Schizophrenia is a Family Affair: Problems of Families in Coping with Schizophrenia

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It has long been noted that schizophrenia is a family affair. Through twin and adoption studies, geneticists have shown that there is an undoubted genetic component in the schizophrenias (Kallmann, 1953; Rosenthal et al., 1968; Gottesman and Shields, 1972; Heston, 1973). On the other hand, it is widely taught in the Western culture that parents cause schizophrenia in their children in some psychodynamic way (by Bateson et al., 1956; Bowen, 1960; Henry, 1963, 1971; Laing, 1971; Laing and Esterson, 1971; Lidz et al., 1965; and Wynne et al., 1958, among others). This belief, stemming from the emphasis of Freud and his colleagues on the importance of early life experiences in the development of psychiatric illnesses, has had great influence on Western belief about the etiology and treatment of schizophrenia. There is no scientific evidence for such speculated family pathology according to a recent comprehensive review of the literature on abnormalities of parents of schizophrenics by Hirsch and Leff (1975).

This paper contends that schizophrenia is a family affair primarily because the schizophrenia of one family member usually affects the functioning of the whole family. The family deserves support, not scapegoating.

The American Schizophrenia Association (ASA), now the major division of the Huxley Institute for Biosocial Research (HIBR), has served an important support system function for families of schizophrenics since 1966 when it was organized in response to the hope offered by the original megavitamin therapy for schizophrenia. The psychiatrists who pioneered the movement and the ever-broadening biochemical approach of Orthomolecular psychiatry (Hoffer and Osmond, 1966) championed the family from the beginning. In the national self-help organization and its local chapters, parents could be sure that they would not be blamed as the cause of schizophrenia in their children and that they could express freely their emotional and social burdens resulting from the schizophrenia in their families.

That they could do this is of great social significance.

Families of schizophrenics contact the Schizophrenia Association of Greater

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Washington (SAGW), the local affiliate with which I have worked for over five years, not only to learn more about schizophrenia and for referrals to Orthomolecular psychiatrists and physicians, but also hoping to find solutions to their many problems stemming from schizophrenia in the family. They have had nowhere else to turn, finally, in a society which has blamed them for the problem of schizophrenia without considering the problems they might have because of the schizophrenia. Here they can be sure of at least the sympathy and understanding of the volunteers of the self-help group.

Some problems that families bring to the Association are heard so often that they become assumed as part of a subculture surrounding schizophrenia. These problems were investigated through a Family/Patient Questionnaire distributed locally and then through the national organization to learn the frequency of the many specific problems and what family members have done to cope with schizophrenia in the family.

This report is based upon questionnaire responses from 228 family members of schizophrenics and 61 patients or former patients. The self-selected population is highly educated, predominantly upper and upper-middle class with some middle class, according to the socioeconomic scale of Hollingshead and Redlich (1958). It is essentially the same population that is portrayed by those involved with theories of family social pathology in the etiology and treatment of schizophrenia, as epitomized recently by Lidz (1973).

Family respondents were generally middle aged or older, their patients were usually in their twenties or thirties. Most respondents were female, usually the mothers of patients. More females than males were self-respondents, but more of the patients reported by family members were male. Some respondents reported for more than one patient in the family, including three sets of identical twins.

Over half of the patients had been ill for 10 years or more—up to 50 years. It had been 10 years or more since a third of them had received the diagnosis of schizophrenia. This diagnosis had been given first by psychiatrists (92 percent, five percent of them Orthomolecular).

Only 10 percent of the former patients reported by family members were considered to be completely recovered, as were 20 percent of the self-respondents. Family members considered the other patients to be recovered but with relapses (10 percent), substantially improved (17 percent), moderately improved (19 percent), variable (27 percent), and deteriorating (12 percent). Seven deaths of patients were attributed to schizophrenia, some of them suicides.

The largest number of ill patients in all categories but "deteriorating" lived in the parental home. Half of the sickest patients were in hospitals.

It has been observed in SAGW over the years that when patients are given referrals to Orthomolecular doctors and quickly recover under Orthomolecular therapy, the organization usually learns of these successes merely by chance. These people or their families use the Association as a onetime referral service and return to their normal lives as quickly as possible. (This, after all, is the goal of therapy.)

It may well be the support system aspect of the organization that explains why some families of chronically ill schizophrenics who have never had Orthomolecular treatment have continued close contact with the organization for years.

The aim of this study was to determine the problems families have in connection with schizophrenia, what treatment they have sought for their patients, and where they have turned for help in coping with the problems and stresses schizophrenia produces in the family.

The major problems for family members were finding effective treatment for (89 percent) and worry about their patients (84 percent).

Worried families: cause or result of schizophrenia?

The mental health axiom that states that "anxious parents cause anxious children" tends to cause a certain myopia in some mental health professionals. If anxiety is considered a probable cause rather than a possible result, very real reasons for parental concern stemming from schizophrenia in the family can be overlooked, dismissed, denied, or even turned back on the family members expressing them. Instead of receiving the meaningful counsel they need, family members are more likely to receive undermining criticism from such mental health workers.

What do families of schizophrenics have to worry about?

Concern begins with the symptoms and signs of schizophrenia, the subjective symptoms experienced by the patients, as well as their behavioral manifestations.

Schizophrenia is a syndrome of symptoms. Seldom, if ever, do patients have all possible symptoms, but most have many. Family respondents reported an average of 10 subjective symptoms of their patients (self-respondents, 14); families reported an average of 10 behavioral signs (self-respondents, eight).

The subjective symptoms which disturbed family members as well as patients comprise the changed world of reality of the schizophrenic: altered sense perceptions, altered emotions, altered thinking, and certain physical symptoms.

Alterations in seeing and hearing (including, but not limited to, visual and auditory hallucinations such as "voices") were experienced by the majority of patients. Over half also experienced an altered sense of time. Somewhat fewer reported the altered sense perceptions of feel, taste, smell, and an altered sense of gravity.

Emotions "too strong" were reported for about two-thirds of the patients, while about three-fourths had experienced "mixed-up" emotions, according to family respondents. Anxiety and fear or panic had been symptoms for about three-fourths of the patients, and depression was reported for even more. Inability to concentrate was reported as a change in thought process for over three-fourths, confusion and/or inability to remember for about two-thirds, and no control over thoughts for half. Over two-thirds of the patients had suffered the physical symptoms of fatigue and/or insomnia.

In general, patients themselves reported subjective symptoms in the same order of frequency as did family respondents, but in higher percentages—up to 90 percent for inability to concentrate. They also reported more anxiety (85 percent) than depression (82 percent). The only major difference was in "mixed-up" emotions: self-respondents reported considerably less (33 percent) than did families (74 percent).

The resulting behavioral signs of concern to the greatest number of family respondents (over three-fourths), as well as self-respondents, were withdrawal from others and unusual sleeping and eating patterns. These were followed in frequency by apparent lack of motivation, poor grooming and personal care. More than half of the family respondents also reported patient argumentativeness, failure to consider the future, poor handling of money, forgetting to do things, refusing prescribed medicine or vitamins.

Almost half of the families reported the patient saying that people were talking about him or her. More than a third of the patients reported by family members had been suicidal, as had 46 percent of the patients reporting for themselves.

Almost a third of the patients reported by their families had damaged property, a little less than a third had physically hurt others, Had run away, had been involved with street drugs or alcohol abuse. About a fourth had upset their neighborhoods and/or had been in trouble with the police. Self-mutilation was reported for almost a fourth of the patients.

Except where noted, self-respondents reported behavior signs in the same general order as did family members, but with less frequency.

Although the frequency of the problems disruptive of society in general was disturbingly high, the problems of symptomatic behavior reported by the majority of family as well as patient respondents were more of the kind that are of concern primarily within the immediate household. This may explain, somewhat, why most of these problems for families have not received the attention of professional investigators, or are considered as results of family interaction rather than as causes for familial concern.

Behavior and beliefs of patients described in extended answers and in person by family members and patients were sometimes bizarre, frequently chaotic, and almost always puzzling. Even without such descriptions, given the array of signs and symptoms above and the sometimes sudden changes in a family member, it is as easy to understand why other family members worry about them as it is difficult to understand why such causes for worry are not often clearly stated in the psychiatric or social science literature dealing with families of schizophrenics. The symptoms were, after all, the reasons why professional help was sought in the first place.

Taking into account the usually painfully altered personality and inexplicable behavior of a member of the family, it might well be expected that disruption of family life would be an outcome of schizophrenia. This, indeed, had been a problem for over three-fourths of the families (Table 1).

Of the social and emotional burdens of families of schizophrenics which at some time had been of concern to half or more, social life and employment for patients were currently problems for 48 percent of the families, with over a third concerned about appropriate patient living arrangements, or worried because patients were unable to care for themselves in order to live independently. Almost a third of the families had continuing financial burdens.

Forty percent of the family respondents had been tied down to care for patients; half of this number still were.

TABLE 1

Problems of Families of Schizophrenics Reported by Family Members

Problem	Past (only)	Both Past and Present	Present (only)	Total Reporting Problem (N=224)
	%	%	%	%
Finding effective treatment	43	39	7	89
Worry about the patient	26	48	10	84
Disruption of family life	40	30	8	77
Social life for patient	19	40	8	67
Employment for patient	17	38	10	64
Financial burdens	28	23	10	60
Patient unable care for self	24	28	8	60
Patient living arrangements	18	25	9	53
Feelings of guilt	33	10	2	45
Getting a diagnosis	37	5	1	43
Tied down to care for patient	19	14	7	40
Getting patient into hospital	27	5	2	33
Fear of patient	23	5	4	32
Getting patient out of hospital	10	10	2	22
Stigma of schizophrenia	13	1	1	15
Other	9	5	4	18

Getting the diagnosis of schizophrenia itself once had been a problem to almost half of the respondents. This was the only problem of concern to a large number that had been reduced considerably. Some of the few who still considered this a problem had been given no diagnosis, or just a nebulous diagnosis notwithstanding the presence of florid signs of schizophrenia. Others hoped for a concrete medical diagnosis.

The psychiatric profession appears to be almost equally divided on the question of whether or not to inform patients or their families of the diagnosis of schizophrenia, judging by this sample of families and patients. Only about half of the respondents said that they were told immediately by the psychiatrist giving the diagnosis. Sometimes it took years (up to 20) for them to learn of it. When not told by the doctor giving it, most families or patients first had learned of it from insurance or hospital records, or from other mental health professionals. One family learned of it from the doctor's first bill; a patient learned of it from his landlord. Surprisingly, in view of labeling theory, the stigma connected with schizophrenia had been the least of problems for family members. It had been more of a problem for self-respondents (30 percent).

Fear of the stigma or labeling was reported as among the more frequent (usually mixed) initial reactions to the diagnosis of schizophrenia. However, twice as many (92 percent) reported curiosity about schizophrenia and relief at being given a diagnosis as initial reactions. Some other responses had been shock, dismay, disbelief, already suspected, concern about prognosis and treatment. One respondent said that the word is not important, what is important is what can be done about it.

Feelings of guilt in family members in regard to schizophrenia was one burden which had been reduced noticeably. Only about half of the family respondents ever had believed that they or some other family member had caused it. However, some of those who had never believed this, as well as some who once did, said that they had been told that it was caused by them, another member of the family, or family interaction in general. Usually the mother or parents were held responsible by psychiatrists or other mental health workers. Other respondents believed that families are responsible because the belief is so widespread in the culture.

Worry about their patients, their symptoms, their behavior, disruption of family life, concern about patient social life and employment, concern that some patients might never be able to function on their own—these were some of the dominant problems for families of schizophrenics.

The overwhelming problem for both patient and family respondents had been finding effective treatment. This had been a problem for 89 percent of them. It remained a problem for almost half of the family respondents and a fifth of the self-respondents.

Therapies and community resources used for the benefit of patients

Culture determines, to a great extent, what a disease is thought to be, who or what is thought to cause it, who or what is thought to cure it.

When the condition had begun in the school years, school counselors and psychologists were very much in evidence. As might have been expected in this group, in this culture, at this time, psychiatry and psychiatrists dominated the scene. Individual psychotherapy had been the major treatment (used by 87 percent of the patients). Other psychosocial therapies included group and family therapy.

About three-fourths of the patients had used chemotherapy (the major tranquilizers alone). Only a little over half of the patients had had Orthomolecular therapy, for reasons heard often in the local Association: patients were hospitalized where the treatment was not available, the current psychiatrist did not believe in it, or the patient refused to try it. (By this time, many patients refused to see any doctor or psychiatrist.) Elettroshock treatment had been used for about a third of the patients.

Behavior modification and religion had been used as therapy by less than a fourth of them, with a scattering of other therapeutic measures, including insulin shock and meditation.

On the average, each patient had used four kinds of therapy. Of these, the biochemical treatments of chemotherapy and Orthomolecular therapy (particularly Orthomolecular) were considered to have been of benefit to by far the greatest number of patients (Figures 1 and 2).

Orthomolecular therapy was considered to have had the fewest adverse results of any therapy. Electroshock (not shown) was rated as benefiting more patients than talking therapies, but had had the highest rate of adverse effects.

Of the therapies considered to have been of **great** value, Orthomolecular therapy was

FIGURE 1

Therapy Used for the Benefit of Patients as Evaluated by Family Members

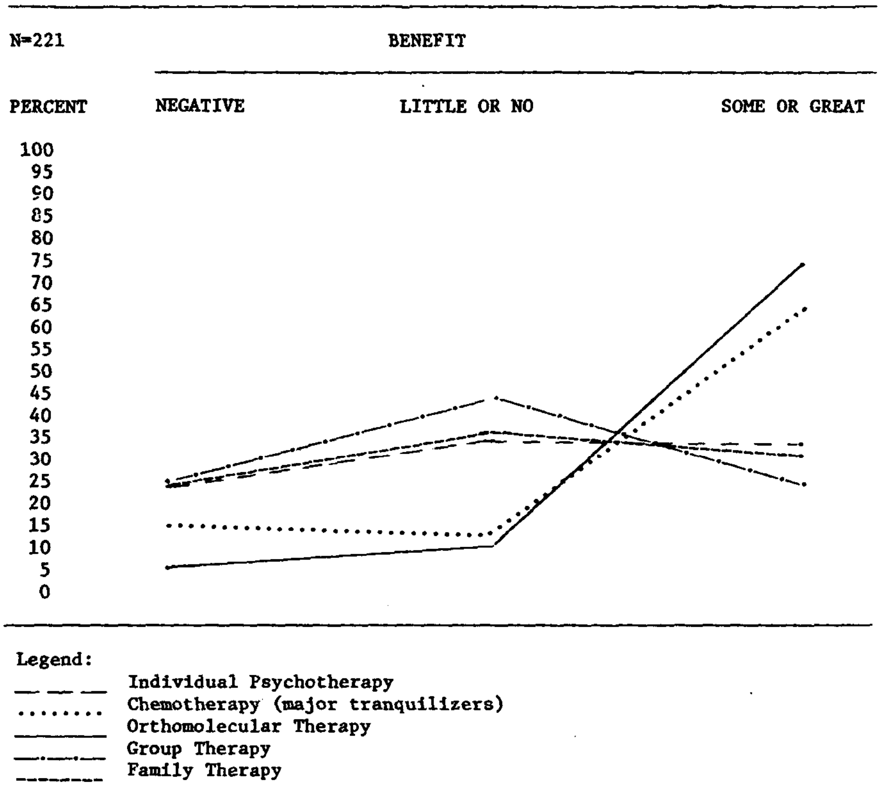
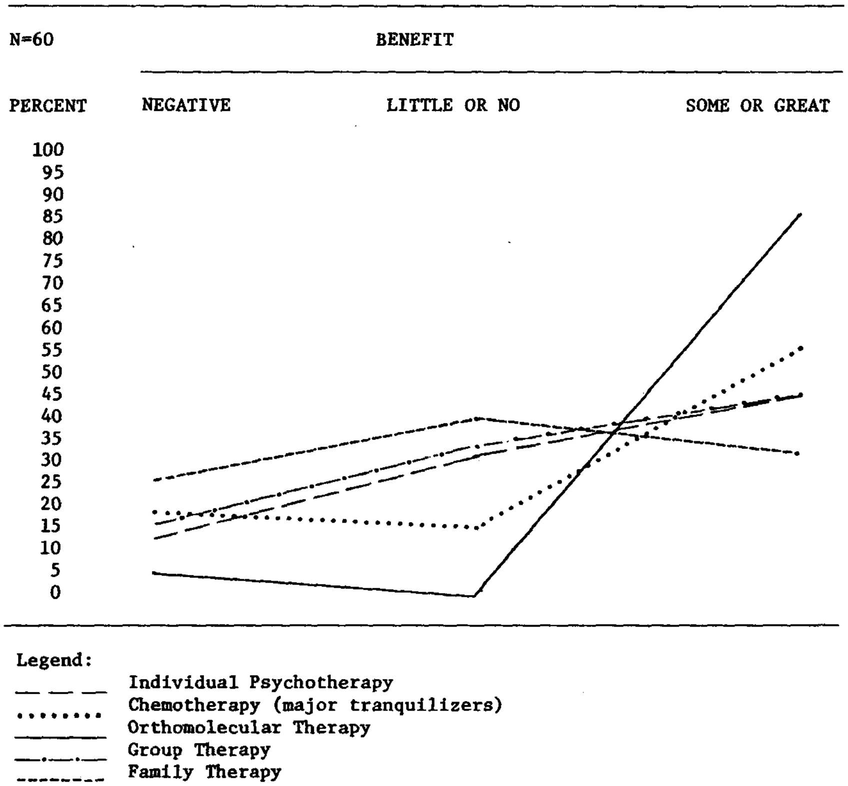


FIGURE 2

Therapy Used for the Benefit of Patients as Evaluated by Themselves



so evaluated by 42 percent of family respondents and tranquilizers by 24 percent, as compared to talking therapies at 7 percent for family therapy, 6 percent for individual psychotherapy, and 1 percent for group therapy. The psychosocial therapies were considered to have hurt more than twice as many patients as had received **great** value from them.

Self-responding patients and former patients found talking therapies to have been of a little more benefit than did family respondents, but found tranquilizers to have been of less benefit and with more adverse effects. Sixty percent of those who had used Orthomolecular therapy considered it to have been of great value, a higher percentage than considered the other therapies to have been of some and great value combined. (And more of them were well rather than still being patients.)

In general, the higher the recovery status, the more use had been made of Orthomolecular therapy. However, although there were success stories of Orthomolecular treatment to rival the most glowing of case histories by treating physicians ("... from complete restraint in a hospital to complete recovery . . ."), it must be remembered that not very many of the patients in this survey were considered to be completely recovered. For most respondents the search continues for completely effective treatment (that patients will adhere to) and for answers to at least some of their other problems. Problems such as the search for employment, social life, and suitable living arrangements for patients are often associated with a measure of recovery.

Patients had used an average of three of the community resources- designed to help the mentally and emotionally ill. Two of these were likely to have been hospitals. Three-fourths of the patients had been in state or private hospitals, or both. Less than a third had used mental health clinics, mental health facilities, halfway houses, vocational rehabilitation centers, or day care centers.

Both state and private hospitals were considered to have been of at least some benefit to about half of the patients. Other community resources were considered to have been of value to less than half of the patients using them except for halfway houses, which had been of value to 71 percent of the patients reported by family members. Self-respondents considered halfway houses of less value (27 percent) and other resources of greater benefit, particularly vocational rehabilitation centers and clinics which had benefited over three-fourths. As was true of therapies, each resource was considered to have been of great benefit to some patients and detrimental to a few.

It was frequently suggested that Orthomolecular treatment be integrated with other community resources, especially hospitals.

The search for effective treatment frequently had been long, difficult, and expensive. Most patients had seen a variety of clinical psychologists and psychiatrists. Some patients had seen up to seven different psychiatrists over the years and had been in and out of various hospitals or institutions, more private than state. Treatment costing $100,000 or more over the years was not unusual.

Resources used by family members to help them cope with schizophrenia

In seeking to cope with schizophrenia in the family, family members had turned to a variety of sources, professional and lay. They used an average of three resources.

As might have been expected in a population reached through this self-help group, more family members had turned to HIBR and its affiliates than to any other single source, with 69 percent attending lectures or reading literature made available through the organization, and 53 percent contacting Association volunteers.

Half of the family respondents had turned to other family members, 47 percent to friends, 42 percent had tried individual psychotherapy, 40 percent had turned to the clergy or other families of schizophrenics, and 35 percent to group therapy. Marriage counseling had been tried by 11 percent.

In general, the families of schizophrenics found lay supports to have been of greater value to them than professional.

Of those who had used resources of HIBR and its affiliates, 95 percent found lectures and books to have been of value to them, and 88 percent found the organization's volunteers helpful. Of those who turned to other families of schizophrenics, 88 percent found this valuable.

Other resources were evaluated as follows: friends were of value to over three-fourths, members of their own families and individual therapy were each of value to a little over two-thirds, the clergy and marriage counseling of value to something over half, and group therapy to less than half.

For most respondents, these resources did not solve problems; at best they helped with continuing problems.

Assistance needed by families

Respondents were asked to list the three (of nine) kinds of assistance or supports they felt would make the lives of their families more satisfactory. The responses were tabulated according to where patients were living at the time of the survey (Table 2). Other than those considered to have recovered (more of whom lived in their own homes, apartments, or rooms) and those considered to be deteriorating (more of whom were hospitalized), the largest group of patients in any stage of schizophrenia lived in the parental home.

Family respondents reported their primary need to be specific suggestions for coping with patient behavior. The second need, generally, was for greater knowledge and understanding of the symptoms underlying patient behavior.

Other needs of families varied more widely in importance, according to where patients lived. For instance, relief from financial stress was needed less by parent respondents whose patients lived with them than it was by the other groups of respondents. It is not difficult to understand the reasons for this. Most of the hospitalized patients were in expensive private hospitals; parents wholly or partially supported many patients who lived away from them; patients living in their own conjugal homes were usually husbands or wives, parents themselves, with others dependent upon their earning power or household management and care of children.

People to talk to who understood what they were experiencing were particularly needed by the "other" residential category, which included patients who wandered from place to place, or whose family members did not know where they were. Confidants who understood what they were going through were also very important to many parents whose patients lived with them. This group also needed temporary

TABLE 2

Supports most needed by Families of Schizophrenics

Ranked[a] by most commonly stated needs

	Patient Living Arrangements						N = 222
Family Would Benefit Most From:	Parental Home	With Own Family	Own Home Apt/Room	Sheltered Living	Hosp. Inst.	Other	Number of Respondents (N)
Specific coping suggestions	1	1	1	1	2	1	(137)
Knowledge of symptoms	3	3	2	2	1	3	(109)
People to talk to	2	4	3	5	5	1	(91)
Relief from financial stress	5	2	4	4	3	4	(84)
Relatives/neighbors understand	7	6	8	8	9	5	(69)
Having patient live away	6	6	5	3	4	5	(60)
Substitute care	4	5	8	5	7	8	(53)
Other	8	6	7	8	8	8	(35)
Therapy for self	9	6	6	5	6	5	(26)
Number of Respondents (N)	(88)	(22)	(41)	(15)	(44)	(12)	

[a] RANK: 1 = most common, 9 = least common need; needs with the same frequency are given the same rank.

substitute care for their patients so that family caretakers could get occasional relief from what reportedly was sometimes an almost intolerable, ceaseless pressure.

Although a few respondents stated that such supports were no longer needed since the patient was now well, and others noted that needs change or that solutions to previously emphasized problems were more important to them, most respondents did note three of the listed forms of assistance or supports as current needs for more satisfactory family life.

Two frequently mentioned problems not listed on the questionnaire that should be addressed were what to do, where to turn, in times of crisis and legal problems evolving from schizophrenia in the family.

Summary discussion and a look to the future

American upper-middle and middle class families can hardly be considered to be a forgotten part of the equation where schizophrenia is concerned; books, articles, and seminars abound to point out what these families of schizophrenics do wrong. On the other hand, the family problems of coping with schizophrenia have been neglected.

Yet these families are the day-to-day primary caretakers of their patients. When hospitalized patients are "deinstitutionalized" and returned to the community, the chances are that "community" means "home."

While most of these families had their patients at home, they worried about them as long as they were ill wherever they were. Families are concerned about symptoms: altered sense perceptions, painful emotions, thought disorders, and physical signs such as insomnia. They are concerned about behavior and how to cope with it. Family life is disrupted. Families are concerned about suitable living arrangements for patients and their opportunities for social life and employment. Some families have spent years and many thousands of dollars seeking effective treatment for their patients.

Orthomolecular therapy was considered the most effective treatment, but was not available to all patients; only about half of the patients in the survey had used it. Effective though it had been, Orthomolecular therapy had not been completely successful for all patients who had tried it or who had benefited from it. For most families, many of their social and emotional burdens of schizophrenia in the family continue.

The two forms of assistance that families felt would help them most in coping with schizophrenia were specific suggestions for dealing with patient behavior and a better understanding of the symptoms underlying it.

People to talk to who understood what they were going through and interim care were very important to parents whose patients lived with them.

Family members in the Association have often talked about how isolated they felt before joining the group—as though no one else had ever gone through anything like what was happening to them. Certainly it is not a general topic of conversation. Still, less than half had made close contact with other families even within the organization.

No two families have exactly the same experiences and resultant problems and needs due to schizophrenia. Still there is a pattern, just as there is a pattern to the signs and symptoms of schizophrenia although no two schizophrenics are exactly alike. Discovering the similarities can help remove the sense of isolation felt by families. This is therapeutic; it is not "therapy" and does not, in itself, solve many of the ongoing problems.

Although it is still possible to read whole books purportedly about schizophrenia without getting a clue as to what comprises the condition, literature covering common symptoms and signs is now being published for the lay public. Among the first such books were those by Orthomolecular psychiatrists Hoffer and Osmond (1966) and Pfeiffer et al. (1970). Some of the most explicit of the literature is available through HIBR, SAGW, and other local chapters. Bowers (1974), El-Meligi and Osmond (1973), and Snyder (1974) have published descriptions and explanations useful to family members and patients. Even with such resources available, the highly literate group of family members of schizophrenics who took part in the survey wants to understand more about the symptoms of schizophrenia. One might well expect that other parents and family members have the same need; the respondents to the questionnaire were "other parents and family members" before they contacted HIBR or SAGW.

Specific suggestions for coping with schizophrenic behavior are the greatest need for families who care for patients day by day. Such suggestions are at a premium in the professional literature. The most detailed book on various aspects of coping is one by the mother of an autistic child (Park, 1976). Specific suggestions for specific circumstances are needed on the scene and at the time. Until recently, HIBR and localchapters have not emphasized this aspect of schizophrenia, concentrating, rather, on understanding the illness and seeking and making available effective treatment. While the original emphasis of the group is expected to continue, there is an apparent movement to give more attention to the social aspect of the Huxley Institute for Biosocial Research.

Early in 1978, SAGW initiated a seminar on coping with schizophrenia in the family. The first program was on understanding symptoms and coping with behavior. The second was on moving the patient into the community, with discussion groups on social life, employment, and living arrangements. Each meeting was attended by close to a hundred people and great enthusiasm was expressed for this direct approach to social and emotional problems. Scheduled programs in the series will emphasize legal and financial aspects of the problem of coping with schizophrenia. Other chapters are beginning similarly oriented events. Social researchers and mental health professionals have recently discovered the importance of self-help groups (Borkman, 1976) and their support systems (Caplan, 1974), although Caplan considers lay support systems to be of value in **avoiding** psychological problems in connection with other illnesses and handicapping conditions, not with problems of mental health itself. The HIBR and its chapters have functioned as a support system within the mental health field, albeit informally, for over a decade. Support is being formalized both within the organization and in groups stemming from it.

In California and Metropolitan Washington, D.C., parent advocate groups for the adult mentally ill are being organized by parents who have been or are members of HIBR, together with families from outside the organization. Similar groups are forming elsewhere as the problems associated with accelerated deinstitutionalization become apparent to more families. While these groups do not advocate a particular form of therapy, most will emphasize the right to treatment alternative to that currently available on a broad scale. They expect to explore what families can do to help each other and to work to gain the needed community supports for patients and families if deinstitutionalization is to be successful.

Problems for families of schizophrenics are not unique to this continent. This has been shown by the Schizophrenia Fellowships of England and New Zealand. The National Schizophrenia Fellowship (NSF) of England was organized in 1972 by and for families of schizophrenics and their patients. According to its newsletters and literature, this self-help group has gained political support and attention from professional journals and the press as it works toward better understanding of schizophrenia and its attendant problems, and strives for the community resources promised when deinstitutionalization was proposed. Although the social milieu is somewhat different in each country and locality, the problems and needs of families are similar.

REFERENCES

BATESON, G., JACKSON, D., HALEY, J., and WEAKLAND, J.: Toward a theory of schizophrenia. Behavioral Science 1,251 -264,1956.

BORKMAN, T.: Experiential knowledge: a new concept for the analysis of self-help groups. Social Service Review 50,445-456,1976.

BOWEN, M.: A family concept of schizophrenia. In: Jackson, D,, Ed.: The Etiology of Schizophrenia. Basic Books, New York, 1960.

BOWERS, M.: Retreat from Sanity: The Structure of Emerging Psychosis. Human Sciences Press, New York, 1974.

CAPLAN, G.: Support Systems and Community Mental Health. Behavioral Publications, New York, 1974.

EL-MELIGI, A., and OSMOND, H.: The experiential world inventory in clinical psychiatry and psychopharmacology. In: Hawkins, D., and Pauling, L, Eds.: Orthomolecular Psychiatry: Treatment of Schizophrenia. W.H. Freeman and Co., San Francisco, 342-385,1973.

GOTTESMAN, I., and SHIELDS, J.: Schizophrenia and Genetics: A Twin Study Vantage Point Academic Press, New York, 1972.

HENRY, J.: Culture Against Man. Random House, New York, 1963.

HENRY, J.: Pathways to Madness. Random House, New York, 1971.

HESTON, L: The genetics of schizophrenic and schizoid disease. In: Hawkins, D., and Pauling, L, Eds.: Orthomolecular Psychiatry: Treatment of Schizophrenia. W.H. Freeman and Co., San Francisco, 54-70,1973.

■ HIRSCH, S., and LEFF, J.: Abnormalities in Parents of Schizophrenics: A Review of the Literature and an. Investigation of Communication Defects and Deviances. Institute of Psychiatry, Maudsley Monographs No. 22, Oxford University Press, London, 1975.

HOFFER, A, and OSMOND, H.: How to Live with Schizophrenia. University Books, New York, 1966.

HOLUNGSHEAD, A., and REDLICH, F.: Social Class and Mental Illness. J. Wiley and Sons, New York, 1958.

KALLMANN, F.: Heredity in Health and Mental Disorder Principles of Psychiatric Genetics in the Light of Comparative Twin Studies. W.W. Norton and Co., New York, 1953.

LAING, R.: The Politics of the Family and Other Essays. Pantheon Press, New York, 1971.

LAING, R., and ESTERSON, A.: Sanity, Madness and the Family: Families of Schizophrenics. Basic Books, New York, 1971.

LIDZ, T.: The Origins and Treatment of Schizophrenic Disorders. Basic Books, New York, 1973.

LIDZ, T., FLECK, S., and CORNEUSON, A.: Schizophrenia and the Family. International Universities Press, Inc., New York, 1965.

PARK, C, with SHAPIRO, L: You Are Not Alone: Understanding and Dealing with Mental Illness. Little, Brown and Co., Boston and Toronto, 1976.

PFEIFFER, C, WARD, J., EL-MELIGI, M., and COTT, A.: The Schizophrenias, Yours and Mine. Pyramid Books, New York, 1970.

ROSENTHAL, D., WENDER, P., KETY, S., SCHULSINGER, F., WELMER, J., and OSTERGAARD, L: Schizophrenics' offspring reared in adopted homes. In: Rosenthal, D., and Kety, S., Eds.: Transmission of Schizophrenia. Pergarnon Press, Oxford, 1968.

SNYDER, S.: Madness and the Brain. McGraw Hill, U.S., 1974.

WYNNE, L, RYCKOFF, I., DAY, J., and HIRSCH, S.: Pseudomutuality in the family relations of schizophrenics. Psychiatry 21,205-220,1958.

Family Advocate Groups

Families and Friends of the Adult Mentally III., 95 East Wayne Ave., # 201, Silver Spring, MD 20901.

Mental Health Advocates' Coalition of Minnesota, Inc., 268 Marshall Ave., St Paul, Minn. 55102.

Parents of Adult Schizophrenics of San Mateo County, P.O. Box 3333, San Mateo, CA 94403.

National Schizophrenia Fellowship, 29 Victoria Road, Surbiton, Surrey, KT64JT, England.

Schizophrenia Fellowship of New Zealand, Christchurch Branch, P.O. Box 593, Christchurch, New Zealand.