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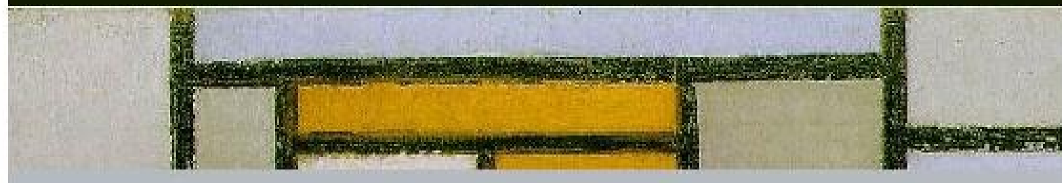

The Family of the Psychiatric Patient

American Handbook of Psychiatry

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Introduction

This chapter will consider the relationship between a set of events usually thought of as being characteristic of a single individual, his psychiatric status, and events taking place in a natural social group, his family.

Interest in the family *of* the psychiatric patient has blended in recent years with an interest in the family *as* the psychiatric patient. As a therapeutic modality, family therapy originated in child psychiatry, drew important technical skills from play therapy, group therapy, and psychodrama, with more recent additions from the encounter and training group fields. On the theoretical side it has drawn much from psychoanalytic theory, from anthropological and sociological studies of the family and of small groups, and, more recently, from cybernetics, general systems theory, linguistics, and kinesics. While the family field has burgeoned in the last two decades as a therapeutic and social movement, it is conceptually diverse and varied. As to practice, there are no generally accepted standards of certification or accreditation, and there is no national organization of family therapists; teaching in the field goes on in many different settings: medical schools, family institutes, freestanding workshops, in-service training programs of social work and mental health facilities, and graduate programs of departments of psychology.

This diversity can be found at all levels of theorizing, research, clinical

conceptions, and therapeutic management. In this survey we will attempt to present the main elements of this array. In doing so we will focus on the following issues:

1. The Concept of the Psychiatrically Relevant Family
2. Categories of Definition of the Relation of the Family to Psychiatric Disorder
3. Psychiatric disorder as an exogenous stress on the family
4. Psychiatric disorder as caused by pathogenic relationships in the family
5. The family as a pathogenic culture carrier
6. Psychiatric disorder as an expression of the systems properties of the family
7. Family Characteristics Related to Specific Psychiatric syndromes
8. The Psychiatric Future of the Family

The Psychiatrically Relevant Family

An anchoring concept used in this essay is that of the *psychiatrically relevant family*, a term used to delimit a natural social system, based upon, but not limited to, the nuclear family. The psychiatrically relevant family may be defined along two principal dimensions, structure and function. By the first term we refer to the *structural units of the family* held in any given instance to be of psychiatric interest, for example, the mother-child relationship, the oedipal triangle, the nuclear family, the household, the three-generational family, the kin network. This is essentially a temporo-spatial definition. By function we refer to those aspects of *family interaction or process* considered of psychiatric interest, for example, role definition, power distribution, communication patterning, identity formation, intergenerational relationships, anxiety sources, defensive strategies. Naturally structure and function here, as elsewhere, are interrelated aspects of the same phenomenon.

The concept is necessary because of the wide variation in definitions of the family from culture to culture, from science to science, within any single science, and from one to another psychiatric problem. Thus relevance necessarily expresses the *ad hoc* nature of present psychiatric studies of the family. Target symptoms, syndromes, attitudes, or traits are used as the defining elements in regard to the disorder being considered, as well as to

define related characteristics of the family. As Leichter says, ". . . the family unit may shift according to the purpose of analysis." It follows that the psychiatrically relevant family should be thought of as a distinctive social unit that may or may not overlap other defined families. Legal, sociological, and anthropological definitions of the family, among others, are useful as definitional starting points in any culture, but such "families" rarely are congruent with the family of interest to the psychiatric theoretician or practitioner.

The starting place for most definitions is the nuclear family[1] (often referred to as the isolated nuclear family); that is, biological parents and children, generally considered in Western society to occupy the same household until the departure of the children in young adulthood to establish new families of their own. Although this is what is most often referred to as the family, it is unsuitable as a definition of the psychiatrically relevant family in many instances, since it may not conform to the group actually dealt with by clinicians; it does not take into account the wide variation in family and household composition, even in Western industrial societies; nor does it indicate the extent of that family that is psychologically meaningful to the individual.

A structural delimitation of the boundaries of the family may begin by noting the *temporal* aspects of such a definition. The outer limit of personal

psychosocial time probably extends backward for four generations and into the future for three generations. Even for the neonate the family extends backward in time; there is a specific *familial* inheritance that is part of the psychosocial matrix into which the new human is born. Naturally the more remote in time, the less influential persons and events are; death and other dislocations alter or obliterate their idiosyncratic influence, and they are finally perceived as part of the general cultural inheritance. With the development in the individual of a sense of a personal future, the family comes to have a meaning as an extension forward of these unfolding processes. Although the extensive branching network of progenitors and descendants can hardly ever be assessed in detail, nevertheless, it is in this matrix that family themes, myths, identity positions, conflicts, and defensive positions are elaborated and synthesized. In connection with the temporal aspect of the family, its constantly changing character over time must be mentioned. Not only does the family have a past and a future, but also it is eternally flowing into new forms, monitoring and processing the developmental changes of its members and of the systems exterior to it.

Thus the psychiatrically relevant family is historical in nature, developmental and changing in character, multigenerational in structure. In addition, it has varying structural boundaries at any single point in time.

The most common subunit of the family of clinical interest is the marital

pair. Without regard to the nature of the presenting problem, the husband and wife are most often apt to be considered as the primary unit of interest. If the group is enlarged, one child may be added, usually the identified patient, or the entire nuclear family may be included. Astute clinicians are sensitized to the defensive exclusion of a particular family member, often one child, from the therapeutic enterprise on the grounds that this person does not need to be involved, or will be damaged by exposure to secret or painful material, and are apt to insist that all members be included.

The issue may be conceptualized differently so as to include as "the family" all members of the household; practically this often indicates who is actually available for therapeutic work. This definition is particularly useful where cultures do not adhere to the nuclear model, and in situations where other persons have been regular and meaningful members of the household (a housekeeper or maiden aunt, for example).

Kin other than the nuclear family are often considered as important and within the bounds of relevance. Most commonly the parents and the siblings of the parents of the nuclear family are included. Many theories of transmission of pathology within families depend on a three-generational model, regarding as critical the necessities imposed on any one generation by the need to mediate and deal with issues originating in previous generations. Ackerman, for example, has emphasized the issue.

Other components of the extended kin network may be included as part of the psychiatrically relevant family as well. Bell discusses four aspects of extended kin articulation with nuclear families. In the first two, extended families serve as countervailing forces, or as continuing stimulators of conflict; here the dynamics of intergroup relations are dealt with. In the second dimension the extended families act as screens for the projections of conflicts, or as competing objects of support and indulgence; here the social psychological qualities of the relationships are being dealt with.

Finally there is a kind of conceptual enlargement of the family system that extends the concept of relevance to other systems with which the family interacts and of which it is a part. The important instances of this are network therapy and ecological therapy. In the first instance relevance is extended to include members of the social networks of which the family is a part; friends, extended family, neighbors, and involved professionals may meet as a group with the therapist to consider the psychiatric problems of one member of that network (Speck and Attneave).

Other workers are more systems-oriented in their conception of the boundaries of relevance. Auerswald, in this connection, speaks of the ecological approach. Typically such therapists include representatives of all social institutions that are believed to have power or to provide an important maintenance function for the family, such as the school, hospital, court, and

welfare department. Thus in these approaches the nuclear family is considered not only as a system in its own right, or as part of an extended family system, but also in relation to its external boundary with other natural social institutions.

Categories of Definition of the Relations of the Family to Psychiatric Disorder

It is possible to classify views of the relations between psychiatric disorder and the family into several distinctively different categories. Each of these categories suggests a differing causal or etiological connection between the two and implies quite different management or therapeutic strategies. The variation between these categories is so great as to suggest profoundly different conceptions of the nature of the phenomenon of psychiatric disorder. Fully coherent and integrated statements of these positions do not exist, nor will exponents of one view hold to it in all circumstances. Depending on the purposes of the moment and on the material at hand, there may be some shifting back and forth between orientations. Nevertheless, the positions are distinctively different; those preferring one view are unlikely to vacate it easily.

Psychiatric Disorder as an Exogenous Stress on the Family

This view of the relation between the family and psychiatric disorder holds that in a particular case there is no substantial connection between the disorder and the family except insofar as it is a misfortune accidentally impinging on that particular context. An analogous situation would be a physical illness that in no way is related to the character structure of the family members or its health practices—a brain tumor, for example. There is taken to be no etiological connection, and the family issues to be dealt with

are thought of entirely as reactive to the event.

The ability of the family to cushion the blows of adversity upon its members is an essential capacity. Stresses originating at other systems levels may impinge upon a family as crises that are dealt with successfully. A death adequately mourned, a disaster coped with or endured, a developmental crisis integrated through personal and group growth—these are all instances of the family healing its own members and protecting its own structure in the face of external pressures.

As a man in his seventies lay dying of cancer, lie requested a physician nephew to visit him. Barely able to speak, the dying man asked the physician in his presence to inform the wife and only daughter that his condition was hopeless. For the first time they were able to openly weep together and begin the process of leave-taking and mourning. In this instance, the extended family could be used to help heal the nuclear family by facilitating available restitutive processes.

Some of the complexities of this model can be seen when one considers how psychiatric disorder itself is to be understood. Is it a stress upon the family system that requires adapting to; is it to be understood as an adaptation in and of itself to strains originating elsewhere; or is a blend of both views perhaps most appropriate.

Early psychiatric interest in the family assumed the disorder to be accidental, to arise endogenously in the patient, and, in its own turn, to pose problems for the family growing out of the need to manage the ensuing difficulties. The era of modern clinical study of the family began when this view was challenged as being universally applicable.

Psychiatric Disorder as Caused by Pathogenic Relationships in the Family

The bulk of research aimed at discovering the causal relationship between family issues and psychiatric matters has been carried out in terms of a model of linear causality. The underlying assumption is that a sufficiently homogeneous psychiatric entity can be delimited and that specific parental attitudes, traits, or practices can be located, most often in the mother, that cause this. The earliest versions of such studies indicted a blend of physical and social heredity as being pathogenic; for example, Dugdale’s study of the Jukes and Goddard’s study of the Kallikak Family.

Psychoanalytic theory, at about the same time —that is, at around the turn of the century— added the important dimensions of relationship and developmental vulnerability as being pathogenically critical. Freud’s cases of Dora and Little Hans are discussed below. Subsequent psychoanalytic literature has richly developed these themes.

In the 60 years from 1910 to 1970 an extensive literature has developed

in this field. Excellent reviews are to be found in Spiegel and Bell and Aldous and Hill. More recently Walter and Stinnett reviewed the literature of the 1960’s on parent-child relationships. They found “a distrust of simplistic explanations concerning the direction of causality in explaining the nature of parent-child relationships.” This includes a greater interest in contingent explanations and in qualified generalizations; even the direction of assumed causality is questioned. They quote Kysar as to the possibility that disturbed children may produce impaired functioning in their parents, rather than the other way around. The authors note a shift in the studies reviewed from an earlier almost exclusive concern with mother-child relationships to greater interest in fathers, although they note that the father-son relationship is explored much more than that of fathers and daughters.

They find that boys seem to be more susceptible than girls to parental influence, that “parental warmth is a factor which influences occupational choices among children as well as their academic achievement, leadership, and creative thinking. Poor parent-child relations on the other hand, are related to aggressive, antisocial behavior, and a tendency for children to be involved in disciplinary action. Extreme parental restrictiveness, authoritarianism, and punitiveness, without acceptance, warmth and love, tend to be negatively related to a child’s positive self-concept, emotional and social development.”

The principal feature of the model being used is that a parental trait or attitude (Levy's maternal overprotection or Bowlby's maternal deprivation are good examples) is damaging because of some direct linear effect it produces on the child. The model is that of medical pathogenicity. The maternal overprotectiveness, for instance, is abstracted from the systems of which it is a part, such as a particular cultural attitude toward women and motherhood, a mode of mate selection, a multigenerational context, a pattern of parental relatedness, the mutual circular reinforcing programming of mother and child, and dealt with as if it existed in isolation and *caused* the pathological response to appear in the child.

If the wrong attitudes, traits, and practices can cause psychological illness in the child, it is reasonable to hope that one can discover these wrong attitudes and, having discovered them, teach parents how to do better. Out of such hopes has grown the broad field of parental attitude and child development research, as well as the influential child study movement in the United States, which, in its political impact and in molding social attitudes, has done much to create the current climate of childrearing practices. While still an active social influence, this movement seems to be reducing its impact. The research yield has decreased considerably as well although the research model is attractive to students, because it lends itself to simple designs and straightforward quantification.

The Family as a Pathogenic Culture Carrier

As might be expected there have been heavy sociological inputs to this field, and investigators and theorists alike have attempted to use the language and research methods of sociology to elucidate the origins of psychiatric disorder in the context of the family. Bales, Bell, Bell and Vogel, Cottrell, Foote and Cottrell, Handel, Handel and Hess, Hare, *et al.,* Parsons and Bales, Spiegel, and Spiegel and Klyckhohn may be mentioned as seminal. The field is vast, and it is only possible here to indicate the general direction research and theorizing takes.

As part of the larger Stirling County Study, Cleveland and Longaker, using the research setting of a rural clinic, investigated neurotic patterns of interaction in a single family. Essentially the approach is sociological and consists of an attempt to relate the problems of the individual, "to certain important features of his personality (needs), to behavior expected of him by the society (role) and/or to difficult and conflicting patterns of cultural prescription (value)." At the same time the cultural patterns of childrearing and modes of socialization are considered, with particular emphasis on interpersonal devaluation as a preferred socialization mode incompatible with the needs, role, and value system requirements of the culture. The authors' view is that the family mediates these constraints and that individuals are "in some sense trapped by the conflicting tenets of these two

broad paths of life" (p. 171).

The predominant analytic model here is sociological; the family for the most part is seen as a straightforward social transmission conduit, with emphasis on role and value conflict and the use of a learned socialization technique—disparagement in this case—as a way of coping with these conflicts. In this view neurosis in an individual is precipitated as an immediate response to excess stress, such as organic illness, that makes untenable a previous integration of needs, role, and value. In analysis of this sort the family is seen primarily as an acculturator and socializes The larger society provides a range of options as to how these functions can be accomplished. Presumably a set of constraints, deriving from the nature of man in general and his procreative, nurturant, developmental, characteristics in particular, operate to determine the final course of these events.

It is necessary, of course, to take into account the particular features of each homogeneous subculture. Vassiliou has attempted to deal with the cross-cultural issue by the use of the concept of milieu specificity. In an article on this subject Greek culture and the historical development of the modem Greek family is reviewed, leading to a picture of the contemporary Greek family. "Man-woman relations are characterized by superordination of the man, mutual ambivalence, and ingratiating and contemptuous attitudes of women toward men." There is a great emphasis on "proper" marriage, with

clear role ascription.

Milieu specificity refers to the particular way in which needs or wishes, presumably panhuman, tend to play themselves out in the specific cultural situation. Attempting to combine the psychoanalytic and sociological points of view, the author uses such terms as penis envy and castration anxiety to indicate these needs and points out how the specific interaction within Greek family life modifies their unfolding.

Miller and Westinan describe a mode of analysis of marriage and family that is based, in the beginning, on the partner's identities, subidentities, roles, and social positions. Identity is defined in terms of both self-identity, that is, how the person views himself, and the objective public identity, that is, how he is viewed by others. The sociological term "altercasting" is used to describe the pressures exerted on others to assume a particular subidentity, presumably complementary in nature. A general theory of pathology is developed based on the degree to which there is compatibility between experience and subidentities. Thus the effeminate husband may be expected to show masculine initiative on his job and be subservient at home. A newborn child may act as a stabilizer, or may tip the balance toward instability, because his presence "requires the development of new sub-identities in parents and siblings."

The family as acculturator may induct its members into roles, value systems, and perceptual-cognitive modes that deviate from those of the larger culture. The dominant culture may define these deviant ways as “sick,” “criminal,” or “defective”; this labeling, in turn, may be regarded by the subordinate culture as political scapegoating. A recent instance may be found in the controversy over the Moynihan Report. This report contended that an important proportion of black families were enmeshed in a particular version of the culture of poverty, growing out of the heritage of slavery days. Moynihan believed that these black families were caught up in a self-perpetuating pattern of female dominance, female economic power, together with male impotence and extrusion from the family. This was related to the systematic attack on the masculine role in the black family in slavery, with the development of a protective matriarchy. Discriminatory social, educational, and employment practices in industrial society were held to undermine further the position of the black male, with the consequence that a vicious generational cycle was established and maintained. Critical to this conception is the notion that the self-image for both sexes is distorted and that family relationships and child-rearing practices are so structured in a hostile white world as to maintain the pattern.

Critics of the report note that there is no such thing as a “homogeneous and perdurable” white family unrelated to class and culture; that even if there were it is questionable if it should serve as a paradigm, or if it “actually

possesses the virtues attributed to it. . Blackness is minimized as etiological in these critiques and poverty emphasized.

Aside from the substantive merits of these arguments one must note the political importance attached to allegedly scientific assessments of family functioning.

Psychiatric Disorder as an Expression of the Systems Properties of the Family

A promising recent theoretical approach to understanding the family comes from general systems theory. Originally this approach was developed by von Bertanlanffy, a biologist, who pioneered the field in the 1940's. Systems approaches consider phenomena as part of networks of circular causality rather than in terms of linear causality. It is an organismic approach where self-regulating mechanisms are the essential building blocks. Thus it is uniquely suited to dealing with living systems. To think of the family in this way is to ask how it can be conceptualized as a set of structures organized so as to maintain patterned integrated functioning of the entire system.

Roy R. Grinker, Sr., notes that "general systems theory includes concepts of integration and process by which integration is maintained in all open living systems inescapable from their environment. Each system is composed ... of sub-systems under control and regulation within specified gradients. Information exchange occurs among sub-systems, and between systems, at

their interfaces by means of reverberating circular transactions” (p. 135). These words felicitously introduce the notion of information exchange.

All energy transformations can be conceptualized as information exchanges as well and understood in terms of the thermodynamic laws. The family, in this sense, is an open system in that there are transactions across its boundaries of information, or energy. The family as a system makes up a set of interfaces with other social institutions and can be characterized then as to the nature of these interfaces and the transactions taking place across them. Among these social institutions would be other parts of the larger kin network, other families, educational systems, medical care systems, and mental health intervention systems.

Internal subsystems of the family include generations, the parental pair, and sex splits, among others. In all of these instances the same principles of interface and information exchange across it apply.

Perhaps the keystone systems concept used by family therapists is that of homeostasis, the tendency of the organism or system to dynamically and actively re-equilibrate itself. Homeostasis, or homeodynamics as Ackerman calls it, has been a conceptual tool of considerable importance to the clinician in the field of family studies. It serves as a reliable guide to understanding mechanisms resisting therapeutic change. Simple examples include roles or

identity positions that must be filled in the family. Speck notes that when a suicidal patient gives up his self-destructive ideation, his role in the family will be replaced by the appearance of a depression in another family member. It is as if the equilibrium in the family can only be maintained by the presence of some expression of this affect. Perry, *et al*., observed that families in a disaster acted as a unit to maintain one parent in the strong protective role and suffered severe anxiety when this no longer could be accomplished. Rashkis noted the importance of depression in maintaining family homeostasis, and numerous other observers, Jackson most importantly, have spoken on this issue.

It is possible to conceptualize new family formation in systems terms in part as an effort by each partner to reproduce in dynamic terms the configurations and interchanges experienced in the family of origin. Tomas has called attention to the importance of sibling position in dynamic terms as a factor in mate selection. Napier speaks of this process as cross-generational complementarity. He describes the matrix of complementary expectations to be filled by the mate, matrices that have developed in the context of the homeostatic requirements of the family of origin. Finally Erlich and Bloch describe therapy in terms of the transaction of two family systems, that of the patient and therapist, as each struggles to integrate old themes (parameters) in the new therapeutic relationship. They point out the similarity, in systems terms, between the new pair formation of therapist and patient and mate

selection.

Family Characteristics Related to Specific Psychiatric Syndromes

Investigators attempting to relate dimensions of family life to pathology have approached the issue in ways that reflect their personal biases, professional technologies, as well as the special nature of the problem being studied. Clinicians in recent years have considered almost all of the well-defined psychiatric entities from the family point of view. In a number of instances rigorous, quantified research has also been conducted.

Schizophrenia

Understandably families with schizophrenic members have attracted great interest on the part of both clinicians and researchers. In the same spirit that has led other investigators to search for a unitary cause for this “disease,” family researchers have tried to define the uniquely pathogenic qualities of the family with a schizophrenic member. While the hope of finding the specific family etiology of the disorder seems clearly illusory, there have been a number of significant contributions to a better understanding of the syndrome.

Overall these studies have become increasingly sophisticated, developing more meaningful typologies of families with schizophrenic members based on the sex, premorbid history, quality of thought disorder, and social class of the index patient.

One group of studies may be broadly characterized as having a psychoanalytic orientation. Alanen, for example, offers a developmental conception beginning with “the defective initiation into important object relations, above all that with the mother.” Davis attempts to get at the oedipal contribution to the etiology of schizophrenia in males. In acute schizophrenic breakdown he claims that anxiety arises out of the relationship with the mother and “the illness begins when a change in this relationship increases the anxiety. The frustration of incestuous wishes contributes to this anxiety.” This is associated with “a failure of identification with the father, a poor relationship between mother and father. . . .”

The most important studies of this genre are those of the Lidz group at Yale, which reports on investigations of middle-class, structurally intact families with schizophrenic young adult members. Middle-class families were chosen for study so as to avoid the effects of social disorganization under economic stress. There were many clinical contacts with the families and with kin, friends, servants, and so on. In addition to clinical interviews at home and in the hospital, a complete battery of psychological tests was administered. To summarize their findings, all families “were severely disturbed, distorted by conflict, and beset by role uncertainties by family members other than the patient.”

Patients’ mothers appear severely disturbed, often bordering on the

psychotic, but without a single predominant personality type, rather showing a wide range of disturbance. The authors underscore the importance of the fact that these women were "paired with husbands who would either acquiesce to any irrational and bizarre notions ... or who would constantly battle with and undermine an already anxious and insecure mother."

The fathers in half the families were described as paranoid, "paired with a submissive acquiescing spouse. . . Again there is no "characteristic type of disturbed father," but a general inability to play the paternal role successfully for a variety of reasons. The suggestion is that if they had married more supportive wives, they might have done better as fathers and husbands. The Lidz group's findings seem comparable with those of Cheek, who says, "The profile of the father of the schizophrenic differed less from that of the father of the normal than the profile of the mother of the schizophrenic differed from the profile of the mother of the normal." Cheek agrees with Parsons to the effect that "schizophrenia may be related to a lesser differentiation of parental sex roles in the family." However, he notes, "Our study does not tell us whether or not this distortion of parental roles has been a cause of, or a reaction to, the schizophrenia."

In the Lidz studies two types of families are described. Schismatic families are "beset by chronic strife and controversy, primarily between the parents. . . . The parents undermine each other's worth, despising each other

as man or woman, depriving each other of much needed support. . . This is particularly important in that it raises severe identity problems for the children.

The second type of family they describe is the skewed family, which may be peaceful on the outside, but where the peace is maintained because the parents have “overtly or covertly reached a compromise concerning a serious personality defect in one or the other.” (Wynne’s pseudomutuality and Laing’s mystification are related concepts.)

Considering the difference between families in which a male rather than a female becomes schizophrenic, they note, among other things, that same sex siblings seem to be more disturbed than opposite sex siblings. Three issues appear to be critical: “(1) the faulty model for identification provided by the parent of the same sex as the patient; (2) the impediments to proper resolution of the patient’s oedipal attachments, created by the disturbed parental interaction; and (3) the failure of the parents to maintain proper generation boundaries between themselves and the patient, either by being seductive with a child or by being more like a rivalrous sibling than a parent, with both patterns sometimes occurring in the same family.”

Considering the influence of parental homosexual tendencies, Lidz and Lidz points out, “The de-erotization of the child-parent relationship is one of

the cardinal functions of the family," and in a series of cases they illustrate the failure to accomplish this in the mother-daughter relationship. In these families this failure increased the insecurities of the child, who focused on a complex and perplexing tie to the mother as a mode of maintaining security.

Turning to the central problem in schizophrenia, the nature of the thought disorder, they say, "We are following the hypothesis that the schizophrenic patient escapes from an untenable world in which he is powerless to cope with insoluble conflicts by the device of imaginatively distorting his symbolization of reality."

The mother of a schizophrenic son is seen as needing the son to complete her frustrated life. She demands the impossible from him, feels only he understands her, and excuses all difficulties as being the fault of some other person or institution. A hopeless enmeshment is created for the child, nor is there any exit from this because of the qualities of the father.

The Lidz group speaks of folie a famille where the life of the family centers around the distorted beliefs of one parent, usually the father, and lives according to a social pattern quite different from the larger social context. The parents hold a rigid and fantastic conception of the environment and the family into which the children must fit without regard to reality or their own needs. These parents are described as being "impervious," unable

to hear the child’s emotional needs, and, in general, much given to projective identification, the attribution to the child of the parental needs, principally in the service of maintaining the parent’s picture of himself and of simplifying a complex environment.

Lyman Wynne and his co-workers set themselves the formidable task of trying “to develop a psychodynamic interpretation of schizophrenia, that takes into conceptual account the social organization of the family as a whole.” They build their theory on the need of all humans to be related and on the striving to develop a sense of personal identity. The attempt to deal with these issues may lead in three directions: mutuality, nonmutuality, and pseudomutuality. The latter they regard as occurring widely and consisting of a “predominant absorption in fitting together, at the expense of the differentiation of the identities of the persons in the relation.” The essential difficulty in differentiation of identity characterizing the schizophrenic is put this way: “There is a characteristic dilemma: divergences are perceived as leading to disruption of the relationship . . . but if divergence is avoided growth of the relation is impossible.” Under these circumstances noncomplementarity, that is, individuation and separation, must be avoided at all costs since it is the most severe threat in these families. Thus, in terms of the development of the schizophrenic modes of life, important motivational systems must be excluded in the spirit of maintaining the appearance of mutuality.

For a variety of reasons, including the painful experience of separation, there is held to be a strong drive toward maintaining a *sense* of relation. The inevitable discontinuity of relatedness in situations of even minor conflict or disagreement cannot be tolerated. Genuine mutuality leading to the growth of the relationship through the exploration and enlargement of alternative modes of interacting cannot be achieved because of the underlying rigidity and fragility. The authors emphasize the role rigidities of these families as well as the absence of imaginative play or affective release in the interactions of family members. Noncomplementarity is seen as being the most serious threat.

Shared mechanisms operate within the family to maintain this pseudomutuality, including the nonrecognition or delusional reinterpretation of any deviations from the rigid family role structure. A consequence is that differentiation and individuation are severely impaired and that it is extremely difficult for the members of these families to distinguish the family boundary. The term used for this by Wynne is "the rubber fence," an "unstable but continuous boundary, with no recognizable openings, surrounding the schizophrenic family system, (which) stretches to include that which can be interpreted as complementary and contracts to extrude that which is interpreted as noncomplementary."

According to Wynne and his co-workers, "The fragmentation of

experience, the identity diffusion, the disturbed modes of perception and communication . . . are to a significant extent derived, by processes of internalization, from characteristics of the family's social organization." In this regard it is possible to see the similarities between the Lidz and Wynne approaches to these issues. Assisting in the formulation of these theories is the subjective experience of the therapist in direct work with these families (Schaffer, *et al.),* an experience that "tended informally to be reflected in the use of words such as maddening, enraging, bewildering, and exhausting. . . ." The sense is that a pattern is established of idiosyncratic meanings within the family that are destructive of meaning to those unfamiliar with the premises and logical interrelationships.

Wynne and Singer attempt to relate schizophrenic thinking disorders to family experience in more detail by a more refined assessment of the nature of the thinking disorder. Clinical observations were "concerned with the styles of focusing attention and communicating in these families, which may have a disorganizing, complementary effect, or may provide models which are internalized in the same form into the ego structure of the growing offspring."

Wynne and Singer's study used parents of childhood schizophrenics, adult schizophrenics, acting-out children, and withdrawn, neurotic children. When the Rorschach and TAT tests of the parental pair were compared, blind ranking of these tests showed high correlation with the diagnosis of the child.

Moreover, it was possible to relate the distinctions between the groups to a cognitive style and experiential mode that might be understandably related to the child's pathology. Thus on the TAT parents of autistic children "have clear percepts; depict people, events, feelings, consequences clearly, compared to parents of adult schizophrenics," who "have people, events, feelings, consequences remaining global, abstract, overly general, attention appears fragmented or amorphous." This would support other findings (Goldfarb and Meyers and Goldfarb, as well as those of Reiss on cognition), distinguishing families of autistic children as being comparatively less pathogenic.

Laing has advanced the view that pathology lies, as it were, in the eye of the beholder. As he sees it, this is true for individual psychopathology, and even more so for the concept of family pathology: "It extends the unintelligibility of individual behavior to the unintelligibility of the group," With various co-workers Laing has constructed an experiential approach to individual and family psychodynamics. Dyads, triads, and more complex networks, of which each individual is a part, are related by mutual percepts and in layers of further complexity, the perception of the perception of the perception. A unique reality is constructed thereby, which is true for the particular individual and family; this reality is to be discovered in the therapeutic work, especially the processes whereby contradictions and illogicalities are reconciled.

One such process of key importance in Laing's thinking is *mystification.* Laing emphasizes that mystification is both an *act* and a *state* and points out that the person being mystified may not know it or feel it. It is a process operating within the family (and elsewhere for that matter) in which the person is systematically forced to deny data from one realm in the interest of maintaining a percept or relationship. Relating mystification to the double-bind concept Laing notes, "The double-bind would appear necessarily to be mystifying, but mystification need not be a complete double-bind" (p. 353).

An extensive case report embodying this point of view can be found in Schatzman. In this paper the Schreber case, which played a key part in the development of Freudian psychoanalytic theories of paranoia, is reviewed, with emphasis on the use of mystification to cover over deeply conflicted issues in the relationship between Schreber and his father. Schatzman concludes that Schreber was indeed persecuted by his father and mystified in addition, by being told the persecution was loving. His delusions then represented an effort to make sense out of this total configuration.

Bateson, Haley, Jackson, and Weakland aim to develop a communicational theory of schizophrenia. The cornerstone propositions are that learning occurs in a context that has formal characteristics and that this context always occurs within a wider context called a metacontext, indeed, within a series of these.

Bateson says, “Even more shocking is the fact that there may be infinite regress of such relevant contexts.” There is a relationship between context and metacontext that may be congruent or incongruent. Metamessages tell the receiver what the relationship is between messages of different levels, with the possibility that “in human relations another sort of complexity may be generated; e.g., messages may be emitted forbidding the subject to make the meta-connection.”

Bateson, Jackson, *et al.,* discuss the relationship between family homeostasis and schizophrenia in communicational terms. The essential feature of this relationship is the *double-hind,* described as a repeated experience in which a person (called a victim) is subjected to messages containing a primary negative injunction, such as “do not do so and so, or I will punish you,” together with a secondary injunction at a more abstract level, which conflicts with the first. It is essential that the “victim” also be prevented from escaping from the field. The authors suggest that an individual repeatedly exposed to this mode of communication will suffer a “breakdown in his . . . ability to discriminate between logical types, ... in a double-bind situation, a shift to metaphorical statement brings safety.” This use of metaphor often corresponds to what is called psychotic behavior.

Specifically, in regard to the family situation in which these events occur, the authors suggest: “1. The child’s very existence has a special

meaning to the mother, which arouses her anxiety . . . when she is in danger of intimate contact with the child. 2. The mother's way of denying this anxiety and hostility is to express overt loving behavior. 3. There is no strong insightful person available to the child to support it in the face of the contradictions." The emphasis throughout is on the child's being forbidden to discriminate the metacommunicative messages, which are inherently contradictory. As the authors note, the child "must deceive himself about his own internal state in order to support mother in her deception."

Analyzing the communicative pattern of schizophrenics in this context, Haley emphasizes that various kinds of *disqualification* occur in messages; for example, that the person is not really the source of the message, that the words are action and not really the message, that the receiver is not really being talked to (this emphasizes the self-negating quality of paranoid statements). The emphasis here is on the schizophrenic's effort to extricate himself from the family communicational pattern and on the conceptualization of the schizophrenic symptoms in those terms. "It can be argued that psychotic behavior is a sequence of messages which infringe a set of prohibitions but which are qualified as not infringing them." Haley emphasizes the degree to which the disqualification process avoids the risk of accepting being governed by other people and that this, in turn, destroys relationships.

Reiss performed a series of experiments aimed at distinguishing the cognitive styles of families with normals, character disorders, and schizophrenics. Five families in each group were tested by a series of experiments; a chief feature of which was to distinguish the degree to which intrafamily cues and ideas were attended to rather than those coming from outside the family. Schizophrenics were distinguished for their attention to intrafamilial cues. This finding is commensurate with the unique and idiosyncratic information environment within the family containing a schizophrenic person.

In an effort to distinguish efforts due to socioeconomic status, the relation Rorschach, in which several family members are asked to compose a response to the Rorschach card, was used to study 17 black schizophrenics, 11 white schizophrenics, and 11 lower-class black control families. The transcripts of the tests done in the homes were studied by raters who did not know the families. The results "indicate the communication and interaction patterns of lower-class families with a schizophrenic differ in a significant way from these patterns in families whose class background is similar, but which do not contain a schizophrenic." Interestingly a distinction could *not* be made in regard to the white and black schizophrenic groups.

Many studies, have investigated the relation between the spouses of schizophrenic persons. Becker, for example, found that the husbands of

schizophrenic wives generally came from materially and emotionally deprived backgrounds, with duty-bound, close ties to harsh, demanding fathers and affectionate mothers. It often seemed as if these husbands did not find it possible to separate from their families of origin in order to make strong ties with their wives. This led to frequent neglect, increasing with the birth of new children, which often, in turn, led to schizophrenic breakdown in the wives.

DuPont and Grunebaum point out that paranoid women tend to marry men who are walled off, passive, and unable to express hostile or erotic feelings. In some instances the wife's psychosis is precipitated by the husband's reduction in sexual activity. They point out that the husband's "eagerness to reunite with his wife and to exclude others was reflected in his failure to support her therapeutic alliance with her psychiatrist and his failure to consider divorce."

Phobias

The case of "little Hans," first published by Freud in 1909, presaged later psychoanalytic theories of pathology in the family as well as techniques of family therapy. The identified patient, a five-year-old boy, is treated through the agency of his father, of whom Freud says, "the special knowledge, by means of which he was able to interpret the remarks made by his five-year-

old son, was indispensable . . . and (treatment was possible) . . . because the authority of a father and a hand of a physician were united in a single person. . .

Strean discusses this case as an early example of family diagnosis and treatment. In the same spirit the celebrated case of Dora can be read as an instance of symptoms appearing in one member of the family as a result of events occurring elsewhere in the family system. Here the identified patient is an 18-year-old girl, diagnosed as hysterical, with a nervous cough, aphonia, easy fatigability, and suicide threats. The precipitating event of her illness was her father's involvement with the wife of a business friend; the friend had on one occasion made a sexual approach to Dora. Freud uses both of these cases to demonstrate the unfolding of psychosexual development; they are equally useful as early statements about the relationship between family interaction and psychopathology.

Repeatedly anxious, phobic patients are viewed as expressing affect present in other members of the family, often a husband or wife. As Fry has observed, "The spouses of the patients in this group . . . are typically negativistic, anxious, compulsive, and show strong withdrawal tendencies." Upon careful study the spouses reveal "a history of symptoms closely resembling, if not identical to, the symptoms of the patient. Usually they are reluctant to reveal this history." It is as if the symptoms of one (more severe)

make it unnecessary to face the symptoms of the other. Frequent collusive involvement is seen. For example, the spouse will volunteer to stay with the anxious patient, even though the patient does not need or wish it.

Fry also notes, as does Carek and Miller, that symptoms seem to break out at a point when the spouse has some change— usually for the better—in his life; there is a constant dual supervision and control, and the couple are frequently held together by the symptoms.

Johnson, *et al.,* writing in 1941, described a pattern of generational transmission of school phobias, in which the mothers of children express “an inadequately resolved dependency relationship to their mothers, with intense repressed resentments.” In turn, their own children are pulled into a pattern of dependency, which is then shifted to the school, because of the differing patterns of authority there. “When the teacher, as a more consistent disciplinarian, frustrates the child, she arouses his rage.” The child’s rage toward the mother is inhibited and the teacher becomes the phobic object. In explanation a three-generational structure is invoked as well as comments about the specificity of interaction in the child’s involvement with the school. The minimum systems model seems to include the child at an interface between his generational family and the school.

Ackerman reports a case of phobia in a four-and-one-half-year-old boy.

He relates this to the mother's inability to establish close contact with the boy, her guilt, domination, inconsistency, overindulgence, and eventually his "frightened retreat from her oral, devouring attitude" (p. 119). The concept of homeostasis, as used by Ackerman, really concerns much more the homeostatic equilibrium of the self, rather than of the family.

Psychosomatic Disorders

Some psychosomatic illness seem clearly connected to aspects of family life. The connection has been made, for example, in certain cases of severe childhood asthma. Purcel, *et al.*, note, "It is clear that substantial numbers of asthmatic children admitted to hospitals lose their symptoms rather rapidly, while others show relatively little symptom change in response to institutionalization and separation from home." An effort was made to distinguish the two groups. An imaginative procedure was used, whereby the child stayed physically in his own home although all parental and sibling figures were removed, and a substitute parent was provided. The carefully controlled study showed that children with a history of emotionally precipitated asthmatic attacks were improved by removing the people from the house—even though the allergenic situation was unchanged.

Meissner, reviewing the problem of the connection between family processes and psychosomatic illnesses, notes that it is necessary to suggest "a

link between emotional dysfunction related to psychosomatic illness and discernible patterns of family dynamics.” The issue is not whether there is a connection between emotional stress and somatic disorder, rather whether there is some unique connection between family patterns and such disorder. Although research in this area has been relatively unproductive thus far, it is our conviction that several modes of investigation will fuse in the near future to improve our understanding of these relationships. Specifically it seems likely that kinesthesiologic studies of family interaction from the viewpoint of operant conditioning, using highly responsive physiological measures, will reveal the subtle modes whereby families teach somatic responses to their members.

Titchener, in a case study of a family in which one son developed ulcerative colitis, suggests, “The rigid and confining patterns of object relations were not only formed in the binary mother-child symbiosis, but were conditioned by the multi-dimensional matrix of object relations constituting the field in which his personality developed.” Jackson and Yalom describe such families as being very restrictive with limited interaction, affectivity, and contact outside the family, and with a communicative restrictiveness through the generations.

Learning Difficulties

Grunebaum, *et al.*, studied the families of boys with neurotic learning inhibitions. They identified patterns of interaction between the parents that prevented the boys from adequately identifying with their fathers or from perceiving their fathers to be competent or worthy.

Similarly Miller and Westman noting that the mothers in these families exercise the real power, "postulate that parents and children resist change in the reading disability, because it contributes to the family's survival." The main line of analysis concerns the support for an identity based on the parent's projections. In addition, "The symptom and subidentity act as governors on aggression between the parents." When the symptom changes, there is increasing disturbance elsewhere in the family—evidence of the homeostatic function of the behavior.

Delinquency

Ferreira explores the concept of the double-bind as it relates to delinquency and speaks specifically of "the split double-bind," where "the victim is caught in a sort of *bipolar message* in which A emanates from father, for instance, and B (a message about Message A) from mother." He notes the special importance for delinquency of *punishment* as a consequence of the efforts of the child victim to avoid the double-bind; each half of the parental pair threatens a series of punishments as the consequence for not obeying his

half of the self-canceling message.

Addictive States

Ewing using concurrent group therapy for wives and husbands, notes that "marriage to an alcoholic is no accident. . . ." The wife seems to need a weak, dependent husband and sabotages efforts to improve his strength or accept her own dependent needs. One case is described in which there is a constant interplay between the husband's drinking bouts and the wife's depression, which requires hospitalization.

Homosexuality

Bieber, *et al.* conducted a study of 206 male psychoanalytic patients, of whom 106 were homosexuals. Brown's findings in his study of Air Force personnel, in regard to mother-son and father-son relationships, are confirmed here as well. The authors consider, too, the "triangular system," involving both parents and the son. The basic mode of analysis consists of "constructing classifications of mother-son, father-son, and interparental power-affect parameters." They find, "The classical homosexual triangular pattern is one where the mother is CBI (Close Binding Intimate) and is dominant and minimizing towards a husband who is a detached father, particularly a hostile-detached one. . . . Chances appear to be high that any son

exposed to this parental combination will become homosexual, or develop severe homosexual problems” (p. 172).

Depression and Suicide

Various writers have related suicide and depression to characteristics of family systems, noting their transactional nature. Thus Goldberg and Mudd develop a categorization based on the notion that “in married persons suicidal behavior may be regarded as a transaction between the suicidal individual and his spouse.” Essentially the threats and plans are seen as a move to maintain domination and control of the partner.

Speck is concerned with the homeostatic equilibrium of the family that is maintained by the suicidal behavior and speaks of families who seem to hold to the dictum, “better mad than bad,” citing case material where improvement in one member, the suicidal patient in this instance, produces an increase in seclusiveness and withdrawal in other family members.

Whitis, speaking of a child’s suicide, observed, “The suicide served to spotlight the apartness each member of this family felt in this inability to communicate with one another in a helpful or constructive way.”

The Psychiatric Future of the Family

Any assessment of the relation between psychiatric status and the family must recognize the influence on this issue of the rapid process of social change presently characteristic of the family in the Western world. As standards of normative behavior change, diversify, and broaden, the reference points used for judgments about deviation change. The social vantage point, i.e., bias, from which a psychiatric judge views phenomena determines the meaning of the behaviors being assessed. Also the very processes of rapid social change themselves, operating on families over time, have an effect equivalent to exposure to markedly different cultural sets and expectations. There is little reason to expect these factors to abate in the future; more likely their effects will intensify.

As a consequence it becomes even more difficult for the psychiatrist confidently to assume that he knows the directions family life should take; yet it is not possible for him to abandon or deny his own value systems since they are the points of reference he must use in order to define behavior as psychiatrically relevant. This is especially so when he is dealing with cultures other than his own. The white view of the black family is notably deficient in this regard, as is that of the male psychiatrist judging the “proper” role for women.

The psychiatric future of the family cannot therefore be separated in

any way from the broad processes at work to create change in society at large. A few of the more important of these processes may be noted. First, there is the rapid change in the status of women vis-a-vis men. Associated with this are profound revisions of the ideal and normative expectations of both sexes with regard to such family functions as childrearing, domestic work, and sexual intimacy. Patterns of pair bonding are changing rapidly; premarital sexual liaisons are openly accepted in many quarters, and the age of permissible sexuality is lowered on one hand and raised on the other. Adolescents and youth are expected to have active sexual lives prior to marriage, while the sexual needs and capabilities of the aged are better understood and accepted.

The contractual patterns of family life are changing, again in the direction of greater permissible variation. Illegitimacy as a status is becoming increasingly obsolete, the singleparent family more common. Not only is divorce ubiquitous, less opprobrious, and easier to secure, but also unconventional household and childrearing arrangements such as group or homosexual marriages are becoming steadily more common and more frequently legitimized. Thus participation in a nonstandard family arrangement is no longer prima facie evidence of psychiatric disorder.

Demographic patterns are changing rapidly, again with profound impact on the nonnative expectations for the family. Deliberately childless couples

are more common, and the birth rate has recently dropped (1972) to the lowest point in U.S. history, a rate approximating that needed to achieve the goal of zero population growth. Abortion laws are increasingly liberalized in the direction of abortion on demand; these, together with changed contraceptive technology and social attitudes, have markedly reduced the number of children available for adoption, increasing the movement into various forms of single-parent adoptions, cross-race and cross-religion adoptions, and the adoptions of children previously unplaceable by virtue of age or physical handicap.

Another demographic change of consequence for the family is the increased number of aged persons in the population. The generational splitting, age-grading, and emphasis on youth that has characterized much of recent U.S. social history has, when combined with patterns of increasing longevity, produced many serious problems of social isolation in the aged. The primary breakdown in ties to kin networks results in an epidemic psychiatric public health problem. Differential mortality rates between men and women accentuate this; a pattern of marriage of women to men two or more years senior, when coupled with this differential longevity, statistically guarantees an increasing pool of older, isolated, sexually active single women.

There are no base lines established for rates of social experimentation in new modes of intimate relatedness. Thus it is only an impression that these

are proliferating at a great rate;

the impression may in part be due to greater acceptance of public discussion of issues formerly barred. Constantine and Constantine, studying group and multilateral marriages, have been impressed with the large number of persons considering establishing such relationships in comparison with the small number actually doing so. Despite this it seems certain that the family of the future, and thus the psychiatrically relevant family of the future, will refer less often to the modal nuclear family of the past and with increasing frequency to a nonstandard pattern of relatedness. Perhaps most important in terms of the generational model that family psychiatry has found to be so helpful, the natural social system into which a person is born, the natural social system in which he lives his adult life and procreates, and the natural social system in which his children (if any) live their lives, all will be different.

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Notes

[1] In general terms family is a biopsychosocial system found in all cultures that acts: (l) to reproduce other families (Families reproduce reproductive units, namely families. It is the human biopsychosocial system that uniquely recruits new components by biological means, i.e., sexual reproduction); (2) to nurture and acculturate young humans; and (3) to care for some of the biopsychosocial needs of its members.