The Linacre Quarterly

Volume 37 | Number 1 Article 30

February 1970

Family Psychiatry

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In medicine, I think, everyone listens to his own music. Not only do we spend most of our time reading our own journals, and listening to our own specialty, but I suspect psychiatry may not be alone in listening mostly to its own school of thought. This Journal offers not only the opportunity of sharing ideas with other specialties but especially a chance to talk of "Family Psychiatry" for a group with a special commitment to the stability of the family.

I want first to review how family therapy differs from the better known analytic approach; to offer some observations on family processes common in many families and voice my concern that the family therapist is headed out of medicine.

Psychiatry entered the 1950's, in this country, with much enthusiasm for psychoanalysis but growing concern about its limitations. Extensive training was required for the small numbers of qualified doctors who could treat a relatively small number of cases. The fascinating work being done with schizophrenics by a number of gifted analysts was not widely known, but even when recognized, was cold comfort to the mental

hospital administrator with a small staff and a mounting population of chronic psychotics – especially the schizophrenics who came to the hospital at the beginning of their most productive years and settled in for long lives of half-living. The insulin coma and convulsive shock therapies of the thirties had been tried and now established in their niches; the former useful in limited numbers of schizophrenics and the latter remarkably useful in severe depressions, but seldom effective in schizophrenia.

Beginning in the fifties there were strides forward on many paths. The era of psychotropic drugs began and their use and efficacy is now a standard part of medical knowledge. Concurrently, and as a result, we have more such patients at home and the increased tranquility at home or in hospitals encourages and permits more attention to the process. Study of family process became more widespread, behavioral therapies have gotten more attention and general scientific progress has permitted ever more sophisticated explorations in biochemistry and neurophysiology of psychological functions.

My special interest is the family. Like psychoanalysis, "family" is a theory, a method of investigation and a treatment technique but the similarities largely end there. Family focuses on interpersonal action and has as its goal the change in family processes. Family eschews the confessional seal approach and is not that kind of a confidential relationship between two people but is rather noted for its multiple participants and its readiness to introduce observers and videotapes and movie cameras as comparisons. Family therapists are not "blank screens" but individuals with opinions, values and even families of their own. Family may involve only two people as Bowen used to do it, with only one member of the family in attendance but picturing the total family ragged around – or, at the other end of the spectrum, *a la* Ross Speck, a room full of people. Speck calls himself a network tightener and goes after the pathologic communications shared by the kin, friends and neighbors of the identified schizophrenic with the avowed goal of tightening bonds and loosening binds. Bowen dwells more on the differentiation of the individual out of what he calls the "undifferentiated family ego mass" which functions like a closed system in which change in one part produces compensatory change in another. He skillfully interrupts the process that keeps them stuck by assuming the posture of researcher teaching the family how to research its operations. Unlike the classical analytic approach which calls for two, three, or more hours per week, or even the analytically oriented psychotherapy once a week, family therapists are experimenting. Bowen has successfully used monthly sessions with multiple families (and the progress obvious on the video-tapes I have seen) and the Multiple Impact Group in Texas, working with the families of disturbed adolescents in crises do a kind of multitherapist marathon intervention with the family in residence at a nearby motel for two days, after which they are sent home to practice for six months what they have learned. Family theory and techniques, like family process, are being and becoming. In an excellent article in 1966, Bowen summarized much of his thinking (as of then, anyway) and described the family movement as "a healthy, unstructured state of chaos." It is difficult to comprehend or accept family theory unless one discards a linear cause and effect model and substitutes something like a circular model in which cause is simultaneously effect which maintains the cause from which it results.

In my experience with families, I have been most struck by the frequency of the reaction-counter reaction process and with the frequency with which many dysfunctional families can make use of awareness of this process. It is rather like the symptomatic treatment of aspirin for the fever, but likewise very useful. Everyone I have met reacts to some extent and/or in some situations, dysfunctional families are caught in it most of the time. Some of the familiar examples for a medical practitioner involve the handling of two situations which officially we endorse; I refer to patients questioning of fees, and patients questioning of results. I wonder if there is anyone who has not, at some time, *reacted* to this with injured pride, or hurt feelings, or rationalizations about difficult and ungrateful patients, rather than acted as the little placards suggest, *i.e.* "Your doctor welcomes questions and discussions about his fees and services." And the public pose that all doctors welcome consultation – if you would like another opinion, just say so.

Conflictual spouses have a high level of communication failure partly because they are trying to avoid the reaction they will elicit anway, so neither tells the other anything much. Verbal and non-verbal exchanges are interpreted as reactions to the self and lead to counter-reactions. If one spouse grimaces – a transient gas pain perhaps – the other *reacts* to the "dirty look" with "Now what are you mad about?" To which the first responds, "Nothing suits you," and they are off to the races. Conflictual couples both select and produce differences so that tidy husbands have disorganized wives or vice versa, and the "allow plenty of time" types are paired with the "there's no point in arriving early" ones. The reaction counter-reaction circuit gets involved because these differences cease to be seen as traits in the other, but are responded to as an affront to, or criticism of, the self once the pair has merged into the emotional oneness of marriage. Individuals can break the circuit anytime that either one can disengage himself by controlling his own response and interpreting the other's statement as information, not accusation or challenge. Decades of popularization of analytic thinking have led to distorted ideas about the value of "expressing feeling" and "getting out the hostility" and obscured the difference between recognizing feelings and acting out.

In a seriously conflictual family, each spouse is so engrossed in cataloging the rejection to which he is counter-reacting that he never notices his own rejection to which the spouse is counter-reacting. The tip-off I get on this is hearing a husband and a wife listening to each other's bill of complaints without either one noticing that each has said, in essence, my spouse shows no interest in me as a person, ignores my positive, tender gestures and avoids me as much as possible.

Another fruitful area for many families is work invested in breaking up the negative reaction – counter-reaction circuits which are maintaining the unacceptable behavior they cannot stand in the offspring. A practically stereotyped one can evolve with the appearance on the scene of the hairy, disheveled teenager in ragged jeans (a reaction to begin with) which elicits a parental barrage of criticism, which elicits an attack on the older gener-

ation's war in Viet Nam and cocktail parties, which elicits a negative discourse on affluent youngsters who have everything handed to them and don't know what it was like to have only one pair of pants during the depression. These exchanges can go on as long as the participants can last, or be interrupted at any point that either ceases the probably irrelevant counter-reaction to the other's irrelevant statements. If the parent just can't stand the "new look" he may just have to avoid it by withdrawing from the scene and declining to be seen with it. The more dysfunctional the family and the more disturbed the offspring, the more the parents describe themselves as helplessly reacting. Rarely do they see Junior as reacting to them at all. The plaint goes, "Doctor, that is the problem. He doesn't care, nothing we say or do affects him at all." Some are able to test out the hypothesis I put forth – that Junior is reacting to them in direct quantitative proportion to their reaction to him, and the power is on their side to boot. This can be demonstrated by disengaging. Withdrawal, silence, cool courtesy may be reactions, but if used as active measures to interrupt a useless pattern the change spoils the stereotyped exchange. The situation is like that described in the old joke – he chased her till she caught him. The distance between most twosomes is fixed all along, and if one retreats the other advances. I suggest that this can be usefully tried by most parents on their own offspring after first noting how much of the time the parent has been initating exchanges, particularly negative exchanges, with the adolescent. Of course if the child is really all bad, I guess the parent might better just wash his hands of the whole mistake. I withdrew from treating one family in which the mother reported, after two weeks of thought, that she could not think of one good thing about her daughter.

Lastly, I am concerned about what I see as a growing trend in the family movement toward separation from medicine. The medical model is discarded, the illness model is called pathogenic with the implication that the less medical one is, the better the family therapist one will become. The attackers are medical but the non-medical disciplines can hardly disagree. Here too, we see process – such attacks by family therapists encourages more study of family therapy by non-physicians who are thus encouraged in their contention that with proper training, they are equally qualified to treat psychiatric problems and that medical training is not only unnecessary, but detrimental. These bright students and adherents then help to reinforce the preference for non-medical model, and so it goes around. If this trend grows, we decrease the chances of integrating, *e.g.* the catecholamine hypothesis with studies of the family process in depression; we return to either-or dichotomies, the body-mind dualism.

ADDITIONAL READING

1. The journal, *Family Process*, published twice a year, offers a varied selection of people and ideas.
2. Bowen, Murray. The use of family theory in clinical practice. *Comprehensive Psychiatry*, vol. 7, no. 5, (Oct.) 1966, pp. 345-374.
3. Bell, J. *Family group therapy*. Washington, US Dept. of Health, Education and Welfare, 1961. Public Health Monograph no. 64.
4. Satir, V. *Conjoint family therapy*. Palo Alto, Calif., Science & Behavior Books, 1964.
5. Ackerman, N. *Treating the troubled family*. New York, Basic Books, 1966.