The Family and Schizophrenia

By WAGUIH R. GUIRGUIS, D.P.M.

The past 30 years have witnessed a major shift of emphasis in the study and treatment of schizophrenia. More attention has gradually been given to the psychosocial than to the individual variables of the illness. The family, as the main functional unit of our social structure, stood out as the unit for research and study in the nature and etiology of schizophrenia. As a result of this increasing interest in the families of schizophrenics, a great number of theoretic and experimental works have been accumulating in the past two or three decades. Because of the huge influence these studies had, and still have, on the understanding and management of schizophrenia, they certainly merit consideration; but they also merit careful and systematic evaluation. Now, with the detachment of time, it is easier to look back and re-evaluate these early important contributions. Here is reported a part of a study undertaken at the Institute of Family Psychiatry in the past two years and to be reported in full shortly.1

As it is impossible, in such a limited space, to review all the studies in this field, this account will concern itself mainly with the five major schools that influenced and cross-fertilized almost every other study in this field. One thing common to all these studies is that they refer to some peculiarities of behavior and communication that they invariably found in the families under study. They all claim, with varying degrees of certainty, that these peculiarities constitute a major etiologic factor of schizophrenia. These are some of the findings of the main schools (Table 1).

MURRAY BOWEN AND THE INTERDEPENDENT TRIAD

As early as 1951, Bowen2 began his work with families in Topeka, Kans., where he used a cottage on the grounds of the Menninger Clinic for the study of schizophrenics and their families. He asked the mothers of his schizophrenic patients to come to Topeka and stay for one to two months at a time, to move into the cottage and take over at least partial care of their schizophrenic offspring. Later he included some fathers as well. In 1954, at the National Institute of Mental Health, Bowen set up his landmark project of hospitalizing whole families of schizophrenics for observation and research.

A constant finding of Bowen and his colleagues was a “marked emotional distance between the parents” for which they used the term “emotional divorce.”3 Both parents are immature, and both deny their immaturity. The mother denies her immaturity with a facade of overadequacy, while the father accentuates his with a facade of inadequacy. Bowen believes that families tend to maintain a state of equilibrium. In families of schizophrenics this equilibrium could be achieved only by a close...
### TABLE 1
THE MAIN SCHOOLS

<table>
<thead>
<tr>
<th>School</th>
<th>Discipline</th>
<th>Concept of schizophrenia</th>
<th>How do families cause schizophrenia?</th>
<th>Special terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowen et al (1954-57)</td>
<td>Psychodynamic</td>
<td>An expression of the whole family’s psychosis</td>
<td>By drawing the child into an interdependent triad of relationships, in which they make contradictory demands on him</td>
<td>Emotional divorce</td>
</tr>
<tr>
<td>Wynne et al (1958-63) (1966-73)</td>
<td>Role and communication theories</td>
<td>An identity crisis</td>
<td>By making it almost impossible to deviate from the rigid family roles without a schizophrenic break</td>
<td>Pseudomutuality</td>
</tr>
<tr>
<td>Jackson et al (1952-62)</td>
<td>Communication theories</td>
<td>A mode of communication</td>
<td>By putting the child in a double-bind situation from which the only escape would be by becoming schizophrenic</td>
<td>Family homeostasis</td>
</tr>
<tr>
<td>Didz et al (1952-64)</td>
<td>Psychodynamic</td>
<td>A transmitted irrationality leading to social withdrawal and giving up logic</td>
<td>By training the child in irrationality, by blurring the sex and generation lines, and by distorting emotional behavior and communication</td>
<td>Marital skew</td>
</tr>
<tr>
<td>Laing et al (1961-67)</td>
<td>Existential</td>
<td>The only sane way of coping with an insane life</td>
<td>By imposing their will and values on the child and labeling him schizophrenic if he started to see things in a different way</td>
<td>Nexus of mystification</td>
</tr>
</tbody>
</table>

relationship between an overbearing mother, a peripherally attached father, and a helpless patient, with each of them dependent on the other.

This concept of “triangulation,” which they called “the interdependent triad,” is, at least in part, determined by the parents’ inability to make decisions. Because neither of them is able to make decisions, particularly the decision to have a baby, the mother assumes a decision-making role against the passive resistance of the emotionally distant father.

The mother, in this interdependent triangular relationship, is making two main contradictory demands on the child: to remain helpless and to become a gifted and mature person. She overinvests in the patient, worries excessively about him, and ascribes the unwanted aspects of herself to him. The rapid growth of the child at adolescence repeatedly upsets the equilibrium of the interdependent triad, and, as the child attempts to be more grown up, the parents’ reaction is to force him back toward helplessness. Psychosis, in Bowen’s view, is an unsuccessful attempt to adapt to the demands of adult functioning in which the person changes from a helpless child to a poorly functioning adult and a helpless patient.2

LYMAN WYNNE AND PSEUDOMUTUALITY

In 1958, Wynne took over the family section of the NIMH from Bowen and continued there through the ’60s and early ’70s. During this time he produced, with his colleagues, a number of significant papers on the families of schizophrenics. With his psychoanalytic background and his special interest in communication and role theories, Wynne has successfully extended basic psychoanalytic concepts from the “individual” to the “whole family.” One of the basic psychoanalytic concepts is
identification with the parents and the internalization of parental codes. Wynne and his colleagues extended this concept to include the internalization of the overall family-role structure (pseudomutuality). Such schizophrenic symptoms as fragmentation of experience, identity diffusion, and disturbed modes of perception and communication are considered, according to this concept, to be acquired by the process of internalization from the peculiar modes of thinking, perception, and communication prevailing in these families.

Wynne and his colleagues found that the families they studied tended to create a pervasive subculture of myths, legends, and ideology that stress the catastrophic consequences of openly recognized divergence from the fixed-role structure set up by the parents. As these families are using such a bland, indiscriminate, but determined effort to make open recognition of differences almost impossible, it seems that the only way of recognizing and openly commenting on such differences is by a truly violent disruptive move, such as the schizophrenic break. Acute schizophrenic break seems, to Wynne and his colleagues, to represent an identity crisis in the face of overwhelming guilt and anxiety as a result of moving out of a particular kind of role structure. The potential schizophrenic, because of the way he was brought up, is particularly unprepared in ego skills and perceptions to assume new roles, such as the occupational or marital roles, which are forced on him by his own growth and maturation.

In their recent work, Wynne and Singer demonstrated in a more carefully controlled investigation that certain parental forms of focusing attention, communicating, and interpersonal relating are intimately linked to the forms of thought disorders of the schizophrenic offspring. Using protocols of the parents' performance on some psychological tests, they successfully differentiated parents of schizophrenics from those of patient suffering from other psychiatric disorders. They also recognized the parents of schizophrenic offspring suffering from different forms of thought disorders, rated them according to the severity of the patient's illness, and managed to place, blindly, each patient with his or her own family. Wynne and his colleagues considered these findings to be strongly suggesting that the manner in which parents communicate is consistently linked to the psychiatric disorder of their offspring and that the parental deviations could be, at least in part, causative of the offspring's difficulties.

THE PALO ALTO GROUP AND THE DOUBLE BIND

Led by Don Jackson, a psychiatrist, and Gregory Bateson, an anthropologist, this group of research workers started in 1952 a research project that lasted for 10 years. Adopting a general communicational approach to schizophrenia, they postulated a hypothetic family situation that could be productive of schizophrenia. It is a situation in which the mother becomes anxious and withdrawn if the child responds to her as a loving mother. She denies her anxiety and hostility by expressing overt loving behavior. In the absence of a strong and insightful father who can intervene in this relationship and support the child in the face of this contradiction, the child will be confronted with a situation in which he will be punished if he indicates love or affection and punished if he does not, and his escape routes from this contradictory situation are cut off. They called this hypothetic situation the "double bind."

Schizophrenia, according to this group of workers, is a specific pattern of communication that the patient adopts to deal with the "double-bind" situation. As the patient-to-be is receiving puzzling and conflicting messages from significant members of his family from which he cannot escape and on whose contradiction he cannot comment, symptoms of psychological disorganization may develop as an attempt to adapt to this impossible situation. He may withdraw from the situation, hallucinate an escape, deny some aspects of it, or project part of it on to someone else. He may, on the other hand, become suspicious or give up trying to discriminate between messages. A person who exhibits one or more of these "appearances" will naturally be labeled, according to current psychiatric classification, schizophrenic.

continued
THEODORE LIDZ:
THE TRANSMISSION OF IRRATIONALITY

From the Yale Medical School came a definition of schizophrenia as an extreme form of social withdrawal in which the patient gives up the logic of his culture by changing the percepts of himself and others. The family, according to the authors, is the primary teacher of social interaction and emotional reactivity; within it the child learns how to talk and behave rationally, and within it he may also have his training in "irrationality." By prolonged exposure to his parents' interpretation of reality and their ways of communicating, the patient-to-be is practically raised amidst irrationality and is chronically exposed to distorted intrafamilial communications. His foundation in reality testing will naturally be precarious, and his recognition and understanding of his impulses and his emotional behavior, and those of others, will be seriously distorted.

According to this school, schizophrenia is simply a "transmitted irrationality." Other characteristics of the families of schizophrenics are failure to form a nuclear family, blurring of sex and age boundaries, marital skew (passive, ineffectual father and disturbed, engulfing mother), which are more common in families of male patients, and schismatic patterns (narcissistic, sexually seductive father and an unempathic, emotionally distant mother), which are more common in female patients.

RONALD LAING:
THE NEXUS OF MYSTIFICATION

Laing is a British psychiatrist of an existentialist background. He described a family situation very similar to the double-bind situation, which he called the "nexus of mystification." It is a pathogenic communication system in which the family decides to "elect" one member as a mental patient, expel him or her from their totalitarian kingdom, affix the label "schizophrenia" on him, and inaugurate him to a lifetime career as a mental patient. The family achieves this by a continuous process of mystification, in which the family is overtly and covertly denying what is going on, putting the offspring in an impossible situation to which schizophrenia is the only "sane" resort.

Schizophrenia, according to Laing and Esterson, is a social event, and the experience and behavior of schizophrenics, as well as their incoherence and confusion, will all become comprehensible once the family context is known and understood. The community and the family as its representative are, according to this school, repressive and punitive forces that are unwilling to tolerate unfamiliar experiences or permit perceptions different from their own. They elect the most "sane" and "insightful" member of the family, elicit frustrated and peculiar behavior from him, label this behavior schizophrenic, and extrude him from the family and community until he learns to see things their way. In Laing's view, we simply drive our children mad.

EVALUATION OF THE FIVE STUDIES

In order to establish a causal link between family psychopathology and schizophrenia, these studies have to meet certain methodologic and logical requirements. We have recently modified the criteria laid down by Susser for "causal thinking" in the health sciences to suit the "causal thinking" in schizophrenia. We think that to establish a causal link, the study must satisfy these criteria:

1. The sample should be identifiable and should be representative of the schizophrenic population.
2. Adequate measures have to be taken to eliminate the observer's bias. The use of a control group and blind techniques are the minimum requirements.
3. The psychopathology should be there before any abnormal behavior is detected in the offspring, and its association with schizophrenia should be a specific and not a chance one. Family psychopathology and schizophrenia should always occur together and their association must be reproducible on repeated replication. The findings of the study should not conflict with the few established facts about schizophrenia.

If we apply these criteria to the studies reviewed above, their conceptual and methodologic limitations will become more evident (Table 2).

The sample. Bowen studied seven inpatient and seven outpatient families selected from "those who would volunteer" and those who had "overt family difficulties." Wynne et al. studied four inpatient families selected by advertising in the media, although in Wynne's more recent work he used larger samples, of up to 280 families. The Palo Alto group studied very few cases, all selected from private practice. Lidz et al. studied, for 12 years, a group of what must have been very rich and very disturbed families. They were disturbed enough to be sufficiently motivated and rich enough to afford undertaking such a lengthy and expensive treatment. Laing and Esterson on the other hand, made the families of 11 female patients the subject contined
TABLE 2

EVALUATION OF THE MAIN SCHOOLS

<table>
<thead>
<tr>
<th>School</th>
<th>No. of cases</th>
<th>Method of selection</th>
<th>Diagnostic criteria</th>
<th>Control group</th>
<th>Blind technique</th>
<th>Causal Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowen</td>
<td>14</td>
<td>Volunteers Overt family difficulties</td>
<td>Not clear</td>
<td>Not used</td>
<td>Not used</td>
<td>Not established</td>
</tr>
<tr>
<td>Wynne</td>
<td>4 (initially 280 (recently)</td>
<td>By advertising in the media Vaguely mentioned</td>
<td>Used in recent works only. Groups were not matched for I.Q.</td>
<td>The prediction was blind, but preparing the test protocol was not</td>
<td>Not established</td>
<td></td>
</tr>
<tr>
<td>Jackson</td>
<td>Not known</td>
<td>From private practice</td>
<td>No attempt to define them</td>
<td>No control used</td>
<td>No blind interviews</td>
<td>Not established</td>
</tr>
<tr>
<td>Lidz</td>
<td>17</td>
<td>Those who can afford a very expensive and lengthy treatment</td>
<td>Not mentioned</td>
<td>Not used; believed unnecessary</td>
<td>Observers have been involved with the cases in prolonged therapy</td>
<td>Not established</td>
</tr>
<tr>
<td>Laing</td>
<td>11</td>
<td>All female All believe in his views</td>
<td>Those considered by the staff and patients to be schizophrenic</td>
<td>Planned to use control but later gave up the idea (&quot;All experiences are unique&quot;)</td>
<td>Its use is against the existential research strategy</td>
<td>Not established</td>
</tr>
</tbody>
</table>

of their study. These patients had all been in mental hospitals before, were all very frustrated by the psychiatric profession, and were looking for something new or unusual.

The samples used in these studies were clearly very selective and could hardly be representative of the families of the schizophrenic population at large.

The samples were not identifiable either, because the criteria for selection and diagnosis were either inaccurate, vague, or unknown. Bowen selected "those showing the symptom configuration categorized as schizophrenia," while Lidz selected those who had "clear-cut diagnosis of schizophrenia, beyond reasonable dispute" without either of them defining what these "symptom configurations" were or what a "reasonable" dispute over diagnosis might be. The Palo Alto group did not even attempt to define schizophrenia, as they believed that it is not an illness anyway. Although Wynne and Singer went into minute detail about the diagnostic criteria of the nonschizophrenic control groups, they vaguely mentioned the clinical picture of those classified as schizophrenics, as if we all know what schizophrenia is. Laing and Esterson, on the other hand, were not satisfied by the diagnosis made by two senior psychiatrists and made it a condition for including the cases in his project that the staff, most of whom were ex-patients, should feel that the patients were schizophrenic.

Method. A great deal of bias is inherent in family studies in general, and unless extra care is given to eliminate such bias, the findings could be seriously questioned. A close examination of the studies mentioned above shows that the measures taken by the researchers to eliminate such bias were not adequate. Some of them used methods of selecting samples and recording observations that were likely to increase this bias even more. They all started with a preconceived idea of what families of schizophrenics would be like, and without random selection of their cases it is practically impossible to rule out the notion that the researchers have in fact in-
cluded those families who fit their model and excluded those who did not.

The ward-living situation adopted by Bowen,\textsuperscript{2} in spite of its clear advantages, increased the bias of the staff who had to live with the families, deal and clash with them, and make clinical observations about them. The same applies to Laing's work, in which the staff and patients were so integrated that it was extremely difficult to recognize who was who in his unit.\textsuperscript{13} Lidz's group\textsuperscript{8} have been involved with the patients and their families in a prolonged psychotherapeutic relationship that must have made it extremely difficult for them to be objective in their assessment of those families. Apart from Wynne and Singer's,\textsuperscript{14} none of these studies have used blind techniques or control groups. Lidz et al.\textsuperscript{8} believe that the use of a control, or comparative, group is unnecessary, as the only value of it, according to them, is "scientific respectability." Laing, by sticking to the existential research strategies, rejected the use of a control group, as he believes in "the uniqueness of human experience."

The control groups used by Wynne and Singer\textsuperscript{14} have been matched for many variables except for intelligence quotient, which is the most important single variable in such a study. Although Singer and Wynne\textsuperscript{8} were blind to the diagnosis of the offspring when they correctly made their prediction, the psychologist who prepared protocols of the psychological tests for them was not blind to the diagnosis, and this must have influenced his account and have consequently influenced the process of prediction that was based on this account.

Establishing a causal link. All these studies have examined the families long after the schizophrenic illness had started in the offspring, and by attempting to reconstruct the family history they all assumed that the psychopathology they described was present before the illness started. As there is nothing in these studies to substantiate this assumption, it is rather difficult to rule out the possibility that the family psychopathology was in fact the result and not the cause of schizophrenic illness in the offspring.

In the absence of well-matched control groups and without the use of blind techniques, it would be a huge conceptual leap to claim that the association between family psychopathology and schizophrenic illness was a specific one. The association could well be a chance one or a false association produced by the biased selection or by the misdiagnosis of the index cases. In spite of the clear similarity between findings of the different schools, serious attempts to replicate some aspects of these hypotheses, using well-defined diagnostic criteria and more stringent methods, failed to support these schools' claims or prove that the psychopathology described by them is not specific to families of schizophrenics.

The studies failed to explain some of the known facts about schizophrenia. They did not explain why one of the siblings becomes schizophrenic while others, living in the same pathologic environment, do not. They did not explain why only 10 percent of the children of schizophrenic parents become schizophrenic while 90 percent of them escape what seems to be, according to these schools, a "transmitted irrationality," a "mode of communication," or a "family tradition."

They did not give a satisfactory explanation for the onset of the illness in adolescence, the sex distribution, its progressive course, and its response to physical methods of treatment. Treatment methods based on these hypotheses are not convincingly effective, and those who achieved some therapeutic success had in fact used drug therapy in conjunction with their psychotherapeutic techniques. This makes it extremely difficult to assess how much of this success was due to the natural history of the illness, to drug treatment, or to psychotherapy.

\textbf{DISCUSSION}

The effect these studies have had on the understanding and treatment of schizophrenia, and on family research in general, is undeniable. The emphasis on the family rather than the individual is certainly a useful and practical approach that is applicable not only to the problem of schizophrenia but to all other psychiatric problems as well. Such terms as the "emotional divorce," "pseudomutuality," the "double bind," "family homeostasis," "mystification," marital "skew," and "schism" de-

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{Dr_Guirgis.jpg}
\caption{Dr. Guirgis is consultant psychiatrist at St. Clement's Hospital, Ipswich, England. A native of Cairo, he was formerly senior registrar at the Institute of Family Psychiatry, Ipswich.}
\end{figure}

continued
scribe new and useful concepts that have largely emerged from these studies.

These main schools have all had great and challenging ideas, but it is unfortunate that the research methods they employed did not match their postulates in quality. Nevertheless, they have all been enormously worthwhile. Because of their conceptual and methodologic limitations and in spite of the huge time and effort invested in them, these studies have not convincingly answered the question of whether the family does in fact cause schizophrenia. This leaves the role of the family in the etiology of schizophrenia open for speculation. Some of these possible speculations have recently been discussed.\(^{16}\)

One possibility is that schizophrenia has nothing to do with the family and that the families studied so far are those of very disturbed neurotics, presenting with schizophreniform symptoms, and could be called schizophrenic only in the American but not in the British or European sense of the term. Howells\(^{17}\) believes that the findings of these schools would be consistent with these families' being of severely emotionally disturbed persons, rather than schizophrenics. In the absence of clear diagnostic criteria and with all these methodologic limitations, this view seems very likely, as one would naturally expect to find severe psychopathology in families of emotionally disturbed patients. In support of this view is the fact that attempts to replicate these studies gave conflicting results: those using ill-defined diagnostic criteria reported similar findings, while those using more stringent criteria\(^{18}\) failed to do so.

Another possibility is that family psychopathology is the result of living and coping with a chronically ill and odd person and not the cause of this person's illness. In support of this view is the fact that similar psychopathology could be detected in families of mentally and physically handicapped children.

Family psychopathology may also act as a non-specific stress factor, which could produce schizophrenia only in those predisposed to it by hereditary, biochemical, or any other factors. In support of this is the fact that similar psychopathology could be detected in families of neurotics, severe asomatistics,\(^{19}\) and school phobics.\(^{20}\) The schizophrenic, according to this view, is doubly unfortunate; he has a biologically abnormal nervous system and a psychologically abnormal family.

Those who advocate a genetic etiology of schizophrenia\(^{21}\) favor the view that both schizophrenia and defective communication are caused by the same genetic factor that is present in full dose in the offspring and in a small dose, or a modified form, in the parents.

Future research, using more definite diagnostic criteria and more rigorous research methods, is the only answer to this important and largely unanswered question: Do families really cause schizophrenia?

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REFERENCES