C/c 559 READING #53

Illness, Family Theory, and Family Therapy: I. Conceptual Issues

LYMAN C. WYNNE, M.D., Ph.D.†
CLEVELAND G. SHIELDS, Ph.D.†
MARK I. SIRKIN, Ph.D.‡

This article examines and clarifies controversies about the concept of illness in the field of family therapy. We contend that illness, as traditionally understood in all cultures, is a relational, transactional concept that is highly congruent with core principles of present-day family theories. Family therapists need not buy into a biotechnical, reductionistic reframing of illness as disease. Rather, it is more appropriate to conceptualize and work with illness as a narrative placed in a biopsychosocial context. Such a narrative includes how shared responsibility for coping and for finding solutions can take place, without becoming involved in disputes about causal models.

Fam Proc 31:3–18, 1992

> *[I]llness is not simply a personal experience; it is transactional, communicative, profoundly social. The study of illness meanings is not only about one particular individual's experience; it is also very much about social networks, social situations, and different forms of social reality. Illness meanings are shared and negotiated. They are an integral dimension of lives lived together. . . . Illness is deeply embedded in the social world, and consequently it is inseparable from the structures and processes that constitute that world. . . [A]n inquiry into the meanings of illness is a journey into relationships. [pp. 185–186]*
>
> —Arthur Kleinman
> *The Illness Narratives*

THE CONCEPT of illness, which has been traditionally central in health care, has had a much more uncertain status in the theories, clinical practices, and training programs of family therapists. Many family therapy theorists, teachers, and practitioners avoid using the concept of illness; they regard it, at best, as a nonrelational distraction from their principal concerns. In contrast, most other health care professionals explicitly regard illness, both physical and mental, as the primary basis for the very existence of health care programs. In this article, we wish to examine the diverse meanings and implications of the concept of illness and to consider whether the predominantly negative and avoidant view of this concept by family therapists is appropriate and justified.

It is not hard to identify reasons often

---

† Dr. Wynne is Professor of Psychiatry and Dr. Shields is Assistant Professor of Family Medicine and Psychiatry (Psychology), University of Rochester School of Medicine and Dentistry. Send reprint requests to Dr. Wynne, Department of Psychiatry, Rm. 1-9011, University of Rochester Medical Center, 300 Crittenden Blvd., Rochester NY 14642-8409.

‡ Dr. Sirkin is the Director, Beren Center, Ferkauf Graduate School of Psychology, Yeshiva University, Bronx NY.

0014-7370/92/3101-0003/$02.00/0

given by family therapists for a jaundiced view of the illness concept:

1. *Illness has been viewed as a static, reductionistic category that closes down, rather than invites therapeutic joining and the exploration of options:* Family therapists have commonly thought of illness as part of a restrictive biological and intrapersonal medical paradigm that they have contrasted with the primary orientation of family theory toward the relational, transactional, and ecosystemic context of human functioning. Further, illness categories have been viewed as fixed niches that fit awkwardly, if at all, into the fluid, subjectively shaped processes of therapeutic, systemic change.

2. *Attention to illness has been viewed as pathologizing and disempowering, neglecting health, strengths, and solutions:* A focus on illness has been viewed as a clinical error because the coping and adaptive skills, the assets and resources of individuals and families are, it has been feared, going to be overlooked.

3. *The concept of illness has implied a faulty causal model:* Ever since the 1950s, family theorists have taken issue with prevailing hypotheses about the biological and psychological etiology of schizophrenic illness. Initially, pathogenic family communication was portrayed as a highly potent etiological factor. However, this causal model was soon recognized to be unidirectional and was replaced with the concepts of circular causality and cybernetic family processes. More recent constructivist and developmental approaches have tended to regard the issue of causality as unresolvable. Because "cause" is one of the first questions that is raised in discussions of illness, it is understandable that illness has not appeared to be a topic for fruitful dialogue.

4. *Illness has been regarded as stigmatizing:* The status of being a patient, of having an illness, especially but not only a mental illness, has been perceived as inherently stigmatizing, as likely to lead to scapegoating, and thus as adding to the difficulties of obtaining support and achieving change.

5. *Illness has been ignored and implicitly or explicitly considered irrelevant in many family therapy training and clinical programs:* Especially in the curricula of most degree-awarding marriage and family therapy training programs, little or no attention is given to major mental and physical illness. A pragmatic reason for this neglect is that the nonmedical setting of family therapy programs, clinics, and offices has selectively screened out families with these kinds of problems. Furthermore, in many if not most medical/psychiatric settings there are bureaucratic and hierarchical difficulties in establishing clinically appropriate, interdisciplinary team collaboration with medical caretakers.

CLINICAL OPPORTUNITIES FOR FAMILY THERAPISTS

The last of these points can be discussed most easily. Despite all of the conceptual and administrative difficulties that family therapists have found in dealing with illness, there has been a persistent and growing trend within the family therapy field calling for greater attention to issues of illness (McDaniel, Campbell, Wynne, et al., 1989; McDaniel, Hepworth, & Doherty, 1992; Rolland, 1984, 1987). A still small but increasing number of family therapists have been challenged and stimulated by their work within medical settings, or in collaboration with physicians, seeing families deeply troubled and burdened by the presence of family members with serious physical illnesses (Gonzalez, Steinglass, & Reiss, 1989; Minuchin, Rosman, & Baker, 1978; Rolland, 1984). These illnesses have been qualitatively diverse, including, for example, myocardial infarction (Carter, 1984), facial pain (Boll, Duvall, & Mercuri,

---

1983), dement
1987), and can
& Cohen, 198
Parra, Dávila d
Espinoza, 198
collaboration
and physicians
primary care ha
dubbed by Bloc
medicine."

Particularly
been a resurge
therapists in m
the most conv
about the bene
been produced
family member
fied as having a
as schizophreni
Goldstein, 1981
al., 1988), an
Szmukler, Dare
Weber, 1989 a
Bennett, Wolin,
(Stanton, Todd,
depressive disor
ber, et al., 199
(Anderson, Griff

Thus, it is clea
largely untappe
with families w
been diagnosed
physical illness
that it has becom
the conceptual a
in the family the
and clarified. If
risk missing out
lenge and oppo
scope, and it w
collaborative an
relation to othe
services.

ILLNES

In discussing
begin by descri

1983), dementia of the elderly (Houlihan, 1987), and cancer in both adults (Wellisch & Cohen, 1986) and children (Velasco de Parra, Dávila de Cortazar, & Covarrubias-Espinoza, 1983). Conceptual and clinical collaboration between family therapists and physicians in family medicine and primary care has become a whole new field, dubbed by Bloch (1983) as "family systems medicine."

Particularly since 1980, there also has been a resurgence of interest by family therapists in major mental illness. Indeed, the most convincing research evidence about the benefits of family therapy has been produced with families in which a family member has been explicitly identified as having a major mental illness such as schizophrenia (Falloon & Others, 1985; Goldstein, 1981; Haas, Glick, Clarkin, et al., 1988), anorexia nervosa (Russell, Szmukler, Dare, et al., 1987; Stierlin & Weber, 1989 a,b); alcoholism (Steinglass, Bennett, Wolin, et al., 1987), drug abuse (Stanton, Todd, & Associates, 1982), manic-depressive disorder (Retzer, Simon, Weber, et al., 1991), and major depression (Anderson, Griffin, Rossi, et al., 1986).

Thus, it is clear that there are abundant, largely untapped opportunities for work with families when a family member has been diagnosed with either a mental or a physical illness or handicap. We believe that it has become increasingly urgent that the conceptual and clinical place of illness in the family therapy field be reconsidered and clarified. If not, family therapy would risk missing out on meeting a major challenge and opportunity for expanding its scope, and it would put itself in a weak collaborative and competitive position in relation to other providers of health care services.

ILLNESS AS NARRATIVE

In discussing the concept of illness, we begin by describing what we believe has been a broad view that has been generally accepted historically and cross-culturally. Prototypically, illness has been defined as a construct used to explain certain nonvolitional, maladaptive patterns of distress and/or behavior that impair an individual's capacity to function (Barrett, 1988). However, such a definition barely starts to convey the rich complex of meanings and perspectives associated with this phenomenon that can, but need not be viewed reductionistically. First, one should note that illness is both subjective experience and observed appearance and behavior. The distinction is important between illness *experience,* the distress, suffering, and perceived loss of well-being, and illness *behavior,* the impaired functioning that is observed by others and is attributed to illness.

Second, it is crucial to realize that both the experience of illness and the observation of ill functioning quickly become part of a transactional, relational narrative (Kleinman, 1988); in this sense, illness is far from being merely a category of intra-individual impairment. To illustrate the unfolding of the transactional illness narrative, let us take the distress of a headache. If the severity is mild or moderate, not severe enough for a person to claim exemption from continuing with work or family duties, most persons will wait for spontaneous recovery, or seek relief with aspirin, but not speak of the episode as an "illness." "Nuisance" levels of distress ordinarily are not regarded as "illness." However, when the headache becomes so severe and disabling that the individual is unable to carry out ordinary role functions or responsibilities, and/or other persons extend special consideration or offer treatment suggestions to the individual, then the problem becomes an "illness" and the individual becomes a "patient."

Continuing with the transactional sequence: If the role disruption is brief, a self-diagnosis of illness will be accepted in most contexts of family members, employers, or others with whom the person has social contacts or obligations. If, however, the distress becomes recurrent or more prolonged and more role-disruptive, both the diagnosis of illness and the relief or exemption from role responsibilities escalates to another level of transactional involvement. At this point, a culturally designated person (a "health care professional"—physician, therapist, shaman) takes the role of confirming or disconfirming the distress/dysfunction as "illness" versus a non-illness such as laziness or malingering. This professional feedback ordinarily includes a diagnosis, a prognosis, and a treatment plan from the perspective, and in the terminology, of the professional. The viewpoint of the professional may or may not be accepted; compliance with most clinical recommendations is partial or temporary. The "patient" and those in his or her immediate social network continue the narrative about the illness experience and observed impairment. Figure 1 outlines illustrative alternative scenarios focusing on the point of first contact between a clinician and a person who someone thinks is ill or distressed. One of the points conveyed by depicting these alternatives is that the experience and perception of distress and illness become altered during the clinical transaction.

The importance of recognizing the transactional nature of illness is underlined by noting some further variants. For example, distressing symptoms, such as diarrhea, that are ubiquitous in some impoverished cultural and socioeconomic groups, may not be regarded as manifestations of an illness in those settings; rather, they are part of everyday expectable existence, with no professional intervention or role change ordinarily taking place (Zola, 1966). But in other contexts, reports of even mild distress or observations of certain kinds of dysfunction may lead other family members, employers, or health care professionals to conclude that the person must be ill, and that certain corrective or preventive measures should be undertaken. For example, a person may report hearing comforting or inspirational voices and not experience distress about hearing them. Such reports, in some contexts, may be part of a respectfully regarded religious experience, and are not considered evidence of an illness. Alternatively, in most psychiatric settings, any hallucination is viewed as evidence of mental illness requiring treatment.

Perception of Illness as a Punctuation Point

The scenarios in Figure 1 pick up the narrative at the point when a person has contacted a clinician about distress, which may or may not be perceived by the person as illness. This perception and the clinical contact trigger or deflect the subsequent flow of events and experiences. Perception of illness is, to apply Bateson's (1942) term, a "punctuation point" in the "infinitely complex stream of events . . . so that this stream appears to be made up of one type of short sequences rather than another" (pp. 84–85). This particular punctuation point is unusually pivotal, because it not only marks the "formal" beginning of the series of transactions that we have been describing, but it also sets in motion a retrospective search for relevant antecedents, which ordinarily are labeled as "causes." Whether or not these antecedents meet the criteria of being "necessary" (invariantly present) or "sufficient" factors, ideas about causality unquestionably influence both the presenting problem and the expectations about course and treatment.

ALTERNAT
ABC

In making th
ness and non-ill
major variations
also differences a
perspectives of (
functional perso
persons (especial
heard about or
culty, and (c) tl
assigned, profess
therapists, sham.
ing, advising abo
or dysfunction.

Illness Versus Di

The three diffe
illness understar
sult in commun
aspect or other
or recurrent illn
the differences
patients and phy
ifest in the impo
tinction between
discussed especia
Kleinman (1988)
Eisenberg crisply
'illnesses'; physi
'diseases' " (p. 1
patients (and the
what is viewed by
as disease involv
constructions of

To elaborate: I
of experiences an
transactionally c
tive that the per
(or prohibited) f
tain ordinary so
exemption (or p
upon the person'
patient, which r
expected to foll

ALTERNATIVE PERSPECTIVES ABOUT ILLNESS

In making the distinction between illness and non-illness, we discover not only major variations in cultural contexts, but also differences arising from the distinctive perspectives of (a) the distressed or dysfunctional person, (b) the various other persons (especially in the family) who have heard about or have observed the difficulty, and (c) those who take culturally assigned, professional roles as physicians, therapists, shamans, and so on, in diagnosing, advising about, or treating the distress or dysfunction.

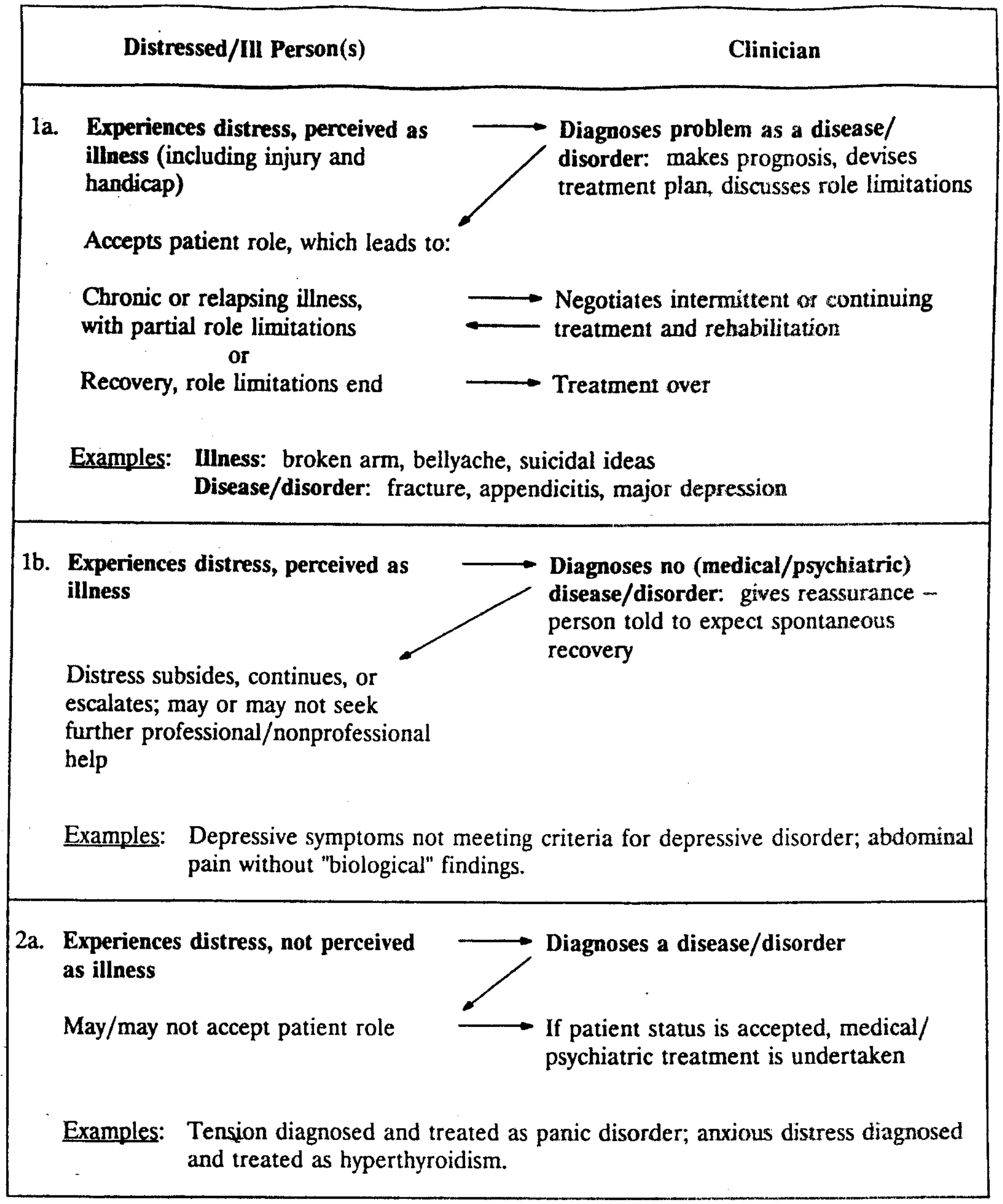
Illness Versus Disease/Disorder

The three different perspectives toward illness understandably and inevitably result in communication gaps about some aspect or other of any major, enduring, or recurrent illness. In English at least, the differences in perspective between patients and physicians have become manifest in the important terminological distinction between "illness" and "disease," discussed especially by Eisenberg (1977), Kleinman (1988), and Fabrega (1974). As Eisenberg crisply put it: "Patients suffer 'illnesses'; physicians diagnose and treat 'diseases' " (p. 11). What is perceived by patients (and their families) as illness and what is viewed by health care professionals as disease involve fundamentally distinct constructions of reality.

To elaborate: *Illness* is the complex set of experiences and dysfunctions that are so transactionally distressing and maladaptive that the person is partially exempted (or prohibited) from continuing with certain ordinary social roles. However, the exemption (or prohibition) is conditional upon the person's acceptance of the role of patient, which means that he or she is expected to follow recommendations for how best to recover from the illness or to minimize the disability.

Disease, in contrast, is impaired health defined much more narrowly from the physician's or practitioner's perspective. Couched in medical terms, it is the professional's construction, perception, or inference about a condition with more or less discretely identified characteristics that are believed to be related to lesions and other abnormalities in the structure or function of biological (or psychological) systems. When a pathophysiological etiology has not been established, as in most of psychiatry, the terms "disorder" and "syndrome" (a pattern of signs and symptoms) are commonly substituted for "disease." Disease and disorder can be diagnosed whether or not the person accepts the role of patient and the associated changes in social-role functions.

The physician's perspective may be narrowly focused in the biotechnical medical model or, more broadly construed, in the biopsychosocial medical model (Engel, 1977, 1980). The latter includes a more complex, contextual understanding of the linkages between bodily systems, self systems, and systems of dyadic and family relationships and the wider society. It is an error to assume that "disease" is understood and interpreted by physicians in terms of any single, consistent "medical model." Instead, there are a variety of medical interpretations of disease, ranging from a reductionistic, noncontextual, unidirectional, biotechnical model to the much more comprehensive biopsychosocial medical model in which disease is understood in multiple-level, systemic terms that include biological functions and psychological experience within their relational and transactional contexts (Engel, 1977, 1980). Physicians and other health care professionals differ greatly in the extent to which they perceive the transactional (that is, the



Distressed/Ill Person(s)	Clinician
1a. **Experiences distress, perceived as illness** (including injury and handicap) →	**Diagnoses problem as a disease/disorder**: makes prognosis, devises treatment plan, discusses role limitations
Accepts patient role, which leads to:	
Chronic or relapsing illness, with partial role limitations ⇄	Negotiates intermittent or continuing treatment and rehabilitation
or	
Recovery, role limitations end →	Treatment over
Examples: **Illness**: broken arm, bellyache, suicidal ideas **Disease/disorder**: fracture, appendicitis, major depression	
1b. **Experiences distress, perceived as illness** →	**Diagnoses no (medical/psychiatric) disease/disorder**: gives reassurance – person told to expect spontaneous recovery
Distress subsides, continues, or escalates; may or may not seek further professional/nonprofessional help	
Examples: Depressive symptoms not meeting criteria for depressive disorder; abdominal pain without "biological" findings.	
2a. **Experiences distress, not perceived as illness** →	**Diagnoses a disease/disorder**
May/may not accept patient role →	If patient status is accepted, medical/psychiatric treatment is undertaken
Examples: Tension diagnosed and treated as panic disorder; anxious distress diagnosed and treated as hyperthyroidism.	

FIG. 1. Illustrative scenarios about illness and non-illness distress.

illness) implications of disease and disorder. Also, there are differences from case to case in the extent to which a comprehensive biopsychosocial model is needed in order to provide care effectively (Herman, 1989).

Because illness and disease involve differing perspectives, illness can be experienced (by patients) without disease, and disease can be diagnosed (by physicians) without the experience of illness. Indeed, it

---

Distress

2b. **Experiences**
as illness

May/may no

Examples: I
c

3a. **Does not exp**
or illness

May be induc

Examples: I

3b. **Does not exp**
distress; othe
exists

May be induc
patient role

Examples: I
p
p
a

3c. **Does not exp**
distress; othe
problem exist

May be induc

Examples: (

	Distressed/Ill Person(s)		**Clinician**
2b.	**Experiences distress, not experienced as illness**	→	**Diagnoses a problem of living (individual/relational)**
		↙	
	May/may not accept client role	→	If client role is accepted, individual psychotherapy or marital/family therapy is undertaken
	Examples: Painful grieving; marital conflict; family experience of burden with home care of chronically ill member.		
3a.	**Does not experience personal distress or illness**	→	**Provides routine checkup; diagnoses a disease/disorder**
		↙	
	May be inducted into patient role	→	Preventive care
	Examples: Hypertension found on routine physical examination.		
3b.	**Does not experience personal distress; others believe an illness exists**	→	**Diagnoses disease/disorder**
		↙	
	May be inducted (with difficulty) into patient role	→	If accepted, treatment/management
	Examples: Individual denies drinking problem, but others believe person has alcoholism; personality changes diagnosed as Alzheimer's disease; posthospital behavior perceived by person as no problem and by family as laziness, but diagnosed and treated by the clinician as negative symptoms of schizophrenia.		
3c.	**Does not experience personal distress; others believe a behavioral problem exists**	→	**Diagnoses relational/behavioral problem**
		↙	
	May be inducted into client role	→	Various forms of counseling and therapy
	Examples: Cult involvement; adolescent behavior viewed as delinquent by adults.		

FIG. 1. *(continued)*

has been found that only 35–50% of initial visits to physicians are for complaints of illness for which the physician finds a medical "disease" (Stoeckle, Zola, & Davidson, 1964). On the other hand, disease may be diagnosed in routine examinations when illness has not been experienced or has been denied, for example, tumors found through X-rays, high blood pressure assessed during a physical examination, or mental disorders inferred from psychological tests or interview assessments. These differences are widely understood by the public and are reflected, for example, in commonly heard comments: "I feel ill [sick], but the doctor says there is nothing wrong with me," or in reports such as: "I feel fine, but the doctor says I have high blood pressure." The scenarios in Figure 1 illustrate the communication gap and difference in perspectives stemming from the subjective experience of an individual patient about illness/distress and the "objective" observations of a physician about disease/disorder. However, it should be recognized that there always are, initially at least, similar communication gaps between distressed individuals and observing members of their families and between distressed family members and family therapists. Therapist efforts to be empathic and to construct a picture of the family members' experience require a dialogic process before even partial success can be expected.

ILLNESS AND RESPONSIBILITY

Family therapists and other psychotherapists frequently have expressed concern that "illness" too readily implies that the ill person is a passive, sometimes hopeless victim, helplessly dependent for guidance and care upon the powerful (though sometimes mistaken and neglectful) professional. From this dismal perspective, the relief from role obligations that is intrinsic to the illness narrative hampers, not helps, active participation by the distressed person in the recovery process, and sometimes may segregate certain classes of chronically ill persons with a stigmatizing, scapegoating label.

However, such interpretations of illness as a passive, care-receiving process ignore the other side of the coin. Patients are always expected to contribute to and participate in their own care except when they are completely incapacitated (at an extreme, when comatose). Caregiving is conditional upon the patient's taking part as an active, cooperative agent in the recovery process.

This dual nature of the illness role was first underlined from a broad sociological perspective by Parsons (1951) and Parsons and Fox (1952):

> [A]s a role the state of illness is partially and conditionally legitimized. That is, if a person is defined as sick, his failure to perform his normal functions is "not his fault" and he is accorded the right to exemption and to care. At one and the same time, however, the sick person is enjoined to accept the definition of his status as undesirable and the obligation to get well as expeditiously as possible. [Parsons & Fox, 1952, p. 32]

From the perspective of community and cultural systems, it clearly is dysfunctional if too many persons are ill for prolonged periods and unable to fulfill expectable social roles. In all cultures, there is pressure to minimize illness and thereby minimize resources needed for care of the ill. Further, if professional caretakers fail to facilitate recovery or are viewed as self-serving by providing unneeded services, broader social and economic pressures will be brought to bear upon them. Additionally, praise is always forthcoming for patients (and families) who are working toward recovery or better functioning.

Our point, for present purposes, is that there is a continuing series of negotiations at various levels, not just between patient

and doctor, bu
community. T
form of trying t
as illness and
tions that are d
ever people ha
the issue of illn
would be naiv
anyone else to
what is illness
caretaking and
missed or set as

Treatment Co
Consent

Parsons' (195
of illness fun
from everyday
responsibilities
refined in cer
medical concept
ance with treat
aspects of illne
culties of speci
medication as p
rest as recom
rehabilitative p
engaging in psy
apy, all are *nego*
right to refuse t
ant, and thus *n*
recognized alm
a person is con
unable to mak
brain damage or
Thus, being
with treatment
bility in which
agent. Inform
ment now form
cess; such rules
some treatment
professional cla
ing of the treat
quences, and wi
to make a reaso
One of the maj
paradoxical int

and doctor, but also involving family and community. These negotiations take the form of trying to specify what is designated as illness and to delimit the role exemptions that are deemed appropriate. Whenever people have distress or dysfunction, the issue of illness is certain to be raised; it would be naive of family therapists or anyone else to suppose that the issue of what is illness and what it implies for caretaking and responsibility can be dismissed or set aside.

Treatment Compliance and Informed Consent

Parsons' (1951) concept of the two sides of illness functioning—the exemptions from everyday roles and the patient's responsibilities for recovery—needs to be refined in certain respects. First, the medical concept of compliance/noncompliance with treatment incorporates the dual aspects of illness and highlights the difficulties of specifying responsibility. Taking medication as prescribed, taking fluids and rest as recommended, participating in rehabilitative programs, coming to and engaging in psychotherapy or family therapy, all are *negotiated* activities. The active right to refuse treatment, to be noncompliant, and thus *not* be a patient, is legally recognized almost everywhere (except when a person is completely incapacitated and unable to make this decision because of brain damage or florid psychosis).

Thus, being a patient and complying with treatment is, in principle, a responsibility in which the person is an active agent. Informed consent rules for treatment now formalize this negotiation process; such rules seemed necessary because some treatments were being given without professional clarification and understanding of the treatment and its possible consequences, and without enabling the person to make a reasoned decision to participate. One of the major ethical shortcomings of paradoxical interventions and some forms of Ericksonian techniques is that informed consent is bypassed and the patient (or family) is inducted into therapy without knowing that this has happened.

Families with "mentally ill" members have complained vehemently when they have been inducted into family therapy without their freely given consent. Family advocates point out that family therapists, at least in the past, have proclaimed that "the family is the patient." These families protest that they came to assist the clinician in the diagnosis and caretaking of an "ill" family member, and they did not want to be viewed, or to view themselves, as an "ill *family*"—a perception that is implied in the recommendation for "family therapy."

Denial of Illness

A similar clarification of Parsons' formulation is needed when illness behavior is attributed to a person without his or her agreement—commonly called "denial" of illness. Persons who are alcoholics or drug addicts, senile, paranoid, or caught up in a coercive cult, may deny that any illness or any other problem exists for which they bear any responsibility. They do not expect to be exempted from any role obligations, nor do they accept responsibility for changing or recovering from the externalized problem. This same kind of issue comes up when family members "deny" the existence of a family "illness" that others, such as therapists, might claim to have observed. Rightly or wrongly, the illness concept for individuals is historically and cross-culturally accepted, so that societal clout can be used to persuade persons to accept a diagnosis and treatment, however grudgingly, if a health care professional believes a person is manifesting illness behavior.

However, there is no comparable cultural tradition for applying the illness concept to families. We contend that this difference is crucial. It means that the basis for the relationship of clinicians with families must be negotiated in each case; this relationship cannot be legitimized by the analogy of individual illness to family illness. This analogy is not accepted as a cultural principle anywhere. Certainly, it cannot, or should not, be presumed that families will knowingly attribute *illness* to themselves as family units. They may accept the idea that they have a family or relational *problem,* but what this means to them then becomes an issue for a case-by-case discussion and exploration. Initially, as we and our colleagues (Wynne, McDaniel, and Weber, 1987) have proposed, this collaborative exploration is better called family *consultation,* rather than family *therapy.*

EXTERNALIZING THE PROBLEM OF ILLNESS

As a problem that is looked at by more than one person, illness is psychologically "outside" the patient as well as other "observers." When a distressed person decides that he or she "has" an illness, the illness is, in effect, psychologically externalized, that is, the illness is afflicting the self, but does not constitute the self. White and Epston (1990) have most convincingly described the clinical value of externalizing presenting problems, particularly when they are "considered to be inherent, as . . . relatively fixed qualities that are attributed to persons and to relationships" (p. 38). A problem perceived as "external" is experienced as more manageable, less restricting, and less fixedly chronic. This perception, or construction, of a problem can be brought into focus by asking two questions, as recommended by White and Epston (1990): What impact has the problem (illness) had upon the lives and relationships of the family members? What impact and influence can the family members have upon the "life" or course of the problem? Giving attention to the second question paves the way for active coping.

Mistakenly, we believe, family therapists often have assumed that accepting individual illness as part of a family's presenting problem would imply a passive noncoping attitude toward the illness. To the contrary, clearly circumscribed illnesses are experienced as much more amenable to effective coping and active treatment than are amorphous, poorly defined conditions or life-long character traits.

Externalizing the problem of illness means not a loss of responsibility but, rather, a heightened recognition of the possibilities of taking effective responsibility. In the narrative of any problem in which persons have felt trapped, the skilled, solution-oriented clinician is able to identify past occasions when the problem became less distressing (de Shazer, 1985). Noticing the circumstances of these exceptions can be the starting point for considering how small changes can be repeated and enhanced.

CAUSAL EXPLANATIONS OF ILLNESS

Another serious problem with the concept of illness in the view of family theorists is that it is thought to imply an incorrect, lineal concept of causality. Patients, families, and most health care professionals do organize the experience of illness in lineal, "causal" sequences. Indeed, one of the first questions raised about any distress, and especially any distress that is perceived to be an illness, is: "What's causing it?" And "cause" is inextricably linked to responsibility and blame. It is noteworthy that the Greek root (*aitia*) for etiology (the study of causes) means not only "cause" but also "responsibility" and "blame."

Systems theorists have given much attention to the concept of "circularity" of cause and effect (see, for example, Watzlawick, Beavin, & Jackson, 1967), disdaining the popular, "Aristotelian" idea of lineal causality or setting aside the concept of causality altogether (Dell, 1982).

Whether or no
flects a wrong-l
individuals and
a presenting pr
they also bring t
Rarely, do their
systemic, circul
of the system-
about an illnes
always differs fr
family member
especially if left i
for undermining
a constructive.
(Wynne et al., 19
tic alliance.

From a bro
cultural perspec
six classes of "
interpreted as
supernatural ca
cal agents; (3)
"external" to t
cesses such as se
nity disorganiz
events; and (6)
Despite the diver
we wish to poi
efforts at interpr
with an inheren
mystifying experi

The family-sys
can be regarded
of the societal
interpretations o
versions, not th
social unit (famil
disturbing or "s
family systems ar
ing or maintain
much of the imp
of family therapy.

It is relevant to
sis has an impo
theories of scapeg
In an important
Bell (1960) note

Whether or not looking for "causes" reflects a wrong-headed epistemology, when individuals and family members come with a presenting problem perceived as illness, they also bring their ideas about its causes. Rarely, do their ideas embrace a balanced, systemic, circular causality. Thus, the view of the system-oriented family therapist about an illness and its causes almost always differs from that of the patient and family members. Such discrepant views, especially if left implicit, have the potential for undermining the process of engaging in a constructive, collaborative consultation (Wynne et al., 1987) or, later, in a therapeutic alliance.

From a broad historical and cross-cultural perspective, we identify at least six classes of "causes" that have been interpreted as explaining illness: (1) supernatural causes; (2) physical/biological agents; (3) unconscious processes "external" to the self; (4) societal processes such as severe poverty and community disorganization; (5) traumatic life events; and (6) family-system processes. Despite the diversity of these explanations, we wish to point out that they all are efforts at interpreting and thereby coping with an inherently distressing and often mystifying experience.

The family-system explanation of illness can be regarded as an alternative version of the societal and traumatic life-event interpretations of illness; in each of these versions, not the individual but a larger social unit (family or society) is viewed as disturbing or "sick." The hypothesis that family systems are "causative" in generating or maintaining symptoms provided much of the impetus for starting the field of family therapy.

It is relevant to recall that this hypothesis has an important root in non-illness theories of scapegoating (Ackerman, 1958). In an important early article, Vogel and Bell (1960) noted that scapegoating by families is but an example of a more general process in human groups that is as old and universal as human society. It is still a plausible hypothesis that scapegoating and triangulation within the family can contribute to emotional disturbance in a child, without such disturbance necessarily being labeled as mental illness. Family therapists, particularly those with a child psychiatry background—for example, Ackerman (1958)—often focused upon the family scapegoating process without diagnosing the child as mentally ill. The formulation that individual symptoms serve a purpose or function for the family system became axiomatic for family therapists from the late 1950s through the 1970s (for example, Haley, 1959; Minuchin, 1974; Satir, 1964).

Although family therapists have avoided the terms "illness" and "cause," the hypothesis of the family system as "pathogenic" was applied not only to specific symptoms but also to those symptom patterns that are conventionally called illnesses and disorders, such as schizophrenia, anorexia nervosa, alcoholism, drug addiction, and so on. The early writings on family factors in schizophrenia specifically stated that "the total family unit is pathogenic" (Haley, 1959, p. 358), meaning, by definition, causative of illness. Although the term "schizophrenogenic mother" was coined by an individual psychotherapist (Fromm-Reichmann, 1948), the term "schizophrenogenic family" later achieved wide currency during the years that the family therapy field was becoming established. The initial formulation of the double bind described schizophrenic patients as the "victims" of the parental double bind, and was concerned with the etiology of schizophrenia (Bateson, Jackson, Haley, et al., 1956). In terms of a theory of individual illness, this formulation left schizophrenic patients, like other victims of "external" agents, free of "fault" and responsibility. However, the perpetrators in this new scenario were now identified as the parents.

Quite soon, when the implications of this victimizing, unidirectional formulation were recognized, the double-bind theory was modified to describe reciprocal, systemic processes in which everyone in the family participates, and for which no *individual* is blamed or scapegoated (Weakland, 1960). Family-systems theorists have subsequently insisted that, in their view, no one person is being blamed for symptoms or disturbed behavior—that the system is bigger than the individual family members who are all caught up, nonvolitionally, in "circular," family-wide processes. Using the concept of circular causality, family systems were no longer unidirectionally pathogenic, but their functioning was described explicitly as deviant and, in popular terms, as "sick" or "ill."

The clinical and conceptual difficulties with this family-systems formulation are several. First, when there has been physical, sexual, or emotional abuse, or any exploitative use of power by an individual family member, locating the responsibility in the family system rather than in an individual perpetrator has seemed to many family members, and to many clinicians as well, to be both unfair and therapeutically inappropriate.

Second, the concept of causality is too deeply rooted to be set aside (except by sophisticated epistemologists). When a family member is grossly disabled by a physical or mental illness, other family members understandably seek professional assistance in understanding and coping with what they usually perceive as a mystifying and frightening change. Almost always, their first questions are: What kind of illness is this? What has caused it? If the clinician fails to be responsive in terms that are explicitly relevant to these concerns and, instead, immediately tries to turn primary attention to family relationships, the family is likely to conclude that the answer is: The family is the cause and is being subtly (or not so subtly!) blamed for the family member's illness. This implication arouses family loyalty and the sense of family identity; family members recoil defensively against, and withdraw from, what they fear will be family bashing. Defensively, at the same time that family consumer advocates have become increasingly outspoken in supporting a biological versus a family-systems interpretation of mental illness (Hatfield, n.d.), families have become sensitive to the implication that a recommendation of family therapy means that the clinician thinks the family, not an individual family member, is ill.

Those parents who accept hierarchical leadership in the family (as urged by many family therapists) experience themselves as responsible and therefore blameworthy if the offspring has become disturbed. This implication was compounded when systemic therapists began to suggest that the patient's symptoms are "helping" other family members. Although such comments have been intended as positive connotations for mutual helpfulness in a family, parents and siblings often perceive systemic interpretations as incongruent with their request for information and guidance about how to understand, help, or cope with an "ill" family member.

Not surprisingly, the alternative interpretation that mental illness is physical/biological and that no one, neither individuals nor the family as a unit, need feel responsibility or blame, is welcomed by families. In recent years, this view has had abundant support in literature and media reports for the public; mental disorders, especially schizophrenia and manic-depressive disorder, have been explicitly called "brain diseases" (Henn & Nasrallah, 1982). Family-system reframings of illness, shifting the focus away from the individual's biology, have not reversed the preference

in present-day.
tures for under
cal/physical ter
A brief comp
Alzheimer's di
have been view
perspective may
ering alternat
"illness." Steing
useful distinct
families" for wh
a "central organi
lies in which thi
has not occurred
as "families wit
"families with a
noteworthy that
"schizophrenoge
hologenic family"
origins of alcohol
complex and vari
from genetic cont
ational transmis
patterns, and a pr
holic individual b
purposeful, probl
an alcoholic spous
sobriety-intoxicat
maintenance clea
ual drinking *anc*
terns.
Unlike alcoholi
and cancer appea
blue," but, as wit
caretaking with a
ron, Horbal, et al.
(Wellisch et al., 1
tral organizing pri
whole. (To be su
involvement differ
each patient and f
ease and cancer a
which psychosocia
ily relationships)
the course of the
comfort of the pat
that these illnesse

in present-day, "developed" Western cultures for understanding illness in biological/physical terms.

A brief comparison of how alcoholism, Alzheimer's disease, and schizophrenia have been viewed from a family-system perspective may be helpful here in considering alternative interpretations of "illness." Steinglass (1987) has made the useful distinction between "alcoholic families" for whom alcoholism has become a "central organizing principle," and families in which this systemic reorganization has not occurred and which are designated as "families with alcoholic members" or "families with alcoholism" (p. n9). It is noteworthy that no term comparable to "schizophrenogenic family" is used; "alcohologenic family" is not used. Rather, the origins of alcoholism have been viewed as complex and varied, arising, for example, from genetic contributions, the intergenerational transmission of family behavior patterns, and a process in which a nonalcoholic individual begins to use alcohol as a purposeful, problem-solving protest about an alcoholic spouse (Steinglass, 1987). The sobriety-intoxication cycles of alcoholism maintenance clearly involve *both* individual drinking *and* recurrent family patterns.

Unlike alcoholism, Alzheimer's disease and cancer appear to come "out of the blue," but, as with alcoholism, the family caretaking with an Alzheimer's (Boss, Caron, Horbal, et al., 1990) or cancer patient (Wellisch et al., 1986) may become a central organizing principle for the family as a whole. (To be sure, the quality of the involvement differs with each disorder and each patient and family.) Alzheimer's disease and cancer are "typical" illnesses in which psychosocial factors (including family relationships) may modify somewhat the course of the illness (or at least the comfort of the patient), at the same time that these illnesses are well-recognized as constituting a burden for other family members. Furthermore, family consultation/therapy may be clearly helpful for all the family members. However, the possibility that family-system patterns might have "caused," for example, Alzheimer's disease, or could induce the illness in another family member, is not considered.

Alcoholism has the curious medical (and legal) status of being both an involuntary illness and a non-illness expression of willfulness or self-indulgence that individuals are expected to control. Recognition of alcoholism as "illness" seems to allow nonalcoholic family members to accept a respectable degree of responsibility for maintaining the drinking, without burdening them with guilt over being *primary* causal agents.

The schizophrenic patient's symptoms, such as auditory hallucinations, are experienced by other family members as mystifying and alien, as coming "out of the blue" (or perhaps triggered by street drugs). During their onset, the functional psychoses are perceived by family members as being more like Alzheimer's disease than alcoholism. Whereas family members can quite readily observe their own participation in drinking rituals, the possible link between family relations and hallucinations is not easy for families to notice, or for professionals to explain or demonstrate convincingly. In this respect, too, the presenting symptom picture of the psychoses is perceived by families as more like a physical illness than like alcoholism.

Quite appropriately, we believe, professionals and the public have been relatively willing to accept a complex, integrative, biopsychosocial view of alcoholism as an illness *and also* a problem with behavioral and interpersonal difficulties. Curiously, and unfortunately, family therapists have been comparatively unwilling to work with a biopsychosocial concept of schizophrenia and the other functional psychoses. Instead, there continues to be an effort to reframe these problems exclusively in family-system, non-illness terms. From our perspective, the acceptance by clinicians of a broad "illness" concept for conditions such as schizophrenia enhances, rather than hinders, the willingness of families to engage in a consultative or therapeutic relationship in which they can nondefensively explore better ways of coping with the problem.

In summary, all human beings, at least those in Occidental cultures, seek explanations for devastating events and experiences such as serious illness; "causes," responsibility, and blame are inevitably invoked in these circumstances in efforts to reduce the stress of ambiguity and provide a clearer basis for coping (Wynne, 1983). Historically and cross-culturally, the signs and symptoms of illness have been "explained" by "causal" agents or events that are external to the "self" of the patient. Such explanations, in which illness is defined in externalized, circumscribed terms, help individuals take stock of what they can do to participate in their own recovery. Similarly, from the perspective of all the family members and the family clinician, a family member's illness need not be avoided or minimized. Rather, if its meanings are fully explored, illness can become a challenge for mobilizing family strengths and shared resources. As we shall discuss in more detail in a companion article on clinical approaches to mental illness, accepting illness as an externalized problem that is *not* inherent in family relationships can facilitate active, effective coping and the discovery of new solutions.

CONCLUDING COMMENTS

We have noted that family therapists, unlike most other mental health professionals, regard illness ambivalently and consider it peripheral to their theories, practice, training programs, and research. Consequently, the field of family therapy has weakened its potential impact upon professional colleagues and the public. We suggest that there is no single, universally optimal, clinical response to problems presented as individual distress or illness. It is the responsibility of the experienced and well-trained clinician to help assess which conceptual framework and approach is most appropriate in any given instance, and to facilitate the implementation of that approach, often with referral or consultative collaboration with other professionals. In this and the companion article that addresses the special issues of mental illness, we suggest that family therapists need to conceptualize and differentiate the varieties of illness/distress from one another in order to clarify, strengthen, and broaden the scope of family therapy, theory, and clinical practice. By recognizing that both physical and mental illness can be appropriate, accepted punctuation points for clinical contact with families and couples, we believe that family-oriented approaches can be better targeted and, at the same time, applied to a much wider range of problems than those currently seen by most family therapists.

REFERENCES

Ackerman, N.W. (1958). *The psychodynamics of family life: Diagnosis and treatment of family relationships*. New York: Basic Books.

Anderson, C.M., Griffin, S., Rossi, A., Pagonis, I., Holder, D.P., & Treiber, R. (1986). A comparative study of the impact of education vs. process groups for families of patients with affective disorders. *Family Process 25:* 185–205.

Barrett, R.J. (1988). Interpretations of schizophrenia. *Culture, Medicine and Psychiatry 12:* 357–388.

Bateson, G. (1941). Social planning and the concept of deutero-learning. In *Science, philosophy and religion, second symposium* (Conference on Science, Philosophy and Religion, New York). New York: Harper & Row.

______, Jackson,
J.H. (1956). T
nia. *Behavioral*
Bloch, D.A. (198
The field and
Medicine 1(1):
Boll, P.G., DuV
(1983). Structu
tidisciplinary f
port. *Family Sy*
Boss, P., Caron, W
(1990). Predicto
of dementia pa
and mastery. *Fa*
Carter, R.E. (19
reorganization
tion. *Family Sys*
Dell, P.F. (1982).
a concept of co
21–41.
de Shazer, S. (19
therapy. New Yo
Eisenberg, L. (1
Distinctions bet
lar ideas of sick
Psychiatry 1: 9–
Engel, G.L. (1977)
model: A challe
196(4286): 129–
______. (1980). Th
biopsychosocial
Psychiatry 137:
Fabrega, H., Jr.
behavior: An in
Cambridge: Mas
nology Press.
Falloon, I.R.H.,
management of
clinical, social,
fits. Baltimore:
Press.
Fromm-Reichman
development of
by psychoanalyt
11: 263–273.
Goldstein, M.J. (ed
in interventions
ics. San Francisc
Gonzalez, S., Stein
Putting the illn

———, Jackson, D.D., Haley, J., & Weakland, J.H. (1956). Toward a theory of schizophrenia. *Behavioral Science 1:* 251–264.

Bloch, D.A. (1983). Family systems medicine: The field and the journal. *Family Systems Medicine 1*(1): 3–11.

Boll, P.G., DuVall, M.L., & Mercuri, L.G. (1983). Structural family therapy in a multidisciplinary facial pain center: A case report. *Family Systems Medicine 1*(3): 78–91.

Boss, P., Caron, W., Horbal, J., & Mortimer, J. (1990). Predictors of depression in caregivers of dementia patients: Boundary ambiguity and mastery. *Family Process 29:* 245–254.

Carter, R.E. (1984). Family reactions and reorganization patterns in myocardial infarction. *Family Systems Medicine 2:* 55–65.

Dell, P.F. (1982). Beyond homeostasis: Toward a concept of coherence. *Family Process 21:* 21–41.

de Shazer, S. (1985). *Keys to solution in brief therapy.* New York: W.W. Norton.

Eisenberg, L. (1977). Disease and illness: Distinctions between professional and popular ideas of sickness. *Culture, Medicine and Psychiatry 1:* 9–23.

Engel, G.L. (1977). The need for a new medical model: A challenge for biomedicine. *Science 196*(4286): 129–136.

———. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry 137:* 535–543.

Fabrega, H., Jr. (1974). *Disease and social behavior: An interdisciplinary perspective.* Cambridge: Massachusetts Institute of Technology Press.

Falloon, I.R.H., & Others. (1985). *Family management of schizophrenia: A study of clinical, social, family, and economic benefits.* Baltimore: Johns Hopkins University Press.

Fromm-Reichmann, F. (1948). Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy. *Psychiatry 11:* 263–273.

Goldstein, M.J. (ed.). (1981). *New developments in interventions with families of schizophrenics.* San Francisco: Jossey-Bass.

Gonzalez, S., Steinglass, P., & Reiss, D. (1989). Putting the illness in its place: Discussion groups for families with chronic medical illnesses. *Family Process 28:* 69–87.

Haas, G.L., Glick, I.D., Clarkin, J.F., Spencer, J.H., Lewis, A.B., Peyser, J., DeMane, N., Good-Ellis, M., Harris, E., & Lestelle, V. (1988). Inpatient family intervention: A randomized clinical trial: II. Results at hospital discharge. *Archives of General Psychiatry 45:* 217–224.

Haley, J. (1959). The family of the schizophrenic: A model system. *Journal of Nervous and Mental Disease 129:* 357–374.

Hatfield, A.B. (n.d.). *Coping with mental illness in the family: A family guide.* Maryland Department of Health and Mental Hygiene.

Henn, F.A., & Nasrallah, H.A. (eds.). (1982). *Schizophrenia as a brain disease.* New York: Oxford University Press.

Herman, J. (1989). The need for a transitional model: A challenge for biopsychosocial medicine? *Family Systems Medicine 7:* 106–111.

Houlihan, J.P. (1987). Families caring for frail and demented elderly: A review of selected findings. *Family Systems Medicine 5:* 344–356.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition.* New York: Basic Books.

McDaniel, S.H., Campbell, T., Wynne, L.C., & Weber, T. (1988). Family systems consultation: Opportunities for teaching in family medicine. *Family Systems Medicine 6:* 391–403.

———, Hepworth, J., & Doherty, W. (1992). *Medical family therapy.* New York: Basic Books.

Minuchin, S. (1974). *Families & family therapy.* Cambridge: Harvard University Press.

———, Rosman, B.L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context.* Cambridge: Harvard University Press.

Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry 21:* 452–460.

———, & Fox, R.C. (1952). Illness, therapy, and the modern American family. *Journal of Social Issues 13:* 31–44.

Retzer, A., Simon, F.B., Weber, G., Stierlin, H., & Schmidt, G. (1991). A followup study of manic-depressive and schizoaffective psychoses after systemic family therapy. *Family Process 30:* 139–153.

Rolland, J.S. (1984). Toward a psychosocial typology of chronic and life-threatening illness. *Family Systems Medicine 2:* 245–262.

______. (1987). Family illness paradigms: Evolution and significance. *Family Systems Medicine 5:* 482–503.

Russell, G.F.M., Szmukler, G.I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Archives of General Psychiatry 44:* 1047–1056.

Satir, V. (1964). *Conjoint family therapy: A guide to theory and technique.* Palo Alto CA: Science and Behavior Books.

Stanton, M.D., Todd, T.C., & Associates. (1982). *The family therapy of drug abuse and addiction.* New York: Guilford Press.

Steinglass, P., with Bennett, L.A., Wolin, S.J., & Reiss, D. (1987). *The alcoholic family.* New York: Basic Books.

Stierlin, H., & Weber, G. (1989a). Anorexia nervosa: Lessons from a follow-up study. *Family Systems Medicine 7:* 120–157.

______, & Weber, G. (1989b). *Unlocking the family door: A systemic approach to the understanding and treatment of anorexia nervosa.* New York: Brunner/Mazel.

Stoeckle, J.D., Zola, I.K., & Davidson, G.E. (1964). The quantity and significance of psychological distress in medical patients: Some preliminary observations about the decision to seek medical aid. *Journal of Chronic Diseases 17:* 959–970.

Velasco de Parra, M.L., Dávila de Cortazar, S.D., & Covarrubias-Espinoza, G. (1983). The adaptive pattern of families with a leukemic child. *Family Systems Medicine 1*(4): 30–35.

Vogel, E.F., & Bell, N.W. (1960). The emotionally disturbed child as the family scapegoat (pp. 412–427). In N.W. Bell & E.F. Vogel (eds.), *A modern introduction to the family.* Glencoe IL: The Free Press.

Watzlawick, P., Beavin, J.H., & Jackson, D.D. (1967). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes.* New York: W.W. Norton.

Weakland, J.H. (1960). The "double-bind" hypothesis of schizophrenia and three-party interaction (pp. 373–388). In D.D. Jackson (ed.), *The etiology of schizophrenia.* New York: Basic Books.

Wellisch, D.K., & Cohen, M.M. (1986). The family therapist as systems consultant to medical oncology (pp. 199–218). In L.C. Wynne, S.H. McDaniel, & T.T. Weber (eds.), *Systems consultation: A new perspective for family therapy.* New York: Guilford Press.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* New York: W.W. Norton.

Wynne, L.C. (1983). Reflections on blame and responsibility for schizophrenia (pp. 205–213). In D.F. Ricks & B.S. Dohrenwend (eds.), *Origins of psychopathology: Problems in research and public policy.* Cambridge: Cambridge University Press.

______, McDaniel, S.H., & Weber, T.T. (1987). Professional politics and the concepts of family therapy, family consultation, and systems consultation. *Family Process 26:* 153–166.

Zola, I.K. (1966). Culture and symptoms—An analysis of patients' presenting complaints. *American Sociological Review 31:* 615–630.

Manuscript received August 30, 1990; revision submitted November 14, 1991; accepted November 18, 1991.

Family Ir
Disease

Depression i:
family caregive
(AD) patients, t
overall behavior
has received litt
focus of the expl
was on one aspe
responses betwe
family members
depressive symp
givers. Family
cially negative r
particular salie
psychiatric disor
salient in a stud
in primary care
tients? Apparent
and extended fan
in problem-solvin
that were video
coded on affect. T
angry and sad
family members t
for over 44% of t

---

* This project was
the Blue Cross/Blue
Committee, 1988–19
Franks, M.D., Tom C
Ph.D., Jeff Harp, M.
Botelho, M.D., my a
helpful comments on
and Sally Rousseau, B
for their careful codin

† Assistant Profes
Psychiatry at the Un
Medicine, Family M
Hospital, 885 South A

0014-7370/92/3101