FAMILY ANXIETY AND SCHIZOPHRENIA

Family Anxiety and Schizophrenia

How does one maintain a focus on the family system when there are major symptoms in one member? How does one not fall into the thinking that the parents' anxiety is "causing" the symptoms in the son? How does the therapist keep the focus on each family member doing their best with dealing with their own emotional process? How do parents deal with each other? How do these variables (and others) impact on the family emotional system?

Dr. Bowen's letters to other professionals who are involved with families that he had previously been clinically connected with were carefully written and rich in his theoretical principles that guided his efforts. His letter of September 1962 is to a superintendent of a hospital where Dr. Bowen's former patient has been hospitalized. He describes in detail the "clinical picture" of the young man, but gives more than equal time in describing how anxiety processes played out with the parents and the family. He also points out anxiety patterns that seem to be present in all families where there is a schizophrenia process involved.

One wonders how much the treatment team at Eastern State Hospital "heard" of his observations. The letter is a clear example of the "therapist as a researcher."

September 21, 1962

Dr.
Eastern State Hospital
Williamsburg, Virginia

Dear Doctor,

This is a response to your request of August 14 for information about , 14 year old son of Mr. and Mrs. of Arlington, Virginia. I am sorry this reply has been delayed. Your letter arrived just after I left on vacation. Three days after vacation there was a professional trip which required another one week absence.

I have known the family since the early Fall of 1958 when the father, mother, and became part of a family research project I was conducting at the National Institute of Mental Health in Bethesda, Md. The family joined the project with the knowledge that it would terminate three months later, at the end of 1958. After I terminated my association with N.I.M.H. in 1959, I began to see the family privately in the same kind of family psychotherapy that had been started during the research. With the exception of two brief interruptions of a few weeks and a few months, I saw them about three years terminating in the Spring of 1962. The family psychotherapy was focused on the family, and specifically on the parents, rather than on . I shall not try to describe the details of the psychotherapy but if your staff is interested, the theoretical premise of the research was described in "A Family Concept of Schizophrenia", a chapter in "The Etiology of Schizophrenia", edited by Jackson and published by Basic Books in 1960. The report on the psychotherapy was published as "The Family as the Unit of Study and Treatment" in the American Journal of Orthopsychiatry, January 1961, pages 40-86. The family was "atypical" and not an official part of the study because was the only child in the group and because the family was in the project such a short time. Since they lived in the Washington area, the family spent no more than half time "living in" with the other families.

Since the theoretical orientation was focused on the family, I have much more information abut the parents than about . I saw no significant difference between these parents and the parents of adult schizophrenic patients. The main difference was that these parents did not have the overt parental emotional disharmony

that was so marked in the other families. The parents had an intense deep disharmony that did not show through the calm and pleasant surface adjustment. A very small percentage of the parents of adult schizophrenic patients had this kind of adjustment. In our papers, this was described as a “silent family”. This was associated with a very fixed and severe process. The parents made some significant changes in family psychotherapy. One of the best indicators of parental change was in dreams, which provided a reading on the emotional turmoil beneath the calm surface. The symptoms of the average adult schizophrenic patient can be correlated point by point with overt emotional stress in the parents. This was not true with the because they showed so little overt evidence of stress. After considerable study we found that symptoms occurred in direct response to the parents’ deeper emotional turmoil revealed in dreams. One of intense periods of disorganization occurred during a dream sequence which also showed the intensity of the parental interdependence. The mother’s dreams concerned her being alone just at nightfall, trying desperately to reach home or reach help, and being blocked by adversity, incapacity, and traumatic events. On another level she was concerned about another attack of rheumatic fever which served as a constant harbinger of death. There was no reality to support the fear about rheumatic fever. The father, 8 1/2 years younger than the mother, dreamed of his wish to die before the mother, lest he be left alone.

During family psychotherapy the parental process “loosened up” until it was more characteristic of an average family with an adult schizophrenic patient. During the same period came out of his “autistic like” unrelatedness and he began to relate to his environment, albeit with psychotic symptoms directed more and more specifically to the parents. The most rapid change occurred early in 1961. Later in 1961 there was a series of events, any one of which could have disturbed the family equilibrium. The father’s only sister, a substitute mother, died just as he was planning to retire after over 25 years in the Air Force. Then there was the stress of moving and finding civilian employment. A few months later they bought the first home they had ever owned. In the early Fall the mother developed anxiety with somatic symptoms and “could not stand” the presence of . The father acted immediately to get out of the home. From our family orientation, the situation was the most favorable it had ever been for significant changes with the entire family group. I urged the family to keep at home, at least for a few months longer, to consolidate as much as possible from the new situation. The father

seemed to “hear” and he agreed on an intellectual level but at home, confronted with the anxiety of the mother, his every move was to get out of the home, just as previous moves had been to find ways and reasons to justify keeping at home. This compliance with the anxiety of the mother is, in my experience, a hallmark of the family with a psychotic offspring.

The primary problem in , in my opinion, is childhood psychosis. There is evidence of a psychotic process that goes back to eighteen months when he “stopped talking.” Over the years the parents followed a course that is not unusual with such families. They had examined at several different places and, as usual, came out with different opinions and diagnoses. Some considered him constitutionally impaired or retarded. For a time in the research project we considered the possibility of autism, but he did not meet enough of the criteria of autism. I have never considered retardation as the primary problem but certainly he “functions” retarded a fair amount of the time. It was on 1960-61 that the overt psychotic element came much more to the forefront. He was much more alert, particularly in the specifically directed symptoms. With strangers he was usually mute but at home, and on the research ward, his talk was usually perseverated psychotic jargon interspersed here and there with clearly formed full sentences that were precise and grammatically correct. These sentences would come when he appeared to be lost in his own world and oblivious to the environment. The sentences would indicate that he had been following what went on around him. Then he would lapse back to his sing-song reverie. He was never a serious management problem at home, not even when the mother “could not stand hime.” It was more that his psychosis was more persistent and more specifically aimed at the mother.

In summary, the response of this family to family psychotherapy was more than we expected when we started with the family in the Fall of 1958. The most significant changes were in the parents. It is hard to estimate how much of the change in was related to the change in the parents, and how much was related to a growth process in and to the passage of time.

Sincerely yours,

Murray Bowen, M.D.