

Commentary on "Constituting Community: Creating a Place for Oneself"

Community Re-Entry: Development of Life Skills

Robert Paul Liberman and Kathy Silbert

For seriously disabled persons with schizophrenia, leaving the predictable, safe, secure, and supervised setting of a psychiatric hospital is a challenging transition that is all too often an experience of failure. Individuals who have limited knowledge, familiarity, external supports, and skills to adapt to community life find themselves caught in the revolving door of hospitalization, discharge, and re-hospitalization. Most publicly supported mental health systems fail to provide continuous, comprehensive, consistent, coordinated, consumer-oriented, and compassionate care for the most disabled of the mentally ill. Individuals who are seriously and persistently mentally ill have major deficits in social and coping skills, cognitive functioning, emotional regulation, and social supports. To expect them to constitute a community for themselves is romantic and fatuous. Even individuals without psychiatric disorders require organized learning experiences, social supports, and helping relationships to successfully traverse the treacherous territory from dependency to autonomy.

Intensive case management, anchored in mutually respectful and trusting relation-

ships, can help bridge the gap between hospital and community. The case manager or other clinicians on a mental health team must be able to elicit the personally relevant goals of the disabled individual, the attainment of which becomes the organizing principles and practices of treatment and rehabilitation. Also important for facilitating independent community functioning are social skills training, education and constructive involvement of the family, and ongoing assessment of symptoms and functioning with regular coordination of medication and psychosocial services by the case manager.

The gradual shift from abject dependence on a mental health system to optimal community re-integration is illustrated by two mentally disabled persons who were engaged by their clinical case manager in a long-term, trusting, confident, and stable relationship. This therapeutic relationship, infused by skills training and mobilization of family support, was the linchpin for the couple's deliberate and steady improvement in community functioning, tenure, and quality of life. Over time, this man and woman developed intimacy and solidarity that enabled

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them to live together, sharing the costs and pleasures of an independent, self-authored community.

light is." Beal and her co-workers have shone a light into the dark recesses of the community where it is possible to see the comings and goings of patients in their natural settings.

VENTURING FORTH INTO NATURAL ENVIRONMENTS

In their article, "Constituting Community: Creating a Place for Oneself," Dr. Beal and her co-authors identified an important dimension of community adaptation for persons with schizophrenia that is usually "off the radar screens" of mental health professionals (Beal et al., 2005). Contrary to the stereotype that schizophrenics are totally dependent on the mental health system and far too dysfunctional to take independent action on their behalves, the patients studied by these investigators made forays into their surrounding community many times a day and in many different ways. They sampled their local neighborhoods and encountered citizens of the community, many of whom were members of their family. Even when a person with schizophrenia is not living with family members, research has shown that they have numerous face-to-face and phone contacts each month.

In our work in five different community mental health centers, Veterans hospitals and the UCLA Neuropsychiatric Institute, we have been repeatedly dismayed to note the indifference and ignorance by psychiatric professionals to the "real lives" of their patients. Case conferences, rounds, consultations and admissions, plus progress and discharge notes focus on the symptoms and functioning of the patient primarily in the mental health setting. Rarely are home visits made; accompanying patients as they attempt to meet the challenges of surviving and adapting to community life is almost nonexistent.

Mental health professionals tend to see or care to see the behavior of patients *that is right in front of their eyes*. This is reminiscent of the proverbial drunk who is looking for his lost keys under the street lamp. When asked why he is only looking under the street lamp, the drunk says, "Because that's where the

ASSISTED VENTURES

While the graphic, anecdotal reports obtained by Beal's research group from their patients with schizophrenia broaden the visibility of their subjects' traversing the community, they lack a context for judging the importance of the activities, locations, and interpersonal encounters described by the patients. Context refers to the consequences of individuals' behavior, whether for good or for ill. A laissez-faire approach to patients who are viewed as having the decision-making, social, and emotional skills to create a place for themselves in the community conspires against contemporary possibilities for teaching the cognitive, social, and emotional skills that disabled persons need for improving their quality of life (Lieberman, Kopelowicz & Silverstein, 2004).

A libertarian ideology all too easily flows from excessive valuation of people with disabilities making a life for themselves when, in fact, such lives are often constricted, unhappy and victimized. Showcasing the limited range and effectiveness of venturing forth on their own and creating their own life style can inadvertently lead to a pessimistic view of what can be done by mental health professionals to enrich the lives of persons with schizophrenia.

The question to be asked is: "What can be done by mental health professionals to *expand the life space and empower schizophrenia patients to live more independently and with greater satisfaction?*" The answer is to provide the full range of mental health services but with an emphasis on teaching skills and creating opportunities for patients to use those skills to obtain their needs. Of course, patients with schizophrenia will wander the streets, have brief and sometimes stigmatizing conversations with their neighbors, visit and talk with their family members, and have

Table 1. Goals Commonly Articulated by Schizophrenia Patients, Evidence-Based Services and Outcomes That Can Help Patients Achieve Their Goals and Experiences Described by Patients in "Constituting Community: Creating a Place for Oneself"

Goal	Evidence-Based Service	Self-Reported Experience
Friends	Social skills training, psychosocial clubhouse (Lieberman, 1989)	"I haven't been able to make any girlfriends or boy-friends." "I don't really talk to anyone. I don't have many friends. I dropped all of my friends because they were using drugs." "People try to help if I'm feeling depressed, but I don't like to talk to them."
Work	Supported employment (Drake & Becker, 1996)	"Maybe working in a restaurant as a bus person or something. If I could get a job I'd be so happy." "If I could sell some of the things I make, I could make a little bit of money and have a little more money to enjoy myself."
Family	Behavioral family therapy (Lieberman & Liberman, 2003)	"My brother keeps badgering me to do something with my time." "She asks me if I want something. She gets them for me and brings them to me."

quiet moments of observing the lively play of children in a park. These self-initiated activities may have positive or negative consequences, but as Beal and her colleagues state, the activities do not necessarily reduce the likelihood of re-hospitalization. Neither do unaided self-directed activities lead to opportunities for patients to achieve the daily life experiences which they clearly desire.

While mental care professionals, as stated before, are often blind to the daily life experiences of their patients outside the mental health setting, Beal and her colleagues appear blind to the congeries of evidence-based treatments that have been shown to assist patients in their strivings to convert hope into reality (Lieberman, 1992; Wallace et al., 2001). Empirically validated services are listed in Table 1 along with the self-identified goals that these services can help patients to reach. They stand in contrast to many of the unsatisfactory experiences described by patients during their interviews in the study by Beals and her co-authors.

We don't need more narrative descriptions of the stagnant and dysfunctional lives of people with schizophrenia. Instead, we need to use those treatments and services that we already know enable these individuals to reach goals that will bring them closer to the rest of humanity: a job, friends, recreation, independent living, and a daily routine punctuated by

healthy pleasures and meaningfulness. If the currently available evidence-based treatments were adopted by mental health organizations, perhaps researchers infused with sociological theories and practices could invest their time and know-how to help these dysfunctional organizations effectively implement treatments that work (Lieberman et al., 2001).

TEACHING COMMUNITY RE-ENTRY SKILLS

Coordinated inpatient and community treatment of seriously and persistently mentally ill individuals—long considered a necessity—is far more the exception than the rule. Inpatient and outpatient facilities often have different administrative structures and clinical procedures. The staff members of inpatient and community-based programs are so concerned about hewing to their traditional, separate, and different ways of working that the needs of the individual patients are lost sight of. Regrettably, 25 years of research and clinical studies reveal that the majority of patients with schizophrenia and other disabling disorders do not follow through with community care, with as many as 70 percent failing to make even their first post-discharge appointment (Klinkenberg & Calsyn, 1996).

Table 2. Skill Areas and Learning Activities of the Community Re-Entry Module

Skill Areas	Learning Activities
Symptoms of mental disorders	Introduction: orientation and motivation
Readiness for discharge	Video questions & answers: learning skills through role models
Planning for community re-entry	Role playing exercises with coaching, corrective and positive feedback
Connecting with the community	Resource management: people, money, transportation, and forms needed to use skills in everyday life
Coping with stress in the community	Problem-solving: how to generate options for removing obstacles to using skills
Planning a daily schedule	In vivo exercises: implementing the skills with the encouragement of staff
Making and keeping appointments	Homework assignments: using the skills in everyday life autonomously
Benefits and side effects of medications	
Evaluating medication effects and side effects	
Solving medication problems with the doctor	
Using your relapse prevention plan	
Identifying warning signs of relapse	
Developing a relapse prevention plan	

Why do discharged patients fail to connect with public mental health facilities where they have been referred or where appointments have been made? One reason stems from the woeful misconception held by practitioners and their mental health programs that, instead of reaching out to the patients, they can wait for the patients to come to them at their convenient office hours. This misapprehension continues even today, despite the well-known deficits that most recently discharged patients have with decision-making, avolition, apathy, initiative, problem-solving, socialization and transportation. Underlying this convoluted thinking resides the belief that mental health practitioners are doing favors to the seriously mentally ill in offering their time and expertise to such an "unmotivated" population.

If mental health systems have failed to build bridges to outpatient care for patients at the point of discharge from hospital, why not empower the patients themselves to make their own passage? The Community Re-Entry Module (2000) was designed to bypass the intransigence of publicly supported practitioners through teaching patients the skills to actively seek and obtain their own comprehensive community care. It has been known for more than 30 years that patients with schizophrenia are able to learn to function at higher levels, *if they are engaged in a teaching program that accommodates the patients' deficits and uses tried and tested behavioral learning principles* (Wallace et al., 2001).

What are the learning principles and how are they applied in the Community Re-Entry Module?

The module comprises a videotape for demonstrating requisite skills to the patients, a trainer's manual and user's guide, and a participant's workbook. The module has 15 sessions, each of which teaches a different set of skills essential for patients to succeed in their transition from hospital to community. These skill areas are shown in Table 2 along with the learning activities that are used for teaching the skills. In effect, the module and the trainer who teaches its skills are providing a "special education" experience to individuals with varying degrees of cognitive deficits. The learning experience is not unlike the special educational services offered to others with cognitive deficits—individuals with developmental disabilities, autism and attention deficit disorder.

Can individuals with schizophrenia learn community re-entry skills? In psychiatric hospitals in the United States and abroad, the average improvement in knowledge and skills, drawn from pre- and post-tests using interview and role-play methods, is from below 50 percent to over 80 percent (Reger, Wong-McDonald, & Lieberman, 2003). Do the skills learned on the inpatient unit generalize to the real world where patients must actually make their own appointments, use their medications reliably, decide on residential options, and build a structured routine for them-

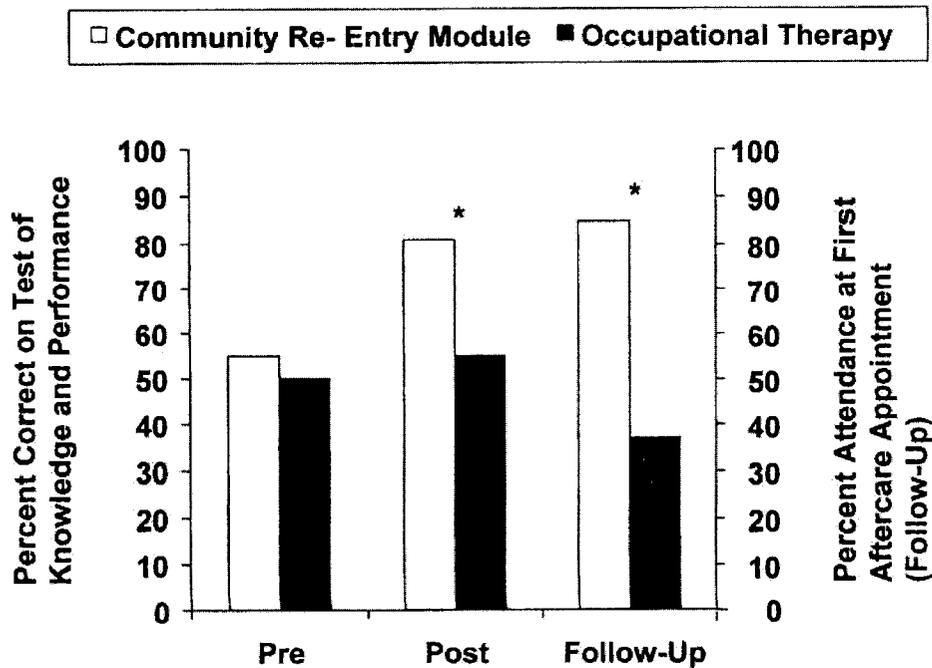


Figure 1.
Effectiveness of Community Re-Entry Module vs. Diversional Occupational Therapy for Continuity of Care.
* $p < .001$.

selves in the community? The results of one controlled study of the Community Re-Entry Module are depicted in Figure 1. In this study, schizophrenic patients admitted for 3 to 10 days to an acute psychiatric unit in a County hospital attended training sessions twice daily for as long as they were hospitalized. Their rate of making contact and engagement with an aftercare mental health program was more than twice as great among those who received the training compared to those who were randomly assigned to occupational therapy and standard discharge planning (Kopelowicz, Wallace, & Zarate, 1998).

If participation in the module is successful in connecting discharged patients with outpatient services, to what extent do the patients remain out of the hospital, avoiding the revolving door of hospitalization-discharge-rehospitalization? A controlled study of the module in Tokyo with chronic schizophrenia patients with an average duration of illness of 20.5 years found that 71 percent

were discharged from hospital without rehospitalization for at least a year. Only 20 percent of the comparison patients who received occupational therapy in lieu of the skills training achieved that criterion (Anzai et al., 2002). Moreover, social and instrumental role functioning improved by 42 percent in the patients who participated in the Community Re-Entry Module but only 14 percent in the comparison group. In other randomized, controlled studies of modules, social functioning was significantly greater in patients who participated in module-based learning groups in contrast with patients who had the same amount of exposure to either supportive group therapy or occupational therapy (Marder et al., 1996; Liberman et al., 1998).

Clinical Vignettes

J.M. was hospitalized at a Veterans medical center because of an exacerbation of his delusions and hallucinations after he dis-

continued his maintenance medication. He attended daily sessions of the Community Re-Entry Module, although when acutely ill he was encouraged to come and go from the group as his tolerance for social and educational stimulation permitted. After 10 days of hospitalization, his symptoms had stabilized and he made a phone call himself to arrange for his continuing care at the outpatient clinic at the medical center. When he returned to his apartment, one of the first things he did was to place his antipsychotic medication on his dining table where he would see it every day and not have to depend on his oft-times unreliable memory. He also brought to his outpatient psychiatrist his Medication Self-Assessment Rating Sheet, a form for monitoring the benefits and side effects from his medication that he had learned to use in the module. At each visit, this form enabled him and his psychiatrist to establish a collaboration in the ongoing management and decision-making of the type and dose of his medication. Two years after his discharge, he was living in his own apartment, managing his veteran's pension, attending a community college and socializing regularly with members of the local American Legion post.

F.G. was homeless, suspicious, fearful, and almost mute when he was found by a member of a mental health outreach team who persuaded him to register at the local mental health center where he could receive assistance in getting financial help and temporary housing. During the next five months, he met weekly with a psychiatrist at the mental health center, while moving from a shelter to a board-and-care home. His application for Social Security benefits was being processed and he gained weight, no longer appearing like an emaciated apparition. His case manager at the mental health center recommended that F.G. join the center's psychosocial rehabilitation program which met twice weekly for 6 hours.

Thinking more clearly, but still impoverished in his communications, F.G. was curious about the educational modules that were offered twice each day of the program. He completed the Basic Conversation Skills Module getting a 100% score on the post-test.

With his confidence rising, he began participating in the Community Re-Entry Module. He was particularly interested in the sessions devoted to identifying warning signs of relapse, which he knew all too well were harbingers of demeaning and threatening voices. Once he began to hear voices, there was nothing he could do to control them. The voices were followed by descent into day-long fears that others could tell what he was thinking and plotting against him. Emotional collapse, confusion, loss of initiative and abject helplessness ensued.

With the help of the module trainer, F.G. pinpointed his warning signs of relapse as irritability, social withdrawal, and a fear that something was just not right. He used those prodromal symptoms in developing his Warning Signs Rating Sheet and Emergency Relapse Prevention Plan. The board-and-care home where he lived was a stressful place. Aggression, drug dealers, and psychotic persons who sometimes screamed throughout the night kept F.G. tense and on edge.

He learned in the Community Re-Entry Module how to discuss, plan, and decide on residential placements, and he used those skills to persuade his case manager to assist him in finding his own place. Initially, it was a single room in a hotel. As he increased his active involvement in the psychosocial rehabilitation program, he advocated for his Social Security pension that was finally awarded to him. Knowing how to go about negotiating the pathways to better housing, F.G. was successful in managing his money and soliciting the help of his case manager in obtaining Section 8 housing. Three years later, F.G. is a leader of the Client's Council at the mental health center and volunteers one day a week in a homeless outreach program. What goes around, comes around. F.G. is now happily ensconced in his own apartment, is the editor of the mental health center's monthly newsletter, works out for 2 hours each day at a local YMCA, and is still learning how to manage his mental disorder through educational programs offered by a self-help club on Saturday mornings.

A COMMUNITY ALL THEIR OWN

Megan and Sam, long tormented by their schizophrenia, were in their early forties when they met in a therapy group held at the community mental health center where they received psychiatric services. Little did they know that their meeting would open pathways to a life of happiness together that would be in stark contrast to the misery they had both experienced since their early twenties. The pathway was blazed by a new case manager who took over professional responsibility for the coordination of their services when they entered her therapy group. Realizing that they had previously received fragmented, reactive, and crisis care at best, their new case manager was determined to plug the holes in their service plan and not let them drift aimlessly as they had in the past. Venturing forth with their considerable impairments and disabilities had led them into environments that ignored them at best and victimized them at the worst.

Both Megan and Sam had tumultuous and catastrophic histories. Megan had been hospitalized 14 times with persecutory auditory hallucinations ("You are a secret agent," "You have been hired by the White House to kill aliens and save the world") and suicide attempts. In addition to her psychotic symptoms, she was deeply depressed and experienced frequent panic attacks. When she wasn't at the mental health center, she was closeted in her room at the board-and-care home where she lived. As if the burden of schizophrenia was not enough, Megan was also obese and suffered from hypertension, lipidemia, dysmenorrhea, gastritis, uterine fibroids, and edema. Her public presentation was of an obese, distractible, frightened, agitated, and worried woman with pressured speech. However, she was well dressed and groomed, with normal memory, awareness of current events, comforted by religious beliefs, and compliant with her medication regimen.

Sam suffered from intractable auditory hallucinations that tormented and degraded him with insults. He also experienced almost daily panic attacks that worsened his lifelong

social anxiety. He was passive, not only in being out of control of his voices, but also in his social ineptness when dealing with others. Sam's initial decompensation into psychosis occurred during his fourth year of college; and he had lived marginally since that time. His 25-year treatment history consisted primarily of recreational forms of day treatment, brief medication management visits, 15 brief hospitalizations, and locked institutions in the community which might generously be called "human warehouses."

At the time he met his new case manager, he had been squandering his life in a board-and-care home. Like Megan, Sam had a plethora of medical co-morbidities: Bell's palsy with residual paralysis of his left facial muscles, peptic ulcers, and lymphoma. On meeting Sam, his case manager observed a man who was appropriately groomed and dressed, cooperative, had a good fund of knowledge, and expressed dissatisfaction with his life. He was anxious, depressed, worried, jittery, and restless.

Treatment and rehabilitation

In the ensuing weeks and months after assuming clinical responsibility for Megan and Sam, their case manager was able to see beyond their prominent symptoms and find two human beings who, despite their chronic illnesses and demoralization, still held out hope for a more normal existence. When their case manager elicited their *personal goals*, they both expressed a desire to strengthen their developing friendship, engage in some type of productive work, expand their social and recreational activities, and live in their own apartment.

Once she felt confident that she had a *therapeutic alliance* with Megan and Sam, their clinical case manager used *social skills training* with homework assignments to give them actual experiences of success in their everyday lives. Megan, who had a longstanding interest in art and creative writing, was helped to set small, realistic, and monthly goals that, when attained, resulted in personal pride and abundant *positive reinforcement* from her

case manager. She attended a local community college and, when stressed by taking three courses at the same time, learned to lower her sights in exchange for more equanimity and success. She took pleasure in the poetry she wrote and in her drawing and painting. Critical in this process was the *supported education* provided by her case manager who intervened at critical times to create accommodations for Megan's efforts to achieve her creative goals.

Sam also responded to *social skills training*, eventually becoming more assertive with the clinicians who were providing services to him at the mental health center. For example, when the clinical case manager first began working with Sam, she intervened with her colleagues on Sam's behalf. When he wanted more flexibility in receiving his weekly allowance, she spoke with the individual who was Sam's money manager. When he had a problem with his medication, she spoke with his psychiatrist. When he needed to reschedule his attendance in the psychosocial rehabilitation program, she made the arrangements with the rehab staff. However, at the same time that she acted on his requests for assistance, she arduously demonstrated her communication skills for him and increasingly coached him to use these skills on his own behalf. As Sam acquired social skills and put them to use to win his needs, his confidence in his own resourcefulness increased.

Social skills training methods were also instrumental for instigating and reinforcing Sam's exercise regimen: jogging and riding his bicycle in his neighborhood, doing yoga, and attending a health club. He was encouraged to activate his interest in sports by reaching out to his sister who shared a passion for the Los Angeles Lakers basketball team. His clinician used techniques appropriated from *supported employment* to assist Sam in gaining a volunteer job at a senior center where he led bingo games, read to the elders, and entertained by playing the piano.

After five years of gradual expansion of their lifestyle, their clinician assented to their desire to live together by sharing an apartment. With her encouragement, Megan and

Sam figured out a budget that combined their respective Social Security pensions to realize this goal. Using the skills they had obtained through years of treatment and rehabilitation, Megan and Sam conducted their own search for an apartment. After numerous interviews with apartment managers and not a few disappointments, they finally landed a place of their own. Given their meager budget, however, they were not able to properly furnish it.

Throughout this time, their clinical case manager utilized techniques from *behavioral family management* (Lieberman & Lieberman, 2003), such as communication and problem-solving skills development, that motivated Sam and Megan to re-invigorate their relationships with their parents. Sam assisted Megan's infirm parents by carrying out chores and shopping for them. He effectively galvanized a closer relationship with his father with the encouragement and positive social reinforcement from his clinical case manager. Shortly after they moved into their apartment, Sam and his case manager practiced how he might make a positive request for financial aid from his father to help furnish his apartment. For example, rather than ask in a beleaguered and supplicating manner, Sam learned to say, "Dad, Megan and I would sure appreciate your help in getting our apartment to feel like home to us. If you could help us financially, we would feel like the place was really ours. We finished painting the rooms but used up our savings for the paint and stuff. We've got our eyes on some good buys for furniture at a thrift shop but need about \$500 to be able to afford it." Sam's father responded generously to his son's request and provided enough assistance for them to get curtains and rugs as well.

At the time of this writing, Megan and Sam have lived together for three years. As their intimacy improved, Megan has become a great support to Sam in his continuing struggle against cancer—chemotherapy has curtailed his lymphoma but he's had to pay the price of many noxious and toxic side effects. Megan's episodes of deep depression have become less frequent with Sam at her side, supporting her involvement in their home mainte-

nance and social activities. Their clinical case manager has gradually reduced the frequency of their meetings and has made occasional home visits to reinforce their successful integration into normal society. There will be no "case closed" or termination. In working with people with schizophrenia, there are no "goodbyes."

CONCLUSION

Underlying the deliberate, slowpaced progress made by Megan and Sam was their clinician's adapting and using those skill areas from the Community Re-Entry Module that enabled them to learn how to (1) schedule their daily routines in which they gradually added more exercise, social, and recreational activities, (2) initiate phone calls and face-to-face interactions with key people in the community, (3) communicate effectively in face-to-face meetings with the key people who could "open doors" for them in finding housing as well as vocational and educational opportunities, (4) problem-solve the bumps in the road inherent in any relationship, and (5) strengthen their relationships with their parents.

Another skill area from the module that was utilized in their treatment focused on increasing their assertiveness in communicating their problems, needs, and side effects to their psychiatrists. In schizophrenia, the passivity that is intrinsic to the experience of psychotic symptoms can be gradually rolled back when there is continuous, coordinated, comprehen-

sive, compassionate, competent and patient-oriented care.

How persons with schizophrenia fare in society is a reflection of the resources, skills, and investment of public agencies in their treatment and rehabilitation (Cohen, 2002). As is described in the article by Beal and her associates, when left to their own devices, schizophrenia patients drift rather aimlessly. Sometimes in their drifting, they may venture into environments that are hospitable and responsive to their needs. Unfortunately, much more frequently the byways of the community are hostile, indifferent, victimizing, and constraining (Turner & Lloyd, 1995). It is generally agreed that the beneficent paternalism of large state hospitals is not worth the institutionalism they breed; community-based treatment alternatives must provide proactive treatment, supportive and long-term relationships infused with structure, encouragement of progress toward personal goals, and training in social and independent living skills.

For those of us toiling in the vineyards of community-based services for the seriously and persistently mentally ill, no one promised us or our patients a rose garden without thorns. However, if we and our patients aim for realistic and attainable short-term goals that are milestones on the long road to disease management, meaningful work, social relationships, and independent living, recovery from schizophrenia is possible (Lieberman & Kopelowicz, 2002a and 2000b).

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