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The Family of the Schizophrenic and Its Participation in the Therapeutic Task

Silvano Arieti

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Family Dynamics

The convergence of the work of Harry Stack Sullivan, who stressed the interpersonal aspect of the psyche rather than the intrapsychic, the pioneering work of Nathan Ackermann in the psychodynamics of family life, and a host of contributions by many other authors, who applied in clinical practice either their own innovations or what they had learned from others, shifted the attention of many psychiatrists from the patient to the family of the patient. Rather than the patient himself, the family became the patient to be examined, treated, cured.

In addition to those already mentioned, many other authors, such as Murray Bowen, G. Bateson, D. D. Jackson, L. Wynne, T. Lidz, have expanded this field. The individual is no longer seen in isolation. Of greater significance is the interaction between the patient who is a family member and the family as a group, with laws and habits pertaining to a group per se.

It would be counterproductive and regressive to deny the value of these contributions. Nevertheless, it is now time that we reevaluate their

observations and data and reconsider some basic notions, especially as they relate to certain psychiatric syndromes.

In this chapter we shall reconsider the role attributed to the family of the schizophrenic and shall present possible modifications. These issues have not only theoretical interest, but are also of practical concern since the study of them may suggest new or different approaches to the role the family can play in the treatment and rehabilitation of the patient. This reevaluation seems an impelling necessity today, when the tendency is to avoid hospitalization or reduce hospitalization to a minimum. For the considerable number of patients who do not recover completely after the initial attack and who remain a serious problem, as far as treatment, management, and rehabilitation are concerned, we may borrow an expression used by President Truman in a different context and say that the buck stops here—in the family. Since day hospitals and half-way houses are available only for a restricted number of patients, there is no other or better place to turn than to the home, no place where enlightenment and guidance from the psychiatrist are more necessary or appreciated.

The following four basic concepts, which were considered valid by most people who practiced a psychotherapy of schizophrenia with the emphasis on the role of the family, must now be drastically reevaluated.

1. The patient became schizophrenic because of what was done to him

by others.

2. Whatever was done to him and was pathogenetic stemmed from family members, especially the mother, who was labeled "schizophrenogenic mother."

3. In the psychotherapeutic attempt, unless the family members participated in family therapy, they had to be left out because it was in the family that the patient had had the original traumatic conflicts that led to his illness. It was, therefore, necessary that the patient be separated from the family, unless, as already mentioned, usual family psychotherapy was instituted and the patient participated in it.

4. The disorder came to be seen solely as the effect of what the environment or the interpersonal world did to the patient. What the patient did with what was given to him by the environment, or, in other words, how he digested, or how, with his intrapsychic apparatus, he metabolized psychologically what was offered to him, was almost totally ignored.

Before discussing these four concepts, it should be stressed again that although they now seem incorrect, they had as a whole a beneficial effect, and that when we consider them in the historical continuity of scientific progress, they must be considered positive. Without them, the patient would still be seen as suffering from an endogenous disorder, or as a metabolic freak—a pathological phenomenon unrelated to or uninfluenced by an apparently

normal environment. He would probably still be seen as the outcome of an exclusively genetic deviation.

As already mentioned, many authors believe that the patient becomes schizophrenic because of what was done to him by a terrible family environment. Some authors have described the mother of the patient as malevolent, and one of them spoke of her perverse sense of motherhood. From some authors, one gets the impression that the parents of the schizophrenic are inhuman, cruel, perverse creatures. Others portray them as transmitting irrationality to the patient directly, just as they would transmit to him the language they speak.

Let us take some examples. One author described a girl whose mother wished her to become a good writer like Virginia Woolf, even if doing so required, by implication, committing suicide. Eventually the patient did commit suicide. In the same article the author, who wished to report typical examples of parents of schizophrenics, described a mother who, referring to her son, said to the doctor, "You must cure him—he is all of my life. When he started to become sick, I slept with him just like man and wife." Other provocative examples were offered in the same article. A schizophrenic woman who was hospitalized told of having her genitalia examined by her physician father each time she returned home from a date in order to make certain she was still a virgin. Also reported is the case of a female patient who

not only spilled food all over herself, but blew her nose in the napkin. The patient did not know that it was wrong to do so because her father, an eminent professor, used to blow his nose in his napkin. In another case reported in the same article, the mother of a patient told her that she was afraid the father would seduce the patient's pubescent sister. The father had confided that the mother was a lesbian and a menace to the three daughters.

Many similar examples from articles by authors who have studied the father and mother of schizophrenics could be quoted. However, the point to be made is that, although dramatic and impressive, these examples are misleading. This author does not deny that parents like those reported in the preceding examples exist (having observed them in families of both schizophrenics and non-schizophrenics); however, if articles and books on the family of the schizophrenic report exclusively, or almost exclusively parents such as those mentioned, the reader may infer that these parents are typical parents of the schizophrenic. To do so would be unjust. Let us examine more closely some of the reported examples. They are not the consequence of internalization occurring through complicated intrapsychic mechanisms. Some of them are simply a result of obedience, such as the girl who committed suicide as the mother had requested. Others are examples of pure and simple imitation, such as the girl who blew her nose with a napkin as her father had done. These are not examples of schizophrenic irrationality. What is transmitted by imitation, indoctrination, conditioning, and so forth, whether

considered desirable or undesirable, is not schizophrenic per se. These transmissions occur in schizophrenia, but *much more so* in neurotics and in the general population.

Both the family and the culture in general may transmit irrationality through phenomena known as psychological habituation, indoctrination, imitation, acceptance on faith, and so forth. But with the exception of rare cases of *folie a deux,* transmitted irrationality and transmitted peculiar behavior are not schizophrenic, delusional, or regressive per se. They may be unacceptable on a moral, medical, pedagogic, or orthopsychiatric basis, but they are not directly schizophrenogenic. The schizophrenic gives his own autistic, or primary process form to whatever has previously disturbed him with nonpsychotic psychodynamic mechanisms. It is the *transformation* and not the *imitation* that constitutes the schizophrenic essence of symptoms or habits. And that transformation is implemented by primary process cognition.

In the second edition of *Interpretation of Schizophrenia,* this author presented evaluations and certain conclusions concerning the findings reported by others regarding the family of the schizophrenic, as well as original findings:

1. Conflicts, tension, anxiety, hostility, detachment, instability had generally existed in the family of the patient since his formative years. However, one must be aware that these

findings cannot be subjected to statistical investigation. It is often an enormous task to evaluate qualitatively or quantitatively the psychological disturbance existing in a family. One must keep in mind that some authors (for instance, Waring and Ricks13) have found disturbed family constellations, previously considered predisposing toward schizophrenia, less frequently among schizophrenics than in control families.

2. It is common knowledge that similar family disturbances exist even in families in which there has not been a single case of schizophrenia in the two or three generations that could be investigated.

3. It is not possible to prove that the adult schizophrenics studied during family research were potentially normal children whose lives were warped only by environmental influences.

4. The one point of agreement among most authors who have subjected schizophrenic patients to deep psychodynamic investigations is that in every case so studied, family disturbance, generally serious, was found. Unless biases have grossly distorted the judgment of the investigators, one must believe that serious disturbances did exist.

5. This conclusion is important. It indicates that although family disturbance of considerable seriousness is not sufficient to explain schizophrenia, it is probably a necessary precondition of schizophrenia. To have differentiated a necessary, though not sufficient, causative factor is

important enough to make this factor the object of deep consideration.

6. In the last twenty years, this author has compiled some private statistics, and although personal biases cannot be excluded and the overall figures are too small to be of definitive value, has reached conclusions different from those of other authors. In relation to sexual assault, seduction, or rape by a parent of the child, events have been found much more frequently in the history of depressed, psychopathic, and hysterical patients than in the history of schizophrenics. The author has also found that in 75 percent of cases of schizophrenia, the mother did not fit the image of the schizophrenogenic mother. Prevailing nonmaternal characteristics have been found in only about 25 percent of the mothers of schizophrenics. What percentage of mothers of non-schizophrenics have been nonmaternal is not known. The mother and father of the patient have often been found to be disturbed, anxious, or hostile and detached, but only in exceptional instances to the degree described in some psychiatric literature. In the larger majority of cases the mother was a person who had been overcome by the difficulties of life. These difficulties had seemed to her enormous not only because of her unhappy marriage, but, most of all, because of her neurosis and the neurotic defenses she had built up in interacting with her children.

7. Another important point has been neglected in the literature. These studies of the patient's mother, beginning with those of Fromm-Reichmann[6] and Rosen,[11] were made at a time in

> which drastic changes in the sociological role of women were in incubation. It was a period immediately preceding the women's movement era. It was the beginning of a time when a woman had to contend tacitly with her newly emerging need to assert her equality. Though no longer accepting submission, she strove to fulfill her traditional role. These social factors became involved in the intimacy of family life and complicated the parental roles of both mothers and fathers.

Furthermore this was the time when the "nuclear family," a development of urban industrial society, was most fully evolved. It consists of a small number of people who live in little space, compete for room and for material and emotional possession, and are ridden by hostility and rivalry. Often deprived of educational, vocational, and religious values as well, the nuclear family is destructive not only for the children, but also for the parents, and especially for the wife and mother.

One can thus become aware of another dimension. Not only are the negative characteristics of the mother magnified and distorted by the future patient, but the seemingly original negative characteristics of the mother are in their turn a deformation, magnification, and rejection, conscious or unconscious, of roles that she believes society has inflicted on her.

What has been discussed so far can be reformulated in different words. The importance of family disturbances in the childhood of schizophrenics

cannot be disregarded. Undoubtedly in the childhood of future schizophrenics there is a deviation from what is considered a normal family environment. This deviation consists predominantly of an environment characterized by more than the usual amount of anxiety, hostility, detachment, or instability in family members. This angle of deviation might have been remedied by the regenerating and self-correcting mechanisms of the organism and of the psyche; but in the case of the future schizophrenic, other circumstances did not permit this correction. Thus, the initial deviation not only persisted but was amplified by subsequent chains of causes and effects. The circumstances may be biological or hereditary. The child may be more than usually sensitive to adverse environment and psychological pain. The time of the adverse contingencies may not permit the psyche to recuperate between one blow and the next. Finally, compensatory mechanisms, such as the presence of useful parental substitutes, might be absent.

If what has been expressed so far is correct, the reason many therapists, this author included, came to believe in the reality of the schizophrenogenic mother and, less frequently, of the schizophrenogenic father must be investigated. In the majority of cases therapists have fallen into a serious error. Schizophrenics who are at a relatively advanced stage of psychoanalytically-oriented psychotherapy often describe their parents, especially the mother, in negative terms, the terms used in part of the psychiatric literature. Therapists have believed what their patients have told

them. Inasmuch as approximately 25 percent of the mothers proved to be the way they were described, it was easier to make an unwarranted generalization that all the mothers of the schizophrenics were the same way.

This is a mistake reminiscent of the one made by Freud when he came to believe that his neurotic patients had been assaulted sexually by their parents. Later Freud realized that what he had believed to be true was, in by far the majority of cases, only the product of the patient's fantasy.

The schizophrenic's mother had definite negative characteristics, but the child was particularly sensitive to them because they were the characteristics that hurt him and to which—in that particular context or because of his own biology—he responded more deeply. He was less affected by, or even ignored, the positive qualities of his mother: the giver, the helper, the assuager of hunger, thirst, cold, loneliness, immobility, and other discomfort. The child who responds mainly to the negative parts of his mother will tend to make a whole of these negative parts, and the resulting whole will be a monstrous transformation of the mother. Similar observations can be made about the self-image of the future patient. The self is not merely a mirror of reflected appraisals, because the sensitive child does not respond equally to all appraisals and roles attributed to him. Those elements that hurt him more, or that please him more, stand out and are integrated disproportionately. Thus the self, although related to the external appraisals,

is not a reproduction of them but in some cases a grotesque misrepresentation. This grotesque self that the patient retains would stupefy the parents if they were aware of it.

These images—the one of the mother as the major representative of the external world and eventually of the neighbor, any others, and humankind; the other the representative of the person himself—will affect, at a conscious and an unconscious level, the patient's entire life. The images are constructed not only by external contingencies, but by the patient himself. Much of the psychodynamic literature has made the error of seeing the child, the adolescent, and the young adult as entirely molded by circumstances, without addition of the elements of his own individuality and creativity to what he receives—his contribution to his transformation.

The geneticist sees the origin of the disorder in the genetic code, hidden in the chromosomes of the patient; the family therapist sees it in the effect of the family and especially of mother and father. But geneticists and a large group of psychodynamic psychiatrists are closer than they think to one another's conceptions when they see the patient as entirely shaped by circumstances alien to his being or at the mercy of obscure forces or as a passive entity that has to accept his chromosomic or familial destiny as ineluctable forces.

Obviously the patient is very much influenced by his family, but he is not just in a state of passive receptivity. Inasmuch as every human being is strongly influenced by his environment, one must acknowledge in him a fundamental state of *receptivity.* But he is not to be defined in terms of a state of receptivity alone. Every human being, even in early childhood, has another basic function which we, following the French sociologist Lucien Goldmann, may call *integrative activity.* Just as the transactions with the world not only inform but transform the individual, with his integrative activity the individual transforms these transactions and in his turn he is informed and transformed by these transformations. *No* influence is received as a direct and immutable message. Multiple processes involving interpersonal and intrapsychic dimensions move back and forth. According to the philosopher Giambattista Vico:

> the being of man cannot be enclosed within a determinate structure of possibilities . . . but it moves, rather, among *indeterminable alternatives,* and even further, but its own movement generates these alternatives [Italics mine].

Thus to depict the mother of the schizophrenic as a schizophrenogenic mother is a primitive simplification. The mother becomes schizophrenogenic if her negative qualities are also processed by the future patient in a schizophrenogenic fashion.

In other words, the patient makes his own contribution to his pathology.

He picks up what he receives from the family and deforms it. The person who becomes schizophrenic deforms in a different way and to a greater degree than the average person and the nonpsychotic. To use an analogy, the deformation of the patient may be compared to the deformation of a sound produced by an echo if the echo in its turn is echoed several times. The original angle of deviation that existed early in life has been increased not only by its consequences, not only by the contingencies of life, but by the patient's contributions to his own pathology because of its own special integrative activity.

The Family's Role in the Patient's Rehabilitation

The second part of this chapter is devoted to the therapeutic role of the family in the psychotherapy of the schizophrenic. What has been discussed about the new psychodynamic formulation can be considered in fact an introduction to what follows. Many authors have already suggested that the family should participate in the gigantic therapeutic task. What has been described by other authors in detail will not be repeated here. The focus will be only on the differences between the new approach and the others that preceded it.

The family can rehabilitate the patient but cannot give him psychotherapy. There is a big difference between these two types of help. And

yet rehabilitation is often confused with psychotherapy or considered a form of psychotherapy. It is useful to stress this point even if it is already familiar to the majority of the readers. Psychotherapy helps the patient become aware of the reasons for his feelings and actions. Psychotherapy helps the patient to understand how symptoms are expressions of needs that he cannot accept and that have, therefore, become unconscious. Psychotherapy also helps the patient to discard maladaptive patterns of behavior and to correct faulty ways of thinking. It would be too much to expect the family to attempt to undertake these arduous tasks. Whereas the psychotherapist and the patient engage in a common exploration of the inner life of the patient, the family members are engaged with him in an external exploration, in rediscovering that the external world is not so terrible as it once seemed but is a place where the patient, too, can find his own niche and much more.

No theory has been formulated on how rehabilitation works (either in the family or with agencies outside the family). In reference to rehabilitation carried on outside the family, it is generally felt that it is effective when it makes available methods that facilitate the patient's relating normally to others, restore his faith in himself, and lead him to engage in fruitful activities.

Relating normally to others includes good attitudes toward neighbors, interchanges with coworkers, friendships, and search for intimacy and love. Restoring faith in oneself means an attitude of hope and promise toward one's

present and future. Fruitful activities include common living, work, useful habits, and also play.

Although rehabilitation includes all this, perhaps the rehabilitation that occurs within one's family includes more. Perhaps even the word rehabilitation is not appropriate in reference to the family. If one persists in using it, one would have to add that it is a special type of rehabilitation that includes reintegration in the family, not just restoring but also improving one's role in that close milieu. It involves familiarization or refamiliarization with one's own family, fraternization with siblings, and with other relatives. The words that have just been used have a warmer affective connotation than words used in association with rehabilitation carried out by agencies.

But first of all, let us face squarely the reality of the return home of a family member to whom the diagnosis of schizophrenia has been applied. A new factor has been added, and the family atmosphere is no longer the same. To make believe that everything is just as it was is masking reality; it requires the imposition of mechanisms of denial, which are likely to cause harm. Moreover, as we shall illustrate shortly, it is inadvisable for the family not to undertake some changes. To recover from schizophrenia is not the same as recovering from mumps or measles. The development of a different family climate is not generally a bad occurrence, but one possibly propitious to a satisfactory outcome. Living with the patient day by day becomes a

therapeutic task, and not an easy one even for the most cooperative family.

The first problem is to decide whether it is in the patient’s best interest to live with the family. Although the decision is made with the participation of everyone involved, the main responsibility for it resides with the psychiatrist in charge. Various views on this point are expressed in psychiatric circles. In a few of them the therapeutic role of the family is not appreciated at all because it was within the context of the family that the patient’s conflicts leading to the illness originated. The patient’s family, the patient, and the patient’s illness are seen in these psychiatric circles as constituting a unity whose abnormality led to the undesirable result. There is no doubt that in a considerable number of cases this is so. The intrafamilial conflicts exist, and the solution or even amelioration of them is so improbable that the best decision is to separate the patient from his family if possible. Even when the psychiatrist thinks the strong negative feelings the patient has for his family are unjustified and based only on his distortions, it is not advisable for him to live with the family until he views his home milieu differently.

At other times, the patient is willing to live with the family, but the psychiatrist decides against it because he feels that that particular family is not able to help a sick member. Some relatives, although well intentioned, are too involved in their own problems, difficulties, illnesses, demanding occupations, or care of young children, to participate in what is always a

demanding task. When the participation of the family members is not possible, the services of a therapeutic assistant or of a psychiatric companion may be resorted to. Cautiousness in making these decisions is necessary for though rehabilitation in the family may be the best, it may also be the most risky. The family must offer to the patient not just a roof but a hearth as well, a place where suffering and joy are shared in closeness and intimacy.

Introducing the Family to the Task

A larger number of patients and former patients continue to live with their families because the psychiatrist feels that the family environment is satisfactory, or the only one available. It is important for the psychiatrist to prepare the family for the task by giving a general orientation. The aim is not to transform the family members into psychiatric nurses, but to make them understand more fully the problems involved so that they can add understanding to their affection and personal concern. A family member has a great advantage over even the best nurse because to the family member the patient will always be a person and not a clinical case. The family member already knows what the patient likes and what he does not like.

In his words of general orientation to the family members, this writer starts by pointing out that we human beings have learned since our early childhood to deal with others, at least in the majority of our relations, in ways

that society or our particular milieu recommend. Society criticizes, rejects, or even punishes those who do not follow acceptable attitudes toward others. Acceptable attitudes generally have been evolved by traditions of many centuries' duration and have deep emotional roots in the life of most individuals. They are maintained not only by example, imitation, teaching, but also by punishment and reward, or even by the use of power. These sociological attitudes have definite educational values, but they may have disastrous effects when they are imposed on or adopted by the schizophrenic patient or one who is recovering from schizophrenia. At least in the beginning of the convalescent status, the family must exert as little as possible those pressures that the norms of society recommend. The patient must feel accepted even if he is different and unconventional. To accept the patient as he is, does not mean, however, to accept indiscriminately his behavior, as we shall see later. He must be gradually integrated into a structured life.

Most relatives insist that they never punish a patient who has returned home and who has displayed unconventional behavior. With great sincerity they state that they recognize that the patient's behavior, even when offensive, is only the result of illness and that therefore they do not consider him accountable. The truth is that, unless they train themselves to do otherwise, they do punish the patient in subtle ways—in ways that may be unconscious to them but not to the patient, who is particularly sensitized to any unpleasant input from the environment. The family member may punish

the patient by avoiding him or by staying with him as little as possible; by not talking to him or talking with brief, curt sentences; by refusing to listen to him or to give explanations; by having a condescending, patronizing, or superior attitude; by being in a hurry in every interchange with the patient; by wearing a perplexed, annoyed, bored, or disapproving expression, and at times even a look of consternation.

One main requirements of the family member is to observe not only the behavior and attitude of the patient, but also his own —especially his own.

Let us assume that the brother of the patient wants to be kind, helpful, and reassuring. Instead of being grateful, the patient who has just returned from the hospital becomes distrustful, possibly contemptuous and hostile. It is normal for the brother to react by becoming impatient toward the patient, annoyed, perhaps angry and condemnatory. In turn the patient senses that the brother has such feelings and thus his prior attitude of distrust and hostility is reinforced. The vicious circle may repeat itself. The brother must train himself to respond not in the way considered normal, but by realizing that the patient still has a great need to project onto others his inner turmoil and to blame others for it.

The example just given explains the complaint which one often hears from the members of the family in approximately these words: “I want to be

genuine, authentic. Since Jean came back, I have to watch every word I say to her. I can't be spontaneous any more. But I don't know if what I'm doing is right. Maybe by being artificial I'm doing harm. I believe in being authentic."

Such doubts posed to oneself or to the psychiatrist are legitimate and worthy of full consideration. The relative must analyze further what he means by authenticity. To watch one's words before talking to Jean does not necessarily mean to be artificial. To behave as if a serious illness had not occurred to a person dear or close to us is not to live authentically. It is more authentic to realize that because of the patient's particular vulnerability and sensitivity, it is better to modify some of our ways and in talking to him to refrain from using words or sentences that may sound ambiguous to him or even threatening. Moreover, let us remember that in recognizing the areas of vulnerability and great sensitivity of the patient, we may discover where and how we have been unintentionally insensitive, and perhaps even callous. We may recognize that we have wanted to impose our ways because we have considered them more appropriate, more efficient, more in agreement with what society expects, or simply because we prefer them.

Another bad habit, which fortunately is found only in very few families, is that of totally disregarding what the patient says as utterly nonsensical and at times even as a subject for ridicule.

It must be clear to the family that remarks and even complaints made by the patient must be listened to and evaluated with respect. Fears and even delusions are real, vivid, and almost always unpleasant experiences for the patients, even if based on complicated mechanisms that only the psychiatrist understands. If the family member does not understand what the patient says, he must at least respond to his request for attention and to his desire to start a dialogue. To the extent that he is capable, the relative must influence and even guide the patient, not by suppressing his activities but by increasing his understanding of them and by clarifying difficult situations. As has already been mentioned, the cooperative family member gradually increases his sensitivity about the patient's sensitivity; he becomes more aware of what may affect the patient unfavorably. His "antennae" must be ready to discern what is disturbing; he must be on the alert, but not too solicitous or too eager; he must remain near and distant, near enough to give when the need is there, distant enough not to scare the patient who is not yet capable of accepting warmth. Following Harry Stack Sullivan's terminology, it may be said that the patient who cannot yet accept too much warmth may put into effect a malevolent transformation and interpret the offer of warmth as having ulterior motives. A family capable of tolerating the difficulties inherent in living with a convalescent schizophrenic is a very important determinant of a favorable outcome.

This general attitude of acceptance, although allowing a considerable

degree of permissiveness, should not extend to an unlimited laissez faire attitude. In a warm atmosphere, which does not resort to rejection, punishment, belittling, or ridicule, the patient generally understands what kinds of actions are appropriate for him. Threatening to send him back to the hospital if he does not behave is extremely disturbing to his morale. If the problems are too difficult, if in spite of the good will of everybody interpersonal tension increases, if there is a possibility of suicide or of violence, rehospitalization must be seriously considered. It should not be presented to the patient as a form of punishment, but as a need for an environment much more programmed and structured than that of a home.

It is fair to say that often the task is too big for the family unless, in addition to the individual therapy of the patient, family therapy is resorted to.

Many authors have reported that family therapy has made relapses much less frequent, has shortened the length of therapy of the individual patient, and has ameliorated the general conditions of the family, even independently from the illness of the patient. So far the role of family therapy has not been stressed sufficiently here. This is partially due to the fact that unfortunately only a small minority of families are willing to undergo this type of therapy. At times some members are willing to accept such a proposal but not the whole family.

Although family therapy is strongly advocated when possible, the family must try in any case to become a “therapeutic milieu,” and in many cases, this is possible.

Specific Issues

Before describing modalities of living with a convalescent schizophrenic, it must be stressed again that each case is different, each constitutes a different situation in an environment that is not identical to any one observed before.

Specific issues that come up rather frequently in living day by day with the patient must be considered. The patient who used to be delusional may no longer be so, but he may distort many interpersonal relations, see them in a worse light than they are, and may be rather accusatory, especially in relation to his parents, whom he now considers the source of his misfortune. To a lesser degree other family members are also blamed. This position of the patient is indeed hard to accept. The best attitude is not to argue with him or to tell him that he is wrong. But it is indeed difficult for many mothers and fathers not to be defensive. Their pride is hurt; they may become incensed and want to speak up as vigorously as possible, as if they were on trial. If they yield to this temptation, the trial will go on and on, endlessly, and progress will not be made. A good attitude for the parent is to say to the patient,

“Perhaps the time will come when you will see what we did and what we tried to do in a different way.” At the same time the parents can reassure the patient by stating that each member will see to it that the needs and rights of everybody are satisfied as fully as possible. The future then will have a greater chance of being much better than the past.

Although the impairments and areas of sensitivity of the patient should be taken into consideration, they should not be magnified. The family members should avoid making the patient more dependent than he is or treating him as an invalid or a baby. It is true that the activities of some convalescing patients are greatly curtailed, but many of them only to a minimal extent. It is necessary to exploit fully whatever is not affected or barely touched by the illness. A main goal is to find a role for the patient within the institution of the family. Some chores must be assigned to him. This is generally easier to do with female patients, who are usually more accustomed to performing domestic duties, but a male patient, too, must assume home responsibilities. The feeling that he is a contributing member of the family will be beneficial, and the residues of pity and discouragement still felt by the family members will have more chance to dissipate.

The patient must be encouraged to take care of his room, but it is also advisable not to restrict his activities to what pertains only to him. On the contrary, it is advisable for him to engage in some activity that will benefit the

whole family. (It has been noted that patients from economically poor families rehabilitate faster after their return to the family than patients from well-to-do families. Possibly the difference is due to the fact that in well-to-do families it is difficult to assign domestic chores to the patient.)

Often, especially following his return from the hospital, the patient is not able to take the initiative. The relative must be the initiator and must be provided with a great deal of patience. It is a characteristic of partially recovered patients to do things at a much slower pace than the average person. Lack of concentration, inhibitions of all sorts, intruding thoughts may interfere with any activity. Nevertheless, if he continues to work on a steady basis and is encouraged in his work, no matter how slowly he does it, he will gain a rewarding sense of satisfaction. With increased confidence in himself, the tempo of his actions will speed up.

It has been observed by many therapists that from the point of view of becoming capable again of engaging in useful activities, patients who return from the hospital to live with their wives or husbands fare much better than those who return to live with their parents. Generally spouses do not treat the patient as an overly dependent person, are less willing to accept a state of passivity, and encourage the patient to resume activities. Parents, on the other hand, are more inclined to resume the parental role and to foster excessive dependency. The therapist is often asked, “Should we push the patient to be

active, or shouldn't we?" Again there is no single answer. With patients who are inclined to be passive, a little push is appropriate, but it must be in the form of a kind push, given with velvet gloves, and never by an authoritarian command. The opposite attitude is valid when the patient is willing to take steps for which he is not prepared: to go immediately back to his usual job, to look for a new position, to go back to college, to finish the semester, to go to live by himself in his own apartment, and so forth. Here a kind of delaying technique should be used. The patient should be advised to postpone these plans until he is able to meet the challenge more efficiently. By no means should he be discouraged, but only invited to reprogram his plans in phases which succeed one another more deliberately. In the meantime, he must be stimulated to exploit whatever assets may be used in the home, from simple errands for the family to complicated accounting.

In dealing with some families, other types of problems appear. Expectations may be too high for the patient. It has already been mentioned that the spouse is generally more prone than the parents to stimulate the patient into an active role. Although this attitude generally has a favorable outcome, it may be detrimental if the spouse's expectations are excessive for the patient recovering from an acute episode. A wife may expect the husband to become the provider right away; the husband may expect the wife to resume fully her maternal duties. Realization that a return to health requires a longer time will ease tension, impatience, and discouragement.

A common complaint, especially among young couples, is that the convalescing patient has become sexually inadequate. If the spouse of the patient is reassured as far as the future is concerned, he will be able to tolerate better the temporary inconvenience. Generally, lack of sexual interest is due to a variety of causes. The most frequent is the medication that the patient may still take. Several neuroleptics diminish sexual desire, especially in the male, and may even prevent ejaculation. Some psychiatrists inform the patient that this is likely to occur and reassure him that this is a transitory phenomenon which will disappear with the decrease in medication, interruption of medication, or shift to another drug. Many psychiatrists, however, neglect to inform the wife of this possible occurrence. She has to be reassured, too, that the phenomenon is not permanent.

Lack of sexual interest, of course, may be due to the fact that the patient has not been concerned at all with sexual matters and has for a long time focused his attention elsewhere, so that he has lost the desire for sex or has become used to sexual abstinence. In other cases, sexual inactivity may be due to the fact that the patient has to reappraise his relation with the spouse and feels he must know where he stands with his partner. It is advisable, of course, for the spouse to suggest that the patient discuss any insecurity, anxiety, or unresolved hostility with the therapist.

Involvement and Over-involvement

Consultations with the therapist will help the family and the patient himself to avoid the opposite dangers of being either over-stimulated or under-stimulated, of being in an environment that offers and expects too much or too little. It is difficult at times to find the proper balance. Overstimulation obligates the patient to cope with the environment beyond his ability. If the patient is withdrawn, lackadaisical, seemingly oblivious, the well-intentioned relatives try to interest him in a thousand different ways, for instance, by taking him to movies, museums, or theaters, by talking and talking, recounting stories of the good times spent together in the past. The patient may feel overwhelmed, especially if he has just returned from a hospital where, in spite of the therapy and of the occupational activities, he felt alone. It may be very strenuous for him to try to adjust to a situation that requires over-involvement or exposure to frequent busy talk.

Some authors have made a distinction between the subjective burden—that is, the family’s estimate of the hardship imposed by the patient’s presence in the home—and the “objective burden,” which was the researchers’ estimate. According to these researchers there was a discrepancy between the objective estimate and the subjective, in the sense that the “objective” estimate was always superior to the subjective. In other words, the burden was always greater than the relatives were willing to admit. Of course, it is arguable how objective the estimate of the researchers was. Assessing the family situation from the point of view of a person who does not have to live

with a recovering schizophrenic and who retains a feeling of distance may also be subjective due to the lack of intense involvement with the patient. At any rate, the fact that the objective burden was considered by these researchers as far greater than the subjective speaks well for the family of the patient. It indicates that, contrary to common belief, most families do their best to participate in the rehabilitation of a dear one and are willing to endure the concomitant hardship.

Related to the problem of overstimulation versus under-stimulation, but not exactly the same, is the problem of over-involvement. British authors, inspired especially by John Wing, who has studied this issue in depth, have reported that over-involvement on the part of the family, including too much expression of emotion, is conducive to relapse. Brown, Birley, and Wing wrote, "Fifteen hours or more a week of face-to-face contact between a schizophrenic patient and a highly involved relative carries a strong risk of further breakdown."

If closeness engenders a revamping of conflicts and a renunciation of privacy, then of course we have the picture of over-involvement described by Brown, Birley, and Wing. This over-involvement seems to be a continuation of a situation found in some families of schizophrenics even prior to the illness. In these families, each member experiences not just a feeling of competition with the others, but an extreme sense of participation, reactivity, and special

sensitivity to the actions of the others, often interpreted negatively. In these cases, the members of the family want to help each other, but because of their entanglements, anxiety, distrust, and misinterpretation, end up by hurting one another.

A morbid degree of over-involvement, however, may not be so frequent as Brown, Birley, and Wing seem to imply. Cultural differences may play a role. Brown, Birley, and Wing have worked with patients and their families who come almost exclusively from an Anglo-Saxon environment. What is considered over-involvement in that milieu may be the usual state of affairs in Italian and Jewish families. In other words, in evaluating these factors, the ethnic background and the prevailing family culture must be considered.

Some of the contrasting, at times even opposite, positions that have to be taken in dealing with a recovering schizophrenic have already been mentioned, and the difficulty of switching back and forth between these different directions has been stressed. A few more must be mentioned. One is the situation in which both the patient's need for companionship and for privacy are essential and must be satisfied. Time must be found for both. Another difficult balance must be made between the patient's need for freedom and for structure. The patient must experience freedom of action, and yet a structure, a routine, a schedule should be worked out with him, at least for the first few months after his return from the hospital. Although

structured, his day should not become packed with things to do or be too complex. The degree of complexity has to be adjusted to his capability.

Important Events and Important Decisions

At times, the family is confronted by unusual happenings in the life of the patient. Although these events are discussed at length with the therapist, the family may become involved with such matters even before the therapist, or may be the only consultant, if there is no therapist. The patient has become acquainted with a person of the opposite sex or, more seldom, of the same sex, and wants to go to live with him or her, or, in other cases, wants to become engaged or get married right away. The family has the strong feeling that the patient is not ready and yet does not want to exert so much pressure on the patient that he feels unfree or unduly controlled. A delaying technique, that tries to persuade the patient to wait for a time when he feels more at ease with the programs that are formulated, is the proper approach here. However, if the patient insists and cannot be persuaded to postpone, it is best to go along with the plans and provide as much help as possible. An attitude of open opposition is not advisable and may be counterproductive.

The same principle applies to dealing with the recovering schizophrenic who wants to become pregnant. Pregnancy and motherhood are real challenges for normal women. To cause such a complication deliberately

while the patient is recovering is not recommended. This point must be clarified to avoid misunderstanding. The author is not saying that recovering schizophrenics or former schizophrenics should not become mothers. Some of them make excellent mothers. There is, however, for many patients a period of time, which varies from at least a year to as many as five years, during which, even in the cases with the best results, there still is difficulty in coping with unusual and demanding challenges, such as pregnancy, childbirth, and motherhood. If the patient is under drug therapy, she must be even more careful not to become pregnant because the safety of most drugs during pregnancy and lactation has not been established.

At times, the patient wants to do something equally drastic, but in a different way, for instance, leave the spouse and children. The spouse who is threatened with being left alone (or with the children) after having gone through the hardship of the illness and having offered loyalty and support, is often mortified. At other times the spouse of the patient is ready to accept the decision, which frequently cannot be reversed. Again, the delaying technique is best, but if the patient goes through with his plans, the family must be supportive. It must be remembered that the patient is not likely to break an important family relationship because of a whim or a capricious impulse, but only because he is not able to cope with the circumstances. If children are involved, the best arrangements must be made for their care. Although, as has been noted, some former schizophrenics or even schizophrenics are excellent

mothers, it is also true that a recovering mother who still feels unable to cope with the circumstances, and this may be very disturbing to a young child. In such situations, a substitute mother must be found.

A question that comes up frequently is: should the recovering patient be told the truth when some terrible event (sudden death or diagnosis of serious disease) occurs in the family or to persons dear to the patient? Over thirty years ago, when working in a state hospital, this author was instructed by older psychiatrists to advise the family always to tell the truth. Certainly one does not want to lie to patients or anybody else. However, there is a favorable and an unfavorable timing for telling the truth. State hospital psychiatrists insist that no bad effects have ever resulted from the revelation of bad news to the patient. They were referring to a group of patients who, in addition to being ill, often lived in a state of alienation aggravated by the environment. Many of these patients were not able to express their emotions. An apparent insensitivity should not be interpreted as imperviousness. Even a catatonic schizophrenic, who seems insensitive and is as immobile as a statue, feels strongly. A volcano of emotions is often disguised by his petrified appearance.

With the recovering schizophrenic the situation is completely different. He is extremely sensitive and would not forgive the relatives for not telling him the truth. And yet knowing the truth may be detrimental when he is still unstable and struggling to recover fully his mental health. The patient has to

be prepared gradually and eventually be told the truth when he has already anticipated its possibility and is able to cope with it.

Concluding Remarks

In summary, living with a recovering schizophrenic is a difficult task, but not an insurmountable one. It may be rewarding not only for the patient but for everyone concerned. If one compares the hardship of living with a recovering or partially recovered schizophrenic with that of living with a severe alcoholic, a blind person, an epileptic, or a chronically ill person with some incapacitating disease, the lot of living with a recovering schizophrenic is considerably better. An atmosphere of hope prevails in many cases, and the satisfaction of seeing results at least partially due to the family’s cooperative efforts confers a joyful climate of further expectation. Even in a family with little children, although the situation is further complicated, the task is not necessarily an impossible one. If the children are old enough to understand, they should be told that a member of the family is ill and requires special attention. Some of the unusual attitudes of the ill person should be explained to the child in terms of illness and in a context of serious but hopeful concern. Children generally respond well to adverse or abnormal conditions provided there are compensating circumstances. In an atmosphere of warm care and frank discussion, the presence of mental illness in a member of the family tends to remain a smaller part of the child’s life than is generally assumed,

and in some cases a part which promotes maturation.

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