Chapter 5

Creating Nonpersons

The Poverty of Schizophrenia

By simply excluding someone from the human group—by which I mean a group that is held together by the needs of survival—we can destroy their possibilities of self-realization, i.e. prevent them becoming a full person.[1] —Rex Ambler

Creating Nonpersons

Terms such as "oppression" and "poverty" may not immediately be seen to relate to the situation of people with mental health problems, yet on a more critical examination, their appropriateness becomes clear. The social history of people with schizophrenia is marked by poverty, exclusion, oppression, and lack of opportunity that bestows upon them the status of nonpersons within society. However, the oppression is subtle. As Tom Kitwood observes in his discussion of the psychodynamics of exclusion: "Many cultures have shown a tendency to depersonalize those who have some form of serious disability, whether of a physical or a psychological kind. A consensus is created, established in tradition and embedded in social practices, that those affected are not real persons."[2]

When individuals and communities create a relational, communicational, aesthetic and linguistic atmosphere that causes the exclusion and stigmatization of those who are perceived to be different, their oppression is deeply damaging and thoroughly destructive of the humanity of a significant section of the population. It is through the myriad of unnoticed social gestures and negative assumptions that people with mental health problems find their sense of self-worth and personhood constantly being eroded. It is through that same process that they come to be perceived, consciously or subconsciously, as "nonpersons" (by society and, sadly,

often by themselves), and consequently excluded from meaningful participation within society.

Poverty of Personhood

Roy Porter notes that the voice of people suffering from mental health problems "is one deeply conscious of having been made to feel different. Generally they complain that 'alienness' is a false identity thrust upon them, or indeed a non-identity, a sense of being rendered a nonperson."[3]

In the light of the current movement toward deinstitutionalization, Porter's observation is highly significant. Barham and Hayward note that:

> As historians of madness have shown, we have inherited from the last century a "deep disposition to see madness as essentially Other."[4] The transformation of Victorian asylums into gigantic custodial warehouses hastened the "decline of dialogue between society and psychiatrist on the one hand and the disturbed on the other (increasingly 'shut up' in both senses)" and irretrievably established their differences.[5] In crucial respects this custodial history is recapitulated in the traditional account of schizophrenia as a narrative of loss in that the pre-illness person goes missing, seemingly abandoned by the force of the disorder. On this view schizophrenia "is more than an illness that one *has*; it is something a person *is* or may *become*."[6] (Italics added)

Barham and Hayward's comments emphasize two points that are important for present purposes. First, historically (and in a slightly different way, contemporarily) society's response to people with mental health problems has been to isolate them, to shut them away from the rest of the population. Consequently, the majority of society has had little or no contact with them, apart from what is very often a distorted and caricatured picture presented through the media. As a result the "public identity" of persons living with schizophrenia has been defined as essentially "other," that is, not belonging to society proper.

Second, those who have emerged from asylums have emerged with a very uncertain personhood and identity. If schizophrenia

truly does destroy the person, as "natural history theory" would suggest, then one is left with the perplexing question as to what these "schizophrenics," these "nonpersons" are who are emerging from the mental hospitals into our communities, and accordingly, how they should be treated.

In highlighting this confusion over the nature of the humanity of people with schizophrenia, Sue E. Estraff emphasizes that schizophrenia is what one might describe as a *totalizing* condition. Schizophrenia "is an I am illness—one that may overtake and redefine the identity of the person."[7] Unlike measles, the flu, or any other common ailment, a person does not simply *have* schizophrenia, they actually *become* schizophrenia. The tendency in public and professional perception is to regard persons ontologically in terms of their illness, that is, as "schizophrenics." Schizophrenia becomes central to the way in which others identify persons, (their social identity) and how such persons themselves build and understand their own identity (their personal identity). Schizophrenia becomes their primary identifying role, and the mental health services their primary reference group. In this way, these persons *are* indeed "lost" to the illness, but not because of any inevitable natural process of deterioration. These persons are lost to the illness because a particular form of social identity is formed around them, an identity that is created by negative societal negotiation and that subsequently becomes a public persona that people with schizophrenia then internalize and build into their own self-conception.

Once again, it is *not* being suggested that social pressures in some way cause or are responsible for the development of schizophrenia. What *is* being asserted is that these persons' life history and the development of their social self, the personal identity, is adversely affected by the cultural ascription of a negative social identity that confuses the person with the illness. It is in *this* way that schizophrenia becomes a social construction, and it is in *this* way that the "schizophrenic" is created, stereotyped, and marginalized. In a very real sense, people diagnosed as having schizophrenia become *nonpersons*.

People living with schizophrenia are deprived of some of the fundamental social experiences necessary for the development of

healthy human personhood. Basic social opportunities that are foundational for the positive development of personhood are simply not available to people who are perceived in the ways outlined above. The following are rarely available to people with schizophrenia: the opportunity to find one's "true self"—who one is as a unique individual; the chance to discover a valued social identity; the opportunity to feel that one has an accepted and acceptable place within society; the possibility of developing a positive personal and social identity; and the opportunity to develop meaningful relationships with self and others. This deprivation is not simply a result of their clinical condition (which does contribute to their social isolation); rather it is the result of fundamental flaws and false assumptions within society's perception of them and the nature of their condition, which leads to their social definition as fundamentally "other." What greater poverty can there be than to be deprived of the circumstances and forms of relationship that enable persons to live humanly and to be themselves? This enforced poverty of personhood oppresses and alienates people with schizophrenia and confirms them in their status as "nonpersons" who are forced to stand on the margins of acceptable society.

Poverty of Opportunity

Carpenter notes the social ambiguity of schizophrenia when he observes that schizophrenia

> strikes at the very heart of what we consider the essence of the person. Yet, because its manifestations are so personal and social, it elicits fear, misunderstanding, and condemnation in society instead of sympathy and concern. Schizophrenia remains unparalleled as a stigmatizing [disorder] with all the societal consequences of personal shame, family burden, and inadequate support of clinical care, research, and rehabilitation. It is ironic that in a society with pride in individual freedom and achievement, the response to a person whose personal capacity is being eroded. . . . is the withdrawal of opportunity.[8]

One of the results of the process of depersonalization is the withdrawal of opportunities to participate meaningfully in society and to gain access to many of the sources of self-respect and self-esteem that are available to others. Poor self-esteem and hopelessness in people with schizophrenia is not simply the product of the disease process; it is also connected to the exclusion from many of the normal relational and material sources from which the majority of the population gain their sense of value, self-confidence, and worth.

For example, within present day capitalist societies, where work is viewed as fundamental to popular understandings of worthwhile human existence, a person's employment is a major source of value, self-worth, and economic sustenance.[9] People with the diagnosis of schizophrenia are often excluded from this primary source of value and income. The positive and negative manifestations of the illness, coupled with destructive public perceptions, attitudes, and stigma, mean that it is very difficult for people with this diagnosis to gain any form of meaningful employment.[10] The condition itself places major barriers to employment, but there are many people who are capable of holding down employment who simply do not get the opportunity because of particular assumptions about their condition. This exclusion from primary sources of value leaves many people with schizophrenia feeling there is no future for them. Consequently, life appears profoundly hopeless and meaningless. For many, the social experience of schizophrenia is one of material deprivation, meaninglessness, hopelessness, and constant devaluation, with no possibility of a hopeful future and no power to alter the trajectory of their lives. This factor may contribute to the 10 percent of people with schizophrenia who commit suicide.[11] It would appear that people diagnosed as having schizophrenia are destined to be dependent persons in a world that values individualism, competitiveness, independence, productivity, and financial prosperity. For those who are in any way dependent, who cannot compete or are not productive, there are few alternative sources of value within a society that no longer understands the meaning of mutual responsibility and "community." As Genine's story suggested, within such a social context it is difficult for an individual to accept his or her illness without acknowledging that it entails a necessary

element of hopelessness and disempowerment accompanied by a withdrawal of opportunity to participate in that which is valued within society.

Poverty of Relationships

The most painful thing for people with schizophrenia is the level of relational poverty they encounter. Certainly some of this is the product of the disease process itself, but schizophrenia seems to provoke society into displaying a particularly negative, impersonal, and at times openly hostile reaction toward those who live with it. These reactions, assumptions, and stereotypes make it extremely difficult for people to find and maintain positive interpersonal relationships—*the* most important source of value and self-esteem available to human beings.

The processes involved in bestowing someone or something with value bear consideration. Things do not have a value in themselves, but only become valuable according to the meanings that are ascribed to them. Thus, for example, "a family portrait may be invaluable to the family concerned, but have tantamount to no value outside of that family. A friendship ring may be of inestimable value to a friend and of absolutely no value to a jeweler. The value of the picture or the ring stems from and depends upon the attitude/relationship of others toward it."[12] David Pailin suggests that a similar principle is appropriate for an understanding of how human beings should be valued: "The fundamental worth of a person is to be seen to lie in the love of others for that person. Worth is not something that belongs to a person as a solitary individual. It is given to each person by the way that others, including—and ultimately—God, regard him or her."[13] This is not to suggest that if a person has no friends or relatives, he or she is not of value. *All* human beings are of ultimate value, and that status is sustained by God's gracious gift of relationship toward them.[14] Nevertheless, on a temporal level, if we gain our sense of value from our human relationships, then we are forced to ask what is the "worth of persons who justifiably consider that no one cares about them? A person who finds herself or himself in such a position is justified in feeling worthless. Furthermore, because no one at all cares about them, they may regard any affirmation of their own dignity as persons as practically impossible as well as pointless. Self-esteem is the product of being of worth to others."[15] The primary way in which we gain and experience self-worth is not through social achievement, material wealth, or an ability to compete in the market place, but through others' love for us. If such relationships are unavailable, or if we perceive ourselves not to be worthy of them, this can lead to a catastrophic loss of self-esteem and deep feelings of being devalued. People diagnosed as having schizophrenia frequently are justified in assuming a lack of love from others.

The Social Isolation of Schizophrenia

In order to understand fully the social processes that are at work in creating the forms of poverty that have been highlighted, it is necessary to develop a deeper understanding of the complex social and interpersonal processes that underlie such forms of social behavior and negative reactions to mental health problems. It is clear that there are particular difficulties inherent within schizophrenia as a clinical condition that make communication and relationship building very difficult. Poor ego boundaries, bizarre speech and behavior, and an inability to maintain eye contact are just some of the features that interfere with the normal process of relational interaction. Because individuals with schizophrenia do not remain within the unwritten codes of social intercourse, other people often do not understand what is going on when they encounter such an individual. The normal characteristics that are necessary for the development of successful interpersonal relationships—mutual symbolic exchange and interaction, common situational definitions, and adequate communication of shared meanings—at times appear not to be present within such encounters. Because of this, one of the major barriers that separate the person with schizophrenia from the rest of society is the fundamental *incomprehensibility* of their condition. Schizophrenia is confusing and disorienting for those experiencing it *and* for those whom they encounter. As such, it is open to being ascribed a number of different meanings and interpretations. As Van Den Bosch points out, "schizophrenia is a severe psychiatric

disorder of the inner world which proves difficult to understand by the outside world. . . . Schizophrenia is probably the most incomprehensible disorder of the mind."[16]

The incomprehensibility of schizophrenia makes it difficult for people with it to relate to others, and for others to relate to them. It also leaves open the possibility of misrepresentation, misunderstanding, and stereotyping. Consequently, schizophrenia poses a major challenge to the normal framework of shared meanings and reciprocal interaction upon which the communication process is built and on which the cultural norm of friendship, based as it ordinarily is on the "principle of likeness," inevitably depends.

Horwitz, commenting on this distortion of communication, which he notes is present in a number of mental health problems, points to the fact that

> any piece of behaviour is made intelligible either by attributing a socially recognisable motivation to the behaviour, e.g. "he murdered his wife out of jealousy," or by locating the action as an instance of a typical social category, e.g., that man is chopping wood. When observers assume that actors know what they are doing and are guided by rules in their behaviour, social behaviour appears to be meaningful. It is when observers cannot find meaning or comprehensibility in behaviour that they are likely to apply labels of mental illness.[17]

According to Horwitz, when individuals step outside the socially accepted norms of communicative behavior, their action becomes incomprehensible to the majority of the population. It is this incomprehensibility which is then used as a defining line between what is normal and what is abnormal behavior.

The attribution of meaning to any social action is a fundamental requirement of all social interactions. No meaningful communicative interaction can occur unless each participant can understand, at least to a mutually acceptable extent, what the other is doing. Horwitz goes on to argue that *intelligibility* is what marks out mental health problems from other forms of behavior within society.

> All societies need some category to designate behaviours that fall outside the boundaries of comprehensibility. The notion of mental illness is rooted in the basic requisites of social interaction: that persons be able to find each others' behaviour mutually comprehensible. Labels of mental illness are applied to behaviour when the categories observers use to comprehend behaviour do not yield any socially understandable reasons for the behaviour.[18]

The failure of observers to find any meaningful purpose in behavior Horwitz calls *incomprehensibility*, and he considers this to be the essential quality at the core of behaviors that are labeled "mental illness." This is not to suggest that mental health problems do not exist, or that they are simply a construction of society. Rather, what we are considering here are the *consequences* of the specific behaviors (illness experience) that tend to accompany particular forms of mental health problems. These consequences are the social products of particular conditions, rather than things that are inherent within the condition itself.

Horwitz' proposition is interesting: According to his analysis it would appear that, contrary to the conflict theories of mental health problems proposed by antipsychiatrists such as R. D. Laing, the identification of mental illness is *not* a power-oriented conspiracy whereby the psychiatrist abuses his power by labeling "innocent persons" mentally ill with concomitant negative social and emotional consequences. In fact the identification of mental health problems is fundamentally a *lay* enterprize.[19] Individuals are primarily marked out by the general population as having mental health problems when they find themselves unable to participate in social interaction according to the tacit rules of comprehensibility that guide all human social interaction. Once marked out, they are brought to the attention of the mental health professionals, who in turn provide an official diagnosis.

Barriers to Love

The incomprehensibility of mental health problems makes it difficult for the "normal" person to relate with the "other." The tendency *then* is to engage in an "I-It" relationship toward the incomprehensible individual and assume him or her to be incapable of entering into authentic relationship, to withdraw one's own relationship, and to pass responsibility for the individual on to the professional.

These observations are important with regard to schizophrenia. The behavior, experiences, and ways of communicating associated with schizophrenia often strike at the basic properties of normal social interaction and comprehensibility. People find it difficult to *empathize* with the experience of schizophrenia. Empathy is a communication skill that lies at the heart of all interpersonal relationships. Most counseling theories would suggest that the counselor's ability to empathize accurately with the client is foundational for the development of a successful and health-bringing counseling relationship. For example, Truax and Carkhuff suggest that

> accurate empathy involves more than just the ability of the therapist to sense the client or patient's "private world" as if it were his own. It also involves more than just his ability to know what the patient means. Accurate empathy involves both the therapist's sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client's current feelings.[20]

If Horwitz is correct in asserting that incomprehensibility is a fundamental constituent of any understanding of mental health problems, and if Truax and Carkhuff are correct in asserting that empathy is basic to the development of health-bringing relationships, then it becomes clear that schizophrenia itself may well cause many people with schizophrenia to become isolated and friendless. It is not simply that their illness, in itself, makes them less desirous of relationships.[21] The problem seems to be that the particular symptoms and experiences that the person encounters make normal communication and relational interaction extremely difficult, thus engendering a negative relational response from those with whom they come into contact. Consequently the person is experienced as somehow "other,"[22] and lines of communication and relationship collapse.

Not only is the individual experienced as essentially "other," he also experiences himself as alien and different. The individual internalizes this social definition of "otherhood," which then becomes a part of his social identity, that is, part of the way in which he perceives himself and is perceived in the world. If one perceives oneself as fundamentally different from the rest of society, it will be very difficult to form any kind of stable and meaningful relationships. If one is perceived by others as fundamentally different, the task can become quite impossible. In this way the "schizophrenic" is created, and defined by self and others as fundamentally different. Under such circumstances, any friendship that is grounded only in the "principle of likeness" is destined to fail both from the perspective of the sufferer *and* the potential friend.

Images of Madness

However, important as these inherent communication difficulties may be, there is a wider social dimension that is inextricably connected with the interpersonal one. It is not only the incomprehensibility of *actual* behavior that causes relational difficulties. There is also a major problem in the way in which an individual is *perceived* in the eyes of the general public, irrespective of her *actual* behavior, speech, or mental state. The tag of "mentally ill" in itself brings about alienation and relational disconnection. Human beings act toward things as they are perceived, interpreted, and defined, and not necessarily as they are. As David Karp puts it, "All objects, events, and situations derive their meanings through human interpretation. We are ultimately free to define anything we choose, including illness."[23] This suggestion is important for developing an accurate understanding of the social history of schizophrenia. The inherent incomprehensibility of schizophrenia is compounded by a socially constructed incomprehensibility that manifests itself in inaccurate, stereotypical, and distorted public images of what schizophrenia is and what a person suffering from it is *actually* like. These images in turn profoundly affect the ways in which schizophrenia is interpreted and understood, and the type of treatment that persons diagnosed as having it will receive.

While such images may not be accurate or truthful, they are no less real in their consequences. Sociologist Agnes Miles, in her research into the public perceptions of mental health problems, found that

> . . . studies have consistently shown that people evaluate mental illness negatively, reject and discriminate against mental patients, and base their views on traditional stereotypes.[24] . . . Overall the public image of a person suffering from mental illness is considerably more gloomy than that of a person suffering from physical illness, and in certain respects it appears to be closer to the public image of a criminal.[25]

Miles concludes that there exists a stereotype of mental health problems and of persons who suffer from them that is negative and widely held by the lay public. A good example of this type of distorted caricature is to be found in media and public juxtapositions of schizophrenia with violence. According to MIND:[26]

> The public's perception of mental disorder is of the raving lunatic or homicidal maniac. . . . In fact the vast majority of murderers have no history of mental disorder—they are as "sane" as you or me—and the vast majority of mentally disordered people pose no threat whatever to anyone except themselves. Violence is a rare occurrence even in acute schizophrenia and is by no means as common as people perceive it to be. . . . The vast majority of patients are in practice more likely to be victims than offenders.[27]

Thus, although there may be a propensity toward violence among some people with schizophrenia (as there is within certain members of society at large), in reality it tends to be directed toward the persons *themselves* rather than toward others. This of course differs from the general perception of schizophrenia that tends to paint a picture of extreme violence as inherent within the condition. Greg Philo highlights this distorted public perception in his research into media images of mental illness.

> Beliefs about schizophrenia were related by group members to images from both factual and non-factual sources. This description from a woman in Motherwell combines both of these: "A lot of things you read in the papers and they've been diagnosed as being *schizophrenic*. These *murderers*—say Donald Neilson, was he no schizophrenic? the *Yorkshire Ripper* . . . on Brookside that man who is the *child-abuser* and the *wife beater*—he looks like a schizophrenic—he's like a *split personality*, like *two different people*. First he gets like self-pity and he brings flowers and works his way back into the house and you could feel sorry for him, then he's a child abuser and a wife-beater."[28] (Motherwell Group, Interview, emphasis added)

This statement contains truths, half-truths, and misinformation, and vividly illustrates the general confusion there is over what schizophrenia is and how people diagnosed with it are assumed to behave. Thus people with mental health problems find themselves criminalized and considered socially unacceptable, not because of what their condition actually *is*, but because of the way it is *perceived* within common folklore. Such false perceptions necessarily lead to disempowerment and the closing down of possibilities for acceptance and a valid and valued place within society.

Disabling Images

Otto Wahl, in his extensive investigation into public perceptions of mental health problems, highlights a study that was done to compare the attitudes of people to cancer and schizophrenia. In this study, undergraduates were read vignettes that portrayed a person as having either cancer or schizophrenia. They were then asked to rate the persons according to a series of traits. Wahl records that "the person identified as having schizophrenia was perceived as less desirable as a friend, less acceptable as a club member or neighbor, and less able to function in the community than the cancer patient."[29]

In the light of Miles' observations concerning the negative attributions that are ascribed to mental health problems, this in itself may not seem too surprising. However, when one takes into account that the vignette descriptions were *exactly the same*, apart from the name of the disorder, one begins to realize that there is indeed a major problem in the public's perception of mental health problems in general and schizophrenia in particular. Wahl's point is of critical importance. It is not so much bizarre behavior or speech to which people react as the particular images of mental illness which they hold.

> It is the public's negative image of mental illness and not the person or specific disordered behaviour to which they respond with discomfort and rejection. They are responding not to what they observe directly about the person with a mental illness, not to the actions or emotions of the psychiatric patients they encounter, but to stereotypes, their expectations, their acquired images of people with mental illness.[30]

People do not respond to the *person as person*, but to the *person as illness*. The fundamental form of relationship that a high proportion of the lay public offer toward people with schizophrenia is grossly ill informed and profoundly *impersonal*. The person living with schizophrenia is thus seen to be highly *stigmatized* in the perception of the public, and almost completely subsumed to their illness.

Understanding Stigma

The observations presented by Miles, Philo, and Wahl make it clear that stereotyping and stigma lie at the heart of the experience of all mental health problems and are intricately tied in with the social isolation that many sufferers experience. Because of the debilitating nature of schizophrenia and its enigmatic public image, people living with this illness are particularly prone to becoming stigmatized. Kirkpatrick and his colleagues in their research into the rehabilitation and social integration of persons with schizophrenia, discovered that "the primary external obstacle [to rehabilitation] identified was stigma, from both society and professionals."[31] Although one might at first consider stigma to be epiphenomenal to the central syndrome of schizophrenia, in fact it is a central part of the experience of people with schizophrenia and is a fundamental blockage to authentic understanding and the possibility of meaningful relationships.

Erving Goffman describes stigma as "the situation of the individual who is disqualified from full social acceptance."[32] The term "stigma" is used to refer to "an attribute that is deeply discrediting."[33] Goffman suggests that when a person is stigmatized because of some defect of character, behavior, or appearance, he or she is "thus reduced in our minds from a whole and usual person to a tainted, discounted one."[34] Goffman suggests that

> by definition, . . . we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as cripple, bastard, moron typically without giving thought to the original meaning. We tend to impute a wide range of imperfections on the basis of the original one.[35]

Miles makes a similar point concerning the subtle ways in which a person is stigmatized through jokes and everyday conversation:

> Such phrases as "Are you crazy?" or "It would be a madhouse" or "It's driving me out of my mind" or "We were chatting like crazy" or "He was running like mad" and literally hundreds of others occur frequently in informal conversations, and the discussants do not mean to refer to the topic of insanity and are usually unaware that they are doing so.[36]

Through the process of stigmatization a particular form of social identity is created and bestowed upon the stigmatized individual, a social identity that is fundamentally spoiled.

More than that, stigmatization acts to devalue and dehumanize those who become stigmatized. To stigmatize someone is to take one part of a person and make that the definitional point for the whole person. Thus people suffering from depression become "depressives," anxious people become "neurotics," and people with schizophrenia become "schizophrenics." Once persons are stigmatized and set apart by the attribution of a negative social identity, it is much easier for others to think of them as somehow less than human and to treat them as objects rather than persons. When persons become stigmatized, once again, in a very real sense they become nonpersons, a designation that, as we have seen, has profound social consequences.

Significantly, this stigmatization comes not only from others; the stigmatized individuals are also part of the society that stigmatizes them and as such shares in the social expectations and norms that, when broken, cause an individual to become stigmatized. Thus, "shame becomes a central possibility, arising from the individual's perception of one of his own attributes as being a defiling thing to possess, and one he can readily see himself as not possessing."[37]

From Mental Patient to Former-Mental Patient

Central to the situation of the stigmatized individual is his or her inability to feel or to experience *acceptance*, either by oneself or by others. "Those who have dealings with him fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding that some of his own attributes warrant it."[38] Even if individuals are able to correct the "blemish" that has caused them to become stigmatized, they are seen as simply having undergone "a transformation of self from someone with a particular blemish into someone with a record of having corrected a particular blemish"[39]—a shifting of the negative emphasis of their social identity from "mental patient" to "former-mental patient," from "schizophrenic" to "schizophrenic in remission."

Conclusion

It has become clear why people with schizophrenia can quite justifiably be considered nonpersons and why effective ministry within this area is fundamental for a faithful, liberating church. The types of relational and social poverty highlighted in this chapter have important implications for a church that seeks to take seriously its ministry of liberation and justice for the poor and the oppressed. Given the nature of the situation and the life experiences of many people with severe mental health problems such as schizophrenia, it is absolutely unthinkable that the church could simply sit back and assume that other agencies should be responsible for the care and welfare of people living under such circumstances. Now that our consciousness has been raised to the lived

experience of schizophrenia, we have no choice but to take prophetic action that will tangibly reveal our critical solidarity with a group of oppressed human beings. It is for such persons that Jesus came, and for them that he has entrusted responsibility for their care to the church that is his body on earth.

Now we need to move on from our social analysis and begin to draw out the implications of the previous discussions for a revised form of praxis for the church community. However, before doing that, it will be helpful to reflect on whether it is possible to generalize the findings of our case study on schizophrenia to other forms of mental health problems.