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# The New Schizophrenia: Diagnosis and Dynamics of the Homeless Mentally Ill

Alvin Pam

*Albert Einstein College of Medicine*

Culture is a major determinant of personality and mental health. It follows that if society does not meet the developmental needs of many of its people, rampant psychiatric symptoms will serve as ineffable comments on the culture. Nevertheless, the mental health field often misses the social implications of symptoms it treats. Traditionally, professionals have viewed schizophrenics as most apt to come from an enmeshed, dysfunctional, and seclusive family system; the patient can neither leave nor remain at home, eventually gravitating between home and hospital. Currently, there may be a new pattern of schizophrenia which is precipitated by fragmentation of family bonds rather than enmeshment. This pattern tends to arise in the context of a "no parent family," into which ten percent of American children are now born, with the patient gravitating over time toward inconsolable object-seeking and homelessness.

Although schizophrenia is a complex biopsychosocial disorder, this paper examines its dynamics and overt symptoms from a purely psychosocial perspective. I start with the general social-systems premise that psychiatric symptoms may not only be a reaction to the environment, but also an implicit, nonverbal, and veiled criticism of the environment. Thus, such symptoms may be used as an index to family and social stresses, as well as to culture-induced conflicts around forbidden impulses. Part I begins by looking at the symptom as covert communication — a metaphor directed to past and present significant others, but counterproductive in that its message is usually dismissed and instead regarded as a byproduct of psychic "disturbance." Next, I relate psychopathology to culture: the type and extent of symptoms (and the diagnoses created to describe these behaviors) reveal much about problems in the culture. The ensuing section deals with the family —

Requests for reprints should be sent to Alvin Pam, Ph.D., Psychology Department, Bronx Psychiatric Center, 1500 Waters Place, Bronx, New York 10461.

the primary enculturating agent — as a nidus within which the particular disorder of schizophrenia may develop. The history of the schizophrenic diagnosis is then traced as it has evolved in Western society.

After this largely theoretical social-psychological prologue, Part II deals with the paper's second premise: that symptoms associated with severe mental illness are presenting nowadays very differently in our psychiatric emergency rooms, with alteration in subtypes, co-morbid conditions, and background factors. Concomitant with such clinical changes are changes in the families from which these patients tend to come, with a notable trend over three decades from the two-parent family, to the single-parent family, and more recently to the "no parent family." Data from demographic studies and case histories are then offered which link this new pattern of psychopathology to the "no parent family."

A word should be said at the outset that this new pattern is not exactly "new." A syndrome will be described, today generically referred to as "MICA" (mentally ill chemical abuser), that in the past was usually classified as "schizophrenia" although never characterized by a formal thought disorder despite psychotic episodes. I will show that this same pattern has been successively called "schizophrenia simplex," later "pseudopsychopathic" or "latent" schizophrenia, and in the 1980's "young chronic." I will also show that the diagnosis of record in about 50% of current cases is still "schizophrenia." To illustrate that a common clinical phenomenon is being described over time, clinicians working with MICA patients in the 1990's will find the typical histories of "pseudopsychopathic schizophrenics" summarized by Dunaif and Hoch (1955) quite familiar: "They often have records of behavior disturbance going back to repeated episodes of truancy, juvenile delinquency, bizarre aggressive outbursts, nomadism, alcoholism and drug addiction, and imprisonments . . . . They do not often deteriorate, despite psychotic breakdowns, but manage to function at the fringe of society" (p. 172). As can be seen, patients of this sort have long been around — but their diagnostic labels have varied because of intermittent inclusion under the rubric of "schizophrenia." What is alarmingly "new," however, is that such patients have suddenly become so prevalent within the psychiatric population that a crisis has occurred in their clinical management, as well as in psychiatry's ability to manage overall.

In Part III, the issue is raised as to whether a new form of schizophrenia, or a new diagnostic equivalent of schizophrenia, is now sufficiently salient within the culture to be included in our standard nomenclature. How should the mental health field regard a psychiatric disorder whose social etiology appears to be marked not by a failure to separate–individuate due to family enmeshment (as the literature indicates may be the case in schizophrenia), but rather by fragmented bonds and inconsolable object-seeking due to disruption in attachment? To anticipate my conclusion, I will opt for a diagnosis

which implies a level of dysfunction comparable to schizophrenia, but would be a distinct nosological category. The appellation I shall propose for this new psychopathological entity derives from Durkheim's (1897/1951) discussion of "anomic suicide." By "anomie," Durkheim meant an absence of norms or laws by which to guide behavior: when a society is in a state of disarray or when an individual can find no niche within the status quo, Durkheim held that suicide becomes a more likely occurrence. This approach to the etiology of suicide emphasizes that lack of integration into a functional social order is devastating to mental health. If one now applies the same principle to the present topic, children from "no parent families" can be assumed to grow up under conditions of "anomie" and so develop in the direction of social alienation, psychological impairment, and existential despair. Hence, clinical symptoms which appear to be the long-term consequences of prolonged childhood deprivation might aptly be classified as "anomic turmoil" (calling it "anomic disorder" would be an oxymoron).

This paper concludes by addressing such questions as: What social forces are pushing families to neglect children so that these youngsters will subsequently be at high risk to drug abuse, mental disorder, and homelessness? When unprecedented numbers of citizens are in "anomic turmoil," what does this tell us about the crucial developmental needs of children which society must ensure? What can psychiatry offer by way of prevention and treatment? And, lastly, is our current conception of schizophrenia so description-bound that we thereby avert from our own view the social genesis and meaning of everyday tragedies to which we bear witness?

## Part I: The Cultural Context of Schizophrenia

### *The Social Significance of a Psychiatric Symptom*

> We must remember that every "mental" symptom is a veiled cry of anguish. Against what? Against oppression, or what the patient experiences as oppression. The oppressed speak in a million tongues, [using] the well-tried language of illness and suffering . . . . They need these . . . devices, for, at a single stroke, they must reveal and conceal themselves.
>
> What of psychiatrists or of others who wish to help such a person? Should they amplify the dissent and help the oppressed shout it aloud? Or should they strangle the cry and re-oppress the fugitive slave? This is the . . . therapist's moral dilemma. (Szasz, 1968, p. 52)

I regard this passage as one of the most beautiful in the psychiatric literature. It argues that symptoms are not only a cry of anguish because of unmet developmental needs, but that they also convey a coded criticism of significant others. Nevertheless, the symptom's message will likely be undeciphered, partly because the addressee may not wish to comprehend and partly

because the meaning disqualifies itself by dint of expression in psychotic "language." Ironically, the patient sacrifices coherent communication (and even thought) to avert offending the addressee, in so doing inflicting worse self-damage than anything the addressee could do, whereas the addressee can go unscathed via denying or distorting the message. Psychiatric symptoms are not a way to solve problems. However, they do at least offer such benefits as indirect empowerment, venting of forbidden affect, and autistic compensation for a dire reality.

In the above passage, Szasz urges mental health professionals to go beyond treatment of symptoms to treatment of powerlessness. If we treat symptoms, we must rely on a model of "adjustment" — the goal is to remove a presenting problem, thereby enabling a patient to resume a place in society. Presumably, society is good and the patient has the problem. However, symptoms might be treated to protect a problematic society from the maladjustment it imposes. Imagine, at the extreme, that we devise a "feel-good" pill so that patients can function in even the most noxious, abusive situations without any distress. By such "treatment," anybody who becomes distraught will soon be rendered quiescent or cooperative. This line of inquiry leads to a paradox: behavior deemed "symptomatic" but occurring in dismal circumstances might be appropriate to the context — indeed, it may be pathological **not** to manifest symptoms! As a field, we have much to ponder as to what constitutes a "symptom" in relation to milieu. At the same time we must reject moralistic paradigms which depict patients as passive "victims." Ideally, clinicians should attend to what is unconsciously self-created in a patient's woes, but remain alert to the social origins and ramifications of the psychopathology we treat.

Alas, all too often mental health professionals are not alert. Like the significant others of a psychiatric patient, we can miss the meaning of a symptom by imputing its etiology to the supposed workings either of a "disordered ego" or a "biochemical imbalance," depending on one's theoretical orientation. The problem is then located **within** the patient rather than at the interface between environment and patient. For example, Tessman (1978) has written a splendid text on treatment of children who have been traumatized by their parents' breakup, but she does not consider adult behavior which necessitates such treatment. Indeed, her position is that breakup is a prerogative of parents so that a child's pain should have no bearing on the breakup. By holding fast to this rationale, note how Tessman's role in the divorce process becomes that of a facilitating technician. In another example, Torrey (1983) attacked psychodynamic clinicians for their assumption that schizophrenia is caused by dysfunctional family patterns rather than by a biological mechanism (he suspects a virus), thus causing unnecessary guilt for the family. In retort, Pam (1990) has argued that this brand of biological

determinism relieved the family of any responsibility on ostensibly "humane" (but really infrahuman) grounds and was not scientific in view of ample evidence that experience in the family is a significant contributing factor to schizophrenia. Similarly, Albee (1990) warned the mental health field against an ideological alliance between NAMI (an organization of relatives of the severely mentally ill) and biological psychiatry according to which families are absolved of "blame." Under the terms of this alliance, family therapy is considered insulting to parents because biology, not the family, is seen as the problem; work with families must therefore be restricted to psycho-education around medication and crisis management. Some ex-patients find this position absurd; Modrow (1992) has complained that such biochemical explanations have enabled his parents to discount the very failings which, in his opinion, led to his own schizophrenia. Schatzman (1973) reviewed one of Freud's most famous cases (1911), noting that attribution of Schreber's paranoid system to a dynamic of "latent homosexuality" psychologized away the fact that the patient had been abused by a father eminent in his day as a pediatric authority who invented torturous restraint devices to enforce discipline.

In the mental health field, any identified causative factor in a psychiatric disorder lends itself to primary prevention since remedies can readily be extrapolated from the research data. The clinician then takes up the cudgels of "culture critic," making recommendations for change — either at the family or social level — to reduce the incidence of the disorder. As pioneering examples, Hollingshead and Redlich (1958) showed the influence of social class on diagnosis and treatment of psychosis; Clark (1965) noted the impact of racism on school performance and self-esteem of black children; and Chesler (1972) pointed to sexism which justified the use of ECT as "treatment" that kept depressed housewives in their unhappy marriages. In recent years, however, psychiatry has largely turned away from a community mental health approach to biological investigation of mental disorder. This shift has alarmed clinicians who feel that an "activist" stance is needed for clients who must contend with issues imposed by the social order (Dumont, 1992). In this vein, Prilleltensky (1989) deplores the "acontextual" work that is now done based on a "defect model" — when both cause and solution to human problems is thought to lie within the self, the status quo is unaffected. He urges the mental health field to reconceptualize its task as "conscientization." Fox (1993) chides the field because primary prevention recommendations are usually relegated to professional organizations to deal with in a political forum where accommodation to an unjust socio-economic system vitiates clinical values. Obviously, since implementation of any primary prevention measure entails advocacy, taking a stand based on clinical research must embroil one in controversy. Despite this drawback, sometimes empirical findings mandate that we do so.

*Culture and Psychopathology*

Anthropologists take as an a priori postulate that culture in great measure shapes personality (Benedict, 1934). Society must mold its young in order to foster adaptability to environmental conditions, as well as to maintain social stability and continuity. The family is the primary agency of cultural transmission; society shapes the family unit which prepares children to be functional members of that community. In spite of a wide range of individual differences within any society, a modal personality emerges which is specific to given groups, times, and places. Even biologically-driven aspects of behavior such as sex and temperament are deeply modified by culture (Mead, 1935).

Sociologists point out that every society defines both what is "normal" and what is "deviant" behavior (Clinard, 1968; Lemert, 1951; Mechanic, 1978). In modern times, such determinations are assigned to the discipline of psychiatry and associated social sciences (Sagarin, 1975). Indeed, a medical-model approach now generates a "diagnosis" that labels and can thereby stigmatize those who are "mentally ill" (Scheff, 1975). In short, the stock sociological viewpoint is that organized psychiatry — officially representing the social order — determines "deviance," offers a putative "explanation" for its occurrence, and if warranted can levy some penalty of social control or ostracism.

In a very influential statement, Mills (1959) insisted that the duty of sociologists was to forge beyond private problems to public issues, since personal troubles are often derivative from broad social conflict or contradiction. Mills articulated a basic tenet for sociology, but one which has sometimes been applied by other disciplines. Kardiner (1939), a psychoanalyst, declared that "when a culture persistently interferes with certain basic needs, neurosis results in a considerable number of individuals . . . . But it is the neurosis [rather than normalcy], which describes . . . the institution which is creating the pressure" (p. 414). Hallowell (1934), an anthropologist, had already insisted that psychiatric breakdown could never be understood without reference to what is defined as "normality" in the community as a whole.

Foucault (1961/1965) traced the search in Western society for a scapegoat — leper, criminal, or madman — whose status as designated deviants emphasized the "normalcy" of others. He stressed the fact that sequester of the insane in unoccupied institutions originally built for lepers began in seventeenth century Europe at the outset of "the Age of Reason." Ostensibly, "madness" was being banished by a society at long last freed of superstition; confinement of the insane thus fostered an image of "enlightenment." The previous theology-based demonology of "witchcraft" was now supplanted by a new medically-based demonology of "mental illness." In his highly provocative style, Foucault was intent on studying the very society which studies the insane.

Foucault's ideas were consonant with the shift in the mental health field in the 1960's from long-term institutionalization of the mental patients toward social and community psychiatry. Opler (1967) gave sociological support to this trend, maintaining that symptoms which are seen as asocial or antisocial actually reflect the cultural stress system. He maintained that all "mental illness" indicates some form of social demoralization: both normal and abnormal behavior "have derived from different aspects of cultural realities . . . . In the most serious illnesses, we see an individual drawn finally into lines of conflict that are internal to be sure but mark a warfare between [self and society] . . . . We may thus speak not only of weaknesses in individuals and families, but in cultural values" (pp. 198–199). Going even further, anthropologist Scheper–Hughes (1979) studied schizophrenia in Ireland, concluding that the environment was "schizophrenogenic." She observed a high incidence in bachelor farmers (often youngest sons who had to stay home to take care of aging parents) in a region of agricultural decline and depopulation, amongst a people observant of a sexually-repressive religion. Scheper–Hughes suggested that the Irish were more apt to institutionalize their young men than to face deep-seated social problems: "Even as a society refuses to recognize itself in the suffering individuals it rejects or locks up, it gives eloquent testimony to the repressed fears, longing, and insecurities of the group. And that particular configuration of Irish schizophrenia, as revealed in the . . . histories of young mental patients, expresses . . . the miseries of adult life in devitalized rural Ireland" (p. 13).

As psychiatry places more emphasis on somatic factors in the genesis of mental disorders, the more environmental stress tends to be regarded as a mere precipitant of an underlying predisposition (Wender and Klein, 1981). Despite the "biopsychosocial model" (Engel, 1980), a notable tendency still exists to biologize, looking for genetic or neurotransmitter causes rather than attributing symptoms to human predicaments — "blaming the victim's body" according to Pam (1990). In schizophrenia research, Murphy (1968) objected to such reductionism on anthropological grounds, pointing to very different international rates to show that culture has an "evocative" effect, no matter what the pathophysiology may be. He cited the classic work of Wegrocki (1948), who declared that a kind of behavior was seen as "abnormal" depending on its function within the culture — the same activity was acceptable if it occurred in accord with sanctioned traditions but unacceptable if seen as evasive. Thus, schizophrenic symptoms might be viewed as "normal" if consonant with religious practice, but as "abnormal" if social norms are criticized, threatened, or flouted.

Social scientists take for granted that culture determines "deviance," with neurobiology playing only a subsidiary or perhaps even a fictive role (Fabrega, 1979). For example, in certain cultures an epileptic is considered a

seer, whereas in the former Soviet Union a political dissident was branded as suffering from a "nervous disorder." Psychiatry tends to be regarded as operating under community standards which cannot be objectively evaluated from within the existing social structure. Hence, social scientists universally insist that cross-cultural and historical training is indispensable if psychiatry is to achieve needed perspective.

*Schizophrenia: Its Family Context*

Two rich schools of thought within the mental health field — psychoanalysis and family-systems theory — regard the dysfunctional nuclear family as the primary etiological factor in schizophrenia, pointing to symbiotic enmeshment as an antecedent condition. While these two approaches are different, they dovetail well because each presents extensive clinical material which indicates that formative childhood experiences set a stage for later psychosis.

In psychoanalysis, Freud considered schizophrenia untreatable by verbal methods, but he held that the condition was caused by a pre-oedipal disturbance, in conjunction with unknown constitutional factors (1914). Later analysts elaborated on the formulation that an intrusive, unempathic mother violated the child's ego-boundaries which culminated in a later schizophrenic disorder; the apogee of this trend is seen in Fromm–Reichmann's (1950) archetypal postulate of a "schizophrenogenic mother." Although this particular phrase has been criticized for its sexism and parent-blaming, the field of psychoanalysis has continued to hold that faulty parenting is the major predisposing factor in later breakdown; e.g., Anthony (1972) viewed the family as the "contagious subculture" of schizophrenia.

British object-relations psychoanalysis also stresses the mother–child relationship in the development of personality; the child's mental health is seen to depend on having a "good-enough mother" (Winnicott, 1965). Bowlby (1977) observed the attachment patterns of toddlers, finding two types of deviation from normal bonding: the alienated behavior of those youngsters who paid little heed to their mother's comings-and-goings, as compared to the clinging attachment of those youngsters who could hardly let their mothers out of their sight. Bowlby perceived the former group in terms of "maternal deprivation"; the children seemed unable to maintain stable bonds to anyone (1982), and ultimately were prone to antisocial behavior. In contrast, the latter group was seen as having difficulties with separation–individuation; the children had been subjected to "smother love" (1977, p. 208)—a term Bowlby prefers to "symbiotic love" which connotes a mutually beneficial relationship—and considered susceptible to neurosis, and in extreme cases to schizophrenia. Ainsworth (1979) studied children at age one and again identified two major deviations from the usual innate propensity toward attach-

ment: an underattached, aggressive, and noncompliant "avoidant" group; and an overattached, easily frustrated, and less competent "anxious/ambivalent" group. Ainsworth (1989) then traced the impact of such early deviations on adult adjustment and found extension beyond childhood to subsequent dealings with relatives, friends, and mates. She noted that the attachment system organized during the first year of life becomes an internal model of relationships that serves as a template for subsequent adult relationships. However, Ainsworth was careful to state that these traits are not fixed in infancy — change could occur because of altered maternal behavior or relevant life events. In a review of the literature on "maternal deprivation," Rutter (1979) found that poor quality of care rather than absence or death constituted the most disturbing neglect for a child. To sum up the findings of psychoanalysis and attachment theories, the thrust of their clinical and empirical data thus far implicates the family, especially the mother, in the development of psychiatric disorder.

In its early days, family-systems theory accepted the "double-bind hypothesis" (Bateson, Jackson, Haley, and Weakland, 1956) which posited that contradictory commands by parents could drive a child crazy. This hypothesis fell into disuse since it was never defined operationally and clinical data did not show that the "double-bind" was a precursor to any psychiatric disorder (Olson, 1972). Jackson (1965) then speculated that implicit "family rules" governed the kinship unit and determined the roles of members. Cybernetic models soon evolved; a paradigm of "family homeostasis" was invoked to explain why certain members needed to be symptomatic for the sake of others and why the family resisted change (Selvini, 1988). The concept of an "identified patient" subtly implied that others were "unidentified patients" and thus treatment must address the family-as-a-whole (Papp, 1983). As for schizophrenics, practitioners of family therapy assumed that such patients had been triangulated into a problematic marriage: e.g., Boszormenyi–Nagy and Framo (1965) stated: "Whenever there are disturbed children there is a disturbed marriage . . . . The schizophrenic patient is almost always enmeshed in the marriage" (pp. 154–155). Thus, the schizophrenic has usually been seen as a "sacrificial lamb" who holds the family together by letting otherwise incompatible parents coalesce around care of a disturbed youngster (Napier and Whitaker, 1978) and enabling so-called "well siblings" to escape. More recently, the field has modified its "systems" approach in which the individual "disappears" within a composite family ego-mass, but the behavior of each member continues to be viewed within a context of family interdependence and enmeshment (Pam, 1993). The field still insists that an individual's disturbed behavior is best understood as a function of family pathology: a symptom-bearer attests to toxicity within the family system, serving as a "scapegoat" (Vogel and Bell, 1960) whose function is to deflect tension between more powerful members.

In short, theory in both psychoanalysis and family therapy points to the family as "schizophrenogenic" insofar as children are used to gratify the needs of a disturbed parent within an enmeshed and relatively closed family system. Note that this situation is more apt to occur in a modern nuclear family than in the extended, three-generation family which had been the modal household unit in Western society (and which still predominates in non-industrialized countries). Indeed, Sarbin (1990, p. 269*n*) has commented that the nuclear family originated concurrently with the earliest recorded schizophrenic cases, suggesting to him that this diagnosis had to be created in order to extrude troublesome members of a fragile new family organization. Sarbin's comment does not imply that extended families had no schizophrenic members — only that before the advent of the diagnosis, such members were not subjected to scientific scrutiny nor removed from the family on medical grounds.

While the evidence for an association between "schizophrenia" as we know it and the modern nuclear family is far from conclusive, it does appear that large segments of the mental health field have assumed some sort of intrinsic connection. However, when children grow up disturbed enough to be called "schizophrenic," therapists of a dynamic bent seldom wonder whether the nuclear family is an ideal unit within which to raise children — rather, they tend to blame "inadequate parenting." This preconception leaves unaddressed the superordinate issue of the nuclear family as a social agency which itself may not always be adequate for the proper raising of children. Compared to the extended family as a child-rearing unit, the nuclear family tends to be more isolated, rigid, and brittle.

*The Shifting Nature of "Schizophrenia"*

Sarbin (1990) observed that the behavior associated with the diagnosis of schizophrenia has changed greatly over the course of its century or so of semantic existence — and continues to change as social conditions change. Such flux poses problems for psychiatric nosology based on biological determinants, but research strongly supports historical relativism in diagnosis. Blum (1978) noted virtual elimination of catatonic and hebephrenic schizophrenia since Kraepelin's time; although it is not possible to prove a "cause" for varying diagnostic rates, these trends indicated that diagnosis fits social eras. Even within Blum's tenure of 20 years at a V.A. hospital in New England, he found a large decrease in diagnosed "schizophrenia" and a corresponding increase in diagnosed "manic-depression" and could not say whether these shifts simply reflected fashions in the mental health field or genuine changes within the culture. Boyle (1990) reviewed the behavioral signs for schizophrenia laid down by Kraepelin and Bleuler; she contends that the deteriorated cases they saw were often organic in nature, with misdiagnosis of

encephalitis lethargica. Further, Boyle argues that the criteria for dementia praecox set forth by Kraepelin and for schizophrenia set forth by Bleuler were based not on empirically established patterns but rather on an inferred concept — no matter how drastic subsequent changes in symptoms have been, the concept remains unchanged. Cancro (1983) declared that there has never even been a homogeneous concept: Kraepelin viewed dementia praecox as disease entities sharing only a common course of progressive deterioration, and Bleuler saw "the schizophrenias" as a group of syndromes sharing a failure of synthesis in different mental functions. Van Praag (1992) also argues that "schizophrenia" is a psychiatric construction, abstracted from a host of symptoms and syndromes, with unclear and possibly diverse biological processes. Ellard (1987) traced the medical archives for descriptions of what today would be called "thought disorder" but found few cases prior to the eighteenth century; he concludes that "thought disorder" — and by extension "schizophrenia" — is an ambiguous and fairly recent conception, crystallized by various vicissitudes in historical and professional conditions. If so, further change must be expected.

## Part II: New Patterns of Psychopathology, New Types of Families

### *Is a "New Schizophrenia" Out There?*

According to psychodynamic and family-systems literature, schizophrenic patients are usually members of enmeshed, isolated, and dysfunctional family units. Yet, mental health professionals are currently seeing fewer families of this type and also fewer patients admitted to psychiatric hospitals with blatant "thought disorder." We are seeing instead more patients no less impaired or persistently disabled than schizophrenics, but who present complex diagnostic pictures of character disorder, cognitive slippage, and substance abuse. I will first describe in this section the symptom-profiles seen in many new psychiatric patients which differ in key respects from those of a generation ago; then I will present data showing trends in American family life are toward fragmentation rather than enmeshment; and finally I will consider evidence that these two clinical phenomena are intertwined.

*Changes in symptom-profiles.* Around 1980, reports began to appear in professional journals about a cluster of difficult-to-reach psychiatric patients. Segal, Baumohl, and Johnson (1977) had already drawn attention to this group by noting that 22% of a young vagrant population in California, many prone to using drugs and "street hustling," had prior psychiatric histories. Segal et al. then called for programs to save this cohort from an existence in sheltered living arrangements, at best, as they grew older. What they advocated, however, would seem utopian only a few years later: placement in

community residences so condescendingly regarded was soon seen as an unrealistic disposition for acting-out clients and the "sheltered living arrangements" often proved to be homeless shelters.

The decline in clinical optimism was evident in the research of Bassuk and Gerson (1980). They identified a series of Boston patients who made repeated visits to the psychiatric emergency room in what seemed to be a cycle of seeking and rejecting help. Because of their demands for immediate attention and instant relief, as well as their negativism and poor judgment, these patients readily evoked intense feelings of dislike by staff. Disposition was almost always problematic; not only did such patients lack social networks but they often rejected referrals. Despite what Bassuk and Gerson insisted was "a common clinical profile," half were diagnosed as psychotic, the rest with character disorders.

Pepper, Kirshner, and Ryglewicz (1981) soon gave this group a name: they defined "young chronics" as deinstitutionalized mental patients who demonstrated chronic social dysfunction and misuse of psychiatric services. The clinical picture could aptly be called "social breakdown syndrome." Although most of the patients in Pepper et al.'s New York sample lived at home, they were often unwelcome there or rootless enough to be thought of as "a homeless generation." In interacting with others, they seemed to alternate between apathetic withdrawal and episodic acting-out which brought them to the attention of police, social service agencies, or mental health workers. Slightly more than half of Pepper et al.'s sample were diagnosed schizophrenic; the rest were considered personality disorders or manic-depressives. The majority was involved in some form of drug abuse. Despite the inherent gloom of a title like "young chronics," Pepper et al. were sanguine about treatment, given new psychiatric, rehabilitation, and residential services.

Schwartz and Goldfinger (1981) described a similar clinical group which, in a variant of Pepper et al.'s term, they called "the new chronics." Their San Francisco sample were typically transient, drug-involved young men who repeatedly appeared in the emergency room of a general hospital with psychiatric, medical, and social problems. They tended to be admitted often but quickly discharged, usually signing out before therapy could be effective. Placement in a community residence was by and large precluded by their non-compliance, aggression, and addiction. Schwartz and Goldfinger concluded that the group's cognitive and ego deficits qualified for a diagnosis of severe borderline personality disorder. They urged long-term hospitalization of such patients, in some measure to protect acute-care psychiatric services from being overwhelmed.

Bachrach (1982) reviewed the literature on "young chronics" and reported that simultaneous findings from all over the country seemed to confirm that a tide of such patients were inundating psychiatric services. She described

this group as rootless, usually drug-involved, and acting much like "neglected children," quoting a Washington D.C. psychiatrist (p. 192) to the effect that "they want what they want, when they want it, if they know what they want, and they throw the adult equivalent of temper tantrums if they don't get it." Bachrach stated that the prevailing clinical opinion was that "young chronics" manifested developmental arrest of some sort — despite the accoutrements of adulthood, they often behaved like deprived, self-centered, and nihilistic children. As for treatment, Gardner (1985) thought the approach which promised the best chance to overcome their crippling lack of motivation and direction was psychosocial rehabilitation.

To bring this account up to date, in recent years the term "young chronic" has been dropped; it has been replaced by "MICA" or sometimes "dual diagnosis." However, such current usage describes only a co-morbid association, lacking any official standing in the DSM-III-R. Further, it does not always apply to the group formerly described as "young chronics," while including under its auspices a far larger, more diverse clinical population. Thus, despite our clinical preoccupation with the "young chronic" group, these patients are now without any distinct diagnosis of their own. Instead, about half the patients are diagnosed "schizophrenic" and about half "severe borderlines."

*Changes in family patterns.* In considering recent demographic changes in the families of psychiatric patients, little time needs to be spent demonstrating that there has been substantial erosion of the nuclear-family ideal of the "two-parent household" for every child. As a result of such factors as increased marital breakup and out-of-wedlock birth, children are increasingly being raised in single-parent families. The U.S. Bureau of the Census (1990, p. 8) reports a national rate of 11% in 1970, rising to 19% in 1980, and standing at 24% in 1990; in particular, Black families have tended toward this type of household organization, with rates of 33% in 1970, 49% in 1980, and 56% in 1990. Some scholars have noted that Black rates are simply precursors of parallel White trends; poverty associated with family instability is now endemic to most single-mother households, Black or White (Pearce, 1978). Another family type replacing the nuclear unit is the stepfamily; Visher and Visher (1979) reported that 13% of American children in the 1970's were residing with a remarried parent or a stepparent, more than double the previous decade's rate, and more recently up to 20% of all children (Kaplan, 1991). Further, 18% of U.S. children are now born out-of-wedlock and only about 34% of children born to married parents can expect to reach age 18 in a home with both adults present (Weitzman, 1985, p. 215*n*). However, despite psychological problems for about one-third the children of divorce (Wallerstein and Kelly, 1980), it does not appear that these youngsters are at especially high risk for schizophrenia; their developmental needs may have

been met well-enough by their one consistent parent or by rearing during tender years within an intact nuclear family.

Whatever the problems of the single-parent family, this paper calls attention to psychopathology associated with the rise of the "no parent family." My thesis is that the roots of much current adult psychopathology may lie in the residual effects of having been raised in a kinship unit so fragmented that offspring will be exposed to frequent, traumatic changes in the person charged with their care; or entry into a chaotic foster care system; or ongoing neglect by their nominally caretaking parent(s). Such children are not "doomed" to emotional disorder, but they are susceptible to many forms of psychopathology due to failure to meet their attachment needs at critical periods, as well as the lack of consistent or suitable adult role models. In a *New York Times* article on the collapse of inner-city families, Gross (1992) states that America's "new orphans" amount to 10% of all children; of these, 76% live with other relatives, 18% live with foster parents, 4% are in institutions or group homes, and 2% are with ex-mates of a parent. The number of "no-parent families" has risen steadily since 1970, with rates for African–American children more than double that for the country as a whole. Senator Moynihan (1989, 1992) has described the growing impoverishment and disintegration of inner-city Black families; he urges national attention to the problem, fearing that America will have to build orphanages when this child-care catastrophe is finally faced.

Although the estimated rate of 10% can certainly be disputed since many so-called "no-parent" children are in good homes with grandmothers or adoptive parents, the extent of the problem may still be understated because other children come from homes which the census bureau considers one- or two-parent, but where neglect is so pervasive that they are de facto "orphaned." While statistics cannot be fixed with precision because the plight of such children is often concealed from outside view, it is clear that the absence, inability, or unwillingness of some parents to take care of their young is causing an upsurge in personal and social pathology. Some of the major factors in family collapse mentioned by Gross include drug-abusing or vagabond parents, death because of AIDS, drugs, or guns, incarceration, and "the teen-age mother who comes and goes while someone else cares for her child." Gross notes that the "no parent family" is now more prevalent than the single-parent family in many urban neighborhoods; the children themselves are ashamed of their situation, with a keen awareness of what a family should be. Needless to say, because their dreams of belonging to a cohesive family unit are shattered time and again, these youngsters often become alienated at an early age from a society which in their eyes has shown them little concern.

*"Young chronics" and the "no parent family."* Two sorts of evidence suggest that there is an association between these two phenomena: data on the

childhood antecedents of homelessness, and case histories of children raised in "no parent families." With respect to the first, we have already seen that "young chronics" constitute more or less a "homeless generation" — what is to be investigated now is whether they tend to come from a "no parent family." Susser, Struenig, and Conover (1987) interviewed a cohort of homeless men: of those who had ever been psychiatric inpatients, the researchers found that half had been placed away from their families at some point during childhood. Susser, Lin, Conover, and Struenig (1991) then interviewed a sample of homeless psychiatric patients in shelters, as compared to a control group of psychiatric patients in state hospitals who had never been homeless. They found that 15% of the homeless group had been in foster care, 10% had a history of group home placement, and 20% had a history of running away from home for over one week; the never-homeless group had respective figures of 2%, 1%, and 5%. Within the state hospital population, any one of these three early experiences was strongly associated with adult homelessness and could be considered social markers for homelessness. A study by Thompson, Belcher, DeForge, Myers, and Rosenstein (1993) showed that schizophrenic admissions to all state hospitals from 1970–1986 have sharply tended toward indigent African–American males, many of whom were subjected to marked family upheaval. However, none of these studies clarifies whether patients raised in fragmented families thereby became disturbed, or whether they were already too disturbing to their families for some reason to be kept at home.

Case histories establish the direction of causality. Perhaps the most detailed study currently available is that of "Crystal" (Sheehan, 1993a, 1993b). Crystal's drug-addicted parents eventually placed her in foster care and later, as a teen-age mother, Crystal likewise placed her children. Sheehan traces three generations of a family afflicted by drug addiction, welfare dependency, petty criminality, and rotation of children amongst relatives, foster homes, and institutions. Each generation seemed to manifest cumulative mental disorder and social impairment. However, no member ever gives up the dream of reunion; the family retains an aura of "cohesion" regardless of the many severe lapses in adult provision for children. A social worker familiar with the case said: "Despite all the history of foster care, they really are a family" (Sheehan, 1993b, p. 79). In contrast, a clinician could cynically insist that however well-meaning the interventions of social agencies and foster parents, the psychic damage to the children was too great to allow these youngsters to overcome the regressive pull back to the disorganized family of origin.

Although many more empirical studies are obviously needed, it does seem plausible that the "no parent family" contributes to the condition Pepper et al. called "young chronic," including great vulnerability to drug-abuse, mental disorder, and homelessness. Whereas schizophrenia has been regarded as

usually developing within the context of an enmeshed family system and results in long-term dependency on psychiatric institutions, these "young chronics" are more apt to have been raised in a "no parent family," with a strong pull in adulthood toward "the street." Thus, our hospitals and aftercare clinics service schizophrenics whose dynamics mesh with the treatment technology we have devised for them, but we also deal with vast numbers of "young chronics" who may be untouched by our programs and tend to wind up as homeless.

*A Psychodynamic Formulation for the "Young Chronic" Syndrome*

Since the case for a "new schizophrenia" has not yet been established, for lack of a better term I will continue to use "young chronic." Pepper et al. seem to have described this group perfectly by their "social breakdown syndrome." The presenting problem is primarily severe impulse disorder, compounded by such secondary factors as drug abuse, antisocial behavior, lack of vocational interest or discipline, misuse of psychiatric and other social services, and homelessness. Evidence has been offered suggesting that the environmental etiology of this condition may be profound childhood neglect — the "no parent family." In these cases, the treating clinician immediately encounters alienation and aimlessness, as well as the patient's yearning to return to a "family" unit that perhaps never existed in reality. As graphic clinical data, consider this precis of a very unusual card 5 TAT story recounted by a male inpatient (card 5 shows a woman peering into a room and is usually seen as a mother checking up on her children or investigating a noise):

> A man was wandering the streets looking for a place to live. He went from house to house. However, in one house, he found the door open but no one home. So he went inside, took some food from the refrigerator, and fell asleep on the couch. The woman of the house now comes home and finds him there, is startled, and doesn't know what to do. She then feels sorry for him and takes him in.

A bizarre ending indeed! The leitmotif of this TAT story is a "rescue fantasy" in which the homeless protagonist (representing the patient) has the daring and good fortune to find a haven with a stranger. In psychodynamic terms, the patient appears preoccupied with regressive wishes to return to a child state, this time with a nurturing instead of a depriving caretaker. These wishes are so overwhelming that the protagonist trespasses the woman's home in a way which society would view as illegal and irrational. Moreover, such a desperate door-to-door quest for any woman who would be his "mother" must be predestined to fail in real life because the seeker offers nothing but magically hopes to receive unconditional care. Diagnostically, the card 5 response did not reveal a formal thought disorder but showed sufficiently impaired

social judgment to be considered strongly indicative of borderline personality disorder. As for history, the patient was a homeless, drug-addicted man who came from a "no parent family." He was never diagnosed "schizophrenic," but had received various Axis II labels over several admissions, including "antisocial," "explosive," and "borderline." He was eventually discharged to a community residence but soon resumed his drug abuse and was homeless again.

Using this TAT story as a guide to the possible psychological workings of a typical "young chronic," the foremost need of these individuals seems to be **inconsolable object seeking** — a search for a family in real or symbolic terms. These patients often appear to want to recapture a lost status as a wanted and cherished child. Much of their impulsive behavior can be seen as a futile effort to assert this birthright, demonstrating at the same time that it was never honored. The symptoms may thus represent a primitive need for fusion with a designated caretaker, as well as rage when this need is not met. However, despite the blindly object-seeking nature of the symptoms, a depriving parent or surrogate is apt to be still more unavailable in adulthood than in childhood so that efforts in the present to extract compensation for the past are bound to be counterproductive. Even when these patients successfully gain the support of new caretakers (e.g., foster mothers or case managers), they usually cannot sustain it — partly because they cannot trust such ties and partly because they are angry about not having had this nurture all along (Magid and McKelvey, 1987). Ironically enough, what "young chronics" do seem to trust are street drugs and homelessness. The drugs induce an oceanic feeling, becoming a toxic "mother" who simultaneously embraces, consoles, and destroys. The homelessness re-enacts the painful absence of family; furthermore, by extending the earlier traumata of neglect, abandonment, and marginality, rebuke of neglectful parents is implicit. In addition, homelessness and drugs convey in action-language the insidious self-judgment that a better fate was not deserved and blame is accepted for being "no good."

## Part III: Conclusions

### *"The New Schizophrenia" — A Viable Concept?*

Although schizophrenia may not be a unitary phenomenon, DSM-III-R (1987) makes thought disorder its hallmark. Does our group of patients meet this criterion? To a degree, yes — we have seen that half are already considered schizophrenic. It can even be said that the group as a whole shows deficits in logic and reality-testing: Schwartz and Goldfinger (1981) found endemic paranoid thinking in their sample, though hallucinations and delusions were rare except under stress or drug-toxicity. Schwartz and Goldfinger

also found gross denial or distortion of reality, lack of social judgment, and inability to integrate experience. Nevertheless, the authors still maintained that disorders of impulse control are the most prominent symptoms, warranting a generic diagnosis of "severe borderline."

Contrary to Schwartz and Goldfinger, my position is that some problems in impulse control might comprise an "action disorder" tantamount to "thought disorder." For example, from my 25 years as a state hospital psychologist, I know of one man who did push-ups on a busy highway, dreading that no one would notice him! Another swallowed gasoline and put a lit match to his mouth to "commit suicide." Still another chased a woman through a lobby with his pants unfastened, a knife in hand, and a shouted intention to "make love." Though these patients could scarcely articulate their state of mind during the events, on mental status examination they did not demonstrate loosening or systematized delusions. Was their erratic behavior to be interpreted only along such dynamic lines as death wishes, cries for help, manic grandiosity, paraphilia, etc. — or did these acts reveal an underlying cognitive disorganization? I contend that such inchoate, irrational forms of "action disorder" point to an unverbalized autistic logic which is expressed not in hallucinations or delusions but rather in quasi-psychotic deeds.

It might be recalled that as recently as DSM-II (American Psychiatric Association, 1968), clinicians could diagnose many patients of the "young chronic" type as schizophrenic despite the absence of thought disorder. Bleuler's "schizophrenia simplex" was included in this edition (p. 33) to describe patients manifesting apathy, blunting, and odd behavior — many of whom were alcoholics according to Bleuler (1911/1950). "Latent schizophrenia" was also listed (p. 34), which was the subtype clinicians used for the non-psychotic polydrug-abusers already coming to emergency rooms and hospitals back then, with the rationale that these patients would be psychotic if they did not use drugs to ward off destabilizing affect. Mention must also be made of the work of Hoch and Polatin (1949) on "pseudoneurotic schizophrenia," a category included in the DSM-II (p. 34) as a form of "latent schizophrenia," which was characterized by pan-anxiety, pan-neurosis, and chaotic sexuality, but not thought disorder. Also under "latent schizophrenia" was "pseudopsychopathic schizophrenia" (Dunaif and Hoch, 1955) which we have already seen is akin to "young chronic." Like pseudoneurotics, the pseudopsychopaths were said to show pan-neurosis and chaotic sexuality, but instead of pan-anxiety, antisocial "micropsychotic episodes" occurred which constituted an "acting out schizophrenia."

Although psychiatrists like Bleuler and Hoch found technical grounds to label patients without thought disorder "schizophrenic," clinicians are now more inclined to tighten rather than expand the definition of schizophrenia. The prevailing tendency today is to diagnosis such patients "borderline per-

sonality disorder." Although "young chronic" dynamics are often borderline, with much splitting, storminess, and misery, I think most clinicians will nonetheless agree that they are less socially productive and object-related than borderlines. In addition, "young chronics" are more treatment-resistant. In terms of needing institutional care, they could stay in psychiatric hospitals for years — which may prolong their lives, but at the cost of constant struggle with staff over compliance with programs and abstinence. At present, as soon as they remit from acute symptoms, they tend to be sent back to the community, or discharge themselves, only to return in short order. Distressingly, what is evident is that many do not fare well whether they have long-term hospital stays or become revolving-door clients.

Despite my gut feeling that the "young chronic" syndrome can be considered a new type of schizophrenia, and that this condition has largely been spawned by the social conditions of the urban poor since about 1980, I have come to the conclusion that a separate nosological category would be more acceptable to psychiatry at this time. A separate category would at least allow the mental health field to unify diagnosis so that there would be milder or worse cases within a common grouping instead of, as is now the practice, the milder cases being seen as "borderline" and the worst cases as "schizophrenic." The proposed category will describe a syndrome distinct from both, though equal in severity to schizophrenia. Its most distinguishing feature will be "micropsychotic episodes" or "action disorder," but transient psychotic breaks will be common. Unlike most DSM diagnoses, it will be framed around antecedent conditions, leading in a continuous line from a past of childhood deprivation to adolescent symptoms and then to future vulnerability to homelessness. Their acted-out behavior will be seen as confused attempts to express, master, and protest earlier trauma.

At the outset of this paper, I informed the reader that "anomic turmoil" would be the proposed name of the new category. This term is really a variant of "social breakdown syndrome" but I prefer it because it implies that patients have internalized and perpetuated the disorder around them and are not just reactive. In this manner, society, family, and patient share in responsibility for the social aspects of the psychiatric problem.

*Conclusion: Taking up the Cudgels of "Culture Critic"*

Too much discussion of a "new schizophrenia" may unfortunately obfuscate the main thrust of this paper. When focus is placed on diagnosis, this can become disputatious so that nothing is done in the real world. Rather, the focus here should be on symptoms as implicit social commentaries. Hence, "anomic turmoil" points to an ominous ongoing deconstruction of American family life, as well as to worsening class and racial relations in this country.

Mental health professionals in the public sector are front-line workers who must note what is happening and lead the fight to identify and change conditions so damaging to the mental health of our patients. If my surmise is correct, these patients are telling us in their symptom-language about unspeakable conditions.

What are the primary prevention recommendations inherent in the clinical symptoms under review? Compassionate treatment is always in order, but perhaps we have to recognize that some of these patients may be damaged beyond our capacity to repair. This point of view is not defeatist — instead, what I am advocating is that it might be more useful to concentrate therapeutic efforts on prevention, treating "no parent families" by increased attention to child-caretakers, especially teen-age single-parents or other high-risk mothers. Greenspan's (1987) work with disturbed women and their infants can be one glowing example. Zigler's (1989) call for universal day-care centers deserves our strongest possible support. We may have to reroute scarce resources from tertiary to primary or secondary psychiatric care, moving mental health workers from hospitals and prisons to therapeutic nurseries and schools. In addition, while we support efforts to strengthen family ties by making parents the priority recipients of our outreach programs, we also need to be much more alert to the neglect of children and to be pro-active on their behalf. This calls for our involvement beyond the clinical to the political level in such controversial areas as welfare reform, family planning, foster care policy, child support and custody in divorce, and children's rights. Hearing what our fail-to-thrive "anomic turmoil" patients can seldom put in words, this is our moral obligation as therapists.

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