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Self-perceived social integration and the use of day centers of persons with severe and persistent schizophrenia living in the community: a qualitative analysis

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Abstract *Background* The study examined how persons with severe and persistent schizophrenia perceive their social integration and how particular types of social integration are related to the use of day centers and patient clubs. *Methods* Problem-focused interviews on self-perceived social integration and the use of day structuring services were done with 100 persons with an ICD–9 diagnosis of schizophrenia living in Leipzig. Transcribed interviews were subjected to computer-aided qualitative content analysis. *Results* Results of the qualitative content analysis show that the study participants can be classified in five different groups according to their self-perceived degree of social integration. The use and the subjective meaning of existing day structuring services was found to be associated with the type of self-perceived social integration. *Conclusion* The heterogeneous ways persons with chronic schizophrenia organize their social lives lead to different kinds of needs for support. In order to meet the needs of the whole spectrum of patients this heterogeneity must be taken into account in the process of service planning.

Key words Schizophrenia – Social integration – Community services – Service use – Subjective meaning – Qualitative research

Introduction

Social disintegration and lack of adequate social relationships are very important non-medical problems of persons with chronic schizophrenia living in the community (Cohen and Sokolofsky 1978, Lipton et al. 1981, Holmes-Eber and Riger 1990, Thornicroft and Breaky 1991, Munk-Jorgensen and Mortensen 1992, Salokangas 1997, Becker et al. 1998, Borge et al. 1999). In Western Europe as in the United States low threshold day structuring services such as day centers or patient clubs are commonly regarded by service planners as suitable institutions for helping these people to structure their daytime activities and to prevent isolation and loneliness (Thornicroft and Breaky 1991, Meeks and Murrel 1994, Albert et al. 1998). However, several studies on how people with severe and persistent mental illness living in the community organize their social life suggest that these people often have ambivalent attitudes to such kinds of services. On the one hand they appreciate these institutions as opportunities for spending the day and meeting other people, on the other hand they disdain them as symbols of their own social disintegration (Garrison 1978, Estroff 1981, Scheper-Hughes 1987, Barham and Hayward 1991, Knowles 2000).

A possible explanation for this ambivalence was found in the studies of Estroff (1981) and of Barham and Hayward (1991) who both discovered that people suffering from schizophrenia or other severe mental illnesses tend to distinguish between relationships with, in their view, "normal" people and relationships with other mentally ill patients, as well as with staff members of psychiatric services. In most cases contacts with normal people were considered as most desirable, but at the same time regarded as difficult to establish and maintain due to the lack of social skills and the risk of stigmatization. In contrast, contacts with other mentally ill people were considered as emotionally beneficial and less demanding, but at the same time these contacts were devalued as a provisional solution to prevent loneliness and social isolation. These results make obvious that systematic knowledge on the subjective meaning of social relationships for people with schizophrenia is needed as a precondition of effective interventions in this area. Existing studies on the social networks of people with schizophrenia usually provide only information about the

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quantitative and qualitative aspects of social relationships, but disregard the aspect of subjective meaning. As a consequence, the discrepancies described above will be ignored or only interpreted as indicators of lacking social skills. However, the experiences and acts of humans are based on subjective meaning systems. Therefore, existing social networks of people with schizophrenia must be considered as results of meaningful efforts of these people to satisfy their social needs under the conditions of chronic mental illness. For example, Corin (1991, 1998) found that two groups of people with chronic schizophrenia characterized by high and low rehospitalization rates differ considerably in their subjective interpretation of their poor degree of social integration. People with a high re-hospitalization rate felt socially excluded, whereas people with a low re-hospitalization rate interpreted their marginal social position as an intentional withdrawal from social demands. Consequently, although they are disintegrated in a similar way, people from both groups would need completely different types of support to maintain their own way of coping with their disease.

According to the information requirements described above, a qualitative approach using problem-focused semi-structured interviews and computer-aided content analysis were applied in this study to analyze:

- How do persons with chronic schizophrenia living in an inner city area perceive their social integration?
- What needs for support in the area of social contacts do these persons express?
- In which way do patients use institutions that provide support in the area of social contacts?
- From the patients' subjective perspective, what are the benefits of using institutions that provide support in the area of social contacts?
- To what extent will the needs for support in the area of social contacts be met by the existing services?

Subjects and methods

Study design and sample characteristics

A cross-sectional study including people with chronic schizophrenia living in an inner city area of Leipzig was carried out from September 1996 to August 1997. The study sample consists of 100 patients who fulfill the following inclusion criteria. They were diagnosed as having schizophrenia according to ICD-9: 295. Their age was between 18 and 65 years. They lived in the catchment area of the study and were in psychiatric outpatient treatment at the time of the interview. Furthermore, as a criterion of the persistence of the disease only persons who had at least four periods of inpatient treatment were included as participants. All psychiatrists in private practice and all psychiatrists working in outpatient clinics in the catchment area were requested for recruiting patients who fulfill the inclusion criteria for participation in the study. Of the 160 persons asked to participate, 112 agreed. All participants were asked to sign a consent form before they were interviewed. As a result of a screening for the verification of inclusion criteria, eight persons were excluded from the sample because of not meeting all of the criteria. From the persons included in the study, 33% came from outpatient clinics, 32% came from community mental health services, and 35% came from private practitioners. After the interviews were completed, four persons were excluded because the interviews could not be analyzed. The study participants were on average 49 years old (SD 13 years) and 46% were male. Eighty percent of the participants were not married and 45% lived alone. Only 3% of the participants had a regular job at the time of the interview. On average the participants had been ill for 20 years (SD 10 years). The average global BPRS score was 36.44 (SD 8.7) and the average global SANS score was 10.31 (SD 4.5).

Instruments

A semi-structured problem-focused interview concerning the person's description and evaluation of his or her current living situation was developed for the study. The complete interview encompasses the description and the subjective evaluation of central domains of life such as family, social contacts, finances, work, housing conditions, leisure time activities, and the subjective assessment of the availability and quality of medical and non-medical psychiatric services. The interviews took 90–180 min to be completed and in some cases it was necessary to divide them into two or three sessions. The interviews were done by two clinically trained psychologists and a social worker who had worked in community mental health services for several years. If possible, the interviews were done at the homes of the study participants. Participants who refused to be visited at home were interviewed either at the mental health service institution where they were treated or at the office of the interviewer. Participants were asked for permission to tape-record the interviews and none refused. The tape-recorded interviews were fully transcribed and great care was taken that the anonymity of participants was completely protected. For each patient general psychopathological symptoms were assessed by means of the Brief Psychiatric Rating Scale BPRS (Overall and Gorham 1962) and negative symptoms were assessed by means of the Scale for the Assessment of Negative Symptoms SANS (Andreasen 1989).

Data Analysis

For the analysis of the problem-focused interviews we used the method of computer-aided qualitative content analysis (Kuckartz 1997, Kelle 1995). In the first step, the interviews were coded according to the research questions by two independent coders (Silverman 2000a, 2000b, Coffey and Atkinson 1996). The coding system was developed inductively, meaning the categories were generated and reversed as long as new information was found within the interviews during the process of the content analysis (Coffey and Atkinson 1996). In the second step, the two code systems were compared by the research group. Differences in the code systems were discussed and a final code system was created. In the third step, criteria for the classification of patients to distinct types of social integration were developed on the basis of the coded interviews. In the fourth step, a classification system for distinct types of social integration was developed by contrasting cases according to these criteria as long as each patient could be classified in one category (Ely et al. 1997, Kelle and Kluge 1999).

Results

The development of a typology of social integration was based on the following criteria which were obtained from the coding system. First, the person feels either fully integrated in normal society or not; second, the person reports having social contacts in more than one social setting or not; third, the person describes their social contacts as frequent or as sporadic; fourth, the person reports having at least one close emotional relationship or not; fifth, the person feels able to establish new social relations to people who are not mentally ill or not. The typology was developed by contrasting cases who fulfilled all, some, or none of these criteria. Then people who fulfilled only some of the criteria were examined for the particular characteristics of their social relationships.

As a result of the classification process described above the following five types of social integration could be defined (see Table 1).

The first group, labeled as *Integrated*, consists of 24 persons who have regular social contacts in different social settings. They have at least one close emotional relationship, they feel able to establish new social contacts with persons who are not mentally ill if they want, and they are satisfied with their social life. The following interview sequence of a 49-year-old woman who has been ill for 29 years illustrates this perception: *"I:… Mm is there anything else good about your present life situation? –P: All right then. I meet lots of people. That's simply conditioned by the garden. – My husband he is administrator in the garden association. By this we often contact the board. And often all of the people who manage and build up all of it. And that builds me up, too. And so I have always got something to be looking forward to…That they carry me along, and also that I'm in practice being reintegrated into the society."* (female, 49 years old, ill for 29 years, living together with her husband).

Altogether people belonging to this group feel integrated in "normal" social life. Most of the patients in this group have no contact with other patients and they do not want to have such contacts. Persons in this group do not express any need for help or for services in the area of social relationships. Only two out of the 24 persons in this group occasionally use complementary psychiatric services for social activities. Some persons have made use of these institutions in earlier times, but have stopped using them because they want to reduce their contact with psychiatric patients.

The second group, labeled as *Integration Oriented*, consists of 21 participants who have regular social contacts in different social settings and these contacts are not limited to mentally ill patients. However, persons in this group feel either partly disintegrated or fear becoming disintegrated in the future. Therefore, they want to have more social contact with healthy people and more opportunities to get involved with "normal" social activities. The lack of money along with the fear of stigmatization were cited as barriers to fulfill these wishes by many of the patients. On the whole, there is also an apparent preference in this group to consider contact with people who are not mentally ill as the preferred option. The following sequence of a 42-year-old male person who has been ill for 20 years illustrates this attitude: "*P:… Once of course, when I was in hospital frequently, I had ill friends, too. (I: Mm) Though – they are a bit too extreme. First they are ill too frequently. And then – they are also – I can hardly describe. Somehow it's better if you, as a sick person, have healthy friends… Apart from that one, apart from that R. Well he's harmless. (I: Mm) And he doesn't get cheeky.*" (male, 42 years old, ill for 20 years, living together with his mother).

The ability to establish and maintain such contacts is perceived as a factor in elevating self-esteem. However, 11 out of 22 people in this group use complementary psychiatric services for their social activities.

The third group, labeled as *Integrated in Psychiatric Consumer Social Relations*, consists of 22 persons who have regular social contact exclusively to other mentally ill persons, and most of them have given in to this limitation because they do not feel they are in the position to establish and maintain relationships with healthy people. The following statement of a 26-year-old male person who has been ill for 6 years gives an example of this type of social integration: *"I: What does it mean to you to have friends who are in the same situation as you? P: What does it mean… well somehow you are a bit in an isolated circle, actually I would like to break out of the thing sometimes. But I obstruct my way myself, you know. All I need is to go places, I mean I do have two or three friends, let's say mates, pals. We help each other and so on, and actually we're together each day. Quarrels or something like that do happen, but that works like this, sometimes one of us tries to rebuke the another one, you know, this is not exactly wrong, is it. Well actually it's honest somehow, it's not as if…*" (male, 26 years old, ill for 6 years, living alone).

The most important problem mentioned by these patients was the lack of close emotional relationships. Patients in this group have mostly lost confidence in their ability to maintain social relationships with healthy people. In most cases these participants feel incapable of fulfilling the demands of conventional social roles. Fourteen out of 22 persons in this group were frequent users of complementary services for social contacts.

Table 1 The typology of social integration

Types of social integration	Criteria for classification of social integration				
	Feeling fully socially integrated	Feeling able to establish new social contacts with non-patients	Having contacts in more than one social context	Having at least one close emotional relationship	Having regular social contacts
Integrated (n=24)	yes	yes	yes	yes	yes
Integration oriented (n=21)	no	no	yes	yes	yes
Integrated in psychiatric consumer relationships (n=22)	no	no	no	no	yes
Family context (n=18)	no	no	no	yes	yes
Disintegrated (n=15)	no	no	no	no	no

The fourth group, labeled as *Integrated in Family Context*, consists of 18 persons who only have contact with members of their family and who have a close emotional relationship to at least one family member. The social situation of the people in this group is illustrated by the following statement of a 36-year-old woman: "*I: Mm, how would you describe your circle of friends? P: Well, the circle of friends, well, we don't really have friends, not really, but, mm, we get on well with my husband's brothers and the sister-in-law and the brother-in-law. It's actually them who are our circle of friends. I: Your husband's relations? P: My husband's, yes. I: And yourself, you don't have any friends of your own, or… P: No. I:… of whom you'd say I've known them for a long time, they're close friends? P: No, not really.*" (female 36 years old, ill for 15 years, living together with husband and son).

Persons in this group feel incapable of establishing new social contacts with healthy people and do not want to have contacts with people who are also mentally ill. Though most persons in this group are satisfied with their existing social relationships, nearly all of them express the need to have more contacts with non-mentally ill people outside of the family context. Only one person in this group utilized complementary psychiatric service institutions for social contacts, while four persons strictly rejected to use day centers as a place to meet people.

The fifth group, labeled as *Disintegrated*, consists of 15 persons who, except one, live alone and who have either no or only sporadic contact with other people. Persons in this group feel unable to establish contact with other people on their own initiative, and most of them suffer from their loneliness. The following short interview sequence of a 54-year-old man describes how people in this group perceive their social situation: *"I: Mm, and apart from your sister, do you have any other friends? P: I do not have any friends, I've had no friend at all. Because I've always been ill. Because I've always, I've always been self-conscious and inhibited and…* " (male, 54 years old, ill for 31 years, living alone).

Persons in this group feel unable to get out of their isolation on their own, but most of them also seem to be unable to use the support of the existing services due to their lack of elementary social competencies. However, these persons suffer from their isolation but they are too resigned to express their wishes for more social contacts. Nevertheless, social relationships with other psychiatric patients are clearly rejected by the members of this group, too. This aspect is also reflected in the fact that only two out of 15 people in this group frequently use complimentary psychiatric services for social contacts.

Type of social integration and individual characteristics of the participants

Comparisons of group means were made to examine relations between type of social integration and age, duration of illness, general psychopathological symptoms and of negative symptoms between the five integration groups. For age and duration of illness no statistical significant differences were found between the groups. The relations between symptoms and type of social integration are presented in Table 2. For both scales a higher score indicates more severe symptoms.

For general psychopathological symptoms and for negative symptoms Table 2 shows the means, the standard deviations, and the 95 % confidence intervals of the SANS and the BPRS global scores for the five groups. On average, persons classified as "integrated" had a global BPRS score of 32.1 (95 % CI 28.8–35.4) and a SANS score of 7.6 (95 % CI 5.8–9.45). Persons in the second group labeled as "integration oriented" had a mean global BPRS score of 36.8 (95% CI 32.5–41.1) and a mean global SANS score of 10.4 (95% CI 9.3–12.5) and the overlapping confidence intervals indicate no significant differences to the integrated group. The average BPRS score in the third group, labeled as "integrated in psychiatric consumer social relations", was 36.9 (95 % CI 32.0–41.9) and the average SANS score was 9.8 (95 % CI 7.4–12.3) which is not significantly different from groups one and two. The average BPRS score in group four, labeled as "integrated in family context", was 38.0 (95% CI 33.2–42.9) and the average SANS score was 11.8 (95 % CI 10.2–13.4) indicating that persons in this group have significantly higher negative symptoms compared to those of the integrated group. Persons in the fifth group labeled as "disintegrated" had a mean BPRS score of 40.7 (95 % CI 37.3–44.1) and a mean SANS score of 13.5 (95 % CI 11.2–15.9) indicating significantly higher psychopathological symptoms and significantly higher negative symptoms compared to group one.

Table 2 Type of social integration and psychopathological symptoms

Type of social integration	SANS Global score		BPRS Global score	
	Mean (SD)	95 % CI	Mean (SD)	95 % CI
Integrated	7.6 (4.1)	5.8–9.45	32.1 (7.5)	28.8–35.4
Integration oriented	10.4 (4.2)	9.3–12.5	36.8 (8.9)	32.5–41.1
Integrated in psychiatric consumer social relations	9.8 (5.1)	7.4–12.3	36.9 (10.2)	32.0–41.9
Integrated in family context	11.8 (2.9)	10.2–13.4	38.0 (9.1)	33.2–42.9
Disintegrated	13.5 (3.9)	11.2–15.9	40.7 (5.6)	37.3–44.1

Type of social integration and use of day centers

The day structuring service mainly used by the study participants is called “Das Boot” (the boat), which is a low threshold day center run by social workers and located central to the catchment area. As a part of the community mental health system this facility offers several therapeutic options, such as occupational therapy, but also provides the opportunity to have a cheap lunch, or just to drink coffee and “hang around” with other people.

Table 3 shows the frequency of the use of the day center by type of social integration. Out of the persons who were classified as integrated in psychiatric consumer social relationships and as integration oriented, 14 (63.6 %) or 11 (52.4 %), respectively, used the day center at least once a month. On the contrary, out of the persons classified as integrated and as integrated in the family context, only 2 (8.3 %) or 1 (5.6 %), respectively, used this type of services at least once a month. Among those who were classified as disintegrated, 4 (26.7 %) used the day center at least once a month.

All participants who reported the use of a day center at least once a month were asked about their main activities when they using these facilities. All reported activities were classified in four categories which are presented in Table 4. The first kind of activities are typical leisure activities such as playing cards or chess, painting, making pottery, and so on. The second type of activity is drinking coffee, which is commonly regarded as a good opportunity to talk to other people. The third type of activity is having lunch. In all day centres in the catchment area patients have the opportunity to get a hot meal at a low price. The fourth type of activity is getting advice or practical support from social workers, such as help if patients have difficulties with authorities, with house owners, with bureaucratic affairs, or with other everyday problems.

As one can see from Table 4 persons who were classified as integration oriented or as integrated in psychiatric consumer relationships are not only the main users of the day center, they also have a more complex pattern of activities for which they are using these facilities. The mean number of reported activities in the last column of Table 4 shows that participants who are integrated in psychiatric consumer relationships reported on average 1.9 activities whereas persons who are classified as integration oriented reported on average 1.5 activities and participants belonging to the other groups reported only one activity. Furthermore, there are some interesting differences between the two main user groups. The percentage of persons who engaged in leisure activities in the day center is more than twice as high in the group of those who are integrated in patient psychiatric consumer relationships than for those who are classified as integration oriented. The percentage of persons who reported drinking coffee as an activity they are doing regularly in the day center is higher in the integration oriented group than in the psychiatric consumer relationships group. The relative frequency of persons

Table 3 Type of social integration and frequency of using day centers

Type of social integration	Frequency of using day centers			
	At least once a month N (%)	Less than once a month N (%)	Never N (%)	Σ N (%)
Integrated	2 (8.3)	11 (45.8)	11 (45.8)	24 (100)
Integration oriented	11 (52.4)	5 (23.8)	5 (23.8)	21 (100)
Integrated in psychiatric consumer social relationships	14 (63.6)	3 (13.6)	5 (22.7)	22 (100)
Integrated in family context	1 (5.6)	6 (33.3)	11 (61.1)	18 (100)
Disintegrated	4 (26.7)	3 (20.0)	8 (53.3)	15 (100)
Σ	32 (32.0)	40 (40.0)	28 (28.0)	100 (100)
	$\text{Chi}^2 = 28.773$, df = 8, $p < 0.001$			

Table 4 Type of social integration and activity pattern in the day center

Type of social integration	Activities in day centers				
	Leisure activities N (%)	Drinking coffee N (%)	Having lunch N (%)	Getting advice or support N (%)	Mean number of activities per user
Integrated	0	1 (50.0)	0	1 (50.0)	1
Integration oriented	3 (27.3)	5 (45.5)	3 (27.3)	5 (45.5)	1.5
Integrated in psychiatric consumer social relationships	8 (61.5)	4 (30.8)	7 (53.8)	7 (53.8)	1.9
Integrated in family context	1 (100)	0	0	0	1
Disintegrated	0	0	1 (50.0)	2 (100)	1
Σ	12 (25.0)	10 (20.8)	11 (22.9)	15 (31.3)	1.5

who have lunch in the day center is nearly twice as high in the psychiatric consumer relationships group than in the integration oriented group and the percentage of participants who go to the day center for getting advice or practical support is slightly higher for those who are integrated in psychiatric consumer relationships in comparison to those who were classified as integration oriented.

Type of social integration and the subjective meaning of service use

As shown in Tables 3 and 4, persons classified as integration oriented and persons classified as being integrated in psychiatric consumer social relationships are using the day center more frequently and more intensively than the participants with other types of social integration. Furthermore, the activity pattern of participants who are integration oriented was found to be different from that of participants who are integrated in psychiatric consumer relationships. For the purpose of exploring the subjective meaning of these different activity patterns, we compared the statements of the persons belonging to the integration oriented group with those of the persons belonging to the psychiatric consumer social relationships group. The results of these comparisons suggest that the people who are classified as integration oriented use the day center or the patient club as a place to go, like a "bar" or a "coffee shop", where they can meet other people and if necessary get some practical help as illustrated by the following typical statement of a 33-year-old woman: *"No, I don't go there to seek help, I go there, well, it's because of P. (I: Mm.), for a bit of a chat, to have a cup of coffee. But I don't really go there now. That is finished now/that was some time ago…"*. (female, 33 years old, ill for 8 years, social integration group 2).

For the persons who were classified as integrated in psychiatric consumer subculture the day center is more a kind of second home or shelter where some of them spend their whole day. The following description of a 53-year-old male patient's typical day illustrates this kind of service use: "*I went to the "Boat" (name of the day center) around lunch time, we played skat. (laughs) Our regular activity/daily routine. And then I went home at about 8 at night, watched a bit of TV, then went to sleep… In any case, I find such facilities positive. 'Cos for some people, well, to be honest with you, if these facilities didn't exist…*" (male, 53 years old, ill for 30 years, social integration group 3).

Looking at what people belonging to the different groups like and dislike in the day center, it becomes obvious that people classified as integration oriented tend to criticize the characteristics and behavior of users who are in their eyes "crazier" than themselves. Therefore, a 45-year-old male patient gives the following appraisal of the day center: "*Well, partly good, partly bad, I'd say. In the past, when we still used to make breakfast at the… when we still had a nice breakfast, had a nice chat. Now things have split up somewhat. People do their own thing now, everyone… They play cards (skat) every day. It is starting to make me sick. They play for money, but they all have hardly any money left, then they lend each other money and so on, which usually ends up with a quarrel. Mm, you have seen it, haven't you, (they) ripped the receiver off the phone, the police come there three times a week, or at least once a month. With the public, we're only half as well-known as with the police, isn't that right?*" (male, 45 years old, ill for 24 years, social integration group 2).

In particular female users from this group complain about sexual harassment by some of the male users as the following statement of a 37-year-old woman demonstrates: "*Well, they (the male users) are simply a bit too unrestrained, and it is a bit too hurtful for my taste, the way they treat women.*" (female, 37 years old, ill for 11 years, social integration group 2).

In total the attitudes towards the day center held by the persons in the integration oriented group reflect the general tendency of the persons in this group to keep their distance from mental illness and to maintain at least a partially healthy identity.

In contrast with persons classified as integration oriented, persons who were classified as integrated in psychiatric consumer social relationships in general consider the day center more positive. As the following three statements illustrate, this higher service satisfaction can be explained by the different meaning these institutions have for persons belonging to this group. Here, a 26-year-old male user describes what meaning the day center has for him: "*Well, to have something to do, to have an occupation is quite good for a start, and then lunch is also good there, and beyond that, nothing much is happening, but it's quite okay, I think.*" (male, 26 years old, ill for 6 years, social integration group 3).

The next 45-year-old male participant expresses his feeling of being socially accepted as his main reason for coming to the day center: "*Well, first of all, the contact consists in that they phhh, accept me, respect me. That I exchange ideas, that one has…. There are two women, at least. I also have a certain affinity, and that is surely reciprocal, too. (…) it is at least, it is a terrain where I also know (my way around), where I quite like to go or where I'd contact if need or where I feel understood, or so.*" (male, 45 years old, ill for 26 years, social integration group 3).

As one can see from the citations, having a place to go where they feel accepted as they are and where they find people to talk to seems to be the most important expectations these individuals have of these institutions. The next statement of a 52-year-old participant illustrates that alongside the possibility of social interaction the day center also can be used for practical reasons such as the low prices for coffee and meals: "*Well, I can eat for cheap, one can have a bit of a chat. There's not much more happening there, actually. But where else should one go, one is all alone in town/in the city.*" (male, 52 years old, ill for 30 years, social integration group 3).

Discussion

Results of the qualitative content analysis of the interviews show that the patients in our sample can be classified in five different groups according to their perception of their "oddity" in relation to healthy people and to the self-assessment of their abilities to establish and to maintain "normal" social relationships. The types of social integration we found can be regarded as different ways to satisfy social needs, e. g., for interpersonal affection, emotional support, social identity, sociability, and instrumental aid under the condition of limited social competencies due to mental illness. Why a person has developed his or her particular way to arrange his or her social life results at least partly from the severity of the psychopathological symptoms as indicated by the differences between the integrated and the disintegrated group found for the BPRS and the SANS. However, the lack of significant differences between the other groups lead us to assume that other factors, such as the particular characteristics of the individual biography, are relevant in this process. Identifying such styles of coping with the problems resulting from chronic mental illness is of great practical importance for the service system. We found that the type of social integration was related to the use of day structuring services in several ways. First, we found that existing services are used mainly by persons belonging to the groups which were classified as integration oriented and as integrated in psychiatric consumer subculture. Participants belonging to the other types of social integration only make marginal use of day structuring services. Furthermore, we found that the use of the day center has a different subjective meaning for people in both groups. Persons classified as integrated in psychiatric consumer subculture benefit more from these institutions because they have resigned themselves to their position as outsiders and they only look for a place were they are accepted as they are. Persons classified as integration oriented, in contrast, also use the day center for meeting other people and if necessary getting support from staff members but for these people the benefit of the day center is reduced because they do not like the "crazy" atmosphere and they miss the opportunity of being in contact with healthy persons. Services supporting the efforts of these people to prevent social disintegration must offer opportunities for training and testing social competencies. At the same time existing barriers preventing these people from normal social contacts such as lack of money or stigmatization must be identified and minimized.

Limitations of the study result from the cross-sectional character of the data because it must be suspected that the way people arrange their social life changes over time depending on the development of their illness and other life circumstances. Further studies should address the question as to how such changes occur and what conditions affect this process of change.

Conclusion

The different characteristics of the five types of social integration we identified demonstrate that speaking of the social disintegration and the social disabilities of people with chronic schizophrenia suggests a uniformity which does not exist in reality. However, beyond correcting the picture of the "schizophrenics", the results of the study are of practical importance because they help to identify the shortcomings of an existing service system and at the same time they offer an informational basis for the development of new types of services or institutions which meet the particular needs of persons with chronic schizophrenia who are trying to lead their lives in modern urban areas. Further research should be done to acquire more knowledge of the dynamics of social integration of people with chronic schizophrenia over time.

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