look. If she can't be found, I guess I'll just have to call the police. (Field notes, visit 4, p. 2)

Physical restraint represents the most direct control strategy used in the face-to-face control process of presencing. It is employed by staff and others when a resident's behavior has been monitored and defined as a visibly imminent, intense, safety risk. Although physical restraint customarily follows the monitoring phase, monitoring can be bypassed. For example, in situations where remedial action is clearly and immediately required, there may be a rush to intervene before a monitoring stage has taken place, as occurred in the following example:

> I was in the front room with the others when N. set the curtains on fire in back. There was an immediate response from everyone to put it out. After we put that one out she went running outside and set another. H. and G. grabbed her and we put that one out too. (Female staff interview, K., p. 21)

The determination that a resident's behavior constitutes a clear-cut threat to safety is made by differentiating it from attention-getting behavior. The general pattern for concluding that an instance of bizarre behavior is not merely attention getting involves three main indicators. First, attention-getting becomes associated with particular individuals, and their behavior is treated as typical. Thus, a resident's past history of behavior at the house constitutes an indicator. Second, attention-getting behavior usually occurs when some competition for staff attention exists among residents. For example

> She started hitting me on the back while I was talking to C. When she got my attention it just ceased. What she really wanted was someone in there talking to her. (Male staff interview, W., pp. 56–58).

This indicator utilizes social conditions to differentiate attention-getting behavior from a genuine safety risk. Third, attention-getting behavior rarely poses a real danger to anyone. This conclusion is reached on the basis of situational indicators.

> She was hitting me pretty hard but not really trying to physically hurt me. I got the feeling that she was just doing it for some kind of attention. (Male staff interview, W., pp. 56–58)

These three routes to establishing that a resident's behavior is geared to get attention are not mutually exclusive, but they frequently occur in combination. Once behavior is established as being attention-getting, "therapy talk," consisting of friendly advice, urging responsibility, and verbal limit-setting, is the intervention chosen. When a resident's behavior is clear-cut in terms of the intensity, imminence, and visibility

of a safety risk, however, the staff intervenes physically:

> We did actually restrain him. L. and I both grabbed him, each on one arm, and when we did he sort of relaxed. He had been breaking things for a good half-hour and there was no other way to handle it. (Male staff interview, W., p. 50)

A decision about how to intervene in a clear-cut safety problem is tempered by the availability of others to back one up. The back-up assumption is a staff member's expectation that he or she can rely on others in the setting to help in either physically restraining a resident or taking remedial action if control already has been lost. When a staff member can assume that others are present, monitoring, and willing to back him up, more risky (less drastic) direct and indirect control strategies are likely to be used.

> W. (a male staff member) stayed outside for about an hour. He could see that Q. (a resident) had sat down at the table and that I was talking to him. Then Q. went upstairs to sleep, and W. went home. (*Manual*, p. 40)

The back-up assumption is based on the ratio of nonresidents to residents in the house, and it is utilized to add multiple presencing and multiple monitoring to a staff member's control strategies. This tactic is particularly effective when used to deter or interrupt potentially or actively destructive resident behavior.

> N. was breaking windows, and he (a staff member) said, "no more window breaking." N. stopped, but it was really having two staff members there that stopped her. (Female staff interview, K., p. 18)

The back-up assumption plays a crucial role in estimating safety risks since it is a reflection of the setting's control resources. It figures prominently in deciding how to intervene and in important ways is governed by the achievement of equitable work relationships among staff members (see chapter 5). When staff members fail to act in accordance with the back-up assumption, they are perceived by others as violating what is considered to be fair behavior. One staff member described this violation of fair behavior by saying, "It's really hard on my shift because I can't count on G. to do anything. He's become a piece of furniture around here." (Field notes, visit 11, p. 1)

Variations in the use of physical restraint to control resident behavior that poses a safety risk occurs with variations in the back-up assumption, as well as when there is a high degree of uncertainty about the legitimacy of physical restraint. Such uncertainty is greatest when

the imminence of the safety problem is ambiguous, as in the case of verbal abuse.

> *Question:* What was he doing?
> *Answer:* Saying things like I'm gonna kill you.
> *Question:* What did you do?
> *Answer:* I didn't do much of anything. I was trying to figure out what to do. I mean, not knowing what to do was an uneasy feeling. The situation was hard to figure out. (Male staff interview, W., p. 50)

In summary, all direct restraint must be justifiable in view of the noninterventionist community ethic.

Manipulating structural aspects of the environment is a third active intervention strategy by which resident control problems may be solved. Just as certain residents are typified as attention getters, others earn reputations as recurring safety risks by virtue of their personal history in the house. Under conditions where control resources are limited or have been exhausted, the structural manipulation strategy comes into play.

The exhaustion of one's resources, called burning-out at Soteria, represents another problem that is a consequence of the presencing process. It is characterized by a depletion of energy and idealism and a narrowing of tolerance boundaries. Burning-out is one byproduct of the demands of presencing, and it occurs despite the use of resources for support and composure that staff find rejuvenating. One staff member who later resigned described her experience with burning-out in the following informal interview.

> I'm really feeling burned-out—especially with U. (a resident) who I just can't give any more attention to and feel like punching most of the time. I'm sick and tired of getting called while I'm at a party to come down here and be with her. She keeps threatening to leave and I wish she would. (Field notes, visit 12, p. 2)

Structural manipulation approaches the borderline of the infra-control process in that it substitutes selected structural alterations for the presence of people in the control of resident behavior.

> I've got very mixed feelings about giving medication. But if a person is into slitting their wrists or breaking somebody else's head, then I'll say, far out, medicate. If I'm not tired, maybe I'll feel like working with it, or somebody else will, to avoid medicine. Being into the health trip, I'm not in favor of giving pills of any kind to anybody. (Male staff interview, C., p. 13)

Structural manipulation may also be introduced when a negligence risk for the staff is at issue. The risk of staff members being or appearing negligent in the eyes of "authorities" is a result of the lack of structural arrangements and the heightened chances that residents will lose self-control despite the infra-control strategies. This problem is particularly likely when an actively psychotic resident exercises his or her option to leave the confines of the house, and a staff member chooses to accompany the resident. The following episode is an illustration.

> She (a resident) said, "I want to take a walk," and I said, "well, I'm gonna come with you." So we went out walking. It must have been around 12:30 at night. It seemed all right until she started talking more disorganized. As we walked around the corner she took her shoe off and started to break windows. I grabbed her and tried to stop her. We were having a struggle on the sidewalk. I was very afraid because she was stronger than I am, and it was hard. She tore the back of my skirt and blouse and I didn't know how long I'd be able to handle her at all. I had a feeling of responsibility for what she could do—a feeling that she could really hurt herself, break more windows, or just get lost. (Female staff interview, K., p. 20)

Resorting to manipulating structures in the environment in lieu of a sole reliance on people occurs either with residents who have earned the reputation of presenting safety and/or negligence risks or when staff control resources are burned-out. A property of this active strategy that keeps it within the infra-control process is that it is only imposed temporarily and specifically to handle an identified problem. When Q. (a resident) broke drinking glasses night after night, a few staff members decided to lock up the glasses and bottles and to use plastic cups for a short time. Another resident who was continuously incontinent was temporarily put into diapers. Another resident's habit of eating the whole week's groceries at one sitting resulted in a padlock on the refrigerator door. It was unlocked as soon as his behavior changed. Finally, although doors at Soteria have never been locked, hooks and eyes were once installed on doors and windows for a short time to deter a resident and give staff time to catch up with him before he ran naked into traffic on the street. All of these interventions involved resorting to structural props; however, their temporariness and specificity distinguish them from most conventional structural elaborations in psychiatry.

Because of the social visibility associated with the number of people at Soteria, all interventions are subject to the tacit evaluation of

participants in view of the community value of noninterference. The underlying premise of the house as reported by one staff member is:

> Allowing people to be where they are at, allowing the future to be open, allowing that uncertainty of not knowing what it is that's going to happen. (Male staff interview, H., p.39)

The presencing process, with its reliance on people rather than on structures and its emphasis on self-control rather than on external control, offers a legitimate means of meeting Soteria's purpose of "allowing to be . . . and yet protecting when protecting is needed" (Male staff interview, H., p. 14).

This chapter has described presencing, one of the three implementing subprocesses of infra-control. Presencing is a process of social control that relies not on preestablished norms, but rather on tolerance ranges and definitional cut-off points to distinguish among varieties of deviance. In this form of social control, people are constantly redefining the nature of their social context. Intervention decisions are legitimized through adaptation to a shared community ethic.

Presencing depends on staff members who behave according to a tacit sense of fairness, for they too have few formal controls over the management and distribution of their work and are themselves responsible for working to enhance the achievement of their goals. Control problems presented by resident patients are solved through an infra-control process called presencing, which relies on face-to-face interactions of people and enhancement of self-control rather than external, established rules and structures.

4

Management of Staff

While they seem at an opposite pole from grey flannel suit conformity, their rebellion it seems to me is not against conformity per se (they have plenty of that) but against what I have called the pseudo-integration of American Society.

(Orin Klapp, *Heroes, Villains and Fools*)

The subject of work has always held a good deal of interest for social scientists. Whenever responsibility for the accomplishment of work is shared by a group of people, basic social questions arise. How much is enough? Who is to do what? How is the quality of work to be controlled? Analyses of complex formal organizations have yielded explanations of the division of labor and distribution of tasks according to rational bureaucratic methods.* The bureaucratic organization of work depends on a hierarchical structure and codified rules. Recently an increasing amount of attention has also been paid to professionals and scientists working in service organizations who rely on an explicitly

*Bureaucratic structure has been described by Robert K. Merton (1969) as a formal, rationally organized social structure involving clearly defined patterns of activity in which, ideally, every series of actions is functionally related to the purposes of the organization. Such organizations integrate a series of offices, or hierarchal statuses, that have a number of inherent obligations and privileges closely defined by limited and specific rules.

negotiated rather than a structural basis for control over their work (Friedson and Rhea, 1963). These individuals, roughly equal in authority, engage in well examined, highly articulated negotiations to determine their sharing of work.

At Soteria House conventional formal structures for control have been deemphasized, muted, and denied. Furthermore, a community ethic negatively sanctions behavior that is not spontaneous, intuitive, and extemporaneous. Formal arrangements for the management of staff work are for the most part absent. There are no job descriptions, formal role distinctions, orientation programs, task assignments, or official evaluations to control and direct staff behavior in carrying out their responsibilities for maintaining the viability of the setting and caring for the resident patients. Instead, work among this avowed company of equals is governed according to a tacit sense of equity among the staff about what is considered to be fair.

I have called the process by which social order emerges and staff work problems are addressed a process of fairing. As an implementing subprocess of infra-control, it shares all of the general properties outlined in the previous chapter. This self-regulating process, the delineation of which emerged from the data in this study, differs in crucial ways from both the bureaucratic and the negotiated models for controlling work. It lacks the formal structure of bureacracies as well as the explicit, highly verbal approach of negotiations. Instead, fairing operations, like those of presencing, are *infra* in nature, that is, spontaneous, tacit, intuitive, and improvised. These properties are apparent in the following interview excerpt:

> *Question:* In the course of those hours did you (two staff members) say anything to each other?
> *Answer:* Not really—the words weren't important.
> *Question:* When you decided to get him (a resident) a bottle, did you say to C. (other staff member) "I'm going to get him a bottle"?
> *Answer:* No, I just got up and started to look for it. I didn't announce it or anything. (Male staff interview, G., p. 25)

Fairing is one of the three implementing subprocesses of infra-control. The other two, presencing and limiting intrusion, are developed in chapters 3 and 5 respectively and are included here only insofar as they bear on the analysis of fairing.

The fairing process has a cyclical pattern with three stages: first, a tacit agreement or fairing code is established and picked up by the staff;* second, behaviors and conditions occur that transgress this code and are deemed unfair; finally, interaction is moved back into the domain of fairness through a variety of strategies that restore the fairing code. In an attempt to contribute to an understanding of control over work among a group of self-regulating equals under conditions of espoused freedom, this chapter presents an analysis of the three stages of the fairing process: *initial fairing, unfairing,* and *restoring.*

THE FIRST STAGE: INITIAL FAIRING

There are two main sources for initial fairing: individual initiative or prerogative in assuming a responsibility for work based on an estimate of one's fair share, and a tacit agreement or fairing code that is established, modified, and picked up by staff members through interaction and accumulated shared experiences. Picking up occurs as a result of reading cues or signals from others. Initial fairing, which relies on each person's initiative to estimate and carry out his or her fair share of work, occurs under two important conditions, the general realization that there is a basic burden of work to be done and role distinctions that make staff rather than residents responsible for the basic survival tasks.

The Basic Burden of Work

Although the shared values among staff members emphasize a pleasure rather than a work ethic and negative sanctions are imposed on doing work when it is not immediately necessary, there are tasks that must be accomplished in order to ensure the well being of the house and its residents. These tasks include submitting a statement of expenditures and receipts in order to collect the funds spent for household expenses; shopping for groceries and preparing food so that the community members can be fed; and talking to resident patients and protecting them from safety risks. This basic-subsistence level of work is the minimum output required of the staff. Since the fates of staff members are linked to the survival of the house at least in the immediate future, staff members acknowledge the importance of doing this kind of work.

*"Picking up" as used here is the process of selectively noting and retaining information. This conceptualization is used by Theresa Louis (1973) in her research on "Illness Concept and Management among Chinese-Americans in San Francisco."

> It's a real world here. There's a bunch of people at the house, and we all have to eat and stuff like that. We always get in touch with the necessities of running the house when we have to. Somebody's got to get it together enough to get in a car and go out to the store and get the money out for some peanut butter and jelly. There's always somebody with enough energy to do that. (Male staff interview, C., p. 13)

Many other tasks are subject to procrastination because of their nonessential nature; they may be done only when someone feels like it or when there is external pressure to accomplish them. Housecleaning is an example. Because the house depends on a research project for economic support, staff members periodically are obliged to comply with extra work requirements, such as a cleanup in preparation for a site visit or the writing of nurses' notes or charting dyad patterns as data sources for the research. These requirements contribute to the process by which Soteria limits intrusion of external control agents by partially revealing itself (see chapter 5). Thus, the research project imposes demands on the staff in addition to those required to meet the immediate survival needs of daily life.

Resident-Staff Distinctions

Role distinctions between residents and staff provide another condition that tempers the absolute freedom of staff members to decide on their own accord what constitutes their fair share of work. Despite efforts to mute or deny these role distinctions, they do in fact exist as a consequence of the economic circumstances of the setting, if nothing else. Staff members are paid salaries, and residents must pay a nominal fee to live at Soteria. Consequently, it is generally understood that the responsibility for the basic burden of work falls to the staff. Staff members usually expect residents to rely on them to do most of the work of the house, and residents in turn are exempt from doing a fair share. When a resident undertakes a task, it is because he or she has expressed a preference to do so.

> 1. (a resident) on the day of her departure from Soteria announced that, since it was her last morning, she guessed that she'd make breakfast for everyone. (Field notes, visit 1, p. 1)

Staff members note that residents have the option to participate in the work system, and this is considered fair unless a resident is responsible for creating work for others and cannot be excused by virtue of being psychotic. Even in this case there is a relatively broad tolerance range for resident whims that make extra work for the staff. One resident was allowed to bake cookies at the same time that a staff member was trying to prepare the evening meal in the kitchen (field notes, visit 3, p. 6). Another resident was allowed to nap all evening, although staff members acknowledged that he would "sleep all evening and then be wide awake and want us to stay up and talk to him at 3 A.M." (field notes, visit 3, p. 16).

Individual Initiative

Once a staff member learns the basic conditions of the setting, the necessity of carrying out survival tasks, and the fact that this work is expected to fall to the staff, his or her individual initiative in assuming tasks characteristically takes one of two main approaches, specialization and emergent pragmatism.

Some staff members elect to assume some tasks rather than others, based on their notions of personal assets or abilities. One staff member explained:

> I don't cook very well but the person I work with does. Since I'm a pretty good dishwasher, she does all the cooking and I clean up afterwards. (Male staff interview, W., p. 1)

However, individual initiative according to specialization can be relied on for task accomplishment only to a limited extent. For certain unpopular jobs, such as cleaning the toilets or cleaning up garbage, nobody claims special talents and staff members therefore maintain an intuitive, spontaneous rhetoric for assuming tasks, using a strategy of emergent pragmatism for distributing labor. Emergent pragmatism involves an on-the-spot assessment of the necessity for doing something, a discovery that somebody else is not available to do it, and an implicit deal. For example, I asked one male staff member how it was decided that he would cook the evening meal that day. He first responded by saying that there was no reason, but on further probing added that his work partner said she would cook the next day because she wanted to leave early to attend a class (field notes, visit 7, p. 1).

The needs and requirements related to residents place further limits on absolute freedom, spontaneity, and individual prerogatives regarding work patterns. Some staff members engage in peer monitoring, keeping track of residents' needs and schedules. A staff member, commenting on

the lovely day, proposed a trip to the beach for the whole house. His partner reminded him that one resident's tutor came that day, so that the beach trip was not possible. She suggesed that her work partner instead go sit in the sun in the backyard (field notes, visit 2, p. 2).

The Fairing Code

Although individual work patterns are influenced by conditions of the setting, the workload is usually distributed by a tacit "fairing" code, or set of accumulated understandings among staff members about what constitutes a fair share of work. An individual learns this fairing code from the signals and cues of other staff members. As one person described it, "staff members are finely tuned to one another." The viability of a system of work distribution based on interpreting subtle cues rather than on being given explicit assignments is enhanced by the fact that staff members share compatible ideological orientations. Most work at Soteria is undertaken within a context of antiwork values, for example, and attempts are made whenever possible to transform work into play. This transformation is accomplished primarily through humor and joking, which serve as an almost constant theme in staff communication.

Transforming work into play is made possible by the pace of activities, which is slow, leisurely, and for the most part unscheduled. The proportionately large amount of free time and the few necessary subsistence tasks foster a nonstrenuous, playful air about doing work. When the finance book was being balanced by a staff member, a resident asked him how the people at Kingsley Hall got their money. The staff member playfully chided: "The residents at Kingsley Hall work really hard! They are all in the basement turning out Kingsley Hall souvenirs" (field notes, visit 5, p. 1).

The community's ideological orientation toward playing at work, in combination with the residents' continual wear-and-tear on the house, result in a forfeit of efficiency. The staff defines this outcome as being acceptable by attributing it to the emergent, unpredictable nature of the setting, which is valued.

> Money could be managed much more efficiently. For example, if someone had planned ahead for stores being closed on Washington's Birthday, groceries wouldn't have to be bought at the 7-11 where prices are so high. It would be really impossible, though, to preplan work, because the house goes through so many changes. (Field notes, visit 6, p. 6)

Compatible values also enable staff members to allow each other a good deal of flexibility about meeting work commitments in the house. It is not unusual for a staff member who is due to come on duty at 10 A.M. to arrive at noon, or for as few as three staff members to show up for the weekly staff meeting. This flexibility results from an assumption of commitment to the house which is demonstrated by the staff members visiting during their nonscheduled hours. It is a common practice for staff members to stop by during the week although their shift is scheduled for the weekend or for them to stay around after they have been relieved. When a staff member does not demonstrate such commitment, the assumptions concerning his or her investment in the house and harmony with house values are called into question. The resentment of other staff members makes them unwilling to allow an uncommitted person the same degree of casualness about deviations from the work pattern. In one interview a staff member made the following comment about another:

> When the house first started, B. used to spend a lot of time here and be really involved. Now she doesn't do any work with residents and has gradually withdrawn her investment in the house. All she does now is criticize. (Field notes, visit 12, p. 7)

The likelihood that new staff members who become associated with Soteria will be compatible with the group's existing values is fostered by a recruiting pattern that depends on communication with an informal network. Most of the staff come to Soteria because of connections through previous work relationships or friendships with staff members already present. For instance, some individuals came to work at Soteria through a staff person they had become acquainted with at a meditation class. Others had worked together in a state mental hospital's experimental ward. Through this network for recruitment, replacement staff people are likely to have the same ideologies as the original staff. Typically, a potential staff person becomes associated with Soteria in the role of volunteer. Time spent around the house in that status acts as an initial screening period during which incompatible individuals are identified by the current staff. When the next staff resignation occurs, a replacement is chosen from the acceptable volunteers. One of the central functions of the volunteers is to provide a ready pool of screened, potential staff people. The shared commitment to alternative life-styles enhances the process of learning the fairing code and provides a common basis for establishing the code.

Joking and humor are recurring themes in interpersonal interaction at Soteria. The ambience of humor periodically reinforces the shared ideology, which is a fundamental condition of controlling work according to a tacit fairing code. People in the setting strengthen their cohesiveness by affirming their separateness from conventional American middle-class values, attitudes, and life-styles.

> I. (a staff member) reads a newspaper article aloud at the kitchen table, entitled "Pot Harms," by Ann Landers. He quotes: "Pot smokers stoop to a low level of motivation and perform foolish acts!" Everyone laughs and cheers for foolish acts. (Field notes, visit 9, p. 1)

Another time, when staff members hinted that a particular person's cigarette-smoking was at odds with the health-optimizing practices in the house, he justified his behavior by joking, "they looked like joints, so I bought them." In this way the potential criticism was defused and high group cohesiveness was maintained. In a third instance, a staff member belched loudly at the table. Immediately he initiated a clown-like performance, urging staff to "get some class and culture into this place, ya bums!" A volunteer who interrupted him by coming in at that point urged him to go on with his routine. He countered sadly that it was impossible, because "it comes from sheer inspiration" (field notes, visit 11, p. 1).

From time to time such humor takes place in ritualized sessions in which the staff delights in belittling conventional society.

> G., T. (two staff members), and D. (a resident) come into the house laughing and imitating a drunk who was walking down the street and fell in front of the front porch. G. starts acting out his own father's behavior, staggering around the house cursing and shouting, "I'm going to beat the shit out of you!" A resident asks, "What's worse—alcoholics or Catholics?" T. answers, "Both—they both puke a lot!" The exchange continues, with another staff member telling an anecdote about being at Lucky's Market, where a woman with a heavy German accent accused her of having a "shocker" (sic) in her pocket. (Field notes, visit 11, p. 4)

Throughout this particular show-and-tell session, there was a great deal of laughing, loud swearing, and references to being "ripped" or "stoned" on pot when these encounters with the outside world took place. Such exchanges seem clearly to foster solidarity and group cohesiveness. In the words of one staff member, "One of the reasons we're able to manage here is because the people know how to generate good energy. We know how to get high together" (field notes, visit 6, p. 5).

The phase of initial fairing has been characterized as one in which the specific division of work among staff members is, for the most part, constantly shifting under varying conditions. Staff people must be highly sensitive to the shifts in order to estimate their fair share and to intuit cues from others about what is considered to be an equitable workload. Over time, however, a number of self-imposed ground rules have emerged that serve as guidelines for solving staff control problems.

Coverage around the clock is achieved through a practice of teaming one male and one female member to be responsible for blocks of three days and two nights per week. This convention was arrived at through a trial-and-error approach initiated by the staff members themselves, and modified and refined over time. Although this arrangement is satisfactory to most of the staff, certain residual inequities remain. For example, some individuals consistently are responsible for the midweek shift, because others who have a longer association with the house have opted for the weekend. Because a number of basic jobs are necessary at midweek, such as the major grocery-shopping trip, the midweek staff people find themselves consistently saddled with the same task. Another inequity is that the blocks of time comprising the work shifts are relatively equal and do not take into account variations in the salaries paid to different staff members, ranging from 200 to 600 dollars per month. These residual inequities remain within the tolerance ranges of the staff unless circumstances occur that add to the existing inequities in the balance of work.

UNFAIRING

Once initial fairing has been established, certain staff behavior may occur that transgresses the tacit understanding of what is fair and thus is defined as unfair. There is tremendous variation in how the fairing code is transgressed and how the balance of work shifts into ranges defined as unfair. A staff member may do too much or too little, do the wrong thing, or do something with the wrong attitude.

Tolerance Ranges

The specific behaviors that constitute transgressions are not static, but rather alter according to their interaction with the tolerance ranges of other staff members. In short, a specific behavior may be defined

differently, depending on the person who does it and conditions in the setting, and on how much the behavior conflicts with the values of others.

Staff members may tolerate behavior from one individual that they define as unfair when engaged in by another. When a live-in volunteer was asked to leave the house because her "behavior was destructive with residents," staff members later admitted that the fact that she was disliked by influential staff people had a lot to do with the decision to ask her to leave (field notes, visit 10, p. 16).

The overall condition of the house can tighten tolerance ranges for behavior. If a resident in the house is going through a difficult time which makes high demands on staff resources, minor deviations from fairing that might otherwise be overlooked are viewed as transgressions and therefore as unfair. A staff member who leaves early to attend a class during such a time limits the available back-up for others who, for example, are dealing with an actively psychotic, potentially dangerous resident. Thus, the individual's early departure is less likely to be tolerated than it would be at a less demanding time.

Finally, although Soteria is characterized by a range of tolerance and flexibility that surpasses more formally structured work situations, there are limits to this range. It is not unusual for a staff person to arrive at noon although scheduled for 10 A.M., and such casualness fits with the antiwork ethic. When an attitude or behavior conflicts with community ethics, however, the staff's ability to accept the unacceptable is severely hampered. When I commented on one occasion that two new residents seemed more mentally disorganized than those I had seen before, a staff member challenged my observation. I explained that "they say things that don't make sense." He then retorted that I was wrong, and the problem was "you just don't understand them." I immediately conceded in an appeasing way and nodded, "yes, I've got you." His response was an emphatic, "No, I got you!" (field notes, visit 10, p. 16). The direct disapproval conveyed to me by this staff member highlighted a tolerance limit for dissonant opinions. It produced adaptive behavior in me in anticipation of a confrontation that would carry with it the risk of my expulsion from the setting.

Group Cohesiveness

Tolerance ranges vary according to the degree of group cohesiveness in the house. When cohesiveness is high, tolerance ranges are broad; as cohesiveness lessens, the tolerance range becomes more

narrow. In turn, the narrowing of tolerance ranges acts to reduce group cohesion even further. One staff member expressed her sense of this interaction in an interview.

> What I've been feeling a lot lately is how we've gotten into such a negativity around here. You know, you walk in, and the place feels negative. Comments are negative. People are looking at other people in such a negative way. Even a resident asked, "Are some staff fighting here?" We can't have an ideal, warm environment all the time, but I think that when we get into the negativity and the biases and paranoia of staff, it's very upsetting and confusing from a resident's standpoint. It sure is from a staff's point of view. Sometimes when this happens, I find it a problem myself to keep in good balance. (Female staff interview, H., pp. 46–47)

Group cohesiveness among staff members is contingent on at least two main factors: the presence of disruptive forces (frustration and conflict), and the effectiveness of strategies for maintaining group solidarity in the face of events that might disrupt it.

At Soteria there are several primary sources of frustration and intragroup conflict. The structural split between the day-to-day life of Soteria with its nonpsychiatric, growth-optimizing, egalitarian ethic, and research grant accountability, which provides the funds for Soteria's continuation, poses numerous contradictions. For example, one staff member commented that although there are not supposed to be any differentiations of authority among people associated with the house, the project director, a professional psychiatric social worker, actually has ultimate decision-making power. "She consults staff, but then doesn't always do what they suggest" (female staff interview, N., p. 1). Another staff member objected to the idea conveyed in the research study that people come to the house so that they can get better and go out and be normal. She felt that "residents get pushed out because of the research project's requirements for an adequate sample in the control group" (field notes, visit 6, p. 4). These two aspects of Soteria's operation are kept remarkably separate, with the day-to-day participants having only limited awareness of and access to the theoretical research side. This split permits the staff and residents to maintain an idealized image of Soteria's purpose without contamination from the reality of grantsmanship and practical economics. On the other hand, the split also heightens the sense of resentment and occasional outrage that emerges when there are ideological differences over a specific decision, or when Soteria is portrayed to a group of professionals in largely

psychiatric medical-model terms. On such an occasion one staff member stated: "That isn't what we think we think we're doing at the house at all. They think of Soteria as a mode of treatment for sick people while we're all just trying to grow together" (field notes, visit 14, p. 1). Another commented: "The research, the way I see it, is for the grants to get the money to run the place. The way they set standards for schizophrenia seems needless to me. For them, somebody has to be a paranoid schizophrenic with slight whatchamacallit" (male staff interview, G., p. 6).

In addition to the contradiction of authority versus ideology that results from the major structural split in Soteria's organization, there are also contradictions in relation to power distinctions among people who function exclusively in the clinical aspect. Although distinctions between staff and residents are denied and muted through the absence of titles, the lack of uniforms, and the use of casual familiar language, they do in fact exist. A major differentiation is economic; because staff members are paid salaries, it follows that they are ultimately both accountable and powerful vis-a-vis residents, who pay to be there and have been qualified for admission by virtue of being diagnosed as schizophrenic. Exercise of the power that is implicit in this distinction must be adapted to fit the anti-authoritarian values of the community. Although this helps to mute the contradiction, the staff does in fact exercise power.

> L. (a resident) was the first person to leave, and I was really against it. I think I told her pretty straight, but not like an authority figure, but on a two-people level. Letting her go was like letting a little girl put herself in a dangerous position. It would have been like saying, "Go ahead and get fucked over. We don't give a damn." (Male staff interview, G., p. 2)

Residents have a notion that the road up in the world consists of first becoming a volunteer and then someday a staff member. This perception is a clear indicator of status differences. Such differences are also apparent in the weekly staff meetings, which staff and volunteers attend without residents and where the focus is on resident behavior, not unlike the reports given in conventional psychiatric hospitals. The professionals clearly direct the discussion in the meetings and are seldom challenged outright, even when nonverbal glances exchanged among staff members convey differences of opinion. The professionals also occasionally violate the sanction against criticism of fellow staff members. One staff person who was sensitive to the implied distinction in the exclusion of residents from the meeting noted:

> While the staff meeting was on, the residents ran the vacuum cleaner and cleaned the living room, just like good little kids while the "parents" discussed them upstairs. (Field notes, visit 9, p. 7)

In the broad distinction between residents and nonresidents, there is another subdivision between staff and volunteers. Many individuals work in the house as volunteers during a screening period that gives the current staff an opportunity to evaluate their acceptability as future staff members. In view of this, volunteers interested in graduating to a staff position usually defer to and appease the perceived wishes of older staff members who can influence hiring decisions. One volunteer told me that when she started to call the psychiatrist by his first name, she immediately corrected herself and referred to him as "Doctor" so as not to alienate the staff members who do likewise. She added that she was also reluctant to make a big issue of her meditation practices for fear that the staff would think she was trying to promote it. Many months later when her position as a staff member was secured, she was more courageous in taking a position and expressing her own interests. Thus, volunteers and others (including this researcher) require staff approval to remain associated with the house, and recognition of this fact produces adaptive and conciliatory behavior toward those who are in positions of relative power. At the same time, such recognition increases awareness of the contradictions between professed and actual equality at Soteria.

Another condition for group cohesiveness is a relative lack of consensus about whether certain actions are in fact legitimate. The value commitments that foster individual initiative in making decisions about how to approach residents and assumption of a fair share of the workload arise without a common, guiding theory. Although divine inspiration is valued and promoted on a general level, individual variation on a specific level can result in conflict. Unlike Kingsley Hall, where there was "an ongoing mutual critique of staff people, "at Soteria the general attitude is that you do what you do, and it isn't open for discussion," said a staff member who had spent time at both Kingsley Hall and Soteria. Unspoken evaluation of each other, however, is constant. For example, N. (a staff member) indicated that she didn't want any part of taking U. (a resident) to the Jack La Lanne Health Spa, but a second staff member agreed to take U., expressing the opinion that it would be fun. Other staff members have made the following evaluative comments about each other.

One of the things that bums me out is when certain staff try to lay their trips on residents. For example, when a staff member tells a resident to get into their feelings, it's really a bummer, because I feel that if someone is ready to get into it they will, without our telling them it's the right time. (Female staff interview, N., p. 12)

I think it's a mistake to give U. (a resident) booze. For one thing, I think that, since she's a juvenile, we ought to be a bit more careful about the age thing. (Female staff interview, T., p. 2)

I refuse to cook all three nights. It's a male–female problem. With H. (a male staff member), he shares everything, and I don't feel like I'm being made to be the slave if I cook dinner. With G. (another male staff member), I say, "You pick your night and I'll take the other," and he usually can do that, or else we don't eat. (Female staff interview, T., p. 4)

I'm not involved in the cleaning much. Nobody is involved enough in it. The house is in pretty bad shape. I'll call the landlord when the toilets stuff up, because it stinks like hell, and everyone else is sitting on their ass about it. (Female staff interview, T., p. 4)

At times she (a professional staff person) is really good to have around. She's a very strong woman, and I admire that. She's dependable and a good buffer between us and the outside world. But there are times when I'd just as soon know myself what's happening as have a buffer. (Female staff interview, N., p. 2)

Finally, contradictions and tensions result from difficulties in reconciling the community ethic and ideals with the occurrence of problems that are the result of life in a group setting.

You know, you get any group of people together and there are problems. So that it's a kind of hard ideal we have around here that everybody would live together in peace and harmony forever. It just doesn't happen, and it feels sort of like a contradiction. We're all here encouraging residents to express their feelings, and at the same time staff isn't doing that. (Female staff interview, H., p. 41)

Strategies for Cohesion

The presence of disruptive forces that lower group cohesiveness and ultimately constrict tolerance ranges are tempered by the effectiveness of strategies used by the group to maintain solidarity in the face of frustrating and conflict-ridden events. *Joking* is foremost among these strategies, both in the cohesion rituals described in connection

with initial fairing and in instances when fairness becomes problematic.

The lack of structure and formal role differentiations among staff as well as the antiwork ethic of the group increase the likelihood that staff members may not take the initiative to do necessary tasks. These same properties make it potentially awkward and problematic to ask a staff member to do something he has not selected to do. Such situations are handled with a joking, playful approach that mutes or masks the authority issue. One evening a vegetarian staff member jokingly criticized the female staff member who was preparing the evening meal by saying in a highly pompous tone, feigning indignation, "I'd prefer that you no longer cook meat in this house" (Field notes, visit 1, p. 2).

Joking can also increase tension about specific behavior directly related to work. When one staff member left before the conclusion of his shift, his work partner joked, "H. is good-hearted but slow." He retorted, "All of us sensitive people are that way." N. (another staff member) spoke up, "It's a good thing that we Libras are objective enough to recognize wit." At another point in the leave-taking, a staff member and resident of the same sex got up and slow-danced together. There was a lot of loud chiding from the group sitting around the room such as, "Back to charm school, you two!" "Where's the Thorazine?" and the like. When the staff member did finally go out the door, there was a flurry of playful scolding, with yells of "Good-bye Chump!" and "Don't come back!" (Field notes, visit 3, pp. 7–9)

In addition to joking with each other to preserve group cohesiveness, staff members use individual composure strategies to strengthen cohesion. One of these strategies may be called *privatizing*, that is, withdrawal from the community space to a personal space for a rejuvenating purpose. The layout of the house provides individual rooms for all residents and staff, although most staff members maintain their own homes and stay overnight at Soteria only on their work shifts. Private rooms, however, offer space where one can withdraw from the communal standard of living in the main parts of the house. A private room can be kept according to one's personal tastes and standards; thus, the condition of rooms at Soteria belonging to both staff and residents range from more chaos and clutter than in the group living areas to absolute cleanliness and order. Private space offers a personal refuge from the compromises reflected in the group life-style. One staff member marked "POISON" on her fresh mushrooms. Another staff person kept his record albums outside in his van, separate from those

belonging to the community. Privatizing serves as one resource for maintaining composure amid the strains of intragroup relations.

Peer consultation represents a second composure strategy for individual staff members. Little formal supervision of staff work with residents is provided, and so staff members rely on spontaneous consultations with one another as problems develop. On several occasions when a particular staff member experienced difficulties in reconciling the noninterventionist ideology of the house with her own inclinations, she initiated a conversation with her partner. In one such conversation, the following exchange took place.

> *N.* (a staff member): I am really angry with U. (a resident).
> *I.* (another staff member): Give her hell. Don't internalize your anger. Get it clear in your own head.
> *N.*: I'm really mad but I don't want to lay my trip on her.
> *I.*: Go talk to her.
> *N.* (whose anger is somewhat defused) jokes: What we need around here are a few more masochists, so I can take my anger out on them. (She jokingly punches a volunteer on the arm.) (Field notes, visit 4, p. 3)

When a resident's problems are so demanding that the staff is exhausted with trying to deal with them, resorting to a *structural control* constitutes another strategy to salvage staff composure. In one instance U., a resident, was urged to move into a day-care program to dilute the demands she was making on the weary staff. This decision was not disguised as being made exclusively for the resident's benefit. Preservation of staff composure and cohesiveness is acknowledged as a valid rationale for utilizing a structural control (field notes, visit 9, p. 4).

In sum, although staff members do not attempt to achieve consensus, consistency, or continuity in their approach to residents and do not desire the structuring of work responsibilities, conflicts and unspoken tensions do occur. When solidarity strategies fail to defuse these conflicts and tensions, group cohesiveness is disrupted. Staff behaviors that may have been acceptable under other circumstances eventually shift the balance of the workload from fair to unfair and necessitate restoration of the fairing code.

Restoring

When interaction has moved back into the domain of unfairing, a rather consistent pattern of confrontation emerges in the restoration of fairing. The staff's negative sanctions against serious critiques and

and explicit evaluations of each other's behavior result in a buildup of resentments over time. Confrontations may be relatively straightforward or highly emotional, and they customarily occur in the context of a ritualized social event. One staff member put it this way:

> Periodically we have a dirty house problem. Everyone gets together at a meeting to talk about it, we set up a cleaning day, and it gets clean. Pretty soon it starts to look pretty much the same, but the real problem is in people's heads anyway. (Field notes, visit 13, p. 1)

At another time male staff members began expecting the women who worked with them to do all of the cooking. When joking failed to produce a change in this expectation, the women initiated a meeting at which the problem was confronted and self-instituted resolutions and arrangements were made to restore relative equity. Such resolutions characteristically fail to persist over time, and inequities tend to return to their prior state. However, the value of the confrontation ritual for defusing resentments and altering tolerance ranges is acknowledged by staff members who have a long-range perspective on how the restoring process works.

A more highly emotional confrontation occurred in Soteria's history when an original staff member wanted to formalize what was felt to be "too much" authority by designating himself to be in charge of finances and volunteers. Assuming a heavier workload is generally not perceived to be threatening to the group's work ethic as long as it does not carry with it the expectation that others work similarly hard. In this case, however, instituting formal arrangements to ensure the individual's authority and to get official credit for the added responsibility resulted in intragroup resentments, definitions of unfair, and eventually factions and power plays. The confrontation in this case reached the outer limits of action when the staff person was finally expelled from the house and his job. Recruitment values that emphasize interest in Soteria as a "place to grow" mitigate against behavior that openly uses Soteria as a place for gainful employment or entrepreneurship in terms of status achievements.

Taking on extra jobs is acceptable as long as it is done in accordance with the staff values and remains spontaneous. For example, a staff member noted without resentment that "R. (a staff member) took over at that point because there's more of a special bond between her and U. (a resident) than with me" (male staff interview, G., p. 1).

Structural arrangements that are instituted to alter unfair behavior

and restore fairing persist only temporarily. Their degeneration takes the form of either gradual backsliding or actual subversion. The latter was particularly evident when, as the result of a confrontation, the professionals involved with Soteria instigated a structural control.

> I arrived at Soteria to discover a huge beige pay phone hanging on the kitchen wall in place of the old, unobtrusive, residential phone, which used to sit on a little table in the corner of the kitchen. When I asked about it, a staff member explained that they had had it for about a week. The phone bills were over 150 dollars a month for about three months, so the project director made a list for everyone to own up to their long distance calls, and no one did. So one day she just came in and said, "we're getting a pay phone."
>
> Later the project director told me that she had no other choice, because Soteria was going broke and they had only budgeted 50 dollars a month for the phone. She related that she had tried locking the phone up for a while, but that only lasted for about a week. Staff members seem to acknowledge that she had no other alternative, but they resent the "way it was done."
>
> The staff immediately informs me about the subversion system that has been worked out, whereby someone calls person-to-person collect to MRI [Mental Research Institute, Palo Alto, a co-funder of Soteria House], where the individual on the other end refuses to accept the charges but immediately calls back, essentially transferring the call from Soteria's bill to MRI's bill and still making it possible for staff to make some calls without using their own cash to do it. (Field notes, visit 12, p. 1)

The pay phone was a structural control to stop staff abuses. It was introduced under conditions of financial desperation, after approaches more congruent with the infra-style were tried. Because it clashed with the general ethic and approach of the community, however, it met with resentment and subversion. It was defined by the staff as an imposition and brought into the foreground the power differentials between the staff and the professionals associated with the research-administrative component of Soteria. It is reasonable to propose that if a more playful, joking approach had been used, even in instituting this direct structural control, it would have defused some of the resentment and resulted in more adaptive behavior by the transgressing staff.

A number of the characteristics of the confrontations that constitute the restoring phase of fairing have been discussed. In addition, confrontations make one aware of the power dimension of fairing. Despite efforts of the staff to deemphasize formal power and authority distinctions, certain individuals in fact emerge as informal leaders with

a powerful influence on others. Power is enhanced by a staff member's ability to promote the visibility of his or her work contributions, either by assuming responsibility for highly visible tasks or by making potentially less visible tasks more public. The work at Soteria ranges along a continuum of visibility. Concrete jobs, such as taking the garbage cans out to the curb the night before the pickup, are clear examples of highly visible work. Work with low visibility, such as doing therapy with a resident, can occur without others being privy to it. It can go unnoticed and therefore not be credited to the appropriate staff member. Sensing this possibility, some staff people have developed ways to heighten the visibility of doing therapy with residents, such as announcing to others that they are about to engage in such activity. One evening when most of the participants were in the living room watching television, a staff member got up in the middle of a program, sighed, and said, "tell me how it ends, here goes the martyr nurse," as she went upstairs with a cold washcloth and some milk for a resident who was upset (field notes, visit 12, p. 6).

Being knowledgeable and keeping track of activities is another important basis for informal power within the infra-process of the house. One staff member functioned rather consistently as an information source. Even when she was not officially on duty, others sought her out for reports on the life of the house.

> W. (a staff member) asks what happened to H. (a resident). T. (a staff member in the house, but not on duty) responds that he lost his job and can't pay the rent. She goes on to say that he can't fill out his welfare forms and that it took him two hours to fill out two lines. She adds that she told him to come around any time, and someone will help him do it. (Field notes, visit 9, p. 10)

The qualification for being knowledgeable, in addition to having the specific psychological temperament, is seniority or tenure in the setting, which provides familiarity with Soteria's ground rules and conventions. When someone called by phone to inquire as to whether a new resident could come to the house, the novice staff member on duty handed the phone to T. (the staff member discussed above) even though T. was not on duty; T. then handled the call and its details in a businesslike manner (field notes, visit 1, p. 2).

Staff members who have become informal leaders are also especially adept at the use of joking and humor as an infra-control tactic for legitimizing their own behavior. For example, one evening the two staff

members on duty violated the health-optimizing norms of the community by sending out for fried chicken instead of preparing the customary organic evening meal. This action was taken amidst a barrage of riotous laughter and joking, while they yelled "Hurray for shit food!" Their humor protected them from the appearance of assuming an ideological stance in opposition to community standards, and it gained for them an exemption from group values (field notes, visit 11, p. 1).

Finally, power within the infra-control process is cumulative. The fact of having powerfully influenced others on one occasion enhances the perceptions of the others that one is powerful when another situation arises. One staff person's history of engaging in ultimatums for the purpose of relatively direct power plays earned her a reputation of having power and influence, especially when direct confrontations took place. This phenomenon occurred with regard to the production of a documentary film about the house, for which the release forms were never signed. When I inquired how this had happened, the staff told me that the film portrayed one of the residents as being fat and ugly, which distressed the resident when she saw it. This staff member, who viewed herself as the resident's advocate, took the position that unless those scenes were edited she would not sign the release forms, and nobody else would either (field notes, visit 9, p. 10).

Another time I asked about how a staff member who had been the subject of a great deal of staff strife had finally been fired. I was told that the project director had planned to allow him to continue, but the informal leader gave an ultimatum that if he stayed, she would quit.

> All of the staff members were polled as to their opinion on the subject, and the decision was reached that he was finished. He offered to come down to the house and try to work things out, but nobody would have anything to do with him. (Field notes, visit 8, p. 4)

Staff relationships with regard to the management and distribution of work are characterized by considerable conflict and strife. Staff members acknowledge the high degree of conflict and attribute it to the intensity of their relationships. However, this constitutes only a partial explanation; the muted structures for managing work and the community ethic that sanctions independent, undirected activity both create ambiguity about the limits of fair behavior. The infra-process of fairing enables staff to survive and work to be accomplished under such unique conditions.

The flexibility and broad tolerance range that characterize both presencing and fairing are predicated on a great deal of freedom from external requirements and restraints. The ways in which potential control forces from outside are limited and contained is the focus of the next chapter.

5

Interfacing with the Public

From the seventeenth century until the last decade, society dealt with madness by creating segregated, isolated centers of confinement. Although the structures of confinement evolved from prisons to asylums and then to mental hospitals, isolation and segregation continued to characterize the madman's relationship with the world. The images are familiar: "The building is situated a mile from York, in the midst of a fertile and smiling countryside; it is not at all the idea of a prison that it suggests, but rather that of a large farm; it is surrounded by a great, walled garden" (Foucault, 1965). Thus, by creating segregated centers of confinement, mainstream society succeeded in ridding itself of reminders of the existence of insanity, and responsibility for imposing a social and moral order was delegated to psychiatric caretakers.

Settings like Soteria, located within the larger community, have brought madness, deviance, and bizarre behavior directly into public consciousness. With the reestablishment of contact, problems of reciprocal control between Soteria and the outside world have developed.

Public interest in Soteria's capabilities for self-control is particularly keen at this point in history, partly because of recent social trends. In 1972 California initiated a 10-year plan to phase out its state mental hospitals. A series of murders by former mental patients generated fear and anger toward "houses that have violent people,"

however, and the original 10-year plan was modified so that 11 of California's mental hospitals would be maintained. Although there are compelling psychiatric, legal, and economic reasons for closing asylums, there are equally strong community reactions against removing structural sources of control and "dumping ex-mental patients into central city areas without adequate alternative treatment modalities" (*Vanishing Asylums,* 1973).

Inspection and licensing boards have been set up to strengthen confidence in the control capabilities of family care and the board-and-care homes through intense monitoring and stringent regulations. Compliance with safety, hygiene, and staffing licensure requirements necessitates periodic inspections and reports.

The outside community frequently confronts Soteria staff with concern regarding the ability to control residents at Soteria. When I asked one staff member about her speech at a local meeting she replied: "All they were interested in was safety. They kept asking what we'd do if someone ran into the street or tried to hurt someone else" (field notes, visit 12, p. 2). The intense pressures on Soteria to generate effective controls are made apparent by the readiness of external control agents to intervene.

The problem of control, in terms of outsiders coming in, is reciprocal. It is proposed here that the preservation of autonomy by limiting the control (potential or actual) of external agents over the infra-control processes at Soteria is essential for its continuation. Soteria must maintain the conditions necessary for broad, flexible tolerance ranges, lack of internal structures, and group cohesiveness and values. The third implementing subprocess of infra-control, *limiting intrusion*, insulates Soteria from external rules, expectations, and values, thereby preserving some degree of autonomy and providing a basic condition for the other two subprocesses of presencing and fairing to operate.

Limiting intrusion, like presencing and fairing, may be conceptualized as having three stages: minimizing approachability, deflecting, and disengaging. Minimizing approachability involves strategies that prevent outsiders from approaching or at least decrease the likelihood that they will attempt to intrude on Soteria's operation. Deflecting refers to patterns of interaction that occur when an attempt is made to encroach on Soteria's autonomy. Disengaging involves activities designed to undo, contain, and cut off intrusion that was not successfully deflected.*

*The work of Jan Tolerud (1974) on unescorted women in public places was influential in the development of these conceptualizations.

Sources of Intrusion

By virtue of a unique set of characteristics, Soteria presents an interface for a broad range of contacts between its members and those of external society, all of whom are potential intruders. The house is neither isolated, inaccessible, or self-sufficient. It is located on a block of houses in a rather congested area of a city. People live in dwellings within a few feet of either side of the building and behind it. Staff and residents come and go from the house relatively freely to use facilities in the nearby community. Trips are made to grocery stores, the doctor, the welfare department, the movies, nearby restaurants, and the beach. Soteria lacks the isolation and invisibility of the state mental hospital, and its participants come into contact with the outside community constantly in the process of daily living.

Just as the house is not self-sufficient in providing for the day-to-day needs of staff and residents, it also is not economically independent. The bulk of Soteria's expenses for staff salaries, rent, food, telephone, and so on are paid for through a collaborative research grant funded by the Mental Research Institute (MRI) in Palo Alto, California and by the National Institute of Mental Health (NIMH) in Bethesda, Maryland. Soteria's relationship with the professional community both locally and nationally is further complicated by the fact that the house is a radical critique of and alternative to the mainstream psychiatry that funds and supports it. Soteria may be viewed as American psychiatry's front office radical; it is allowed to survive within the system, but enjoined to be on good behavior by psychiatric professionals who take a more than perfunctory interest in its continuation.

The mass media, enticed by the experimental and sensational aspects of Soteria, bring the house into contact with a broader public. Soteria must be attuned to the kind of press reports it gets, which greatly determines the reaction of the public to the facility.

The keepers of social order, such as the public health department, the state mental health board, the fire and police departments, the welfare office, and medical and psychiatric personnel, must all interact with Soteria's operation because—regardless of the label chosen to depict it—Soteria is not the private home of a nuclear family. As a board-and-care home, a residential treatment facility, a crisis development center, a research project, or even as a hippie commune, Soteria has characteristics that foster intrusions by agents of the public order.

Soteria is part of a loosely connected network of alternative

psychiatric houses. Others in the Bay Area at the time this study was conducted included Bonita House in Berkeley and Diabasis House in San Francisco.* Such alternative facilities shared relatively compatible ideological orientations and provided a network from which staff members were recruited. Informal alliances among people from these settings invested them with a special right of entry at Soteria by virtue of their comradeship with Soteria's ideology.

Thus, both formal and informal organizational conditions put Soteria into contact with a broad range of potential sources of intrusion. The infringement on autonomy that could result from such intrusion is acknowledged by the Soteria staff.

> We recognized from the onset the crucial nature of our relations with the community in which we were embedded. Establishing an open facility to treat acutely psychotic persons in the community we saw as a very high-risk venture. The neighbors, police, and mental health and social service communities could see to it that we would be unable to operate should they choose. (*Manual,* p. 60)

On one occasion when a staff member spoke of wanting to plant a vegetable garden in the backyard, the psychiatrist-landlord joked, "you'll have to get a permit from the city planners stating what elevation each species will be grown at" (field notes, visit 9, p. 6).

The staff at Soteria is aware of the necessity of evolving strategies to restrict the influence of outsiders on their operation. They also perceive limiting intrusion to be one of their responsibilities toward the residents.

> At Soteria, when people come here they are out of balance with out there (outside society). We don't see our job as straightening them out. Instead, we kind of buffer and protect them from dealing with out there so they can straighten themselves out. We don't do it to them. We just make a place for them to do it in. (Field notes, visit 11, p. 5)

*Diabasis (from the Greek, meaning "crossing over") was founded in 1974 by psychiatrist John Perry and his associates with a grant from the North East Mental Health Center in San Francisco. Diabasis focused on the use of a Jungian model, drawing heavily on the use of archetypal forms to effect reintegration of the psychotic personality. Bonita House was founded by psychiatric nurse Karen Beauvoir and took its name from its street address in Berkeley. The purpose of the organization was to provide an alternative to psychiatric confinement that would vest considerable autonomy in its 15 to 19 residents.

MINIMIZING APPROACHABILITY

The first stage in the process of limiting intrusion is to minimize Soteria's approachability, which is accomplished by *situational positioning, limiting disclosure,* and *avoiding incidents.*

The ability of staff members to maintain polite but distant relationships with immediate neighbors and thereby minimize the approachability that accrues partially from intimacy is related to properties of the neighborhood in which Soteria was established. (The neighborhood was described at some length in chapter 2.) It is a central city transitional area where old and somewhat shabby frame houses have been turned into rooming houses. The people are heterogeneous, and their stays in the area are relatively transitory. As one staff member said:

> There have been little or no problems with the neighbors because it's such a mixed neighborhood; a nursing home on one side, transients in rooming houses, hippies around the corner. We're nice to them and the same goes the other way around. As far as most of them go, we just haven't gotten to know them at all. We just have a "Hi, how are you?" relationship with the people in the nursing home next door. (Field notes, visit 12, p. 3)

The neighborhood surrounding Soteria strikes a contrast with both the homogeneity and intimacy of suburban tract homes and the status concerns of high-income areas such as San Francisco's Pacific Heights, where property owners are highly concerned about maintaining the quality of the neighborhood. Soteria is situated in an area that minimizes identification of its residents as deviants and at the same time promotes a noninvolvement and disinterested tolerance among neighbors.

As a safeguard, however, Soteria was established in the neighborhood with very limited disclosure about what it was: "We began without fanfare, and didn't broadcast our plans widely; we didn't want to create unnecessary obstacles to beginning to operate" (*Manual,* p. 69). In keeping with its intent to maintain a low profile and to limit the intrusion of official requirements and constraints, Soteria's administrators opted for a board-and-care license rather than for licensing as a residential treatment facility.

> If we had called ourselves an in-patient treatment facility, they'd have been down there laying on all sorts of regulations like "Where's the nurses' station?" and "You have to have fireproof drapes." (Field notes, visit 10, p. 7)

Additional tactics were used to keep a low profile. A policy was made to choose staff members who were not actively and politically at war with the establishment, in the hope of curtailing areas of potential conflict with outsiders. Choosing the project's psychiatrist as the landlord extended the tolerance range for wear and tear on the house and insulated Soteria from another type of problematic encounter with outsiders. An initial positive image was sought by painting the house and cleaning up the yard, thereby converting a neighborhood eyesore at least temporarily into a somewhat attractive place. Finally, some legitimizing was initially accomplished with the health-care community by selecting professional staff members who were well known and respected by other local professionals.

Thus, Soteria was set up and introduced into the community in ways that minimized the likelihood of intrusion by outsiders. The notion of continuing the original low profile has persisted over time and is evidenced in the staff's use of avoidance as a key strategy to decrease the chance of calling attention to Soteria. Specifically, staff members attempt to avoid public scenes or disruptions:

> Staff are always nervous about going to the movies with residents in case somebody gets freaky. At the drive-in it's a little easier to handle. If somebody gets spaced out at the walk-in, it could get us into trouble publicly. (Female staff interview, T., p. 11)

Another staff member described an episode in which a resident had gone shopping with her at a local shopping center and suddenly knelt down and started praying in front of a display of greeting cards. "From then on I just tried to steer her (the resident) away from going into places where she could break anything or disturb anybody" (female staff interview, H., p. 13).

Staff members are acutely aware that a public scene would draw attention to Soteria and carry a high risk of causing intrusion on its autonomy, and they go to great lengths to avoid such occurrences. Even in the case of uncontrollable resident behavior, staff members move beyond the infra-control process of presencing reluctantly, if ever, to invoke conventional controls such as calling the police. This reluctance can be explained partly in terms of the community values, but the outcome for the house's vulnerability also seems to be a crucial consideration.

Another example of avoidance is reflected in the choice of locales for excursions. People do venture out of the insulated setting of the house; however, the places chosen for excursions are usually ones such as the beach or the mountains, where the social visibility of unusual behavior is low and tolerance ranges are broader than one would find at a restaurant or concert. When exceptions are made and staff and residents attend a lecture or film, it is likely to be an in-group function such as R. D. Laing's speaking engagement in Berkeley or a screening of the film *Asylums,* made in London about Kingsley Hall and presented as a benefit for Diabasis House in San Francisco. These in-group activities ensure low social visibility and high tolerance ranges for disruptive activity.

Despite the numerous tactics used by the staff at Soteria to lessen the chances that the house will be approached by outsiders, a number of organizational conditions necessitate some interaction. Soteria employees also have devised strategies to deflect these approaches.

DEFLECTING

When it is necessary for outsiders to come into contact with Soteria, the deflection of potential intrusions is accomplished primarily through variations in the disclosure of information about Soteria. In some cases, staff members have opted not to disclose any information in their contacts with external control agents.

Staff members frequently act as escorts, companions, and intermediaries for residents on excursions from the house. In the absence of formal guidelines about what to reveal about Soteria, some staff members have experienced uncertainty and have chosen not to say anything. Frequently, however, this approach results in a lack of leverage for obtaining special treatment or consideration.

> I went with F. (a resident) to the emergency room for her suicide attempt. At that time I was, well, uncertain about how much to say about Soteria, or whether to say anything. Since I didn't they wouldn't let me sit with her, and I couldn't get any information from them. (Female staff interview, H., p. 41)

Staff members quickly learn that they can exchange a partial disclosure about Soteria for special treatment that would otherwise be denied them unless they had special credentials.

> When I (a staff member) took J. (a resident) in for a vaginal exam and pregnancy test, I had difficulty with the doctor as to whether he'd let me stay. I tried to delicately let them know she needed support without

saying that she was crazy. I finally said, "she comes from a crisis development center and has been going through heavy emotional trips," and he finally said okay, I could stay with her. (Female staff interview, S., p. 6)

Although limiting disclosure of information about Soteria is one strategy for deflecting potential intruders, it can carry less desirable consequences. In addition to denial of special treatment by external agents, another disadvantage is the possibility of misinterpretation of insufficient or erroneous information. The misconceptions of outsiders about the house can heighten the possibility of external intervention when an incident occurs.

M. (a resident) was always running away. Once she ran into the street between two cars, and I can remember that a green station wagon, with two fellas in the front seat, stopped—obviously looking over the whole situation. It must have looked awfully weird, me (a black male staff member) standing there and this young girl, running, clothes half off and all. Although they drove off, they could very easily have thought, you know, "this guy's after her to rape her, and we'd better protect her from him." (Male staff interview, W., p. 102)

On another day, misinterpretation by a neighbor posed a more direct threat to Soteria's autonomy.

One afternoon, when we left her (a resident) alone for just one minute, she ran into a neighbor's house and played in the children's rooms and cluttered the house. When the neighbor came home, she was furious and frightened and called the police, her husband, and her parents. For about half an hour she refused to speak to any one from the house. When we did talk to her, about an hour later, she said she was convinced that the house was ruining the neighborhood and the moral life of her daughters.

Staff members dealt with this rather precarious situation by calmly explaining that Soteria was a house for emotionally disturbed young people and they were specially trained to deal with them. This partial revelation succeeded in defusing her intention to take action against Soteria.

She seemed relieved to learn that we weren't a house full of drug abusers, like she had thought. When she learned that Soteria was a legitimate facility, she decided not to press charges. (*Manual,* p. 63)

The specific details included in partial revelations vary a great deal, although the purpose of the disclosures is always to limit intrusion. The professionals associated with Soteria monitor in a general way some of the disclosure of information that occurs.

When C. (a resident) asks if Soteria is a home for the mentally disabled, the psychiatrist-landlord corrects her by telling her it's a board-and-care home. The question was asked because the resident was filling out a welfare form. (Field notes, visit 5, p. 1)

The partial disclosure of information about Soteria can occur under relatively spontaneous circumstances in a specific incident, or it may occur in a more ritualized way. Because Soteria relies on external funding sources, from time to time it has to tell the funding agencies what it is they are supporting. When the staff takes the initiative to partially reveal Soteria in a ritualized form, the inclination of outsiders to investigate Soteria is deflected. In short, partial revelations of the activities at Soteria take place through self-portrayals. These self-portrayals share two general properties: ambiguity and a tendency toward chameleonlike protective coloration.

Keeping descriptions of Soteria rather ambiguous, especially in terms of its relationship to a theory, limits a potential critic's ability to evaluate its success or failure. Without some framework to use as a criterion, it becomes difficult for an outsider to judge the rightness or wrongness of the approach. Thus, ambiguous self-portrayals also serve to deflect evaluations by outsiders. An example of such ambiguity can be found in the *Manual,* where the "constant variation" rhetoric is advanced and patterned approaches are denied.

This manual is not intended to be a cookbook for dealing with acute psychosis. Such a view would be contrary to our emphasis on individuality . . . . The persons with whom we work cannot be fit into techniques; each must be dealt with individually. (*Manual,* p. 4)

This ambiguous position about Soteria's theoretical basis is admitted later in the same document.

On the one hand we profess an atheoretical stance for day-to-day practice; on the other, we present (in the research) a tightly reasoned theory to guide our atheoretical practice. Our intention is to steer a course between these polar positions. We wish to maintain our ability to respond to individual situations in a free and open way. To remain congruent with the aims of this project the theory must remain open to change and development and evolve as we accumulate experience. (*Manual,* p. 6)

In addition to being ambiguous, self-portrayals of Soteria take on different characteristics, depending on the audience to whom the information is being disclosed. The professed purpose of Soteria's staff

manual, presented as a joint effort by staff and residents and jokingly entitled "The Care and Feeding of a Soteria," is "to provide some examples of how various types of behaviors which might give rise to interpersonal problems were dealt with in Soteria" (p. 4). However, in the interviews conducted by the project director that served as the data base for the manual, she clearly provided a script to the interviewees that highlighted certain aspects of Soteria. At one point she explained to the staff member she was interviewing:

> I think what we should do now in talking about it is just tell it the way it is, and like there may be some places where I'll press you, because I'll have certain ideas about something or be trying to prove that there is or is not something at Soteria. (Male staff interview, G., p. 26)

She tells another staff interviewee:

> Of course, what we want in this report, this kind of description, is to show how things that lots of people think are problems really are not. (Female staff interview, H., p. 28)

And finally, the script was guided in the following way to promote the portrayals of staff behavior at Soteria as being warm, loving, nonpunitive, and humane.

> Just one thing I want you to bring out was that we didn't take any punitive action against anybody or really spend a lot of time investigating or placing blame for starting the fire. (Male staff interview, H., p. 2)

The manual in general takes a self-justifying posture and emphasizes many of Soteria's value commitments. Staff members are portrayed as "real" people who genuinely care about the residents. The dedication of the book is "To our residents who teach us..." and the manual appears to be a group product. I later learned, however, that numerous staff members objected to this positive image of Soteria. They said that they had had relatively little say in it and resented being portrayed as "sweet sensitive, love-everybody flower children" (Field notes, visit 2, p. 1).

The manual's portrayal of Soteria is almost unrecognizable in contrast to a letter written to solicit financial support for the house from funding agencies:

> Soteria is a residential treatment program for first-episode schizophrenics utilizing a developmental crisis model. Six specially trained nonprofessional staff work with the residents under the supervision of a psychiatrist, a psychologist, and a social worker. (Letter to Clinical Foundations, April 16, 1973)

As in other presentations to mainstream professional psychiatric audiences, this self-portrayal attempts to link Soteria to conventional psychiatric therapeutic ideologies. In an exchange between the audience and a panel composed of Dr. L. R. Mosher and selected Soteria House staff members at the April 1974 American Orthopsychiatric Association Convention in San Francisco, one professional staff person protested, "even someone as respected as Karl Menninger said, like we do at Soteria, that some people come out of their illness weller than well." In information disclosed to a professional audience at the same convention, Soteria's antipsychiatric origins were deemphasized: "antipsychiatry is a term that I'd prefer Soteria not be associatd with." The point that Soteria is not a fad also was made to deflect potential criticism: "Soteria is not this year's panacea for solving the complex riddles of schizophrenia. It is only one mode of treatment."*

In sum, professionals at Soteria recognize that if they portray Soteria to fellow professionals in the rhetoric of day-to-day staff ideology, they risk being dismissed as naive or ostracized as outrageous. Soteria is portrayed to outside professionals as an objective, experimentally designed research project. It is differentiated from conventional inpatient psychiatric settings only in its abstention from the use of phenothiazines.

The one condition under which a conventional image of Soteria may not be portrayed to professional audiences is when staff members are invited by the professionals at Soteria to participate in the disclosure of information. Staff members joke about the aggressive, outspoken postures they wish to assume, which are at odds with the customary approach taken by Soteria's professionals and must be softened by them. In relation to a speech about Soteria that was to be presented in New York City, one staff member boasted:

> I think I'll take a big bag of bullshit on stage and throw it at them. B. (the professional who invited the staff member) would shoot me. I think I'm going to be very critical. Like, "We don't use drugs because we think it's a perverted way to deal with people." (Field notes, visit 11, p. 4)

Another staff member, speaking extemporaneously in a meeting of professionals at the Mental Research Institute, offered a metaphor to explain Soteria's use of the word "growth." She saw the house as a

*From comments made by a panel composed of Dr. L. R. Mosher and selected staff members in response to audience questions and comments at the 1974 American Orthopsychiatric Association Convention in San Francisco.

garden with all the plants growing together. The plants with big, broad leaves shaded the smaller, more delicate plants from the sun, and in turn the small plants nourished the big ones. A well-known psychiatrist attacked the concept by sarcastically inquiring whether the staff members were the gardeners and then dismissed the description as too simplistic (MRI meeting, March 20, 1973). In hearing about the occasion, another staff member commented:

> I wish I had been there because I would have told those people off. They should be the ones to do the translating. They're the bilingual ones who went to school to learn all the big psychiatric words. (Field notes, visit 11, p. 2)

Modifying the disclosure of information about Soteria to fit the audience of outsiders is, for the most part, an effective strategy to deflect criticism. The self-portrayals may be criticized for being vague, ambiguous, or contradictory, but criticism and interference with actual operations at Soteria are generally avoided.

DISENGAGING

The third phase in Soteria's process of limiting intrusion is disengagement from outsiders who have succeeded in approaching the setting and avoiding deflection. Disengaging is accomplished primarily either by barring access to the house or by appeasing and compromising with intruders so as not to jeopardize relations with the outside community. Denying physical access to outsiders is formalized to a certain extent within the infra-control process in a self-initiated ground rule against brief tourist-type excursions through the house by visitors. One staff member told me how important she thought it was to guard the privacy of people in the house.

> If someone comes to the door and says they have an appointment with B. (the project director) I'll make them wait outside until I check with B. that they really do. (Field notes, visit 9, p. 10)

One afternoon I had the opportunity to observe a staff member in the process of limiting access to two young, hip men who simply walked into the kitchen and asked, "Mind if we join you for a while?" The staff member on duty replied, "Let's go upstairs and talk about it." Once up there, he told them, "it's a general kind of rule that it's too

disruptive to have people just come into the house for a few hours to observe." One of the visitors continued to press, asking if he couldn't just approach people in the house individually to see how they felt about letting him hang around and observe for a few hours.

The staff member eventually compromised in order to appease the two visitors. He agreed to let them stay upstairs and talk to any staff member who wanted to come up. He then entered into a long monologue of partial disclosure about Soteria, emphasizing the ideology and value commitments of the day-to-day clinical staff and using hip jargon ("spaced-out," "heavy," "bummer," etc.). His strategy worked effectively to disengage the two visitors who had walked into the house, and they left voluntarily within the next hour (field notes, visit 10, p. 4).

When professionals go through proper channels to negotiate entry into the house, people at Soteria have set up an effective structural mechanism for disengagement. Curious professionals are referred to the "panel of distinguished visitors," a group of nationally prominent professionals from all of the health professions who were given a quick tour and self-portrayal of Soteria when the house was started. These individuals are invested with the obligation to inform interested members of their respective professions about Soteria, which effectively enables the house to disengage itself from direct contacts and visits. When I first inquired about visiting Soteria, I was urged to contact Hildegard Peplau, a psychiatric nurse on the panel, who would tell me about Soteria instead.

Special precautions were taken to limit disclosure of certain aspects of the setting when an inspection by the public health department took place. An 18-year-old resident given to foul language, mud baths, and shouting the details of her masturbation practices was given three doses of Thorazine the day before the inspector came and stayed in a room with the project director during the actual inspection (field notes, phone conversation with D. [a staff member], p. 8).

Some staff members related the need to disengage from individuals who had justifiable access to the setting and yet were viewed as intrusive. They explained that it was hard enough to be working with other staff people around problematic behavior without the increased stimulation of an outsider.

> M. (a professional person involved with Soteria) was here, and it was kind of intrusive. I felt uncomfortable because I had to put up with his positive feedback. It's, like, very difficult to get a compliment while you are doing something. You don't want somebody else to comment about it, because even positive feedback is just another thing to think about,

which is hard when you are dealing with somebody who's disorganized. (Male staff interview, G., p. 3)

Infra-control processes of presencing and fairing require that intrusions be kept to a minimum. Perhaps it was sensitivity to this proposition that enabled me to negotiate and maintain my own access to Soteria. On my last day in the field, the staff member who had emerged as an informal leader told me:

> You know, you're a first—an exception. No one has ever been allowed to come in and do research. But when I met you I liked you, and I thought what you were trying to do was okay. So I told B. (the project director) that you could stay. (Field notes, visit 14, p. 4)

The people at Soteria attempt to disengage from outsiders and limit their potential intrusion in a manner that continues to maintain a consensus of social support. Realizing the power that neighbors and other members of the community have to initiate action against Soteria if negative critical impressions were fostered, the members of the house attempt to appease and cooperate with them and to comply with their requests for minor modifications when these occur. One staff member related the following story about the nursing home next door.

> We knew Mary next door, an old lady who kept trying to run away from home. She usually didn't make it very far, and the nurses would come over here after her. At first they weren't very friendly, but when we were really friendly and cooperative toward them, they started coming and smiling and saying, "oh, Mary's here, bothering you again." (Female staff interview, S., p. 6)

Another time when staff at Soteria were building a workshop in the backyard, the neighbor in the house behind the yard complained that water was draining off the workshop roof onto her property. The Soteria staff gave up the idea and dismantled the workshop rather than risk a hostile confrontation with a neighbor in the community (field notes, visit 2, p. 1). The long-range survival of the program is given higher priority than day-to-day incidents. The staff at Soteria assumes a compliant posture on the latter to protect the former.

SIGNIFICANCE OF LIMITING INTRUSION

Preserving autonomy by limiting the intrusion of outsiders is a complex and important process at Soteria. Like the other implementing subprocesses of infra-control, it is not codified according to guidelines

or rules; nevertheless, certain patterned infra-strategies are discernible. Although these strategies are generally intuitive and variable, they effectively limit the control that outsiders exert on Soteria's operations. Since limited intrusion is both a condition for the other subprocesses of infra-control and an infra-control subprocess in its own right, extensive consequences for the whole infra-control system could result if this condition were altered significantly. More open disclosure and access could only enhance the codification and formalization of control processes that now function at an infra-level at Soteria.

6

Deinstitutionalization: Alternatives for Residential Care

The perceived world has no absolute basis outside man confronting his tasks. The perceptual object is never finally constituted, but is always, spatially and temporally a compound of perspectives open to further exploration. Certainty is never achieved. . . . We are always in the process of self-constitution. We choose our world and our world chooses us.
(Maurice Merleau-Ponty, *Phenomenology of Perception*)

This study has examined organizational conditions and unfolding interaction at Soteria House. In the course of the investigation, multiple points of view have been encountered on what Soteria really is. It has been portrayed as a research project, an anti-psychiatric community, a crisis intervention center, a radical alternative to conventional ways of dealing with schizophrenics, a board-and-care home, a place to grow, a womb, a part of a social movement, an innovative organizational model for deinstitutionalizing residential psychiatric care, and a house with violent people who are ruining the morals of the neighborhood. Clearly Soteria has different shapes and meanings when viewed from these perspectives.

My attempt to discover the basic social processes at Soteria rests on the assumption that social worlds, despite all the differences of perception, follow some basic ordered patterns. Because an assumption that

situations have absolute or intrinsic meanings was discarded at the outset of the study, my methodological approach has been to determine the multiple meanings conferred on situations by participants in the natural setting. Thus, infra control has earned its designation as a basic social process or core variable through systematic analysis of the qualitative field data from Soteria. The approach in this research has been to generate explanations in contrast to a methodology of verifying an imposed and preconceived theory. Although the analytic framework of infra control is offered here with a great deal of confidence about its salience and explanatory power, it is not the only analysis that might have emerged from the Soteria data.

THE COMMUNITY MENTAL HEALTH MOVEMENT

For the past two decades hospital psychiatry has undergone a revolution in the treatment of the seriously disturbed. The practice of incarcerating patients for prolonged periods in large institutions where they received merely custodial care has given way to the community mental health system. The reason for this change was the realization that, in the typical state institution, the patients not only received little in the way of psychological treatment, but lost certain social and interpersonal skills needed for successful reentry into the community—and all at the expense of their civil liberties. Theoretically, if persons received vigorous early treatment close to home and could stay in their own community support system, there would be no need for long-term hospitalization, and the debilitating effects of institutionalization could be eradicated.

The community mental health movement represents the essence of the new hospital psychiatry. Its purposes are to deemphasize long-term hospitalization, to institute brief hospitalization for the stabilization of acute crises, and to develop community resources to treat and support mentally ill patients without resorting to institutionalization. The hospital is no longer viewed as the end-point in the life of the psychiatric patient, but rather as the point at which the patient and his social network reintegrate.

Community programs established in the United States consist of two essential features: psychiatric services in the community which would have previously been part of the state hospital program, and services for persons who formerly would not have been considered in need

of psychiatric care. The emphasis of the latter is on consultation and education in the hope of preventing emotional breakdowns under a period of stress.

Coupled with the emphasis on community treatment and evolving as well from a dissatisfaction with custodial care, in most states humanitarian concerns for the mentally ill have precipitated legislation geared at securing certain civil liberties and legal rights for patients. These laws generally stipulate procedures to be followed in order to hospitalize an individual with or without his consent, as well as criteria for hospitalization and regulations regarding continued care and discharge. The effect of these changes on the practice of psychiatry has been the intrusion of significant economic and legal forces into the psychiatric hospital treatment context. Government planners and administrators now establish health policy and priorities. The demands made by these new systems have substantially altered the practice of hospital psychiatry to the extent that complicated mechanisms for processing patients through treatment have developed. These new processes are designed to negotiate a complex maze of nonclinical considerations peripheral to the treatment programs themselves.

In short, conventional treatment in the community health system has become a highly prescriptive, elaborately formal structure of policy, regulations, and standards, and complying with these procedures demands increasing attention from mental health professionals. The old state hospital warehouse has been replaced by a similarly bureaucratized clearinghouse where care and treatment consist primarily of an institutionalizing *dispatching* process that denies self-care, self-determination, and self-control to patients. Instead, they are screened, medicated, stamped with a diagnostic label, sorted into a legal category, and disbursed back into an unwelcoming community (Wilson, 1982).

Inpatient hospital units under the community mental health system must fill the gap in the social control left by closing the traditional state hospitals. Psychiatric clinicians in such settings must become agents for the community; and regardless of how much the community may desire successful treatment and rehabilitation of the mentally disordered, it demands safe custody of those individuals it rejects. Viewed in this way, the community mental health inpatient facility must respond to multiple contradictory messages from both community care ideology and the tradition of institutionalism with its emphasis on isolation and custodialism. It must protect the community, but at the same time guarantee the patient's rights. It must provide for the custodial needs of

individuals who society rejects and yet facilitate their return to the rejecting community.

The preceding discussion highlights the reason for community psychiatry's lack of true innovation. Lest it be used to justify a further drug therapy solution to madness and a retreat from the principles of community psychiatry, I have tried to place the apparent criticisms in context. Leaving aside these contextual considerations makes it easier to point out the deficiencies in community psychiatry and to conclude that it has not been viable. This is particularly tempting at a time when public opinion is turning away from a social conception of the cause and treatment of mental disorders to one more biologically based. I do not propound the desirability of the old state hospital system, but rather argue that a system intended as an alternative to the state hospital has done little to promote the goal of deinstitutionalization for patients.

DEINSTITUTIONALIZATION: CONTEMPORARY PSYCHIATRY'S MAGIC WORD

Between 1955 and 1975 a new term "deinstitutionalization" was introduced, and under its banner the census of resident patients in American state mental hospitals decreased from 559,000 to 193,000, or approximately 60 percent. Impetus for moving patients out of state hospitals came from a variety of sources. The hospitals were overcrowded and had too little in the way of staff, services, and financial support. Inadequate standards of care were the norm and living conditions were generally considered to be inhumane. Court pressures had begun to mount to upgrade facilities, which was prohibitive at a time when state budgets were tight (Bassuk and Gerson, 1978). The discovery of antipsychotic medicines and new techniques of crisis intervention and brief therapy offered new hope at a time when long periods of hospitalization seemed to do more harm than good (Bachrach, 1978). Increased awareness of the extent of mental and emotional problems among the general population following World War II contributed to the passage of the National Mental Health Act of 1946, and National Institutes of Mental Health (NIMH) programs of training, research, and financial aid further supported the reform movement. The goal of the deinstitutionalization movement was a 50 percent reduction in the patient population of state hospitals for the mentally ill within two decades (Bassuk and Gerson, 1978). This goal of returning people to the

community was not fully realized until the 1960s, when President Kennedy's "bold new approach" was implemented. The approach essentially consisted of the Community Mental Health Centers Act of 1963, which funded construction of community mental health centers where the chronically ill were to be treated following discharge from the state hospitals.

For the past 20 years the locus of care for the severely mentally ill has indeed shifted from state institutions to the community, and "community mental health" has been used synonymously with the term "deinstitutionalization." One might expect that deinstitutionalization would have considerable consensus of meaning for its advocates; however, it is surrounded with definitional disorder. What more precisely is deinstitutionalization? What is its agreed upon nature? To raise these questions is to confront confusion, for the term is copiously discussed with varying degrees of authority and precision in psychiatric literature. The lexicon of diverse terminology used to explain deinstitutionalization adds to the difficulties of studying and assessing practices within this unsettled field and of commenting on Soteria House's relationship to it.

According to Bachrach (1978), deinstitutionalization is simultaneously a fact, a philosophy, and a process. One well-known fact is that the resident population of state hospitals has decreased from 1955 to 1975 from about one-half million to about 190,000, or about 66 percent. The process is the avoidance of traditional hospital settings and the expansion of community-based facilities for treatment of the mentally ill. The philosophy represents an expression of civil libertarian rights and modification of the environment as the primary avenue of social change.

Bassuk and Gerson (1978) equate deinstitutionalization with a massive reform movement ostensibly called community mental health. However, they raise questions about whether deinstitutionalization represents an enlightened revolution or an abdication of responsibility. Due to shortcomings in legislation, lack of funding, and the unanticipated impact of discharged patients on communities, the dual promise of an extensive support system of comprehensive, coordinated community care and prevention programs has never been fulfilled. According to these critics, hospitalized patients are released haphazardly to a nonsystem of aftercare that results in hardship and even tragedy. They challenge that the aims of social reform and effective treatment have become entangled and that although social justice may be a necessary condition for successful treatment, it is not alone sufficient.

Klerman (1979) views deinstitutionalization as being primarily a shift from a state-owned and operated monopoly to a pluralistic and diversified system of services—the result of a short-lived consensus among lawyers interested in civil rights, budget advisors pressured by economic forces who view deinstitutionalization as an opportunity to shift mental health financing from state to national levels, and theorists and researchers in social psychiatry. In this view deinstitutionalization is primarily a shift in location and funding arrangements.

Talbott (1979) calls deinstitutionalization a misnomer and substitutes his own term "transinstitutionalization," wherein the chronically mentally ill patient has his or her locus of living and care transformed from a single institution to multiple wretched ones in a shuffle to despair and national tragedy. He characterizes the outcomes of the deinstitutionalization movement as: (1) the dramatic appearance of large numbers of dirty, hallucinating strange faces on city streets in low cost ghettos and deteriorating neighborhoods, in his terms "naked men dancing on Broadway and bag ladies on Park Avenue"; (2) transfer of thousands of patients to nursing homes; (3) mental health service patterns of use characterized by a total lack of follow-up and a revolving door of continued readmissions; and (4) demoralization, demedicalization, and deterioration within remaining state hospitals.

Stern and Minkoff (1979) identify six paradoxes of value that have led to ineffective and inefficient deinstitutionalization programs. Foremost is the community mental health paradox; that is, the stronger the commitment to ideals of primary prevention and consultation by community caregivers, the greater the stress when these ideals do not work. As a result we are tempted to conclude that if chronic patients don't do well under community programs, the life in state hospitals may be better for them.

Craig and Hyatt (1978) write that in Watzlawvik's framework, deinstitutionalization has been a first-order change when a second-order change was required to enable chronic patients to function at optimal levels.

Fink and Weinstein (1979) remind us that some see deinstitutionalization as the establishment of community mental health centers to rid the community of the causes of mental illness such as poverty, racism, unemployment, poor housing, crime, or riots. In their view, an attempt to make community mental health programs responsible for the quality of life rather than the treatment and prevention of mental illness has been the fatal flaw.

The literature on deinstitutionalization, despite its variations, does yield one clear area of agreement. The public policy shift that moved the locus of care and funding arrangements for the chronically and severely mentally ill from single-purpose custodian state hospitals to multipurpose services near patients' families and communities has not solved the problems of care for this population of patients.

INFRA CONTROL AND DEINSTITUTIONALIZATION

It is toward the original goals of deinstitutionalization that Soteria House and its infra control processes are directed. Deinstitutionalization is one of the most important developments in the history of psychiatry, but it has been plagued by a variety of problems. In addition to the revolving door syndrome, that is, short stay with rapid turnover and repeated readmissions, there are large numbers of discharged patients still disturbed and living bleak lives in board-and-care homes, nursing homes, and on skid row. As many writers point out, the deinstitutionalization movement originally designed to provide relief from long-term hospitalization has let patients "slip through the cracks." The flaw seems to bee that deinstitutionalization has fostered a widespread devaluation of any form of long-term residential care. However, if we view institutionalization as the process by which an individual is denied self-care and self-determination to the point of rejecting personal independence in exchange for institutional control and decision making, brief hospitalization need not be the goal. Instead, mental health professionals can begin to study alternatives to institutionalization, specifically those that will help patients to relinquish institutional dependency and control and acquire self-care and self-control.

Neither the theoretical perspectives nor the methodology in this investigation was selected to evaluate the effectiveness of Soteria House as a mode of community-based psychiatric treatment for schizophrenics. The longitudinal comparative outcome research project which provides for Soteria's economic support addressed this question. Based on two-year outcome data, it reported no differences in remissions or levels of symptomology between Soteria patients and those treated conventionally in the community mental health system. However, Soteria patients received medication less often, needed less outpatient care,

showed significantly better occupational levels, and were able to live more independently over the follow-up period (Mosher and Menn, 1978). Infra-control processes of care shifted responsibility and control as much as possible from staff members to residential patients, conveying the expectation that people are responsible for themselves and their actions. The flexible structure of house activities allowed for time to develop interpersonal skills, and the growing list of Soteria graduates, volunteers, and staff members offered discharged residents a network of social contact and support. All of these characteristics contrast sharply with institutionalizating practices of state hospitals and many community mental health centers.

My study has considered the viability of the Soteria approach from the perspective of its ability to demonstrate the control capabilities of infra-control processes with young, diagnosed schizophrenics whose behavior required residential care. However, Soteria's place in the community mental health system and its potential contribution as an innovative alternative for achieving the goals of deinstitutionalization also merits discussion.

Our disenchantment with deinstitutionalization should be used to rethink the concept from its origins of being a "magic cure" to making it genuinely innovative. The following proposals offer a starting point.

We must continue to pursue the goals of deinstitutionalization, confused as they might be. State mental hospitals as studied by Stanton, Swartz, Goffman, and others have become a system of rigid regimentation, personal repression, and long-term confinement producing among the inmates an iatrogenic disorder known as institutionalization. This disorder is both a process and an effect. It refers to care and treatment comprised of structures and processes that emphasize routine and control and systematically dehumanize patients by denying them self-care and self-determination. Institutionalization constitutes a chronic condition in which a person's ability for self-care and self-determination in day-to-day living is so markedly impaired that life outside the institution is not possible. Among the deleterious effects on patients in institutions are chronic incarceration with little attempt at treatment, atrophy of interpersonal and living skills, stigmatization, and adoption of behavior patterns dysfunctional to successful reentry into the community.

We originally believed that institutionalized patients were created only through long-term confinement in institutions. Deinstitutionalization was based on the premise that if hospital care could be prevented and the length of hospitalization decreased, the effects of institutionalization

could be eliminated. It is time to replace those premises and redefine the meaning of the term. Institutionalization can occur in any time-frame and setting in which care is delivered. Deinstitutionalization is a process that can be applied to residential facilities.

The most significant problem in the contemporary American health care system is dealing effectively with chronic mental illness. Sustained and not merely transitional life-support settings are needed for many chronic patients. Alternative living situations must balance a patient's freedom with the ability to protect the patient and the community. Research on the social context of psychiatric care has yielded findings that properties and processes in a treatment environment do affect individual patient outcomes. Key processes in such settings include training in self-care, community living skills, improved employability, incentives for taking more responsibility, development of social skills, and provision of leisure activities.

A successful program for deinstitutionalization would be enhanced by the contributions of specialists in the treatment of chronic patients. Nurses have as a primary responsibility the job of creating an environment for patient care. Because of their 24-hour, 7-day a week presence, nurses have always actively participated with hospitalized patients in processes of institutionalization. Nursing care has emphasized rigid structures and routines and staff control of patients' behavior. Nurses represent a likely source of specialists in residential alternatives where chronic patients can be taught to develop skills of self-care and self-determination.

In their comprehensive review of research on the treatment of the chronic patient, Test and Stein (1978) describe Soteria House as "a residential setting with a permissive unstructured milieu staffed by paraprofessionals who attempt to guide resident patients through their psychoses." Their description was confirmed in my own observations, and I developed the explanatory scheme of infra control to explain how some degree of social order was possible in such a permissive, unstructured milieu. The effect of this improvised, emergent, tacitly self-regulatory mode of operating was a marked increase in self-determination and self-control of staff members and resident patients alike. Some might argue that Soteria House is merely a small, isolated innovative exception that self-selected the least entrenched and most hopeful psychiatric clients and was composed of ideological zealots and a sizable Hawthorne effect (wherein any new approach temporarily seems to get better results). In short, Soteria House is merely part of the

nonsystem of pilot projects that lack a broader perspective or the necessary conditions for expanding into a system.

Although Soteria House has survived economically for 10 years with the support of research grant funds, most contemporary mental health care systems emphasize an eclectic, pragmatic approach that yields a vast array of institutional approaches for handling a large and diversified caseload with efficiency. Psychiatric professionals have come to understand their work in terms of intake, screening, referrals, discharge, rates of turnover, budgets, facilities, and staffing. Soteria House by contrast is an experiment on an extremely small scale. It continues to be highly selective of both clients and staff members. In this sense, although infra control may prove adequate in preserving social order under Soteria's unique conditions, the inability to handle large numbers of diversified patients may limit its status within the broader movement. In order to constitute any real competitive force, Soteria and its infra processes would most likely have to be generalized and perhaps transformed. Nevertheless, the infra control system at Soteria, even when viewed as experimental, should be examined for its applicability in humanizing other psychiatric care delivery systems in order to select out principles of care, management, and organization that might effectively be integrated into established models, particularly those directed to the growing population of chronic patients.

An intriguing question with regard to the generalizability of principles and processes from Soteria is whether codification and formalization will result. The histories of other innovative and alternative organizations suggest that increased size and complexity often bring increased codification. Agreement about a single articulated theory for Soteria, explicit reliance on a predetermined repertoire of techniques, staff disillusionment with the idealized image of Soteria's ethic over time, and more open disclosures to outsiders could all result in the formulation of a structure. The spontaneous nature of infra processes would be forfeited, and the Soteria House approach transformed. For close to a decade, however, the insulation of the day-to-day clinical operation of Soteria from its systematic research aspect has fostered independence of staff members' values. The relatively frequent turnover of staff ensures an influx of fresh idealism, eliminates disillusioned and burned-out staff, enhances the ability to generate group cohesiveness, and helps the interpersonal approaches in working with patients from becoming standardized.

DEINSTITUTIONALIZED CARE FOR "TRUE CHRONICS"

As described by Goldman et al. (1981), true chronics are patients who suffer severe and persistent mental or emotional disorders that chronically interfere and substantially limit such primary aspects of daily life as personal self-care, interpersonal relationships, work, or schooling. Prolonged functional disability caused or aggravated by severe mental disorders is the chief distinguishing characteristic of this population of chronic patients. These patients have required institutional care for an extended duration and are at high risk for continued institutionalization.

A precise answer to the question of who the psychiatric chronics are is not as easy to come by as Goldman's reference to "true chronics" suggests. The general definition of chronic disease established by the Commission on Chronic Illness is:

> All impairments or deviations from normal which have one or more of the following characteristics: are permanent, leave residual disability, are caused by nonreversible pathological alterations, require special training of the patient for rehabilitation, may be expected to require a long period of supervision, observation or care. (Strauss, 1975, p. 1)

The American Psychiatric Association Conference on the chronic mental patient used the following general definition by Bachrach (1979): "Those individuals who are, have been, or might have been but for the deinstitutionalization movement on the rolls of the long-term mental institutions, especially state hospitals. Bachrach (1979) defines chronic patients by location. She identifies five subgroups of the population that at one time would have been the residents of state hospitals. In the community are patients released from the hospital and persons who have never been hospitalized. Soteria House focuses on the latter group. In hospitals are old long-stay patients, recent admissions who are short-stay, and new long-stay patients who probably will not be discharged. Minkoff (1978) refines Bachrach's general definition by distinguishing three separate but overlapping chronic populations: the chronically mentally ill, the chronic mentally disabled, and chronic mental patients. The chronic mentally ill refer to psychiatric diagnoses that render a person continuously ill for two years according to DSM-III. The chronic mentally disabled is a subgroup of the chronic mentally ill characterized by partial or total impairment of instrumental role

performance and is closest to Goldman's definition. Chronic mental patients are those persons who have continuously and or for a long duration been hospitalized or recipients of mental health services.

For any of the possible properties one may select to define a chronic population, certain identified services are required (Turner and TenHoor, 1978). These include material resources such as food, clothing, housing, medical and psychiatric care, transportation, and money. Also needed is vocational rehabilitation resulting in marketable skills and job opportunities. Finally, and perhaps less tangible, are needs for socialization skills, day-to-day coping, reduction of bizarre behavior, motivation to be involved with life, and nurturing, affirming, helpful interpersonal alliances. The Self Care Nursing Model describes a psychiatric nursing approach for meeting needs of chronic psychiatric patients through a residential alternative.

THE SELF-CARE NURSING MODEL

Nursing has evolved out of a tradition that emphasizes a 24-hour, 7-day a week commitment to patient care, a holistic view of mind and body, care rather than cure, and maximizing strengths. Nursing also includes knowledge about mental disorder, chronicity, institutionalizing processes, and effective approaches to patients in residential settings. The skills nurses use include problem solving, decision making, health teaching, and interpersonal communication. In brief, the Self Care Model originated by Orem (1971) guides nurses in using nursing techniques to assist patients to establish, maintain, or increase self-care and self-determination in day-to-day living. Using this approach, the psychiatric nurse can minimize the institutionalizing effects of psychiatric care and emotional disabilities and thus assist the patient in avoiding a lifestyle of institutionalized psychiatric chronicity and dependency.

Orem defines self-care as the practice of activities that individuals initiate and perform on their own behalf to maintain life, health, and well being. Self-care activities produce conditions that support the individual in development and maturation. Orem identifies eight self-care requisites that are universal to all human beings. These have been adapted and consolidated by Underwood for psychiatric patients and include air, food, and fluid; elimination; body temperature and personal hygiene; rest and activity; and solitude and social interaction.

A second set of requisites are termed by Orem "therapeutic self-care demands." Meeting self-care requisites in a therapeutic way occurs when nursing action supports life processes and promotion of normal functioning; helps to maintain normal growth, development, and maturation; prevents, controls, or cures disease and injuries; and prevents or compensates for disability.

Nursing activities according to Orem include caring for patients who are critically ill, unconscious, or unable to participate in decisions; guiding patients who require direction or supervision to make choices or take action; and acting as an advocate for patients in their attempts to obtain resources essential to life, health, and well being. Support may be offered by a look, a touch, or physical presence as well as by verbal exchange. Two other nursing functions stipulated by Orem are to provide an environment that promotes personal development and includes respect for human beings and the use of their actualized potential, and teaching patients to obtain knowledge or skills essential to a particular series of acts. All of these nursing activities may be used in a wholly compensatory, partially compensatory, or supportive and educative system of care depending upon the patient's self-care level. However, the goal of these services is to maintain, or increase the patient's ability for self-care and self-determination in day-to-day living.

The categories of universal self-care requisites, therapeutic self-care demands, helping methods, and types of nursing care systems were implemented and studied by Underwood (in progress) on six inpatient psychiatric wards. The self-care approach implements an environment that supports the acquisition of community living skills rather than hospital adjustment.

The self-care approach includes systematic and regular assessment of each patient for self-care and adaptive functioning, systematic and regular assessment of self-care activities in each of six categories, nursing care plans which address self-care problems identified through the assessment process, and integration of the nursing approach with other interdisciplinary team treatment plans.

The findings from Underwood's time series design and variance analysis are still in progress. However, preliminary findings of a pilot study at the Langley Porter Psychiatric Institute in San Francisco, California, were clear-cut. Implementation of the self-care approach produced a nursing care delivery system that encouraged program clarity, clear communication, group cohesiveness, and increased time for staff and patients to interact. This environment had demonstrable

positive impact on patients' ability to be helpful and supportive to each other, to act openly, to express feelings, to focus on and prepare for community living, and to be self-sufficient, responsible, and independent in their personal self-care (Underwood, 1978).

The generalizability of the Self Care Model, the concept of nurse-run Self Care Centers as part of deinstitutionalization, and the psychiatric nurses' unique contribution to mental health services as teachers of self-care are all empirical as well as intriguing possibilities.

NATIONAL STUDY OF PSYCHOSOCIAL RESIDENTIAL ALTERNATIVES

The study of Soteria illustrates one residential setting that functions as a sanctuary for the expression of feelings and a "journey through madness." The Self Care Nursing Model is a residential approach emphasizing a practical orientation and the teaching of community survival skills to chronic patients. These two examples represent two possibilities in an expanding network of community-based residential healing communities. The Center for Schizophrenia Studies at NIMH has compiled a preliminary directory of nontraditional settings which constitutes a descriptive catalogue of what could be an evolving social movement undergoing rapid reorganization, reform, and growth. In the 1978 directory there was a total of 60 settings located in 24 states. Most were in California (8) and Minnesota (5). The diversity represented by the characteristics of each setting can be seen in the descriptions of the client population:

1. Only acute schizophrenics without prior hospitalization are accepted.
2. Chronics are accepted and acutes if in remission.
3. Patients may have secondary substance abuse problems.
4. Patients may not have drug or alcohol problems.
5. Ages 13 to 18, from 6 to 13, any age.
6. No organic brain disease, retardation, or communicable disease.
7. Anybody can come.
8. Clients need not be able to pay.
9. Clients must be able to pay.
10. Clients must live in the CMHC catchment area.

11. Clients can come from anywhere.
12. Clients can be delusional but not really psychotic.
13. Clients may be psychotic but not violent, suicidal, or fire-starters.
14. Clients are forced to participate in house activities.
15. Clients don't have to participate in anything but must be interested in making changes.
16. Residents must be diagnosed and referred by a therapist with whom they can continue in therapy.
17. Residents must consider themselves to be "students" because they are learning to recover, and they receive an orthomolecular diagnosis.

Table 6-1 summarizes the overall typologies into which the directory settings could be categorized. It may be productive for future studies to address in a systematic fashion critical questions about the categories of patients suited to such approaches, the structures and processes of residential care that are effective in minimizing institutionalization, and the criteria for success utilized by such settings.

Of particular interest to clinicians and social scientists concerned with the short- and long-term impact of psychosocial milieus on the chronically and severely mentally disordered are the following questions.

1. Can major typologies of milieus be constructed, based on ideological and operational variables?
2. What are the structural features characterizing such settings?
3. What social-psychological processes represent the dominant mode of interaction?
4. What diagnostic categories of patients appear to benefit from nonmedical, nonhospital, residential treatment?
5. What roles do mental health professionals assume in these settings, particularly nurses? What are the characteristics of nonprofessional staff?
6. How do such settings compare to conventional, hospital-based modalities in terms of cost effectiveness and patient outcome?
7. What relationships exist between these alternative settings and the community mental health system?

Table 6-1
Case Models

Typology	Clients	Cost	Staff	Philosophy	Problems
SHAPE UP AND SHIP OUT *Example:* Pathroads (Planned Alternatives to Hospitalization), Salt Lake City, Utah	Male and female 18–35; CMH catchment referrals who can pay	$45. per day	Confrontive, firm, enthusiastic, task-oriented professionals and nonprofessionals	Fixed lifestyle; directive; behavior modification used; working is expected	Space
QUASI-RELIGIOUS *Example:* The Farm, Summertown, Tennessee	Any age; from any area; payment not required	$1. per day	No one considered "staff"	Religious farm community; reliance on self-healing	—
SUPPORTIVE FAMILY, SELF-CARE *Example:* William Ware Residence, Eugene, Oregon	Male and female over 18; not admitted if violent or if substance abuse problem exists	$130. per month ("donation")	Professionals who are "together"	Teach living and deemphasize mental illness label	Restrictive state regulations
HALF-WAY HOUSE *Example:* Acute Day RX Program, Providence, Rhode Island	Male and female over 18, from catchment area; only acute schizophrenics; secondary substance abuse acceptable	No payment necessary	Creative and flexible professionals and non-professionals	Socialization training for self-care outside hospital	Third-party payment licensing
REST HOME — SANCTUARY *Example:* Burch House, Littleton, New Hampshire	Male and female, adolescent or older, from any area; only acute schizophrenics without substance problems	$15. per day	Two full-time and trainees	"Listen to wisdom of the heart" on 14 acres of land; yoga, meditation, nutrition; no medications	Funding
ECLECTIC HEALING STRATEGIES *Example:* Earth House, Belle Mead, New Jersey	Male and female 18–30s; from any area; willing to learn to recover and participate; able to pay	$50. per day	Professionals and non-professionals with stability, strength, dedication, and support of ortho-molecular theory	Orthomolecular; includes dance, art, massage, and nutrition	Funding; third-party payments; zoning for house

CONCLUSION

The theory of infra control elaborated in this study provides a beginning conceptual guide to the everchanging daily conditions of life at Soteria. Concepts such as presencing, fairing, and limiting intrusion make the theory flexible enough to explain a variety of changing situations and also to be readily reformulated and extended in the face of new conditions. This book began by asking how social order is possible under conditions of espoused freedom. In the course of its development, infra control has been identified as a highly patterned process which depends on an insulated, cohesive community ethic.

Health care professionals have come to question the necessity and inevitability of demeaning practices which convey to patients that they are incapable of assuming responsibility for even their most intimate personal needs. Irresponsibility and diminished capacity have become accompanying properties of the label of mental illness. The theory of infra control at Soteria explains how one model of social control, relying heavily on expectations for self-control and self-determination can effectively solve control problems of acute, unmedicated psychotics and nonprofessional staff members in an unstructured deinstitutionalizing milieu.

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Index