SEMINAR DAY

Schizophrenia and the Family: II. Adverse Effects of Family Therapy

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Theoretical formulations of the past thirty years have championed the hypothesis that family interaction contributes heavily to the etiology of schizophrenia, a position that has dominated contemporary family therapy even in the absence of solid empirical confirmation. The possibility that sociogenic modeling of schizophrenia is not only incorrect but even harmful to families, and to the relationship between families and clinicians, has never been taken seriously, despite its implications for the practice of family therapy. The author describes untoward effects of the sociogenic hypothesis in his own ten-year experience with families of chronic schizophrenics and examines pertinent reports in the family therapy literature, offering the reinterpretation that many communicational aberrations are adaptations to two therapist attributes: (a) failure to absolve the family of initial causal responsibility, and (b) failure to inform the family about the nature of the illness.

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THE IDEA that family interaction contributes to the etiology of schizophrenic disorders has enjoyed wide acceptance in the past 25 years. However, two problems with this perspective have become apparent in more recent times. First is the dearth of confirmatory evidence. Whether the family contributes at all to the occurrence of schizophrenic disorders is still a wide-open question because (a) minimal methodological conditions for drawing valid conclusions regarding the role of family interaction are not met in available studies (24), and (b) experimental investigation has not afforded us with evidence that discriminates between the *etiological* model and other models that give equally plausible accounts for observable peculiarities in family interaction. For example, the *responsive* model holds that family peculiarities are expressions of the impact of the schizophrenic on family members and family organization. The *biogenic* model regards these peculiarities as incomplete or subpsychotic expressions of the same genetic and biochemical processes that give rise to clinical schizophrenia.

The second problem of the sociogenic model lies in its effects on the quality of relatedness that can be established between clinicians and family members. *When either therapist or family harbor the belief that schizophrenia is caused by personal experience with family members, therapeutic misalliance is bound to follow.* My thesis in this paper is that sociogenic modeling constitutes a barrier to trustful and respectful collaboration between relative and therapist and may foster splitting of family and therapist by the patient (4). When a therapist invokes the family as a causal agent,

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a situation is created in which patient and family may actually make more positive long-term adjustments to schizophrenic vulnerabilities by avoiding professional help (2, 7). I will describe these phenomena as I have witnessed them in my own work with families. Then I will review several reports in the relevant clinical and experimental literature.

Misalliances in My Own Work With Relatives

Over the past ten years I have had occasion to meet regularly with a number of families in the absence of their chronic schizophrenic offspring. At first this arrangement developed by default, inasmuch as the schizophrenic member was unwilling to involve himself or herself in ongoing family therapy, and yet the parents were interested in learning what they could do in the patient's behalf. As time passed, I observed that something distinctive was occurring in such meetings, something less likely to occur in meetings that included the index patient. Parents were clearer in their thinking (8), more able to develop as an executive subsystem (5), and manifested an increased healthy self-interest (2). Hoping to support such developments, I began actively to encourage meetings of relatives without the patient. This led naturally to the creation of a support group for relatives, as described by Leff (16). Begun in early 1980, the group continues into the present time. Four or five couples, each of whom have an adult offspring with a chronic or relapsing-remitting schizophrenic disorder, meet with me for two hours every other week. Schizophrenic offspring are not a part of the group's membership. Nor are well siblings or other relatives included at present, (although the parents have recently discussed the idea of special meetings involving siblings). The encounter with relatives, unhindered by the presence of the ill person, has had a profound effect on my thinking about the relationship between family life and schizophrenia.

I came to this work ten years ago with the view that family interaction is causally related to onset of psychosis. I was trained in a tradition that assumed madness to be an interpersonal affair, and so in family meetings I listened to the parents talk about life with the ill person, abstracting from their reports those interactional phenomena that I thought suggestive of parental pathogenicity. I then set out to alter that pathology. Typically I would fail in that endeavor, only to explain the failure as a manifestation of tenacious, pathological resistance to self-disclosure.

The usual result of these early efforts was a deep sense of alienation from the relatives. I would become bored or discouraged with the work, often disliking, and sometimes quietly hating one or both of the parents. They behaved in ways that confused me. I found myself feeling offended inasmuch as *their conduct did not confirm me or my theory.* I found myself wondering to what extent this was intentional on their part. My discomfort would lead inexorably to progressive detachment from the family. Inherently appropriate questions regarding the nature of psychosis and important practical management issues would go unaddressed or addressed apathetically. Looking back on these times, I am sure I was not very helpful in the face of the family's *own* disappointment and helplessness and in the face of their need for some degree of certainty as to what they were dealing with. Even when I did make appropriate recommendations, e.g., suggesting that an overinvolved parent pull back and adopt a less involved posture, I did so "knowing" that their involvement had caused the psychosis. This was knowledge oozing contempt and blind to any authentic caring (22) that may have survived the onslaught of incoherence and unpredictability. All in all, my encounters with parents felt like a series of careful negotiations with kidnappers for the release of a hostage.

It should be clear to the reader that, throughout the early phases of this work,

genuine empathy for the parents was an uncommon, or at best inconstant, experience. And inasmuch as empathy is a precondition of productive involvement in any human encounter, these were ineffective encounters at best. In fact, the dominant experience for me was rejection and dismissal of one directive or interpretation after another. At worst, I may have disrupted parental participation in the patient's life. My attitude most certainly perpetuated guilt—by not actively countering it and sometimes by covertly fostering it. In the presence of continuing guilt, the parents were certainly unable to look at their situation with curiosity. And without curiosity, they were unable to learn new and presumably more benevolent ways of living with the patient. I like to think that since I was not altogether certain that what I was doing with families was well founded, it was easy for them to rebuff my more destructive suggestions and insinuations. But I fear this is yet another way of insulating myself against the realization of having done appreciable harm.

Misalliance in the Family Literature

Other workers have noted similar phenomena in passing. Tietze (25) interviewed mothers of hospitalized schizophrenics and reported a characteristic response among mothers of chronically psychotic patients to the interview situation.

> The immediate response of all mothers was one of curiosity, optimism, and appreciation of the interest taken in their children and themselves. Their enthusiasm, however, waned when the *meaning of interpersonal relationship* and its implication dawned on them. Those mothers whose children had been irretrievably withdrawn for years and who had little hope for recovery were reluctant to accept the importance of environmental influences and preferred to believe in constitution and heredity as etiologic factors. (italics mine) [25, pp. 55–56]

The possibility that these mothers were responding to observer bias is not raised by the investigator. Yet this seems an obvious, necessary precaution in these times, when the contributions of constitution (13) and heredity (11, 12, 26) have been so well demonstrated. Beels (4) described the dilemma from a position closer to that of the relatives' own experience:

> Performing a sort of sanitizing "therapy" on family members to turn them into a better "environment" for the patient also does not work, if for no other reason than that the family cannot stand the guilt. They are often in an agony of self-reproach over the patient's breakdown to begin with, and to be told by the professional staff that the very manner of their love and concern is what caused it is too much. Further, that position will not form the basis of a therapeutic relationship with the family, since it implies a conspiratorial split with the good staff and the treatable patient on one side and the bad family on the other. [4, pp. 250–251]

Anderson et al. (2) alluded to the risk of misalliance in their emphasis on joining the family through the creation of an ombudsman relationship:

> Families are often ignored or mistreated by mental health professionals, or at best given sympathy without direction. Often the family is used only as a resource for gathering historical information about the patient with little attention to their needs and concerns. In many cases, whatever contact is made with the family contains the implication that they are to blame for the patient's problems, further stimulating guilt, pain, and potentially leading to the family's withdrawal from the treatment system. [2, pp. 494–495]

These and other observers (3, 6, 10, 14, 15, 17) have drawn attention to the negative impact that mental health professionals sometimes have on families of schizophrenics. None of these writers suggest, however, how the family therapist is to convince himself that the family is not, in fact, to blame for the illness. Even the contemporary *Zeitgeist*, stressing interaction of constitutional and experiential processes, exposes the clinician to concepts involving

the family as a causal agent. Blame is avoided only at the expense of conceptual clarity—by declining to address the issue of etiology altogether. With few exceptions (2, 9), family-oriented models of schizophrenia do not reach into the neurophysiological sphere sufficiently to be useful to the clinician.

A Clinical Illustration

In 1962, a group headed by Lyman Wynne, composed of NIMH clinical investigators and clinical faculty of the Washington School of Psychiatry and the Washington Psychoanalytic Institute, reported on complications in work with the families of schizophrenics (20). Since, to my knowledge, this is the only description in any detail of the impact of a schizophrenic's family on a therapist, I will analyze it in some depth. These comments are not intended as criticism. In the early 1960s, the evidence that would bring professional attention back to psychobiological processes was little more than an idea in the mind of a handful of scientists. And in the absence of such data, the sociogenic model at least gave clinicians something positive and creative to do. The object of this analysis is to establish as best we can what sort of clinical ambience families might have encountered in psychiatrists working from a sociogenic model. I believe the therapist-family interactions so richly described in this report are representative of a whole generation of encounters between families and family therapists.

Schaffer et al. (20) studied interaction in families containing a hospitalized schizophrenic member. Their anecdotal report focused on some recurrent peculiarities of the encounter with the family, in the interests of identifying the presumed family pathology in schizophrenia. The method consisted of direct observation of family behavior in a relatively unstructured setting, which also served as the context of family therapy during the patient's hospital stay. Regarding the nature of the therapeutic presence, we find the following:

> The model for the setting . . . was derived from that of the psychoanalytic situation, at least with reference to the participation and goals of the therapists. . . . The therapists' long-range goal, and the major emphasis they present, is that of discovering as much as possible of the dimensions and sources of the current predicament. . . . *Advice is generally restricted to the invitation that the members of the group notice whatever thoughts they may have during the sessions, and get them said.* The overt participation of the therapists is otherwise confined to comment, and, in its broadest sense, interpretation. (italics mine) [20, p. 34]

Therapist and family often seemed engaged in a test of wills, bent respectively on building and destroying meaningfulness regarding family interaction.

> *The psychiatrist*, in his efforts to introduce the idea of relation and continuity, *violates the culture of the family*: in just the same way, the family's responses—the systematic destruction of meaning and the denial of authenticity—are experienced by the psychiatrist as acts of extreme violence. These exchanges—which have very little to do with conversation—both among the family and between them and the psychiatrists, are essentially characterized by the mutual failure or inability to understand, tolerate or confirm the other's experience. The psychiatrists's dread of meaninglessness and fragmentation, manifest in his search for coherence and pattern, and sometimes in his insistent bombardment of the family with interpretations, is countered by the family's shared dread of meaning and relation, manifest in the systematic destruction of meaning, the routine elimination of implication, and the insistence on fragmentation of experience. (italics mine) [20, p. 44]

The clash of values and orientation is described as stemming from the family's refusal to accept a truth delivered by the psychiatrist. However, one can also examine such interactions from the reverse point of view, namely, that the family is refusing to accept an unbearable falsehood, but that,

since the psychiatrist is a high status authority with complete administrative control over the sick offspring, the family will not openly challenge these statements. The family's responses to interpretations, which looked to the therapist-investigator like destruction of meaning, might then better be regarded as *the family's effort to preserve their own preexisting system of meanings.* Consider, for example, the following passage, purporting to illustrate the irrationality and denial of family members in the face of benevolent and knowledgable physicians. I ask the reader to view this passage from the vantage point of the family and consider that father may be attempting to deal with some quite unusual ideas and behaviors emanating from the treatment team.

> As the work went along, the father complained with mounting bitterness that the therapists provided neither guidance nor leadership. At the same time he contemptuously dismissed everything that was said as "just plain imaginary"—his rather stark euphemism for "crazy." The reflected idea that he was complaining, or that he felt in some way abandoned, elicited an identical response. A review of the extended sequence (in effect, the therapists' uneasy opposition to the snowballing denial) was again wholly dismissed save as further evidence that the therapists irresponsibly distorted everything he said. During one session, the father spent most of the hour amplifying and refining many of his previous statements of intense ambivalence toward the psychiatrists. He said, among other things, that they sadistically *withheld much that would relieve the family's plight with Fred,* and he commented sarcastically on "the men of science" who were insanely *suspicious of every little thing that happened and whose stupid preoccupation with making mountains out of molehills* simply advertised their pathetic lack of any true sense of proportion. Their only contribution to these "farcical" sessions was to make an already intolerable situation worse. (italics mine) [20, pp. 38–39]

We might infer with the authors that father is responding to the therapists' efforts to make intrafamilial events meaningful. By a direct challenge to the therapists' competence, he hopes to neutralize this interloper with his disagreeable truth. Or we might view the account as an unwitting record of valid objections: something in the therapists' delivery or in the nature of their leadership is genuinely an assault on the family. Contrast this approach with a contemporary view:

> The provision of information regarding theories of pathogenesis, course, outcome, symptomatology, and effective management of illness tends to decrease guilt, anger, and other emotional responses of the family and the resultant need to react by either over-protecting or attacking the patient. . . . The provision of information (however incomplete) appears to increase the family's understanding and tolerance of the patient, and improves their ability to set limits appropriately. Furthermore, information tends to decrease conflict among family members concerning the patient's capabilities and the most helpful way of responding. In turn, the intensity of family life is diminished and a constructive supportiveness is enhanced. [2, p. 493]

How different this is from the Washington group's "invitation that the members of the group notice whatever thoughts they may have during the sessions, and get them said" (20, p. 34).

Looking into the report, we might hope to find something of the authors' theoretical framework, at least as regards the etiology of schizophrenia. There is little here, presumably because it is taken for granted that schizophrenia has interpersonal origins. But in a passage describing membership in family therapy sessions, we find the following:

> Optimally the [family] group might include everyone significantly involved in the situation *within which the disorder came about*—all those immediately participant in the shared dilemma, impasse, or crisis of which the illness may be regarded as one manifest aspect, although by no means the only important one (italics mine). [20, p. 33]

Embedded in this passage is the common enough suggestion that the illness is to be viewed as a reflection of preexisting family pathology. Allusions such as "the patient (a term to be understood here as invariably contained within quotation marks) ..." (20, p. 34) suggest an unreadiness among the authors to consider schizophrenia as having meaning apart from family interaction, as possessing a physicalness that would render the term "patient" authentic rather than metaphoric. There is no mention anywhere in the report of the possibility of contributory physiological processes. In another place, we find:

> To act exclusively on the family's conception and to base the entire strategy of treatment and thought on this, may, we propose, serve to *reinforce the structure of the family and thus help to perpetuate the form of the matrix within which, say, schizophrenic patterns endure.* ... It is necessary to remain ... alert to questions unlikely to arise within the family, questions for example, about *the genesis of the situation within which this person, rather than another*, has become ill, and about *the functional value of the illness for the family* as a group. (italics mine) [20, p. 34]

Here again we catch the drift of a definite point of view: (a) schizophrenia is intrafamilial (rather than physical); (b) the family chooses its ill member transactionally (rather than genetically); and (c) the illness is a plus (rather than a burden) to the family.

Imagine yourself a parent in consultation with a therapist espousing these views. You are attempting to absorb the shock of psychosis in your child. In all likelihood you are already in "an agony of self-reproach" (4, p. 251) about the illness. And then you are told (albeit implicitly) by an authority believing in his own benevolence that you are the cause of it. This might possibly have some impact on your communicational style.

The Central Hypothesis: Observer-Induced Peculiarities

All this lead me to reconsider an iatrogenic hypothesis, i.e., that *unusual forms of family interaction*, and also unusual interactions between family members and outside observers, *result from the family's realization that an authority regards the family's way of being with each other as the source of the illness.* Presumably an observer can communicate his sociogenic beliefs to the family by focusing his inquiry on family life prior to the onset of illness. He may also accomplish the same end by failing to show adequate concern for the impact of the illness on the family and by failing to interpret the illness in psychobiological terms. Such therapist behaviors might be expected to evoke (a) guilt or derivatives of guilt including shame, remorse, and self-hatred; (b) evaluation apprehension; and (c) plummeting self-esteem. These disagreeable internal states might in turn have deleterious effects on family behavior: (a) severely limiting forthright self-disclosure; (b) degrading the family's ordinary problem-solving routines; (c) increasing the family's sense of burden; and (d) diminishing the likelihood of collaboration between family and therapist.

Experimental Studies

Mishler and Waxler (18) postulated that aspects of the investigative setting might give rise to peculiarities in family interaction. There is a dearth of evidence bearing on the hypothesis, however. One barrier to experimental investigation is inherent in the hypothesis. It is altogether unconscionable deliberately to expose families to interviewing methods suspected of being harmful. The only clear path is planfully to create an ambience of respect, affirmation, and mastery and then to assess whether previously observed interactional or communicational peculiarities persist. If the iatrogenic hypothesis is valid, differences be-

tween schizophrenic and control families will diminish or disappear under that experimental condition.

Direct assessment of the iatrogenic hypothesis has not been attempted in families of adult schizophrenics. The closest work is that on parents of childhood schizophrenics. Schopler and Loftin (21) studied performance on the Object Sorting Test (OST) in two cohorts of parents of childhood schizophrenics. Group I parents were told the purpose of the test was "to study how parents who have a problem child are able to influence the success of their other children in getting along in school, at home and with their friends" (21, p. 176). A semistructured interview immediately preceding the administration of the OST intentionally evoked interest, confidence, a sense of competence and pride in parental accomplishments with unimpaired children. The OST was billed to these parents as a way to understand thinking styles associated with successful child-rearing. Group II parents were not interviewed prior to OST administration and were told only that the test was a part of ongoing research into childhood psychosis. Comparison groups were parents of mentally retarded children and parents of normal children. Protocols were scored independently and blindly by two psychologists with high interrater agreement.

Group II mothers showed significantly more ($p < .01$) deviance than Group I mothers, mothers of mental retardates, and mothers of normals, whereas Group I mothers were not different from mothers of retardates or of normals in number of deviant responses. Group I and II fathers and fathers of normals scored similarly. The investigators drew several conclusions from the study. First, set effects may have a powerful influence on parental performance in cognitive testing, a fact not previously documented in family studies of childhood psychosis. Second, noting that the impairment scores for Group II parents were indistinguishable from scores attained by parents of adult schizophrenics in other studies using the OST, they suggest that set effects may have a substantial influence on parental performance in that population also. They speculate that "thought disturbances reported by Singer and others, using clinical assessments other than the OST, may also be influenced by parental reactions to being evaluated on their reactions to a schizophrenic offspring" (21, p. 180). Third, the authors point to the potential for damage in clinical encounters based on the sociogenic model, at least for the parents of childhood schizophrenics: "If the thought processes of parents, especially mothers, of psychotic children can be impaired or disorganized by being judged or evaluated, some of the psychotherapy currently in use may produce such results and may be detrimental to the interest of child and parent" (21, p. 180).

Wender et al. (26) drew attention to Schopler and Loftin's work, suggesting that situational effects may be considerable in the individual and family Rorschach methods pioneered by Singer and Wynne (23). Wynne (27, p. 537) countered these objections in two ways. First, the OST does not bear directly on findings from Rorschach studies because it is not a measure of communication deviance. Second, independent measures of test anxiety carried out by Singer on Rorschach protocols (28) functioned as controls for situation effects. We can hardly be satisfied with this, however. Scrutiny in a context of blame or imagined blame might give rise not just to anxiety, but more specifically to impairment of forthright self-disclosure. Vagueness and diffuseness of replies, cryptic and ambiguous remarks, denials and reversals of earlier responses, negative responses, critical and disparaging remarks, etc., might arise as the relative attempts to cope with a blaming point of view manifest in the examiner's behavior or questions. All these types of communication figure prominently in

Singer and Wynne's construct of communication deviance (23). In view of the significance of potential iatrogenic effects, and of the harm done if parents are wrongly regarded as having caused psychosis, it is remarkable that no replication of Schopler and Loftin's work has been attempted in parents of adult-onset schizophrenics using Rorschach methods. At this point in time, the study of situational effects is unexplored territory in this population. Iatrogenic modeling must therefore be taken seriously as a way of accounting for communicational peculiarities reported in families of schizophrenics.

Discussion

How does the family respond to covert blame? We can differentiate two basic reaction patterns. First, the family rejects the therapist. It seems quite possible that the phenomena described by Schaffer et al. (20) were not so much attributes of their families' ongoing interactional styles, as they were responses of a beleagered family to an uninformative and covertly accusatory authority. Denial, inattention to, and ridicule of interpretations, and even efforts to discredit the therapist's observations, may be seen as strategies to counter the unpalatable and ultimately crippling insinuation that the family has caused the grotesque irrationality of psychosis to be visited upon its child. Anderson recently described the characteristics of this reaction:

> The net result is that the family withdraws from a hostile situation and protects itself in whatever ways are available. They may deny, project, retaliate, or just disappear. [1, p. 698]

In fact, it is altogether possible that the family is responding, in its denials, not so much to direct statements of blame as to the absence of explicit absolution: when left floating in the general ambience of the therapy, the family's fear of having been a pathogenic force crystalizes as guilt, especially if the therapist never deals with their fear openly. From the vantage point of the family, a therapist's interest in making connections between relationships and the illness is then equivalent to condemnation.

Second, covert blame may trigger attempts to repair the presumed damage. Regarding themselves as the cause of illness, parents might reverse some previous child-rearing practices. Assuming the problem to have been cruelty, they might invite punishment in kind at the hands of the ill offspring. Assuming neglect, they might adopt a habit of ministering excessively to the ill person, losing their ability to set appropriate and necessary limits. Invoking marital strife and contention, they might evolve a veneer of togetherness and mutuality.

In all likelihood, since divergence of opinion is an ordinary, even essential step in solving complex problems, we might expect to observe combinations of these two basic reactions in the majority of families. One member will discredit the therapist and become inaccessible, whereas another remains a believer and attempts by reparative maneuvers to nurture the illness out of existence. The regularity with which such combinations of behavior are actually observed in families of schizophrenics lends a measure of face validity to the hypothesis.

Reciprocal Disconfirmation

Ironically, Schaffer et al. (20), in support of their notions about family denial maneuvers, quote Michael Polanyi on these phenomena. Polanyi observed that outrage and rejection are typical responses to unfamiliar systems of meaning. He described the "unpleasantness incurred in the treatment of our eyes by new works of art":

> We are shocked by the offer of an unfamiliar system purporting to be meaningful. When the public is pressed to enter the new framework so as to discover its meaning, *their bewilderment turns into indignation.* They are outraged by the respect paid to what seems to

> them deserving of contempt, and *angry at the implied contempt for their own standards of excellence.* There were scenes of violence around the Parisian audiences of Stravinsy in 1913 and similar disturbances had occurred in various countries at the first performance of some of Wagner's operas. In such conflicts the two sides are actually fighting for their lives, or at least part of their lives. For *in the existence of each there is an area which can be kept in being only by denying reality to an area in the existence of the other.* And such a denial is a shock to the conviction of the other and an attack against his being, to the extent to which he lives in this conviction. (italics mine) [19, pp. 200–201.

We infer from this that for Polanyi the artist's offerings were valuable even if difficult for their audiences. Schaffer et al. (20) suggest a parallel process in the way families respond to therapists. But if, additionally, we note that Polanyi appreciates the relativity of the process—two parties, each one fighting for its life—we search for parallelism here too. Therapist and family proffer mutually exclusive realities and yet are bound together out of a common interest in the patient. Prior to the onset of psychosis, the family lives in its reality from day to day, hardly questioning its motives and life routines. With the onset of illness, the family reels under the double impact of its terrifying unpredictability and the awesome question of its origins. Turning to the physician, the family finds an authority offering the doubly unacceptable package of blame and passivity. First, the physician seems to be saying, by his questions—by the significance he attaches to interactions between family members—that the family has fashioned its own monster. And he seems to be saying, or at least thinking, that the parents are monstrous for having done so. Second, the physician offers little direction through which to adapt to the patient's new status. He tells them the treatment is to cloister the patient, to quarantine him from contact with the rest of his family. He talks of the patient's need to separate from the family. The guilt and helplessness induced in the family is more than its membership can bear. They flinch, retreat, retaliate, and attempt to neutralize or ignore or challenge the physician's blameful vagueness. The physician takes all this as evidence confirming his preconception of the family as a pathogenic force. His resolve to cloister the patient increases. And his alliance with the family, assuming he ever meant to have one, capsizes under the weight of his desire to save the patient from their presumed malevolence. Thus is the stage set for a lifetime of adversity, mistrust, vagueness, and obfuscation—on both sides.

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