

*An agrarian metaphor for the care of the schizophrenic patient provides a useful strategy for presenting our work to the public and to ourselves.*

## *The Invisible Village*

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This chapter is a meditation on the professional task of providing treatment and services for chronically mentally ill patients throughout their lives, or at least until they are ready to leave the shelter of the organizations we construct for them. The question it addresses is, Under what environmental conditions does the schizophrenic nervous system, though impaired, still continue its lifelong functions of enabling the patient to learn, adapt, and grow through experience?

To answer that question, we clinicians must think about schizophrenia on a larger scale, in the same way that patients and their families have always had to think about it: as a life—a life lived in an extended social space or a culture—and over the course of a lifetime. We also need a positive metaphor for our work with schizophrenia because almost all our ways of thinking about it have so far been negative: they have come from experiences of what we should not do, of errors in our treatment which lead to relapse, of stressful experiences from which patients should be protected. Viewed this way, schizophrenia is a very discouraging illness to work with, and I have always felt that those of us who devote our work lives to schizophrenia need a way of thinking about it that will be at once true, intelligible, and encouraging.

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## The Idea of the Village

Let me invite you think about schizophrenia in an unusual context: the context of agricultural village life, which anthropologists have been describing for us for the last forty or fifty years. I first connected schizophrenia with this image of the Third World agrarian village when I read a paper by Waxler (1979), "Is Outcome for Schizophrenia Better in Nonindustrial Societies?" This was a detailed prospective study of first-break schizophrenic patients in Sri Lanka, followed up five years later with examination of course of illness, frequency of relapse, and level of social performance. Waxler found that the course of schizophrenia is indeed better in nonindustrial, village agricultural societies, where the large extended family is the economic unit, than it is in industrial societies, where the competitive individual is the economic unit.

These results were in agreement with the World Health Organization's (1979) study of nine different cultures and with Murphy and Raman's (1971) comparison of patients from London and Mauritius, who were followed up after twelve years. This same idea was also developed by Cooper and Sartorius (1977), who took a historical perspective and suggested that the industrialization of Western society in the nineteenth century created the conditions in which schizophrenia came to medical attention as a serious illness. The research in this area has been reviewed by Day (1980), who suggested several alternative explanations for the observations, and by Häfner (1987), who concluded that the observations generally support the World Health Organization (WHO) hypothesis that the cultural environment affects the course of the illness.

We are talking here not about the lifetime incidence (or risk of occurrence) of schizophrenia, which seems everywhere to be about the same, but rather about its course as defined by the frequency of relapses or hospitalizations and by the level of social functioning between episodes. It would be especially striking if the life lived by schizophrenic patients is better in those areas of the world where the medical treatment of the acute episodes of illness is less sophisticated than in the industrialized West. This conclusion would be consistent with the idea that medical treatment is useful primarily for the acute episode and has little to offer toward long-term improvement. Certainly the long-term treatment of schizophrenia is more the establishment of a way of life for the patient than it is a treatment in the professional sense. In the rest of this chapter, I shall deal with the contradictions between the best conditions for that way of life, as it is lived between acute episodes, and the conditions actually provided by the culture of industrial civilization.

In caring for schizophrenic patients in our society, we must try to establish for them (and for ourselves as their long-term caretakers) a kind

of *invisible village* not unlike the agrarian villages of Third World countries or of our own past. The patients' village must be invisible in that it must survive quietly and unobtrusively within the surrounding city, the competitive industrial complex which is the main engine of our civilization.

We have already successfully established certain parts of that invisible village. In what follows I will present certain aspects of the agricultural village life of developing nations which I believe are similar to some features of successful social programs for the maintenance of schizophrenic patients in our country.

### **Integration of Healing with Social Support**

The agrarian village I have in mind is typically a very self-contained and self-sufficient place, with few distinctions between family life, economic life, government, religion, health care, and so on. The village is all of a piece. When someone becomes mentally ill (or physically ill, for that matter), that person is not handed over to a specialized organization such as a mental hospital to be treated and then brought back when he or she is well. Healing is done by the local healer, who frequently is part of the religious and other ceremonial life of the community. That healer often mobilizes the power of the village, which is represented by the leaders, the ancestors, and the extended family, all of whom are together in a healing ceremony.

Healing is relatively public in the agrarian village, especially in comparison to our own psychiatric treatment, which emphasizes confidentiality and so implies shame and stigma. The village healing ceremony calls on the accessible belief system of the society in general rather than encouraging a highly specialized science that is the exclusive property of a profession.

Waxler (1979) believes that such a small society is able to integrate treatment in this way because it does not label, ostracize, and stigmatize its mentally ill members as ours does. This may not be so. In fact, there is evidence (Murphy, 1976) that members of such societies do label their psychotic patients as crazy and different but are not able to segregate them because they have no institutions to which to send them. Patients are kept within the family and the economy, because life outside the family and the economy is simply unimaginable. If some form of hospitalization should take place, in the compound near the healer's house or even in a Western style hospital, the family accompanies and cares for the patient. Family members do this not necessarily because they like the patient or the extra duty but because it is natural and necessary in their culture to provide that kind of care.

In some of our programs for the chronically psychotic, we have been

able to establish continuity of care; administrative control over the whole spectrum of treatment modalities; an integration of the philosophies of treatment across medical, social, and rehabilitative programs; and the active involvement of the family and neighborhood. To the extent that we have been successful, we have begun to approximate for our patients the advantages of living in an agrarian village.

### **Socialization into Specific or Speculative Roles**

Using the language of sociology, we could say that family and work roles—as well as the patient (or impaired) role—are easily identified by young people growing up in an agrarian village. Children have plenty of opportunities to see what it would be like to be older, with specific abilities and responsibilities, or to become disabled. As a result, training for future life roles is relatively easy. Since the individual is expected to find life, work, marriage, and other aspects of social position within that small society and since ritual obligations in fact may prescribe both work and marriage partner, the social organization of the village endorses a life course, from childhood to old age, which is easy for people to visualize. Everywhere in sight are parents, aunts, uncles, and cousins living that life. In both ceremonial and practical ways, the elders initiate the young into their future roles. They receive, that is, what Parsons (1964) called a *socialization* into very specific and expectable, and generally mutually congruent, roles.

A more familiar way to put this is to say that agrarian village people do not have careers. In contrast, our own society is built on careers, and starting a career requires socialization into a variety of speculative roles. Our young people must make a series of blind jumps during adolescence and young adulthood into tentative vocational pursuits and mate seeking. Many of these jumps involve going outside the small circle of family and other supports to compete with other careerists. The conduct of a brilliant career—even a modest career—in our culture requires making all the right jumps and connections to promote one's self into the right groups. Such role-altering and role-seeking behavior has often been romanticized and is often the subject of our great novels.

However, the initiation and socialization of youth into careers in our society present enormous contradictions, for we have invented some unrealistic rehearsals for adult life. Technical change is occurring so rapidly that neither our elders nor anyone else knows how to introduce young people to their future. Although we have institutions such as schools, colleges, television, and long-term psychotherapy in which adult responsibilities may be imagined, the representations they afford are imperfect.

Moreover, economic uncertainty and delays imposed by competitive

recruitment make it impossible simply to show a young person how to do his or her job. Uncertainty or ambivalence is the dominant mood of many of our initiation ceremonies. Initiation is increasingly left to the young people themselves, who form their own groups and invent such initiation ceremonies as recreational drug use or cult membership. This conformity in rebellion reveals an underlying need for a socialization process that the society does not provide. For the role-seeking young person, adolescence is a terrible time of life.

### **The Special Problem for Schizophrenics**

For someone who has a vulnerability to schizophrenia, a vocational or marital career in our society presents a virtually impossible challenge. Characteristically, psychotic breakdown occurs precisely at one of those early life jumps—into school, job, marriage, or even the adolescent rehearsal for marriage. Schefflen (1981) suggests that this may be related to the fact that the schizophrenic nervous system is not very well suited to the subtle adjustments of interpersonal exchange that most people bring to bear when meeting strangers. The immediate evocation of trust through the skillful management of reciprocal nonverbal behavioral cues is apparently something that pre-schizophrenic people are not wired for, and they seem to become worse at it the more they try it and meet with failure.

This defect can be treated. Carefully designed behavioral training programs that teach schizophrenics how to conduct a job interview or how to make a date have had some striking success (Lieberman, Mueser, and Wallace, 1986). However, such interventions require very skilled and labor-intensive programs. In the absence of such programs, people with this illness must, for the most part, settle for the company of fellow patients and caretakers. They have a hard time breaking into normal society—“making it normal” (Estroff, 1981)—and they have difficulties with social interactions. They live, in effect, in a self-constructed or professionally constructed village society with special, and often inadequate, supports. It is the job of the professional caregiver to fashion that village to conform to the realities of schizophrenics’ lives.

What are the antecedents of village society for schizophrenic patients? To answer that question, it is necessary to recall the era of the state hospital, which was the nineteenth century’s solution to the problem of chronic schizophrenia. As our nation developed an industrial environment, we provided a reservation for the insane. The state hospital was certainly a village, and a very visible one, with initiation ceremonies, role models, an authoritarian ruling class, in many cases even an agrarian economy. Patients who entered it did not leave (if they ever left) until they had learned the role of submissive and inoffensive patient and could fit

into one of the few niches which the larger society kept open for them: the room in the family attic or the welfare hotel, with (more recently) the monthly trip to the clinic for medication. Behind the facade of medical treatment, the state hospitals were often societies that taught the inmate role to new residents (Goffman, 1961).

The evils of such a situation were eloquently described by Goffman in his famous indictment of total institutions, *Asylums* (1961). Psychiatrists, notably Gruenberg (1974), subsequently produced research that identified the result of this socialization as the *social breakdown syndrome*, the de-skilling that makes inmates unfit for life in the larger society. Psychiatry's response to that critique was to send patients out of the hospital to what we assumed would be a better life in the community. Deinstitutionalization effectively destroyed the village life of the state hospital.

There is considerable evidence today that deinstitutionalization failed because the support provided in the community was inadequate (Bachrach, 1983). But what happens when deinstitutionalization does work? What happens if we successfully replace the old state hospital with a village structure in the community? What kind of society ensues, and how are its members initiated?

### **Training in Community Living: Making It Crazy**

Almost the only anthropologist to observe such a society is Estroff (1981), who went to live in a very successful invisible village, the Training in Community Living (TCL) program of Stein and Test (1978) in Madison, Wisconsin. There, dedicated mental health workers helped participants find and keep homes, activities, and friends; ran their day program; and went to find them if they were lost or in jail.

Estroff entitled her book about that experience *Making It Crazy* because that was how the patients, mostly young adults, referred to the life they led. Making it crazy was their resigned alternative to the social ideal of making it normal—that is, getting a job, passing for someone with a career. In spite of the social integration provided by the efforts of the staff, there seemed to be few ways to overcome the time-killing boredom and the lack of self-esteem.

Even under the best of circumstances, such as those prevailing in the TCL program, making it crazy as a young person in our society is not an inspiring role in life. It is however a possible role, which may be seen as an alternative to making it normal—if the social context supports it. In the case of the TCL program, the necessary context was provided by the staff and other patients. The members of the TCL village typically spent large amounts of time talking to each other (and to Estroff). Like young people everywhere, these patients were mainly occupied with defining themselves: their initiation into that group consisted of talking with the

older residents about who they were, what they were doing, how the drugs they took affected them, whether they would ever get off the drugs, what they might become, and, in the meantime, what they meant to one another and how they might help each other along. The most positive role they discovered in this process was the role of experienced and sympathetic helper of others: the village, at its best, became a mutual aid society, a self-help group.

### **When Deinstitutionalization Does Not Work: Failing to Make It Normal**

Deservedly praised as an example of successful deinstitutionalization, the TCL program thus illustrates the special developmental needs of schizophrenic young adults. What happens, however, when deinstitutionalization does not work? What happens if we provide young people with no place to talk, no help with their living circumstances, nothing to do?

In most parts of the United States we have denied these social essentials to most of a generation of chronic mental patients. These are the people whom Pepper, Ryglewicz, and Kirschner (1982) call young adult chronic patients. Bachrach (1982) points out that they constitute the first generation of truly deinstitutionalized patients and that we have given them a double message (Bachrach, 1986-7). On the one hand, we have told them that we want them out of state hospitals where they might become stigmatized and turned into chronic patients. But on the other hand, we have suggested few alternatives for them. The design of our rehabilitation programs implicitly suggests that these patients should try to enter the open job market—to make it normal. But when they do that, many of them relapse and return to square one as hospitalized patients again. It should not surprise us if, after a few such experiences, our patients become truly marginal: they are able to adopt neither a normal career nor an identity as a sick individual.

We also have some marginal individuals in the greater society, and in fact we have always had them. Huckleberry Finn is perhaps our most celebrated marginal preadolescent. Some of our youth become vagabonds, what the Germans of another century called *Wandervogel*: wandering youth, troubadours, renegades, street people, gang members. Young people do not necessarily have to be crazy to adopt this outlaw role; it has been available for centuries whenever society has told some of its youth that there is nothing for them to do—for example, after a war when the troops come home or when unemployment is high.

But if a young person happens to be psychotic or vulnerable to psychosis and assumes this noncareer identity for lack of an alternative, there are some real problems. Having adopted a lifestyle and companions

that are anything but compliant, young mentally ill individuals are constantly at war with the mental health services, that offer them the only help they are going to get. Indeed, they may find themselves spending a great deal of time in the criminal justice system, which further hardens the outlaw part of their identity (Lamb and Grant, 1983).

Moreover, the youth subculture promotes recreational drug and alcohol use as a central ritual, and those substances often precipitate relapse into psychosis and rehospitalization. Like residents in the TCL community in Madison, young chronic patients who participate in the drug subculture spend a great deal of time talking about what stuff is good for your head; but the medications they refer to are coke, speed, and PCP. In sum, our society does provide a role for deinstitutionalized young adult chronic patients, and that role is both readily available and potentially destructive for their mental health.

The Vietnam War should have taught us that street drugs provide a very attractive solution for people who are trapped in a no-win situation, which is precisely the way our young patients feel. We need to develop an alternative that can compete with the culture surrounding the use of street drugs—an alternative social and chemical maintenance system in between, and in place of, psychiatric hospitalizations.

### **The Noncareer in the Invisible Village**

Young chronic mental patients need to be initiated into cultural roles that give them a sense of belonging. But what is the specific content of those roles? Lacking the state hospital as a socializing agent, what must we do to convert the patient status into a meaningful identity for young chronically mentally ill individuals?

Our mental health programs must offer useful and productive life opportunities that provide many of the features of agrarian village life. These programs must contain a positive definition of the patient's place within the society, especially for the individual who does not have the option of outside employment. Thus, the patient role might revolve around the status of helper: the individual might aspire to become an active helper of others in the same group. This would enable patients to view the future not as a climb up a mountain with a series of blind jumps from ridge to ridge but rather as a fairly level march across a plain with plenty of picnics and overnight stops and celebrations of being there with the same traveling companions. Several authors who have described successful living and working programs have commented on this aspect of their cultures (Mosher and Menn, 1978; Budson, 1983).

Clearly, day hospitals, drop-in centers, sheltered workshops, and other forms of partial hospitalization may, and in some cases already do,



serve as the core of these new invisible villages. Such villages must provide patients with adequate space and time to hang out and talk as they pursue vocational and nonvocational goals. Indeed, our most successful day centers appear to be those which involve patients most fully in activities of daily living—cooking, making household objects, and repairing and establishing the physical world (Linn and others, 1979).

Most work in industrialized societies is a very lonely business in which the self-starter is rewarded. The ability to organize one's own work sequences is extremely cost-efficient in an industrial system built on competition, and it is typically the key to success. By contrast, in pre-industrial agrarian villages, work consists largely of agricultural activities, food gathering, and communal housekeeping and child-rearing. Generally speaking, work in these villages is performed in groups.

If a member of the group has a vulnerability to psychosis, the communal nature of the work provides protection, because the cues to the work sequence are in the social and physical aspects of the work itself rather than in the memory and concentration of the worker. In such communal activity, delay or idiosyncratic timing is less of a problem than it would be in the industrial or office environment, because the group can compensate for individual deviations in various ways.

Many successful programs for schizophrenics illustrate this principle. Farms are some of the best environments for the maintenance of schizophrenics in remission, and Spring Lake Ranch in Vermont is an outstanding example (Huessy and Wells, 1985). Another example is the Fairweather Lodge (Fairweather, 1980), where a group of patients capitalize on their shared experience in the hospital by forming a group before discharge. Under staff supervision, the individuals gradually learn simple cooperative tasks, so that when they move to the community, they do so as a group able to live together in a house. They are then collectively responsible for the maintenance of the house as well as for outside work. Any member of the Lodge may be disorganized at some time, but by relying on the organization of the group, each has confidence that group equilibrium will be restored.

Shared work programs have been established in cities as well. In sheltered employment programs such as the one at Fountain House in New York (Conte, 1983), the patient and the mental health worker both learn the job, so that the worker may coach the patient and relieve him or her if necessary. The job is shared by several patients, making it possible for them to take time out. The program guarantees the employer only that the work will be done, not who will do it. Recent research from Fountain House indicates that it generally takes about five years of this kind of shared responsibility before a worker is able to handle the loneliness of an unsupported competitive job (Malamud, 1985).

## **Ideology: Family and Group Support**

A final (and most important) aspect of agrarian village life is something I will call *ideological integrity*. That is, village life is lived in an atmosphere in which there is agreement among the ways in which work, nature, human relations, and the supernatural are understood. Even an uncanny event such as the advent or persistence of mental illness has an explanation. Although professionals will almost certainly not agree with such local explanations as witchcraft, these constructs provide answers to the besetting problems of both the sufferer and his or her family and friends. In the midst of an experience that threatens and violates all trust, order, and predictability, schizophrenic individuals and those close to them need an explanation that focuses on the familiar. (This need is probably the basis for the delusions and paranoia that apparently accompany psychosis in all societies: the uncanny experiences are real and require consistent explanation.)

In our own society, and especially in our mental health system, we have encouraged patients and family members to find their own source of ideological integrity by associating with a single therapist. We have supported the notion of a wonder-doctor, one who *really understands* the patient. In our individual model of treatment, the severity of the illness necessitates the search for an especially gifted doctor.

Since society provides such an opportunity and since schizophrenia presents such a challenge to physicians, it is not surprising that many of us have yielded to the temptation to impersonate that charismatic figure. Our fascination with verbal therapy for schizophrenia follows from a similar dynamic. The verbal productions of the patient are so mystifying, or, when understood, the experiences the patient describes are so uncanny, that there is an irresistible temptation to make psychodynamic sense out of it all.

But approaching schizophrenia from its verbal side is trying to make a strength out of this disorder's greatest weakness. There is simply no evidence that insight psychotherapy works for schizophrenic patients. The McLean study (*Schizophrenia Bulletin*, 1984)—the ultimate and most comprehensive effort to make a case for psychodynamic treatment—makes it clear that if there is any difference between interpretive and supportive psychotherapy for schizophrenia, the outcomes favor supportive treatment as the path to measurably better social role function. And I would submit that if a therapist is to support a patient in achieving improved social role function, the way to proceed is directly, not by talking about it. Thus, although I do not mean to minimize the importance for a schizophrenic person of establishing a consistent, trusting relationship with a professional, such a relationship is not improved when the extra burden of psychotherapy is added to it.

If families cannot rely for ideology on the wonder-doctor (or on only slightly more problematic wonder-theories like megavitamins or regression to the birth trauma), what direction should our efforts take? I would suggest that we can, and must, turn to the sort of ideology that binds the village together into a working group. One such method is the *psychoeducational approach* to serious long-term illness.

In effect, the psychoeducational approach creates a new subculture by introducing a number of patients and their families as a single group into the larger society of medical healers and researchers. This is done, for example, in the all-day survival skills workshops held by Anderson and Hogarty's team in Pittsburgh (Anderson, Reiss, and Hogarty, 1986) and in the Falloon and Liberman (1983) approach to multiple family groups. Families and patients feel they are members of the treatment team, part of an enterprise with scope and history, with a contract for long-term—indeed, lifetime—membership. The powerful social process of educational meetings makes it possible to discuss the uncertainty of knowledge in many areas, the variability of outcome, and the direction of needed research, without losing the confidence of consumers. That confidence is based on the integrity of the group and its purposes rather than on the belief that one therapist knows everything there is to know about how to cure a particular patient.

With the psychoeducational approach, morale comes from the group, not the leader. Such a group enables both patients and their relatives to be initiated into a new role: the role of experts in the treatment of schizophrenia.

Psychoeducational programs thus form an essential element in my concept of the invisible village, joining families and practitioners together in a community of effort and discussion. Because schizophrenia is such an alienating illness, it makes patients and their relatives feel as if they do not belong to the usual human community or cannot use the usual language and concepts to describe their experience. For them, the availability of a reference group that specifically focuses on that experience and provides a language for talking about it is a powerful healing force.

There is, of course, a downside to the invisible village in which schizophrenic people and their families and caretakers may live: there are hazards inherent in maintaining such a small society, and a patient clearly takes risks in becoming a village dweller. One serious risk is an error in the diagnosis that is part of the initiation into an adult life there. Once the error has been made, it may be difficult to reverse, because of disabilities that may be learned when individuals become members of the invisible village. For this reason we must be cautious in introducing patients and families into the village and certainly should not do so immediately after the first psychotic episode, when diagnosis is most

uncertain. In addition, we must continually sharpen our diagnostic and prognostic skills by examining the whole range of our patients' experiences over very long periods of time.

Even if the diagnosis is correct (whatever that means in the present flux of debate on the subject), we still have much more to learn about the ways in which opportunities open up in the course of a schizophrenic person's life and make it possible for the individual to move out into the larger world. As the mediators and arbiters of those opportunities, we in the mental health professions have a heavy responsibility to study the natural history of schizophrenia under many different conditions of treatment—even in environments and institutions that differ vastly from our own, such as anti-psychiatric self-help groups or megavitamin orthomolecular day hospitals—to see how patients diagnosed as schizophrenic make the most of their opportunities under varying ways of life and ideological supervision. If we set up many different types of villages and leave the gates to the world wide open, the next research challenge will be to see who goes through those gates, and when, and how, and what we may have done to help that difficult transition.

Returning again to the question posed at the beginning of the chapter, we can see that the schizophrenic nervous system, though handicapped by certain vulnerabilities, can compensate by relying over long periods of time on features of the environment, features found both in the agrarian village and in successful social treatment programs. Schizophrenic patients need to be able to depend on those environmental supports for much of their lives, though there is now evidence that in middle and later life many can do without them (Harding, Zubin, and Strauss, 1987). But young patients in particular cannot do the lonely, forward-looking planning and problem solving that is needed to start a career in our society. They need the group as a social extension of those organizing abilities, to give them the feedback and stability that their individual minds do not reliably provide.

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