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PARENTING AND SCHIZOPHRENIA

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**Department of Social Policy and Applied Social Studies
University of Wales, Swansea**

**Thesis submitted to the University of Wales in candidature for
the Degree of Doctor of Philosophy, 1997.**

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Declaration

I declare that this thesis is the result of my own independent study carried out under the supervision of Professor Peter Raynor, and that all indebtedness to other sources is acknowledged in the text.

I further declare that this thesis has not already been accepted in whole or in part for any degree and is not currently submitted in candidature for any degree.

Signed: *M Klein*

Confirmed: *P. Raynor*

Date: 25/4/97



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SUMMARY

The first part of this study reviews the evidence for biological, vulnerability-stress and psycho-social models of Schizophrenia focusing on the latter, particularly on pathogenic parenting models. The reasons why, despite lack of evidence, pathogenic parenting models gained the popularity they did are explored, including mental disorder as a disorder of mind rather than body, the claims of non medical professions to treat mental disorder, issues of therapeutic optimism and pessimism and political and social factors, including the status and societal view of women in general, and mothers in particular.

In the second part of the thesis the existing literature on the plight of the parents of people with Schizophrenia is reviewed.

The author conducted in depth interviews with parents of thirty persons with Schizophrenia (patients in a forensic or a community setting) looking at three main areas: subjects' views on the aetiology of Schizophrenia, burden and stress, and encounters with mental health care professionals.

The subjects discounted pathogenic parenting models. However, significant levels of feelings of "guilt" for causing the disorder were recorded. High levels of stress and burden were found. Levels of contact with professionals were low and professionals were poor at information giving. However, levels of blaming by professionals were lower than expected with almost

as many instances of professionals counselling parents not to blame themselves.

The seemingly paradoxical results of discounting pathogenic parenting models, low levels of professionals blaming and nearly equal levels of overtly non-blaming, yet high levels of guilt are best explained by Attribution Theory. The author concludes that this may also explain more recent, disappointing, findings on the impact of family psychoeducational programmes and argues that the lessons of Attribution Theory in other contexts should be taken into account when designing such interventions.

INTRODUCTION

This study is divided into two parts; the first part is an examination of the history of Schizophrenia, leading to a major issue in Twentieth Century mental health, that of the attempt by professionals to show that parenting is a vital factor (often held to be the most important factor) in the origins of psychiatric disorder. The second part of the thesis begins by reviewing literature that explores the experiences of parents, and other significant family members, of people with Schizophrenia and examines their relations with mental health professionals in the light of the development of pathogenic parenting models. It then proceeds to an empirical study of the experiences of the parents of patients with Schizophrenia drawn from a sample of parents of patients with Schizophrenia in Rampton Hospital and parents of patients with Schizophrenia in the community, in the catchment area of Bassetlaw District General Hospital. It explores the issues of blame and guilt elucidated in the first part of the study and the review of the literature, and seeks to test a number of hypotheses based on these issues. It also explores crucial issues concerning the quality of interaction between mental health care professionals and the parents and families of people with Schizophrenia in the context of the family psychoeducational approach.

Although much literature exists on the various theories which have evolved on the aetiology of mental health disorders, and in particular Schizophrenia and pathogenic parenting models, there

has never been an attempt (as far as the author is aware) to examine models developed in the Twentieth Century, which may still be being applied to patients and families today, and trace their historical roots. In particular, the author feels that it is vital to understand exactly why Freud and the psychoanalytical tradition were so influential in order to understand the development of pathogenic parenting as an approach to Schizophrenia. To do this it is, of course, necessary to examine the history of psychiatry over the past two centuries drawing out the themes of: the rival claims of organic and non-organic explanations of disorder, therapeutic optimism and therapeutic pessimism (particularly in the face of the hereditary explanations) and rivalry between the medical professions and the non-medical for supremacy in the treatment of the mentally disordered.

Arising from this history of Schizophrenia, its aetiology and possible treatment models, is the ever present influence, for most of this century, of the view within the professions dealing with the mentally disordered that seeks to blame parents for either the disorder itself, or the failure of the disorder to remit. Parents may be aware that they are being blamed by professionals and may suffer guilt as a consequence. However, they may also suffer guilt as such ideas gain a lay currency and become part of society's perception of the origins of such disorders. Finally, parents still feel guilt and blame, even if not overtly blamed by professionals, and this may adversely affect relationships between parents and professionals.

PART ONE

THE PERSPECTIVE OF THE MENTAL HEALTH CARE PROFESSIONS

SCHIZOPHRENIA - PROBLEMS OF DEFINITION

There are two major classification systems for mental disorder in use today. The International Classification of Mental and Behavioural Disorders, Tenth Edition (ICD-10) has been developed by the World Health Organisation and represents the general international consensus. In the abridged version of this manual¹ Schizophrenia is described as follows:

"The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting on or discussing the patient in the third person; thought disorders and negative symptoms."

The second major system is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)², developed by the American Psychiatric Association. In this latest version, Schizophrenia is described as follows:

"The characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention. No single symptom is pathognomonic of Schizophrenia: the diagnosis involves the recognition of a constellation of signs and symptoms associated with impaired

¹ Cooper, J E (ed) (1994) The Pocket Guide to the ICD-10 Classification of Mental and Behavioural Disorders. Churchill Livingstone. Edinburgh. Page 92.

² American Psychiatric Association (1994) Diagnostic and Statistical manual of Mental Disorders, Fourth Edition. The American Psychiatric Association. Washington, DC. Page 274.

occupational or social functioning."

The manual then goes on to describe the negative and positive symptoms including the hallucinations, delusions and thought disorders referred to in ICD-10

Historically, Kraepelin (reprinted in Hamilton ed.³) was the first to differentiate what he termed "Dementia Praecox" from Manic Depressive Psychosis. Bleuler⁴ later described the two "fundamental" symptoms of emotional flattening and thought disorder (loosening of associations). It was Bleuler who coined the name Schizophrenia and was responsible for the influence of a loose definition of a disorder that was to influence American and Swiss psychiatry and cause enormous problems in comparison of research with British and European studies, where there had been an adoption of the much tighter definition developed by Schneider (Hirsch and Shepherd eds.⁵).

Kurt Schneider was significantly influenced by Karl Jaspers. Although Jaspers wrote comparatively little specifically about Schizophrenia, he was an important influence for a number of reasons. Jaspers' career started in medicine and psychiatry but subsequently his interests and academic positions were in

³ Hamilton, M (ed). (1967) Abnormal Psychology. Penguin Modern Psychology.

⁴ Bleuler, E. (1924) Textbook of Psychiatry. Translated A A Brill. Macmillan. New York.

⁵ Hirsch, S and Shepherd, M. (1957) Themes and Variations in European Psychiatry. John Wright. Bristol.

psychology and philosophy. He was able to bring a wider critical perspective to the works of both Kraepelin and Bleuler.

Jasper⁶ thought in terms of different forms of understanding that included the subjective and objective. He accepted the importance of the pathological approach but rejected Kraepelin's rigid insistence on seeing Schizophrenia entirely through the perspective of neurological disease. He also accepted the value of the objective psychology started by Wundt. What he felt was missing and sometimes had been wrongly dismissed, was a subjective psychology - a phenomenology of mental processes. He argued that the psychiatrist should bring an empathic understanding to the patient's mental phenomena. Only when empathy was not possible should a more analytical approach be considered. He was undoubtedly in sympathy with Bleuler's attempts to introduce the subjective but was critical of his lack of methodological clarity.

Schneider revised and narrowed the concept of Bleuler's Schizophrenia by talking in terms of first rank symptoms. He argued that, in the absence of epilepsy, intoxication or gross cerebral damage, the presence of certain factors was crucial for the diagnosis of Schizophrenia. These factors were: auditory hallucination, in which the person hears his own thoughts echoed out loud, other persons discussing or arguing about him in the third person or voices forming a running commentary on his

⁶ Jasper, K. (1963). General Psychopathology. trans Hoeri, J & Hamilton, M W. Manchester University Press. Manchester.

behaviour; the person might also indicate that his thoughts were not his own, thoughts are being put in his mind (thought insertion), being taken out of his mind (thought withdrawal) or known to others (thought broadcasting); passivity phenomena, feeling one's acts are being controlled or being generated by other persons or bodily functions are being controlled - somatic passivity. A final symptom central to the diagnosis of Schizophrenia is primary delusion in which a normal perception takes on abnormal meaning.

Schneider also argued that other primary symptoms could also occur in Schizophrenia but, of themselves, were not diagnostic. These other symptoms include: hallucination of other senses such as smell, touch and taste, emotional disturbance and inappropriate affect, disturbance of thought often resulting in disturbed speech and other peculiarities such as "knight's moves", "word salad" and neologisms, motor abnormalities and secondary delusions.

Schneider also listed negative symptoms which included: emotional apathy, slowness of thought and movement, under-activity, lack of drive, poverty of speech and social withdrawal.

Within the broad umbrella of the term Schizophrenia are up to eight sub-types and these are as follows: Acute Schizophreniform Psychosis which is characterised by sudden onset and a clear precipitating stress (the outlook in this form of psychosis is quite good with a reasonable chance of recovery and a low chance

of recurrence); Hebephrenic Schizophrenia, which usually occurs in young males, positive symptoms such as thought disorder tend to dominate and there is an initial profound disintegration of personality and social functioning; Paranoid Schizophrenia usually occurs, in contrast to Hebephrenic Schizophrenia, in older people and especially in women (it is characterised by acute symptoms including delusions and frequently reoccurs but within this illness the personality is usually preserved to a large extent). Catatonic Schizophrenia is characterised by the so called catatonic stupor, abnormal movements and impaired conscious state (the sufferer can maintain bizarre postures and usually is unresponsive except for eye movement). In Schizo-Affective Disorder the schizophrenic symptoms are present with clear symptoms of affective psychosis. The main characteristic of Simple Schizophrenia is the negative symptoms with progressive deterioration of personality and social functioning. Late Paraphrenia is more associated with elderly patients who suffer from florid and bizarre hallucinations and delusions. Symptomatic Schizophrenia is used to describe those who show signs of Schizophrenia as a result of damage to the brain or interference with brain function.

Primary handicaps of Schizophrenia include low intelligence, poor physical health, prolonged poverty and unemployment. Secondary handicaps of Schizophrenia are those directly attributable to the illness and the experience of psychosis with loss of insight and negative symptoms. The tertiary handicaps of Schizophrenia are the reduced chance of maintaining employment, lasting

relationships and a settled life following repeated attacks of the illness and the side effects of treatment.

Such a bland description masks the very real problems associated with any discussion of the disorder. As Clare⁷ puts it:

"In the last resort, however, the validity of the claims on behalf of a causal role for disordered family relationships or abnormal brain functioning or faulty genes or other aetiological factors . . . can only be tested if there is some prior agreement as to what clinically constitutes the disorder in the first place."

Perhaps the first question to be asked is, in Schizophrenia do we see one or many disorders? The brief description above reviews eight forms of the disorder but are they linked or separate? In fact, Kraepelin's concept of Dementia Praecox involved an attempt to both combine and differentiate various forms of madness, unifying Hebephrenia, Catatonia and Paranoia under the umbrella of one single illness, but an illness separate and distinct from Manic Depression. Historically, a paranoid-type illness had been described as far back as 1818 by Heinroth, a German psychiatrist, and both Hebephrenia and Catatonia were ultimately variations on Morel's term coined in 1852, "Demence Precoce", which was associated with a debilitating mental illness, usually starting in adolescence and characterised by bizarre behaviour, withdrawal and self neglect leading to intellectual deterioration.

In one sense, Kraepelin's unifying approach is typical of the Nineteenth Century view of seeing all forms of insanity as being

⁷ Clare, A. (1980) Psychiatry in Dissent. Controversial Issues in Thought and Practice Second Edition. Tavistock Publications. Page 161.

one. Bleuler⁸, however, the coiner of the word Schizophrenia, was more open to the possibility of the plural - to the concept of several different Schizophrenias. Both the looser definition and, therefore, the comparative over-inclusivity plus the influence of psychoanalytical thinking led Bleuler to see Schizophrenia as sometimes being endogenous, an inborn disorder that might be triggered by environmental factors or a reactive disorder which was almost exclusively due to environmental factors. The endogenous form had the poorer prognosis.

More recently, Crow⁹ has hypothesised that what we may be seeing in Schizophrenia are two distinct syndromes that he referred to as Type I and Type II Schizophrenia. Type I Schizophrenia he associated with prominent positive symptoms, acute onset, good pre-morbid adjustment, good response to treatment, intact cognition and intact brain structure. The disorder in this context was essentially neurochemical and potentially reversible. In contrast, Type II Schizophrenia was characterised by negative symptoms, insidious onset, poor pre-morbid adjustment, impaired cognition and structural brain abnormalities. This disorder was characterised by neuronal loss and was irreversible. Although a promising hypothesis, there were two major methodological problems in investigating this approach. These were an inability to measure positive and negative symptoms

⁸ Bleuler, E. (1950) Dementia Praecox or the Group of Schizophrenias. Translated by J Zinkin. International University Press. New York.

⁹ Crow, T J (1980) "Molecular pathology of schizophrenia: More than one disease process?" British Medical Journal. Vol 280, pp 66-68.

and the problem of establishing which variables were dependant and independent in the syndromes. Even when solutions to these problems were found, the two syndrome approach failed to account for how patients who had both positive and negative symptoms could have both reversible and irreversible abnormalities, could have both good and bad pre-morbid adjustment, or where the dominant syndrome seemed to change over time.

If there is a historical confusion over whether Schizophrenia is one or many disorders, separate or distinct, and if there are two major traditions that involve significantly different diagnostic criteria, is it possible to make any useful statements about the problem? If we cannot consistently and reliably decide who suffers from the disorder and who doesn't, how will it be possible to explore the nature of the illness and its causes?

It is these issues that Clare¹⁰ attempts to address. His argument is that the situation has not been good, but sufficient efforts are being made to improve consistency to the point where the term Schizophrenia might be used in a meaningful way. On the negative side, he points to studies such as Katz, Cole and Lowry¹¹ who showed that a group of American psychiatrists when shown film of patients rated them quite differently on such terms

¹⁰ Clare, A. (1980) Psychiatry in Dissent. Controversial Issues in Thought and Practice Second Edition. Tavistock Publications.

¹¹ Katz, M, Cole, J O and Lowry, H A. (1969) "Studies of the Diagnostic Process: the Influence of Symptom Perception, Past Experience and Ethnic Background on Diagnostic Decisions." American Journal of Psychiatry. Vol.125, pp 937-947.

as apathy. Using similar material, Lorr and Klatt¹² found that American psychiatrists rated behaviour as being more abnormal than British psychiatrists. Passamanick, Dinitz and Lefton¹³ demonstrated markedly different rates of diagnosis within a group of female patients randomly distributed between three wards. Their study suggested that these rates were more an artifact of the psychiatrist responsible for each ward rather than a reflection of the characteristics of the patients themselves. Ward, Beck, Mendelson, Monk and Erburgh¹⁴ in a study that compared discrepancies between diagnosis by different psychiatrists, found that the major problem areas were where, not surprisingly, textbook diagnostic criteria did, in fact, overlap. It is not so much that the psychiatrists disagreed in what they saw, but that the conventions of diagnosis failed to differentiate clearly.

This is the negative side but attempts have been made to improve the situation. Wilson and Meyer¹⁵ demonstrated that there were no significant differences in proportions of different diagnosis

¹² Lorr, M and Klett, C J. (1967) Inpatient Multidimensional Psychiatric Scale. Consulting Psychologists' Press. Palo Alto.

¹³ Passamanick, B, Dinitz, S and Lefton, M. (1959) "Psychiatric Orientation and its Relation to Diagnosis and Treatment in a Mental Hospital." American Journal of Psychiatry. Vol. 116, pp 127-132.

¹⁴ Ward, C H, Beck, A T, Mendelson, M, Mock, J E and Erburgh, J K. (1962) "The Psychiatric Nomenclature: Reasons for Diagnostic Disagreement." Archive of General Psychiatry. Vol. 7, pp 198-205.

¹⁵ Wilson, M B and Meyer, E. (1962) "Diagnostic Consistency in a Psychiatric Liaison Service." American Journal of Psychiatry. Vol. 119, pp 207-209.

over a two year period at a hospital despite different patients and different diagnosticians when the diagnosticians receive similar training. This conclusion was also reached by Wing, Birley, Cooper, Graham and Isaacs¹⁶, who also showed that consistency of training led to a rate of 84% agreement in diagnosis. Within Europe, and in the context of Schizophrenia within the influence of Kraepelin and Schneider rather than Bleuler, there also seems to be a broad area of consensus. Kendell, Pichot and Von Cranach¹⁷ showed video tapes of interviews of 227 patients in a London psychiatric hospital to groups of English, French and German psychiatrists in London, Paris and Munich. The French and German psychiatrists all spoke English. Their diagnostic conclusions indicated that there was a broad consensus that spans national boundaries and training boundaries on Schizophrenia, neurotic illness, personality disorder and alcoholism, though marked differences occur concerning the affective disorders.

If improvements can be made in consistency in training within one country (and a degree of consensus seems to exist within Europe at least), there still remains the problem of standardising European and American terminology. With hindsight, some American commentators acknowledge the problems associated with Bleuler's

¹⁶ Wing, J K, Birley, J L T, Cooper, J C, Graham, R and Isaacs, A D. (1967) "Reliability of a Procedure for Measuring and Classifying 'Present Psychiatric State'". British Journal Of Psychiatry. Vol. 113, pp 499-515.

¹⁷ Kendell, R E, Pichot, P and Von Cranach, M. (1974) "Diagnostic Criteria of English, French and German Psychiatrists." Psychological Medicine. Vol. 4(2) pp 187-195.

loose definitions. Karno and Norquist (in Kaplan and Sadock ed¹⁸) write:

"As a consequence of Bleuler's influence on American psychiatric thinking, the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) provided a troublingly nonspecific definition of schizophrenic reactions, asserting that they were characterized by fundamental disturbances in reality relationships and concept formations, with affective, behavioural and intellectual disturbances in varying degrees and mixtures. In the second edition of DSM (DSM-II), the definition mentioned symptoms that differentiated Schizophrenia from paranoid and mood (affective) disorder but provided little more clarification."

Clare refers to research that demonstrates that even the considerable gap between the American conception of Schizophrenia and the European and British is bridgeable. Cooper, Kendell, Gurland, Sharpe, Copeland and Simon's¹⁹ study of 1972 showed that although there were wide differences of rates of diagnosed disorder in sample groups drawn from New York and London psychiatric patient populations and, specifically, a rate of twice as many people with Schizophrenia, when the cases were examined by a mixed British and American team trained to use the same standard diagnostic schedule there was no significant difference in the rate of diagnosis of Schizophrenia in the New York and London samples. Interestingly, there was still a significant difference in two other categories where the New York sample still showed significantly more diagnosis of alcoholism

¹⁸ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore. Page 699.

¹⁹ Cooper, J E, Kendell, R E, Gurland, B J, Sharpe, I, Copeland, J R M and Simon, R. (1972) Psychiatric Diagnosis in New York and London. Oxford University Press. London.

and affective disorder. Finally, the World Health Organisation Pilot Study of Schizophrenia²⁰ in 1973, (a fully world wide study to see if Schizophrenia can be consistently and reliably identified across the globe), showed that Schneider's first rank symptoms were still the most effective discriminators. The study showed a core 66% of cases of Schizophrenia from psychiatric centres across the world where there was a 90% chance of being diagnosed schizophrenic and a further 23% who would be rated as probably schizophrenic. The remaining 11% classified as doubtful schizophrenic cases came mainly from two centres chosen to represent the USA and the USSR, in Washington and Moscow.

As Clare stresses, these studies show that, at its best, psychiatric diagnosis of Schizophrenia compares favourably with diagnosis of non psychiatric illness. For example, Butterworth and Reppert's²¹ study in 1960 of diagnosis from taped heart sound, showed at best and at specialist level a 79.1% accuracy.

It would seem, and it is the main thrust of Clare's argument, that although there have been major problems in the past, it is possible to consistently and reliably identify a group of persons who suffer from a condition that, for want of a better term (and perhaps a better term is wanting) can be called Schizophrenia. The problem has been in the main historical, stemming, as it

²⁰ World Health Organisation. (1973) The International Pilot Study of Schizophrenia WHO. Geneva.

²¹ Butterworth, J S and Reppert, E H. (1960) "Auscultatory Acumen in the general Medical Population." Journal of the American Medical Association. Vol 174, pp 32-34.

does, from two distinct and not fully compatible traditions. It has been made worse by failure to use standard diagnostic categories even within traditions. However, since Clare wrote, there has been a growing pressure to standardise and address this problem (see DSM4 and ICD10) and there is a recognition that it has to be solved in order to address the major questions of whether Schizophrenia is one or many disorders and what is/are its/their aetiology.

SCHIZOPHRENIA - AN HISTORICAL APPROACH

One of the more interesting questions in any historical study of the nature and treatment of Schizophrenia is why there appears to be a lack of any specific references to a disorder like Schizophrenia until the Eighteenth and Nineteenth Centuries or, as Jeste, Carmen, Lohr and Wyatt²² ask in the title of their paper: "Did Schizophrenia exist before the Eighteenth Century?" This is related to another question asked by writers including Hare²³: was insanity on the increase in the Nineteenth century?

These questions might seem somewhat academic but they have important implications. If it could be demonstrated that Schizophrenia is a disorder of modern times or, conversely, if there is scant evidence for the existence of the disorder before the modern period, then this would constitute a powerful argument against psychoanalytically derived models of Schizophrenia and pose problems for other models based on social and psychological processes. The subjects of this thesis, pathogenic parenting models and their destructive impact, have their origin in psychodynamic models, in Bleuler's theories on the origins of Schizophrenia and the work of those working within the psychoanalytical tradition such as Frieda Fromm-Reichmann. If it is demonstrated that Schizophrenia is a disorder of modern times

²² Jeste, D V, del Carmen, R, Lohr, J B and Wyatt, R J. (1985) "Did Schizophrenia Exist Before the Eighteenth Century?" Comprehensive Psychiatry. Vol. 26 No. 6, pp 493-503.

²³ Hare, E. (1983) "Was Insanity on the Increase?" British Journal of Psychiatry. Vol. 142, pp 439-455.

then proponents of psychological and social models must explain why these social and psychological processes only existed in modern times. If one blames stress, poverty or the family, one has to find an explanation for the fact that all these existed before 1800. The psychoanalytical tradition has a particular problem since Freudian thinking has pretensions to universality, postulating itself as a theory for all time and all people.

Hare has re-opened the debate which aroused strong argument in Nineteenth Century British (and for that matter European and American) psychiatry - was insanity on the increase?

As Hare points out, with the Lunacy Act of 1845 came the first attempts to keep national statistics on the prevalence of insanity. Insanity in this context was a legal term, like Mental Disorder in the current Mental Health Act 1983, and embraced mental handicap as well as mental illness. Commissioners in Lunacy charged with collecting these statistics published annual reports called "Blue Books" which gave statistics on insane persons living in public and private asylums, workhouses and those being kept in the home. The Commissioners continued till 1914 when they were replaced by the Board of Control. Whatever the inadequacies of the categorisations used by the Commissioners, the statistics were collected diligently and consistently.

What these statistics show beyond any doubt is an increase of prevalence of insanity, for example the Ninth Annual Report of

the Commissioners in Lunacy in 1855 recorded an increase from 10,000 to 16,000 in the numbers of pauper lunatics in the preceding eight year period. Jones²⁴ has demonstrated an increase of asylums and their size over the period 1830 to 1940 in excess of the growth of the population, inconsistent with a fixed ratio of sane to insane in the population. It is accepted that the number of persons being placed in asylums increased out of proportion to the population during the Nineteenth Century but that after the First World War the trend, if anything, began to decrease.

The real controversy, then and now, is what interpretation should be placed on this increase. On the one hand were those who accepted the increase but attributed it to factors other than disease, on the other were those who argued that the increase in prevalence reflected a real increase in incidence. Amongst those who held this view at the time were those who viewed the trend as being truly alarming.

Those who did not believe that there was a real increase in incidence adopted many arguments to explain the trend. The Commissioners themselves, in the Report mentioned above, gave three arguments why the trend should not cause alarm. The first was that improved health care in the asylums meant that the insane were living longer and therefore, without any increase in incidence, there would still be an increase in prevalence. The

²⁴ Jones, K. (1955) Lunacy, Law and Conscience 1744-1845 Routledge and Kegan Paul. London.

second argument was that changes in legislation increased the boundaries of definition of insanity and thus increased their number. The third explanation was that improvements in medical science and observation had increased the early detection of insanity.

Further arguments were put that the Irremovable Poor Act of 1861 encouraged parishes to send their lunatics (especially "idiots") to asylums because there was now no financial inducement to keep the poor insane at home. Maudsley²⁵ argued that the "Four Shilling" Act of 1874, which gave the local authority four shillings towards the cost of maintaining pauper lunatics in asylums, was a positive encouragement to classify paupers as pauper lunatics.

Some of those who doubted a real increase in incidence argued that there was a hypothetical pool of lunatics in the population and that the increase in prevalence was a sign that this pool was being mopped up as a result of changes in legislation that offered negative or positive inducements for lunatics to come within the ambit of official statistics, and that improvements in psychiatry and the reputation of, and confidence in, asylums also played a part. The expectation was that, at some point, this hidden pool would finally be mopped up, that the rate of incidence was fixed and constant and that the rate of prevalence would, therefore, at some point in the future, only change in

²⁵ Maudsley, H. (1877) "The alleged increase of insanity." Journal of Mental Science. Vol. 23, pp 45-54.

line with changes in the population.

Writers such as Robertson²⁶ wrote optimistically that:

"I think I am justified in saying that we see the limits of our labours in providing for the care and treatment of the insane poor; and further, that we have nearly gained the desired end. It is allowing a wide margin in our calculations for the future if we place the possible total number of lunatics and idiots at one in 400 of the population . . . We would thus require, with a population of 22 million, 33,000 beds in public asylums. Of these, 26,000 are already provided."

Among the lesser arguments put forward was that prevalence as measured by the Commissioners was a poor measure, that even the criteria of new admission would only refer to new admission at a given asylum and lunatics drifting from asylum to asylum would appear many times in the statistics.

Hare marshals the arguments for an increased rate of incidence and argued persuasively that insanity really was on the increase during the Nineteenth Century. He argues that anecdotal evidence from physicians actually working at the time contains many reports of fears of an epidemic of insanity. He places particular weight on evidence from those working in sparsely populated areas in rural Scotland and Ireland where local doctors would have the opportunity to get to know their community intimately and where their perceptions would not be clouded by the transient populations associated with the big industrial cities. He also points to similar noted increase in America and France. In the

²⁶ Robertson, C L. (1869) "The alleged increase in lunacy." Journal of Mental Science. Vol. 15, pp 1-23. Page 14.

latter case, he quotes Jarvis²⁷ and Pliny Earle²⁸ who both viewed insanity as being on the increase in the United States.

In the case of the British statistics, he argues that those who talked in terms of a pool of unrecognised insanity which at some unspecified point in the future would be mopped up (and that this pool explained the increase in prevalence) were presented with the following problem. With their "steady state" model of insanity, various estimates of the ratio of sane to insane members of the population were calculated. These ratios were always having to be changed and Robertson's 1 in 400 of the population being insane looks hopelessly optimistic compared with current estimates of one in a hundred suffering from Schizophrenia alone. Hare points out that those who used the decline in death rate in asylums as an argument, or part of an argument, to explain the increase in prevalence would have to be highly selective. Although there was a trend of decline in death rate between 1870 and 1885, this trend disappeared after that date and cannot be used to explain the increase in prevalence at the very end of the Nineteenth and early Twentieth Centuries. Another argument put forward was that although there was an undoubted significant increase in the number of pauper lunatics this was not mirrored by a similar trend in lunatics in private care. As Hare points out, this is a weak argument since mental disorder, and in a modern context, Schizophrenia, is notorious

²⁷ Jarvis, E. (1852) "On the supposed increase in insanity." American Journal of Insanity. Vol. 8, pp 333-364.

²⁸ Earle, P. (1887) "The curability of insanity." American Journal of Insanity. Vol 33, pp 483-533.

as a paupering disease and therefore differences in public and private asylum rates cannot be necessarily attributed to social causes. Many pauper lunatics may well have started life from a more affluent position.

In his final argument concerning the statistics, Hare mentions that the inadequacy of the statistics was amended somewhat from 1869 by the inclusion of first admission (to the current institution) and when the inadequacy of this approach (the failure to take into account previous admissions to other asylums and institutions) was recognised, an attempt was made to record true first-ever admissions from 1898 onwards till 1914 when the "Blue Books" ceased. Hare shows that, in fact, there was a very close relationship between rates of admission and rates of first admission between 1869 and 1887 and a slightly less but still impressive correlation between rates of admission and rates of first-ever admission between 1898 and 1914. In short, although the flat rate of admission was not the same as the incidence (first-ever admission) it would have seemed to have shadowed it sufficiently well that it might be reasonable to surmise that as far back ^{as} 1846 the increase in admission was related to a real increase of incidence.

To go back further requires one, once again, to bring in the anecdotal but, as Hare reminds us, concern at the increase in insanity goes back to the Eighteenth Century. In an interesting precursor to modern viral theories of Schizophrenia, Hare quotes

William Perfect²⁹ who referred to a belief that:

". . . instances of insanity are at this day more than they were at any former period " and attributed it to "the epidemic catarrh, more generally known by the name of Influenza, which raged with such violence . . . in the year 1782".

Hare also reports that in 1891 Clouston³⁰ reported an unprecedented increase in admissions for melancholia to the Royal Edinburgh Asylum which he attributed to the Influenza epidemic of 1889-90.

Two other factors are also of importance. It was noted that the age of onset of insanity was dramatically decreasing.

Hare³¹ writes:

". . . but I have been unable to find there, even in the first edition of Haslam's 'Observation on Insanity' (1798), any account of what we would recognize as acute schizophrenia. Andrew Harper, in 1789, said it was well known 'that young people are hardly ever liable to insanity and that the attack of malady seldom happens before an advanced period of life', and in 1861 the Frenchman Renaudin remarked on the increasing number of cases where insanity had begun before the age of 20, adding that; 'formerly, insanity of an early age was a very rare exception'."

Hare quotes Robert Jones³² as wondering, in 1906:

". . . whether the early physicians knew of the condition increasingly referred to as dementia praecox - a condition 'then apparently so rare, now so common'

²⁹ Perfect, W. (1787) Select Cases in the Different Species of Insanity, etc. Rochester. London. Page 448.

³⁰ Clouston, T S. (1891) "Asylum Reports." Journal of Mental Science. Vol 37, pp 598-599.

³¹ Hare, E. (1983) "Was Insanity on the Increase?" British Journal of Psychiatry. Vol. 142, pp 439-455. Page 450.

³² Jones, R. (1906) "The evolution of insanity." Journal of Mental Science. Vol 52, pp 629-661. Page 649.

- and said that such cases almost invariably begin in depression."

The impression was that the character of insanity was changing from a disease to which the young were relatively immune to a disease, which, like some forms of Schizophrenia, singled out the young.

To this can be added the common Nineteenth Century observation that insanity was proving to be a more chronic disease, more resistant to treatment and more disabling. A final observation is that the "Blue Book" statistics differentiated between General Paresis of the Insane (GPI) and other forms of insanity. During the period when reliable statistics were available GPI remained fairly constant while overall prevalence of insanity increased.

Hare comes to the intriguing, but highly controversial, conclusion that during the Nineteenth Century and probably the latter part of the Eighteenth Century insanity really did increase and that probably a new form of insanity was responsible. That form of insanity bears many of the hallmarks of Schizophrenia in terms of age of onset and intractability. Hare then goes on to talk of a slow epidemic of the disorder, attributing it to organic disease caused by an unknown environmental factor. As Hare points out, it is hard to attribute social and psychological causation to a disease that afflicted people of all classes from all backgrounds living under a variety of political and economic societies. Not surprisingly, the most tempting explanation is a viral model.

The modern evidence for a viral model of Schizophrenia is discussed below but before that we must say a few brief words about attempts to show that Schizophrenia pre-dates the Eighteenth Century. Jeste, Carmen, Lohr and Wyatt³³ have postulated, in the author's view unsatisfactorily, that there is early evidence existing for Schizophrenia. Their strongest example involves the controversial case of George Trosse, a seventeenth century minister, highly regarded by his contemporaries for both his skills as a preacher and his probity. In the years 1656-57 he suffered three episodes of psychotic breakdown which he described graphically in his autobiography.

Trosse was born into an affluent Exeter family but although he showed early academic promise at the local grammar school he did not immediately go on to university and chose instead to be a merchant. At the age of fifteen, he was sent to France to learn the language. He stayed there for two years developing a dissolute life style which included heavy bouts of drinking. From time to time he tried to give up drinking but these efforts failed. At the age of seventeen, he was apprenticed to a merchant in Portugal where his dissolute lifestyle continued. At the age of twenty, he returned home and for the next six years lived an aimless, idle life, by his own account breaking all the Ten Commandments (sic) and, of course, still drinking heavily.

Immediately prior to his first breakdown in 1656, when he would

³³ Jeste, D V, del Carmen, R, Lohr, J B and Wyatt, R J. (1985) "Did Schizophrenia Exist Before the Eighteenth Century?" Comprehensive Psychiatry. Vol. 26 No. 6, pp 493-503.

have been twenty-five years old, he had suffered a bout of what he described as the ague, and had, while drunk, suffered a fall from his horse and had been put to bed drunk. When he woke, he experienced fear and trembling and heard a voice saying "Who art thou?" which he took to be the voice of God. He then saw a "Breath" coming through the roof: "about the bigness of a man's thigh" which he took to be the Holy Ghost and heard a voice saying: "Thou wretch". He experienced feelings of guilt for his past sins and contemplated suicide. This state continued for several days and those around him became so concerned that he was taken to a physician's house in Glastonbury. He resisted the move and was sometimes so violent and suicidal that he had to be restrained by manacles. The hallucinations (he saw devils in the garden) and delusions continued for some weeks and were accompanied by great bursts of activity in which he wrote reams of scriptural verse and committed to heart the Gospel of St Matthew!

He was discharged home having recovered, but soon fell in with his old companions and returned to his old ways including drinking to excess. He again began to experience feeling of remorse and guilt and suicidal ideas and had to be taken back to Glastonbury. He recovered, was sent home, fell back into his old ways and the pattern repeated itself for the third time.

The cycle appeared to be broken in 1657 when Trosse went to Oxford as a student. He settled down well to his studies and though while there he suffered a little from melancholy, felt

doubt and temptation and still experienced infrequent visual and audio hallucinations, he both recovered from his illness and discovered his vocation during this period.

His subsequent life was characterised by sobriety and hard work. Like Bunyan, his contemporary, he suffered a period of imprisonment for his Non-Conformist beliefs. He gained a considerable reputation as a preacher and his sermons were said to be characterised by a good deal of common sense. Also he had a noted kindly disposition. He died at the age of 81, had been preaching on the very day he died and he retained all his mental faculties to the last (Gilling³⁴).

Hare³⁵ reviews and disputes the claim of Trosse as the earliest known example of Schizophrenia in the United Kingdom as follows. There are many problems associated with interpreting an autobiographical account some three hundred years old. Although Trosse's personal integrity, after his breakdown when he wrote his account, is not in doubt and the account itself has the immediacy and detail of veracity, the account was written for a purpose, as a sermon on a sinner who saw the errors of his ways. This has led Hare and others to suggest that though the account may be in the main correct, there might be some areas of exaggeration. Even with this caveat in mind, however, there are

³⁴ Gilling, I. (1715) The Life of the Rev. Geo. Trosse. Late Minister of the Gospel in Exon. John Clarke. London.

³⁵ Hare, E. (1988) "Schizophrenia before 1800? The case of the Revd George Trosse." Psychological Medicine. Vol. 18, pp 279-285.

three or possibly four diagnoses to choose from namely: Schizophrenia, affective disorder, alcohol psychosis in the form of Delirium Tremens and/or Alcoholic Hallucinosiis.

In favour of Schizophrenia, Jeste et al have argued that Trosse's illness fitted in detail the diagnostic criteria for Schizophrenia in DSM-III. Against this, Hare argues that the breakdowns themselves probably lasted no more than three months each and such shortness of duration is not typical of Schizophrenia. Also atypical of Schizophrenia is the dominance of visual over audio hallucinations. Thoroughly untypical of Schizophrenia is the fact that on recovery Trosse's personality and intellectual ability was sufficiently intact to gain a university degree and to gain such success in his vocation.

In favour of an affective disorder are the periods of melancholy and suicidal thoughts, as well as thoughts of unworthiness and worthlessness. The lack of long term damage to personality and intellect noted above would be consistent with an affective disorder, as would the spells of over activity.

Perhaps the most plausible explanation is some form of alcohol related disorder. The first breakdown was immediately following an excessive drinking session which was in itself the culmination of ten years of alcohol abuse. He recounts being "seized with great fear and trembling" at his first attack and experiencing visual hallucinations, all of which are compatible with Delirium Tremens. He is detained in the physician's house and presumably

has less scope for drinking but it is when he returns home and falls back in his old ways, including drinking to excess, that the attacks re-occur. It is at Oxford, where he embraces both his studies and his vocation, that he adopts a more sober lifestyle, and the symptoms diminish eventually to cease.

In the main, the picture fits well Delirium Tremens but, as Hare points out, there are some problems with this explanation. First of all, there appears to have been no period of abstinence or withdrawal prior to the first attack and the duration of the illness is also atypical. Hare resurrects the concept of "Alcoholic Hallucinosis" as described by Marcel in 1847 as a possible explanation of Trosse's symptoms. Marcel (quoted in Johnson (1961))³⁶ describes the symptoms as follows:

" . . . an acute psychosis in persons who have abused alcohol for many years, with auditory hallucinations of a threatening or obscene nature, with possibly also frightening visual hallucinations, and delusions secondary to the contents of the hallucinations. The patients were orientated but had great feelings of anguish and could at any time attempt suicide. The age of onset was between 25 and 45, the duration of illness varying between a few weeks and several months. The prognosis was good."

Although, once again, many features fit with Trosse's account, Hare cites the continued visual hallucination, the disturbed and violent behaviour and the rapidity of relapse as being atypical of Alcoholic Hallucinosis. Indeed, the term itself is still very

³⁶ Johnson, E. (1961) "Acute hallucinosis, paranoid reactions and schizophrenia as psychosis in alcoholic patients." Acta Societas Medicorum Upsaliensis. Vol 66, pp 105-128. Page 118.

much surrounded by controversy. Bleuler felt that in many cases of Alcoholic Hallucinosiis one saw Schizophrenia precipitated by alcohol, though current thinking suggests that, although acute cases (and if Trosse is a case in point it is an acute case) may resemble Schizophrenia, in some areas it is a separate disorder. The modern controversy concerning Alcoholic Hallucinosiis is not its relationship with Schizophrenia but rather whether it is related to, or separate from, Delirium Tremens.

In conclusion, the author agrees with Hare that whatever the final conclusion is on the case of the Reverend George Trosse, and at this distance in time a definitive answer is unlikely, it is probable that his illness was alcohol related in some form or other. In answer to the question "did Schizophrenia exist before 1800?" the case of George Trosse does not provide the evidence necessary to answer in the affirmative.

General Paresis of the Insane and Schizophrenia, an Historical Analogy?

If Schizophrenia is a modern disorder then the case for certain biological models, particularly viral models, becomes strengthened and the analogies with certain forms of mental disorder that are known to be caused by infections become pertinent. It is worth, at this point, reviewing the history of one form of insanity, caused by infection, that was also felt, at one time, to be social or psychologically caused but, with the benefit of hindsight, is now seen as clearly biological. The

disease in question is General Paresis of the Insane - insanity caused by Neuro-Syphilis.

In his study, Rosen³⁷ notes the earliest record of Syphilis itself in Europe in the 15th Century followed by a silence of almost two centuries before GPI emerged in the literature on insanity as a (numerically) significant disorder. Rosen offers a number of reasons to explain this hiatus: in its original form the disease was acute and frequently fatal and the victims did not live long enough to develop the neurological form; demographic changes might also have played an important part bearing in mind the "time-bomb" nature of GPI - that the disease can lie dormant, sometimes for decades, before attacking the central nervous system. There may have had to have been a significant increase in life expectancy before a significant number of infected persons appeared as a significant proportion of the insane population. Also, not everybody infected with Syphilis would go on to develop GPI.

Another important factor was the necessary mental thought process among clinicians to see mental disorder, embracing both mental illness and mental handicap, as consisting of a number of different diseases. Indeed, the significance of GPI is not just that at a given time in history it was a numerically significant disorder but more in the insight it gives us on how progress was made in differentiating one form of insanity from another and

³⁷ Rosen, G. (1968) Madness in Society. Chapters in the Historical Sociology of Mental Illness. Routledge and Kegan Paul. London.

from there to a significant understanding of the cause of the disorder, leading, eventually, to prevention and treatment. The author agrees with Rosen's view that the history of GPI might have many valuable parallels with the development of understanding of Schizophrenia.

The development of the understanding of the nature of GPI is very much associated with the Paris school of clinical pathology which fused clinical and anatomical approaches. By the middle of the Nineteenth Century, workers in this school had differentiated a disease characterised by disturbances of motility, mental derangement and pathological changes in the nervous system noted at post mortem. In 1871, Westphal noted differences in the patellar tendon reflex that enabled him to differentiate between Tabes Dorsalis and GPI (the reflex was absent in the former but present in the latter).

Even with these clues to an organic basis in a now clearly differentiated GPI there was, in the Nineteenth Century, and particularly in France, a tendency to see the origins of the disorder in the social and the psychological, and to dismiss or ignore the growing weight of evidence linking GPI with Syphilis. Rosen quotes Bayle as explaining the large number of former Napoleonic soldiers and officers among the population of asylums as being attributable to the terrors of war, excessive drinking and disappointment at the defeat of Napoleon! Bayle himself noted that about one fifth of his patients had indulged in "venereal excess" and many had contracted Syphilis. He considered a link

between Syphilis and madness, only to dismiss it! Esquirol observed that about one in twenty patients at the Salpêtrière had been prostitutes but once again failed to see the link; he failed to see that one form of insanity at least might be an occupational disease for this profession.

Rosen attempts to explain this almost wilful blindness as follows: he points out, as has already been explored above, that during the Nineteenth Century there was a fear bordering on panic that the number of persons suffering from mental disorder and being treated in asylums was dramatically increasing. Regardless of whether the increase was real or apparent, many who regarded the increase as being real at the time attributed it to social, political and psychological causes. Rosen points out that the social, political and psychiatric were inextricably linked in the Nineteenth Century not only in European but also American thinking, and that this was true in the context of GPI. GPI and other forms of insanity were frequently seen as being indirectly or directly the result of modern living. Bayle's views on the link between the Napoleonic campaigns and insanity have already been mentioned but more general theories were developed to attribute insanity to the growing complexity of life.

In America, as Sicherman (in Scull³⁸) has pointed out, the growth of the mental hygiene movement in the Nineteenth Century was inextricably linked to the move of that country from a rural

³⁸ Scull, A. (1981) Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era The Athlone Press. London.

society dominated by Puritan Christian certainties to a more secular, major industrial society. Moral therapy preached that mental disorder was the result of extremes, of both continence and incontinence. Thus its proponents argued that not only was excess of alcohol consumption deleterious but that so was teetotalism and celibacy as well as sexual profligacy. The rush and bustle of modern living, with its extremes, placed an unendurable strain on the nervous system and the strain manifested itself in mental disease. Sichertman points out that many of the proponents of moral therapy had come from those same rural, Christian communities that were fast disappearing, had seen family members die in epidemics and had embraced modern medicine both as a profession and a new faith to replace the old faith that had failed them. The creed of this new faith, put simply, was moderation in all things and this faith also acted as a bulwark against a new way and speed of living for which the old ways provided no preparation.

In Europe, also, the example of insanity was used as a means to criticise modern living and its excesses. Within this debate, the organic basis of GPI continued to be denied, and social and psychological explanations developed to explain organic change despite the progress in understanding of the nature of Syphilis itself in France during the Nineteenth Century. Degenerative models of insanity also played an important part. Krafft-Ebing believed that changes in society had led to a general physical deterioration in the population and that this included neurological deterioration. Morel's essentially Lamarckian

Degeneration Hypothesis of 1857 had an important impact. He hypothesised that degeneration was the result of intoxication, the society one mixed in, temperament and congenital disease. Once acquired, these negative characteristics would be passed on to future generations and would be cumulative in their impact. Mental illness was felt to be the main example of such a degenerative disorder.

The ghost of GPI as a disease of specifically social and psychological origin was only laid to rest by a series of experiments and research in the latter half of the Nineteenth Century and the beginning of the Twentieth century. In 1857, Esmarch and Jessen proposed Syphilis as the cause of GPI. Support for this position came from Jaspersen in 1874, whose study showed that 90% of all paralytics had previously had Syphilis. Fournier, in 1894, showed that a previous history of Syphilis was far more common in patients with GPI than in patients with other forms of mental illness. Krafft-Ebing, in 1897, showed that nine sufferers of GPI with no known previous history of Syphilis showed no secondary symptoms when inoculated with syphilitic material indicating an immunity resulting from previous infection. Finally, with Wassermann's development of the test that still bears his name in 1906, and Lange's development of the colloidal gold test in 1912, it was possible to test for syphilitic history in sufferers of GPI. In 1913 it became possible to test for the presence of the syphilitic organism, post mortem, in the brains of GPI sufferers. These tests paved the way for the early detection and treatment of Syphilis and the eventual decline in

the incidence of GPI.

In summary, GPI can be seen as a disease that has its own natural history. Probably unknown in Europe before the Fifteenth Century and probably not a significant cause of insanity till the Seventeenth or Eighteenth Century, the increase in its incidence may be attributable to one or several factors including a change in Syphilis itself from an acute and often fatal disease to a chronic one and/or an increase in lifespan that allowed Syphilis time to develop to GPI.

Despite the impact of the Paris School, fusing clinical and pathological methods, the detection of neurological damage in paralytic cases, the differential diagnosis of GPI and Tabes Dorsalis and a greater understanding of Syphilis itself, during most of the Nineteenth Century there was a great reluctance to interpret the disorder in purely organic terms. There was still a tendency to view all mental illness as being part of one whole, and its origins as being social, political and psychological. In part, mental illness was seen as being the result of specific social and political events and, in a vaguer sense, as being the result of modern industrial life. Krafft-Ebing felt that modern life led to a general physical decline with specific neurological aspects and Morel, who believed in the inheritance of acquired characteristics, felt that degenerative and immoral behaviour, presumably freely chosen by the individual, plus other negative characteristics, could be inherited by future generations and, if presumably dominant, would in the long run be cumulative to

the disadvantage of society. All these notions acted as a brake on establishing the link between the known facts of GPI and the known facts of Syphilis. With the gift of hindsight and with all (or at least most) of the pieces of the jigsaw in place they seem absurd and irrelevant.

BIOLOGICAL MODELS OF SCHIZOPHRENIA

Modern writers such as Wyatt, Kirsch and DeLisi (in Kaplan and Sadock ed.³⁹) point out that there are certain "facts" to do with Schizophrenia that have to be explained and lend themselves, in part or in whole, to biological explanation. In this section, the author will review these facts and then review the biological explanations that attempt to explain these facts.

Among the "facts" that Wyatt, Kirch and DeLisi describe are striking differences between males and females in terms of age of onset. Although the life-time risk for both sexes is roughly the same, the age of onset tends to be earlier in males (between eighteen and twenty-five) than in females (between twenty-six and forty-five). Also, the outcome seems poorer for males than females and the latter respond better to neuroleptic medication. In female sufferers, the disease has been noted to vary in severity with the menstrual cycle and to improve during pregnancy. Having first degree relatives who suffer from Schizophrenia increases the risk to an individual. The evidence for a genetic component is discussed in detail below.

There also appears to be a limited correlation between season of birth and Schizophrenia with a higher than normal rate of winter and early spring births in populations of persons with Schizophrenia studied. The course of the disorder itself is

³⁹ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

variable with patterns of recovery and remission. There is also evidence of brain abnormalities in people with Schizophrenia and once again this is discussed below.

The fact that neuroleptic medication is generally successful in treating the positive symptoms of Schizophrenia (even if how and why they are successful remain obscure) seems suggestive of a biological explanation. To this list, Karno and Norquits (also in Kaplan and Sadock ed⁴⁰) add the following: higher than average rates of obstetric complications in the birth of people with Schizophrenia, lower social class (though this may be explicable in terms of social drift: Schizophrenia is an impoverishing disease), lower probability of being married (though, once again, is this cause or effect?), higher than average rates among immigrants and among urban and industrial populations and also the problematic issues surrounding stress as a precursor to schizophrenic episodes.

What evidence there is, and what models they suggest for biological explanations of Schizophrenia, can best be described under the following headings: studies of abnormalities of brain structure and function (in post mortem studies and with modern technology with live subjects); the dopamine model of Schizophrenia; other biochemical models; endocrine models; viral models; the evidence for a genetic component and, finally, the role of obstetric complications.

⁴⁰ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

Evidence for Abnormalities of Brain Structure and Function

Evidence for brain abnormalities in people with Schizophrenia has been reviewed by Berman and Weinberger (in Kaplan and Sadock ed⁴¹). The earliest attempts to establish a link between such abnormalities and the disease were via post mortem studies. Such studies from the Nineteenth Century to date have been hampered by numerous methodological problems. As has been mentioned above in the context of European versus American-Swiss diagnostic criteria, the first problem was to establish that the brains being examined belonged to individuals suffering from the same disorder. As Berman and Weinberger point out, if there are differences in the brains of people with Schizophrenia and non-schizophrenics these differences are likely to be subtle and can be masked if there is a failure to control for such factors as the age and sex of subjects. How the tissue is prepared is important as is possible damage to the tissue as a result of preparation. Length of time between death and post mortem study and sometimes the circumstances of death can lead to tissue damage that could be wrongly attributed. Tissue changes caused by treatment, medication or ECT, may also confuse the issue.

Post mortem studies, for all their methodological problems, have consistently shown brain abnormality among people with Schizophrenia but the problem has been in making sense of the sheer diversity of the findings. Damage to no single part of the

⁴¹ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

brain has been found in even the majority of studies, let alone in all brains of sufferers examined, leaving open the possibility that even if there is just one single Schizophrenia it may be associated with damage to different parts of the brain (or that Bleuler⁴² was correct in thinking in the plural, that there are ^{many} different Schizophrenias, each of which may have one or many causes).

What little consistency has been found is described by Berman and Weinberger as follows: there seems to be consistent evidence of brain atrophy in terms of increase in size of ventricles, decreased tissue weight and especially atrophy of the frontal lobes. Also noted has been a decrease in volume of the limbic system. Berman and Weinberger stress that atrophy is a general term and it is not clearly known what neuronal element (neurons, glia or neurophil) is the most affected. Also noted has been changes in neuron size and shape, so called "cortical dysmorphism".

One of the more intriguing possibilities is that the abnormalities noted may not be the result of damage associated with the onset or course of the disorder but a failure of the brain to develop normally; in short, it is not some mechanism of destruction associated with disorder but that the disorder is associated with developmental failure, and the brains never develop to their normal adult form and size.

⁴² Bleuler, E. (1950) Dementia Praecox or the Group of Schizophrenias. Translated by J Zinkin. International University Press. New York.

The 1970's and 1980's have seen the development of two, potentially revolutionary, techniques in the context of studying brain abnormality and Schizophrenia. These are X-Ray Computed Tomography (CT Scan) and Magnetic Resonance Imaging (MRI). Both of these methods can produce images of the living brain thereby avoiding some of the methodological problems associated with post mortem studies described above. These techniques have one precursor in the form of pneumoencephalography, a method by which air is pumped into the ventricles of the brain displacing cerebral spinal fluid, thus providing sufficient contrast to show up the size and shape of the ventricles on X-ray. Enlargement of the ventricles and widening of the cortical sulci in people with Schizophrenia was observed in studies using this method; however, the method was limited and invasive.

CT Scan works by rotating an X-ray beam source round the subject. The X-ray beam becomes attenuated in relation to the density of the material it passes through, and from the attenuation a computer can reconstruct a two dimensional map of radio density of the tissue. It is possible to take several X-ray "slices" or sections of the brain.

The first CT Scan study of the brains of psychiatric patients was done in 1976 and since then the most common findings of studies have been supportive of both post mortem and pneumoencephalographical findings. These findings are enlargement of the lateral and third ventricle and widening of the cortical sulci. However, it should be noted that these studies show a wide

overlap in values for enlargement in both normal and schizophrenic subjects. That is to say that ventricular enlargement, for instance, is not in itself predictive of Schizophrenia.

CT Scan, though undoubtedly an improvement on pneumoencephalography both in terms of definition of image and comfort for subjects, is a technique that has its own problems. It is an X-ray technique and, as such, carries its own health risk for subjects with repeated use, limiting its applicability for long term and predictive studies. As mentioned above, the images produced are two dimensional "sections or "slices" and this raises problems when examining factors such as ventricular size. The most reliable measure appears to be the ratio of ventricle to brain volume and this can lead to inaccurate estimates with only slices to work on.

From the mid 1980's, Magnetic Resonance Imaging (MRI) became available and this has three advantages over CT Scan: the images are clearer and it is possible to differentiate different sorts of tissue much more accurately than with CT Scan. It does not use radiation and is therefore thought to be risk free, meaning that it can be used repeatedly for prospective and long term studies; it can be used to construct three dimensional images and, therefore, to measure volume more accurately.

The following is, necessarily, a very brief description of what is, in fact, a very complex technique. MRI works by placing the

tissue to be examined, the brain, in a strong magnetic field. This causes certain atomic nuclei, most commonly hydrogen, to align themselves with the magnetic field. An electromagnetic signal for the appropriate frequency is then applied which causes the atoms to tilt out of alignment. When the signal is stopped, the atoms realign causing them to send out a radio signal which is picked up by receivers and used to construct the images.

Given that the technique has only been available for less than a decade, the amount of information collected on brain abnormality in Schizophrenia is necessarily limited and at this stage does not clarify the issue. Brain abnormalities have been noted, including reduced frontal lobe area. MRI is likely to prove one of the most powerful tools in this area but the results, currently, are limited.

All the above studies examine the anatomy of the brain of people with Schizophrenia subjects - a static approach. An alternative approach is to examine dynamic neurophysiological processes. Essentially, there are three major techniques in such studies: Electroencephalography (EEG), Xenon-133 Regional Cerebral Blood Flow (rCBF) and Positron Emission Tomography Studies (PET).

EEG is both the oldest and the crudest of the methods, detecting the electrical emissions from millions of neurons. Solomon and Masdeu (in Kaplan and Sadock ed.⁴³) note this crudity and argue

⁴³ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

that this may account for the variability of findings noted with this technique. They summarise the key results of research in EEG and Schizophrenia as follows: the rate of abnormal EEG, particularly Beta activity, is two to three times that of the normal population, but most Schizophrenia sufferers still have normal EEGs. High rates of abnormal EEGs among people with Schizophrenia have been noted where there is a family history of psychosis or when the disorder has been of early onset. Abnormalities in EEG are more frequently seen in cases of catatonic Schizophrenia, and least often seen in paranoid Schizophrenia. Solomon and Masdeu report that alpha-rhythm activity may not respond to visual and emotional stimuli and also that alpha-rhythms may be absent during hallucinations. Most surprisingly, they report a better prognosis being associated with abnormal EEG and conversely a poorer prognosis associated with normal EEG.

RCBF techniques have their origin in earlier attempts to measure the rate of blood flow in the brain developed by Kety in 1948. In Kety's technique, subjects inhaled nitrous oxide; samples of blood from the carotid artery and the jugular vein then showed average rates of oxygen consumption to the brain. Studies using this technique showed differences between people with Schizophrenia and normal subjects.

It was in the 1960's that a variation in this technique was developed in which a saline solution containing the radioisotope xenon-133 was injected into the carotid artery, and the rate of

arrival and disappearance of gamma rays in the cortex could then be detected and measured. This provided a measure of blood flow in various parts of the brain. Studies using this technique showed that certain areas of the cortex showed increased blood flow in response to specific activities i.e opening and closing of the hand.

The modern version of this technique involves the non-invasive technique of inhalation of xenon-133 gas by the subject. Berman and Weinberger summarise the results of studies in this area as follows: the research shows that subjects with Schizophrenia differ from normal subjects in terms of "hypofrontality". When given certain tasks subjects with Schizophrenia show less blood flow to the frontal cortex than normal subjects. This is most consistently so when the tasks and situations involve psychological stress, contingency planning and divergent thinking.

Positron Emission Tomography (PET) involves the use of radioisotopes that emit short lived positrons. Unlike RCBF technique, this allows the possibility of gaining images beneath the cortex. Two findings are of particular importance with this technique. First, the phenomena of hypofrontality observed in RCBF studies have been confirmed using this technique. Second, findings by Wong, Wagner, Tune, Dannals, Pearlson, Links, Tamminga, Broussoule, Ravert, Wilson, Toung, Malat, Williams,

O'Tauma, Snyder, Kuhar, and Gjedde⁴⁴ showed that patients being treated for Schizophrenia, and also patients diagnosed as suffering from Schizophrenia who had never received drug treatment all showed increased dopamine receptor density in the striatum. This result lends support to the so-called Dopamine Hypothesis of Schizophrenia, one of the stronger and more enduring biological hypothesis of the aetiology of Schizophrenia.

The Dopamine Hypothesis

In its most basic form, and there are several variations on the core theme, the Dopamine Hypothesis states that sufferers from Schizophrenia have an excess of the neurotransmitter substance dopamine, and it is this that causes the symptoms of the disorder.

The two key observations that have led support to this hypothesis are as follows. As mentioned above, one of the "facts" concerning Schizophrenia that requires explanation is that neuroleptic medications *do* have a proven beneficial effect in curbing the positive symptoms of most sufferers. Research in the 1960's showed that major tranquillizers such as chlorpromazine and haloperidol had the effect of causing an increase of brain 3-methoxytyramine - a substance that metabolises dopamine. A

⁴⁴ Wong, D F, Wagner, H N, Tune, L E Dannals, R F, Pearlson, G D, Links, J M, Tamminga, C A, Broussoule, E P, Ravert, H T, Wilson, A A, Toung, J K T, Malat, J, Williams, J A, O'Tauma, L A, Snyder, S H, Kuhar, M J and Gjedde, A. (1986) "Positron emission tomography reveals elevated D₂ dopamine receptors in drug-naïvé schizophrenics." Science. Vol. 234 p 1558.

possible explanation for what might have been happening was that the drugs were blocking the dopamine receptor sites on the nerve cells and it was this that prompted the increase in the dopamine metabolite. The second observation was that of all the drug induced psychoses, it was Amphetamine Psychosis that most closely mimicked a form of Schizophrenia - Paranoid Schizophrenia. In terms of positive symptoms, Amphetamine Psychosis and Paranoid Schizophrenia are very hard to tell apart, but, along with duration, the two differ in that the negative symptoms of Schizophrenia are not found in the drug induced psychosis. Amphetamines undoubtedly do cause an increase in the amount of dopamine in the central nervous system but it should be added that it also causes an increase in another substance - norepinephrine - which has become the subject of an alternative biochemical model to the dopamine hypothesis and is described below.

The evidence to support a dopamine excess model of Schizophrenia has been difficult to obtain and is, at best, equivocal, though Wong et al's research mentioned above has interesting possibilities.

An alternative to the dopamine excess model is the dopamine deficit model. This model owes its origins to the following observations: the Influenza epidemic of 1916-17 was associated with the disease Encephalitis Lethargica (for a popular account of

this strange disease and its consequences and treatment see Sacks⁴⁵). The disease was often mistaken for Schizophrenia and Hunter⁴⁶ argued that Schizophrenia was an epiphenomenon of Encephalitis Lethargica.

Sacks has described the relation between Encephalitis Lethargica and Parkinson's disease. In Parkinson's Disease there is destruction of the dopamine producing neurons; in the dopamine excess model of Schizophrenia, the disease could be seen as having many characteristics of a direct opposite of Parkinson's Disease. In the dopamine deficit model, the two would have much in common. While rare, it has been known for an individual to suffer from both Parkinson's disease and Schizophrenia. Both diseases also share certain deficit symptoms such as mild intellectual impairment, apathy, depression, lack of speech spontaneity and problems of concept formation.

Wyatt, Kirch and DeLisi⁴⁷ note three variations on the basic dopamine hypothesis.

The first states that sufferers have a vulnerable dopamine system and that stress causes an increase in dopamine production which

⁴⁵ Sacks, O W. (1976) Awakenings. Penguin Books. Harmondsworth.

⁴⁶ Hunter, R. (1972) "Psychiatry and Neurology. Psychosyndrome or Brain disease." Proceedings of the Royal Society of Medicine. Vol. 66 pp 359-364.

⁴⁷ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

cause the positive symptoms of Schizophrenia. The process, over time, causes the destruction of the dopamine receptors causing the negative symptoms.

The second states that there may be variation in the regions of the brains of people with Schizophrenia in ability to metabolise dopamine and that this may be particularly so in the prefrontal cortex. This variation may incorporate the initial process outlined in variation one - that stress causes an increase in dopamine activity which is the cause of the initial symptoms of the disease. This explanation attempts to account for why neuroleptic medication is effective in dealing with some symptoms of the disease, perhaps associated with specific regions of the brain where the dopamine metabolising system is still intact, but not other symptoms associated with other areas where the system is not capable of activation.

The third variation states that in animal experiments, destruction of dopamine centres in certain parts of the brain by neurotoxins is soon compensated for by an increase of dopamine in other areas. It is argued that if such an effect is taking place in the brains of people with Schizophrenia this may account for certain unusual observations such as laterality differences.

Alternatives to the Dopamine Hypothesis

As has been mentioned above, amphetamines produce not only an increase in dopamine but also an increase in another

neurotransmitter, norepinephrine. The role of norepinephrine neurons remains unclear, but they seem to be involved in learning, memory, sleeping and waking cycles and anxiety. Most interestingly, animal research seems to implicate such neurons in the locus ceruleus with the reward system and goal directed behaviour. Lack of goal directed behaviour is very typical of people with Schizophrenia, as is a lack of hedonistic behaviour. However, hard evidence for norepinephrine deficit or norepinephrine neuron deficit has not, so far, been found.

Serotonin is thought to be involved in inhibitory function in the central nervous system. In animals, activation of the serotonin system has been demonstrated to have inhibited behaviour whereas inactivation of the system increases behaviour. Particular interest has been shown in serotonin because LSD is thought to block serotonin sites, but once again the evidence for a link with Schizophrenia is unclear.

γ Aminobutyric Acid (GABA) is found in many parts of the brain. Animals injected with substances antagonistic to GABA show behavioural abnormalities. Decreases in GABA lead to increases in dopamine activity, and it has been suggested that abnormalities in the GABA system may lead to the increases in dopamine suggested in the dopamine hypothesis of Schizophrenia.

One of the more curious findings within the area of Schizophrenia and biochemistry is that oral doses of methionine have no effects on normal subjects but cause acute psychotic episodes, or cause

existing symptoms to worsen, in subjects with Schizophrenia. What this means, though, is not quite clear. Among other substances that it has been suggested might be implicated in Schizophrenia, but once again with no definitive results, are serine, phenylalanine, tyrosine, asparagine and histamine.

Endocrine Models of Schizophrenia

At various times, attempts have been made to implicate the endocrine system in the aetiology of Schizophrenia.

Among the "facts" mentioned above that require explanation are: the different peak age of onset between males and females, variations in severity noted in female sufferers within the menstrual cycle and improvements also noted in pregnant women with Schizophrenia. A weak case might be made for also including the observed low fertility of people with Schizophrenia though, in the author's opinion, this might just as well be attributed to the damage that Schizophrenia does to social functioning than to any specific biological relationship. The stronger arguments have led some researchers to focus on gonadal function, and the possible role of gonadotropic hormones in Schizophrenia. Once again, however, the findings have been equivocal and replication elusive. Early reports note gonadal atrophy in sufferers from psychoses as well as deficient secondary sex characteristics but this has not been replicated. Early findings that showed low androgen-oestrogen ratio in male sufferers have not been replicated. Attempts to use testosterone and gonadotrophin in the

treatment of Schizophrenia have not proved to be beneficial.

Despite the alternative social explanation for low fertility of schizophrenic women (and also above average rates of spontaneous abortion), some investigators have investigated pituitary function in Schizophrenia and have found low rates of follicle-stimulating hormone and luteinizing hormone. Also noted has been the inhibiting effect that dopamine has on prolactin secretion.

The pineal gland is responsible for the synthesis of melatonin and the observation that hyperpigmentation sometimes occurs in people with Schizophrenia has suggested that malfunction in the pineal gland may be associated with the disorder. Experiments in the 1920s involved giving people with Schizophrenia beef pineal extracts. These seemed to demonstrate improvement but the research methodology was too crude to place much reliance on the results.

Disorders of both adrenal and thyroid function are known to produce psychotic symptoms. These include Cushing's Syndrome and Addison's Disease (respectively an excess and an insufficiency of adrenocortical hormone) and so called "myxoedema madness" caused by severe thyroid dysfunction. However, once again, clear evidence of a relationship between these phenomena and Schizophrenia has not been forthcoming.

It should be added that a major problem in studies that attempt to link endocrine function with Schizophrenia is that neuroleptic

medications are known to have an effect on those functions. For instance, it is felt that neuroleptics may lower oestrogen rates in females and testosterone rates in males. A clear relationship can only be demonstrated with subjects who have never had, or have abstained for a sufficient period from, such medication.

Genetic Models of Schizophrenia

The suggestion that Schizophrenia may be in part or in whole genetic goes back as far as the concept of dementia praecox itself. In part, this was due to the commonplace observation that sometimes "madness" seemed to run in families and also the Nineteenth Century interest in eugenics (one immediately thinks of Galton) and fears for the future if deviancy in its widest sense could be inherited. The Lamarckian views of Morel have already been mentioned above, and the author will later return to this subject when placing pathogenic parenting models in a social and intellectual context.

Within modern psychiatry, genetic models are still very popular as an explanation of the causation of Schizophrenia, though often seen in a more subtle form; some cases of Schizophrenia have a genetic component but genetics on its own is not sufficient. A genetics plus environmental (psychological or biological) approach is to be preferred. Such an approach reflects the current orthodoxy. Against this are a few writers such as

Marshall (in Bentall ed⁴⁸) who attack, and in Marshall's case vehemently attack, such a position from both a philosophical and a technical point of view. However, to appreciate the radical position it is first necessary to review the evidence put forward from the orthodox perspective.

Cloninger (in Kaplan and Sadock ed⁴⁹) covers the complicated and difficult review of research in this area. Until comparatively recently, when screening and mass screening of genetic material became possible, the major approach had been epidemiological. It involved comparing people with Schizophrenia and non schizophrenic subjects with other family members and seeing if rates of correlation varied with degree of genetic heterogenicity.

One of the most important research methods in seeing if a given factor is genetic is monozygotic twin studies, and this approach has been used in Schizophrenia. One of the earliest studies was by Kallman⁵⁰, in 1938, which seemed to indicate impressive evidence of a genetic cause of Schizophrenia. Kallman found subjects who were both schizophrenic and one of a pair of monozygotic (truly identical) twins. He attempted to trace their

⁴⁸ Bentall, R. ed. (1990) Reconstructing Schizophrenia. Routledge. London.

⁴⁹ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

⁵⁰ Kallmann, F J. (1938) The Genetics of Schizophrenia. J Augustin. New York.

identical sibling to see if they, too, suffered from Schizophrenia. Monozygotic twins are the result of one fertilised egg that has split in two and therefore both twins are genetically identical. The higher the degree of correlation on a given trait or disorder between sets of twins, the higher the probability that the factor is genetic. The lower the correlation, the higher the probability of an environmental component. Kallman found a much higher than expected number of identical twins where both suffered from Schizophrenia and, though the results of later research were perhaps not as spectacular later studies, eg Kringlen (in Wynne, Cromwell and Matthysse ed⁵¹), Tienari et al⁵² and Fischer⁵³ all point in the same direction.

Are these twin studies capable of alternative explanation? Is there something special about being an identical twin, within the context of Schizophrenia, other than genetic identity? Cloninger states that rates of Schizophrenia in identical twins are not higher than found in the population as a whole, ie if you have an identical sibling who suffers from Schizophrenia, you are at much greater risk than if you had a non-identical sibling sufferer, but the mere fact of being an identical twin does not

⁵¹ Wynne, L C, Cromwell, R L and Matthysse, S ed. (1978). The Nature of Schizophrenia: New Approaches to Research and Treatment. Wiley. New York.

⁵² Tienari, P, Sorri, A, Lahti, I, Naarala, M, Wahlberg, K E, Pohjola, J and Moring J. (1985) "Interaction of Genetic Psychosocial Factors in Schizophrenia." Acta Psychiat Scand (Supplement). Vol. 71:19.

⁵³ Fischer, M. (1973) "Genetics and Environmental Factors in Schizophrenia." Acta Psychiat Scand (Supplement). Vol. 238:1.

increase the risk. However, two other biological models might account for these results.

There is much current interest in viral models; in particular, looking at unusual clusters of birth dates. The evidence for a viral model is explored in more detail in the next section, but the tentative interpretation of these unusual clusters is that there is a higher than expected rate of Schizophrenia amongst subjects whose second trimester of gestation coincided with the season and year of major Influenza epidemics. The suggestion is that the mother contracted the disease and passed it on to the foetus at a critical period of development and that the long term consequences might have been Schizophrenia or a predisposition to Schizophrenia.

What monozygotic twins share along with identical genes is, of course, identical chronicity of gestation and, at first sight, a viral model is as plausible an explanation of concordance of Schizophrenia in monozygotic twins as a genetic model.

Another way in which monozygotic twins are the same is in the experience of the intra-uterine environment and obstetric complications and problems. A major area of research in schizophrenic aetiology is obstetric complications. Higher than average rates are observed in the birth of subjects who later develop the disorder. Thus, if one twin suffers obstetric complication that might be related to later Schizophrenia there is a high probability that the other twin will also suffer. This

seems in line with the twin studies, though the suggestion that being twins in itself increases the risk of obstetric complication related to Schizophrenia seems to be contradicted by the non abnormal rate of Schizophrenia in monozygotic twins as a whole.

However, both these equally plausible explanations for high concordance rates amongst monozygotic twins seem not to be supported by studies such as Kringlen, Tienari et al and Fischer (referred to above) who showed marked differences between rates of Schizophrenia in monozygotic and same sex dizygotic twins. Dizygotic, fraternal twins are the result of two eggs fertilized at the same time. Genetically they are only as similar as any other full siblings, however, they share the same chronicity of gestation and the same intra-uterine environment as identical twins. Such Studies done in this area seem to show that dizygotic twins suffer a risk closer to ordinary siblings of concordance of Schizophrenia rather than a risk closer to monozygotic twins. This suggests that a genetic factor rather than obstetric complication or viral infection is the more likely explanation for the twin study results. However, the fact that the concordance rates for same sex dizygotic twins are still significantly higher than same sex non twin siblings suggests that there might still be a case for obstetric complication and/or viral explanations in some cases.

There are problems with the genetic model. If genetics is implicated in Schizophrenia, it cannot be by a simple Mendelian

route. If Schizophrenia is purely genetic why are not the identical siblings of all twin schizophrenics also schizophrenic? As Cloninger points out, if Schizophrenia is the result of a dominant gene why are not all the children of one schizophrenic parent also schizophrenic? If the gene is recessive, why are not the children of parents who are both schizophrenic always schizophrenic? Once again, the observations show that having a parent with Schizophrenia increases the risk of Schizophrenia but the evidence is against a simple Mendelian model. Supporters of a genetic approach, such as Cloninger, are obliged to take an interactionist approach, seeing the genetic component as providing the predisposition towards the disorder, but environmental factors, be they biological or psychological, as the necessary trigger factors for the disease to actually express itself.

This is probably as far as the epidemiological data can take us but, as Cloninger points out, new techniques allow the genetic mechanisms themselves to be examined themselves. At some point in the future, and perhaps the not too distant future, it should be possible to resolve once and for all if a gene, or combination of genes, is implicated in Schizophrenia.

This much is the orthodox position but in a thought provoking, though hardly impartial chapter, Marshall (in Bentall ed.⁵⁴) attacks the whole corpus of work in this area both

⁵⁴ Bentall, R. ed. (1990) Reconstructing Schizophrenia. Routledge. London.

philosophically and technically.

His first argument is that scientific research does not take place in a social and historical vacuum and quotes Bernal⁵⁵ to good effect:

"Often enough the ideas which statesman and divines think that they have taken from the latest phase of scientific thought are just the ideas of their class and time reflected in the minds of scientists subjected to the same social influence."

Marshall examines the background of Kallman and stresses the influence of Kallman's beliefs and background on his work. According to Marshall, Kallman's world view was shaped by the "zeitgeist" of Germany of the 1920's and 30's. Kallman supported eugenics and Marshall argues that his views can be seen as a continuation of Nineteenth Century views on the importance of heredity which, in turn, could be used as a "scientific" rationalisation for the social stratification of society. Understandably, though somewhat unkindly, Marshall brings in the case of Cyril Burt, the psychologist and alleged scientific fraud, who was another proponent of the importance of genetics. Burt argued that the class system mirrored real differences in ability, specifically intelligence, between the classes (presumably maintained by selective breeding within the classes). Marshall specifically states, however, that he is not accusing Kallman and others of fraud. What he is saying is that scientists are likely to select their areas of research in line with their pre-existing beliefs and that unwittingly (though in the case of

⁵⁵ Bernal, J D. (1965) Science in History. C A Watts. London. Page 93.

Burt, perhaps wittingly) they may be selective in their treatment of findings. He also argues that the pre-existing beliefs are much likely to be social, historical and political than scientific in origin.

On a technical level, Marshall criticises Kallman and subsequent studies. He cites the usual argument about early twin studies that insufficient care was taken to diagnose true monozygosity (briefly, that dizygotic same sex twins often do look identical and more reliable evidence such as examination of the placenta and, today, genetic fingerprinting, should be used to back up mere visual impression). The author is not sure how much this argument supports Marshall's case against genetics. The classification error that researchers are likely to make in the absence of reliable data on monozygosity is to misclassify dizygotic twins as monzygotic and, to a much lesser extent, to misclassify true monozygotics as dizygotics. If heredity is irrelevant, misclassification will make no difference, but if it is relevant then the effect of misclassification would be to flatten out the differences in concordance between monozygotic and dizygotic twins, and it is this difference, as has been mentioned above, that argues the case for genetic rather than viral or obstetric complication explanations. In short, had Kallman and others been more rigorous, the case for genetics might have been stronger!

More significant are the criticisms that in Kallman's study the diagnosis of Schizophrenia was carried out by Kallman himself and

was not double-blind. Indeed, Kallman was to maintain later that a diagnostic criterion for true Schizophrenia was a family history of the disorder.

A similar criticism is that twin studies have shown a tendency to compound the already difficult business of setting diagnostic criteria for Schizophrenia by being over-inclusive, by including borderline states and other psychotic disorder. To replicate the early studies requires finding identical twins, who have been raised separately, where both twins can be traced and where one or both suffer from accurately diagnosed Schizophrenia. All these events are low probability events in themselves, particularly now where less stigmatization of illegitimacy means that fewer children are adopted and certainly fewer twins are likely to be separated. To find any subjects would be an achievement in itself and, increasingly, one must rely on small scale, less reliable, studies. The temptation to broaden the classification of illness to increase subject numbers must be enormous.

Marshall's final criticism of such studies is that sometimes the rate of concordance has been inflated by twins being counted twice when both are schizophrenic.

Viral Models of Schizophrenia

Some of the facts suggestive of a viral model of Schizophrenia have already been reviewed above. Briefly, Hare's "slow epidemic"

hypothesis, suggesting reasons for the increase in insanity in the Nineteenth Century, is supported by careful analysis of contemporary statistics that argues for a real rather than apparent increase. The changing nature of insanity during the period from a disorder not usually found among young adults to a disorder mainly of young adults suggests that, to a large degree, this increase could be accounted for by "Dementia Praecox" - Schizophrenia. As Hare⁵⁶ has shown, two observers, in the Eighteenth and in the Nineteenth Centuries, had even suggested that insanity might be linked to Influenza. It is interesting to note that some writers such as Der, Gupta and Murray⁵⁷ argue that Schizophrenia is now declining and, by implication, the epidemic has passed its peak.

If Hare is correct, then the epidemiological data, over time, is supportive of a viral model of Schizophrenia. The data, in terms of geographical spread, is, if anything, more problematic. The current view on the distribution of Schizophrenia is that the disorder is fairly evenly spread in all cultures throughout the world with the exception of certain small "hot spots"; northern Sweden, western Ireland and Croatia and "cold spots"; Micronesia and Papua-New Guinea. In fact, such circumscribed hot and cold spots provide some small support for a genetic model. However, has this near evenness always been present? The problem is that many early studies with newly contacted communities hardly

⁵⁶ Hare, E. (1983) "Was Insanity on the Increase?" British Journal of Psychiatry. Vol. 142, pp 439-455.

⁵⁷ Der, G, Gupta, S and Murray, R M. (1990) "Is schizophrenia disappearing?" The Lancet. Vol. 335 pp 513-516.

reported insanity as an issue at all in contrast with recent studies of the same communities. The traditional view is that early travellers and anthropologists either failed to notice, or did not look for, signs of insanity (and in particular Schizophrenia) in these communities. However, an equally plausible, though ultimately probably untestable hypothesis, is that Schizophrenia is an infectious or contagious disease, introduced, like Syphilis and Measles, to unsuspecting isolated communities by European travellers.

So much is speculation, but what we do seem to be seeing is both a change in the ratio of type of Schizophrenia and a decrease in severity. As far as the latter observation is concerned, it is undoubtedly difficult to disentangle a hypothesised decrease in vehemence of the disease from improved treatment, although in the former case most workers within mental health are aware of the marked decline in the numbers of hebephrenic and catatonic people with Schizophrenia (see Templer and Veleber⁵⁸, Achte and Taylor⁵⁹ and Morrison⁶⁰). Why should two such distinctive subtypes of a disorder simply decline in numbers? Is this a sign of epidemics that have run their course, or a population that has developed an immunity?

⁵⁸ Templer, D I and Veleber, D M. (1982) "The Decline of Hebephrenic Schizophrenia." Journal of Orthomolecular Psychiatry. Vol. 11 No. 2 pp 100-102.

⁵⁹ Achte, R and Taylor, M A. (1976) "Catatonia: a prospective clinical study." Archives of General Psychiatry. Vol. 33 pp 579-581.

⁶⁰ Morrison, J R. (1974) "Changes in subtype diagnosis of schizophrenia 1920-1966." American Journal of Psychiatry. Vol. 131 pp 674-677.

Another argument in support of a viral model is the small but still significantly greater number of winter births among people with Schizophrenia, and also births subsequent to major Influenza epidemics (see Barr, Mednick and Munk-Jorgensen⁶¹ and Wyatt, Kirsch and DeLisi in Kaplan and Sadock ed⁶²). The model suggested is that Influenza or an Influenza type infection infects the mother, then the foetus, at a particularly vulnerable time, the second trimester, causing neurological damage that will function as a neurological time-bomb when the subject reaches early adulthood.

The real problem with the viral hypothesis is the lack of any clear evidence for the existence of the virus itself, though the difficulties of finding such a virus, if it did exist, should not be underestimated. A number of forms of viral encephalitis produce symptoms similar to Schizophrenia including AIDS Encephalitis, which has provoked interest in retro viruses in this area, though this is still a subject of great controversy.

Schizophrenia and Afro-Caribbeans

Schizophrenia is more commonly found in poorer communities. In this country there is concern that persons of Afro-Caribbean

⁶¹ Barr, C E, Mednick, S A and Munk-Jorgensen, P. (1990) "Exposure to Influenza Epidemics During Gestation and Adult Schizophrenia." Archives of General Psychiatry. Vol. 47 pp 869-874.

⁶² Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

origin and persons from lower socio-economic groups are over represented among the schizophrenic population. Such observations must be interpreted with care. Schizophrenia is a known impoverishing disease and care must be taken to ascertain socio-economic grouping before onset of the disease. Even so, can one interpret the association between poverty and Schizophrenia as part of the well observed relationship between infectious disease and poverty; disease exacerbated by overcrowding, poor diet, poor hygiene facilities and close contact with others caused by greater reliance on public transport?

There is, of course, great controversy as to whether Schizophrenia observed in some Afro-Caribbeans is true Schizophrenia or not. Even if the high rate is truly due to Schizophrenia, can this be explained by the relationship between immigrant status plus racial prejudice and poverty, and therefore, disease? Alternatively, do Afro-Caribbeans have a lower rate of resistance to a hypothesised Schizophrenia virus contracted in this country?

The subject of higher than average rates of Schizophrenia amongst Afro-Caribbeans is both a complex and a controversial one. As Littlewood and Lipsedge⁶³ in their review of the literature point out, the consistent finding is that Schizophrenia is far more common in Britain among persons who are of Caribbean or West African ancestry than in the host population. Other studies

⁶³ Littlewood, R and Lipsedge, M. (1981) "Some social and phenomenological characteristics of psychotic immigrants." Psychological Medicine. Vol. 11 pp 289-302.

(Royes⁶⁴ and Burke⁶⁵) seem to show that the rates of Schizophrenia in the Caribbean region itself approximates to that of the population of the United Kingdom. What, then, is special about being a Caribbean or West African immigrant to this country? Arguments fall, crudely, into two camps; the social that emphasises the importance of being on the receiving end of discrimination, and the biological that asks whether there is something special about these immigrant groups and the nature of their psychosis.

The social argument, put most strongly by writers such as Burke⁶⁶, can further be divided into two main arguments that are not mutually exclusive. The first states that overt and covert racism pervades the encounters of Afro-Caribbeans with figures of authority and that this leads their behaviour to be misidentified in the first instance, perhaps leading to excessive reaction by the police including Section 136 place of safety orders, and that in terms of psychiatric examination and diagnosis they tend to receive as cursory and second rate a standard as they do in other medical disciplines. The author finds this argument quite powerful as an explanation of why Afro-Caribbeans are over-represented as detained patients and as patients in secure facilities but finds it less compelling as an

⁶⁴ Royes, K. (1962) "The incidence and features of psychoses in a Caribbean community." Proceedings of the Third World Congress of Psychiatry 1961, Montreal. Vol. 2 pp 1121-1125.

⁶⁵ Burke, A W. (1974) "First admission and planning in Jamaica." Social Psychiatry. Vol. 123 pp 109-111.

⁶⁶ Burke, A W. (1974) "First admission and planning in Jamaica." Social Psychiatry. Vol. 123 pp 109-111.

explanation for why presumably sane Afro-Caribbeans might be misdiagnosed as insane people with Schizophrenia rather than being treated as deviant in some other way. The second argument is that the stress of being an immigrant in a hostile and racist host country is somehow implicated in the onset of the illness as a stress factor.

From the more conventional psychiatric approach comes the idea that what we may be seeing in many cases of so called Schizophrenia in Afro-Caribbeans is a true psychotic disorder but one that may not be the Schizophrenia seen in the host population, or may not even be Schizophrenia at all! The sort of figures quoted by authors such as Littlewood and Lipsidge (having adjusted for factors that are known to be associated with the disorder such as gender, age and marital status) of a composite rate in West Indians of three times that of the host population may mask an under reporting of affective disorder. Interestingly, the rates for Asian immigrants tend to be somewhere between that of Afro-Caribbeans and the host population. That a number of cases in this group show acute onset coupled with rapid recovery and good long term prognosis seems to point to a different form of psychosis. This strikes some accord with the social argument in stressing the need for informed and sensitive assessment of such persons for correct diagnosis. Certainly, there needs to be a greater cultural awareness in assessing religious or paranoid components to a disorder in a group that may genuinely be more religious and genuinely might be subject to persecution.

Various studies have attempted to look at the rates of psychosis in non Afro-Caribbean immigrants. The evidence for higher than average rates of Schizophrenia in Irish immigrants to Britain conflicts with Bagley⁶⁷ by showing a difference between this group and the host population. It is significant that Cochrane⁶⁸ showed none. Krupinski⁶⁹ found high rates in European immigrants to Australia but Cochrane only found that some European immigrants to Britain showed higher than average rates compared with the host population. Proponents of the genetic approach might argue that immigration from known "hot spots" i.e. western Ireland and Croatia might as well account for these results, as might the experience of being an immigrant.

Writers like Littlewood and Lipsedge and Harrison, Owens, Holton, Neilson and Boot⁷⁰ review Ødegaard's⁷¹ negative selection model. This model attempts to explain the high rates in Afro-Caribbeans in Britain as being the result of those with problems, perhaps with incipient psychosis, tending to emigrate more readily

⁶⁷ Bagley, C. (1971) "The social aetiology of schizophrenia in immigrant groups." International Journal of Social Psychiatry. Vol. 17 pp 292-304.

⁶⁸ Cochrane, R. (1977) "Mental illness in immigrants to England and Wales." Social Psychiatry. Vol. 12 pp 25-35.

⁶⁹ Krupinski, J. (1967) "Sociological aspects of mental ill-health in migrants." Social Science and Medicine. Vol. 1 pp 267-281.

⁷⁰ Harrison, G, Owens, D, Holton, A, Neilson, D and Boot, D. (1988) "A prospective study of severe mental disorder in Afro-Caribbean patients." Psychological Medicine. Vol. 18 pp 643-657.

⁷¹ Ødegaard, Ø. (1932) "Emigration and insanity. study of mental disease among Norwegian population of Minnesota." Acta Psychiatrica et Neurologica. Supplement 4, pp 1-206.

leaving their more content and mentally fitter countrymen and women behind.

The problem with this approach is that studies such as Ratcliffe⁷² and Walvin⁷³ seem to indicate that those who immigrated to this country tended to be the more, rather than the less, adapted members of society. The model can only be plausible in current circumstances if one presupposes that Schizophrenia is genetic, as current studies are increasingly based on second and third generation immigrants.

Finally, the author finds himself agreeing with Harrison et al⁷⁴ when they say:-

We remain extremely cautious, however, in interpreting our findings, because reported variations in rates of schizophrenia have been recruited enthusiastically by many authors in support of their favoured aetiology."

Harrison et al⁷⁵ recommend that:-

"Similarly, potential biological differences in terms of genetic factors, neuro-chemistry, pre-and perinatal trauma, virology and immunology merit further

⁷² Ratcliffe, P. (1981) Racism and reaction: a profile of Handsworth. Routledge and Kegan Paul. London.

⁷³ Walvin, J. (1984) Passage to Britain. Harmondsworth. Middlesex.

⁷⁴ Harrison, G, Owens, D, Holton, A, Neilson, D and Boot, D. (1988) "A prospective study of severe mental disorder in Afro-Caribbean patients." Psychological Medicine. Vol. 18 pp 643-657. Page 654.

⁷⁵ Harrison, G, Owens, D, Holton, A, Neilson, D and Boot, D. (1988) "A prospective study of severe mental disorder in Afro-Caribbean patients." Psychological Medicine. Vol. 18 pp 643-657. Page 655.

investigation in relation to high rates of schizophrenia reported here, as well as attention to the possible effects of living in inner-city decaying areas with high unemployment and poor housing."

Obstetric Complication and Schizophrenia

The rationale behind obstetric complication models is based on the following observations. As noted above, Schizophrenia is associated with neurological damage and abnormalities but recent research, reviewed by Lewis⁷⁶, has shown that such damage tends not to be progressive and degenerative and can be detected within weeks of the first breakdown. To date, the sort of technical, ethical and cost factors reviewed above have prevented a predictive study to see if such damage and abnormalities pre-date the onset of illness. Such reasoning has opened up speculation that the neurological damage seen in Schizophrenia may pre-date greatly the onset of the illness and may even pre-date birth. The suggestion is that neural maturational processes have to occur before pre-existing damage expresses itself at all, or at least to a clinical degree. Lewis (ibid) points out the commonplace observation that those who suffer from Schizophrenia frequently are reported to have shown minor oddness and peculiarities of character before the disorder manifests itself.

To countenance such a model requires us to re-evaluate our common sense notion of early neurological damage and its expression. Lewis points out that adult psychiatry has suffered from a lack

⁷⁶ Lewis, S W. (1989) "Congenital risk factors for schizophrenia." Psychological Medicine. Vol. 17 pp 5-13.

of contact with child psychiatry where notions of delayed and unusual expression of congenital and long standing neurological damage are accepted as commonplace. Prior, certainly, to the introduction of the CT scan, most of what was known of the repercussion of obstetric complication was known from post-mortem studies, leading to the conclusion that obstetric complication either led to neurological damage of a catastrophic dimension or not at all. With CT and other techniques, it is now clear that neural damage due to obstetric complication is far more common than hitherto supposed and that although the effects can still be serious in some cases, in other cases the effects can be delayed or there may be no apparent effects at all. This, in turn, requires a review of the so-called "Kennard principle", (see Kennard⁷⁷), which states that the immature brain has the power to both heal and re-organise after damage, though this is not true of the mature brain. In fairness to Kennard, it should be pointed out that she, too, was aware that such damage could have effects that were not apparent or did not express themselves till much later. Such damage as does occur can often be associated with critical periods. Otake and Schull⁷⁸ examining the records of the learning disabled born in Hiroshima shortly after the atomic explosion found a high number of individuals where irradiation had occurred during the eighth to the fifteenth week of gestation. It is worth mentioning, once again, that

⁷⁷ Kennard, M A. (1936) "Age and other factors in motor recovery from precentral lesions in monkeys." American Journal of Physiology. Vol. 115, pp 138-146.

⁷⁸ Otake, M and Schull, W J. (1984) "In utero exposure to A-bomb radiation and mental retardation: a reassessment." British Journal of Radiology. Vol. 57, pp 409-414.

studies have attempted to link both Influenza epidemics and season of birth coinciding with the second trimester with Schizophrenia.

Lewis (ibid) points out that there is growing interest in the period of brain development associated with consolidation of connections of the neurons. Originally, it was felt that damage occurring during this period would logically be associated with the destruction and loss of neurons. What is interesting and paradoxical is that the reverse is true. The model that now seems correct is that during foetal growth there is a proliferation of neurons and interconnections, followed, in the healthy and normal brain, by a period of natural dying off of significant numbers of neurons and the destruction of interconnections. Research has shown (see Rakic and Riley⁷⁹) that the areas surrounding damaged parts of the brain retain their immature neurons and connections and it is argued that such cerebral immaturity may only be expressed when that part of the brain "comes on line" at specific point of development. It remains to be seen what the implications of this are for Schizophrenia.

One of the major problems of research in this area is establishing if there was, and if so, in what form, the obstetric complication occurred. Frequently, hospital records may not be available and one must rely on the family for evidence.

⁷⁹ Rakic, P and Riley, K P. (1983) "Regulation of axon number in primate optic nerve by prenatal binocular competition." Nature. Vol. 305, pp 135-137.

O'Callaghan, Larkin and Waddington⁸⁰ have demonstrated a very high degree of concordance between hospital records of obstetric complication and mothers' reports though this still does not address the problem of accuracy in the hospital record itself, which coupled with the problems of definition and diagnosis of Schizophrenia itself could blur the issue.

It should be said that obstetric complication as a category of explanation is not mutually exclusive to other explanations such as viral models.

An Overview of Biological Models of Schizophrenia

From the earliest post-mortem studies to the use of the latest techniques such as MRI and CT scan, there is a consistent thread of evidence to suggest that Schizophrenia is associated with low levels of brain damage. Evidence for specific localisation of this damage is less clear, though what little evidence there is suggests that the damage is present from the earliest point of onset of the disorder. Technical, cost and safety aspects have, hitherto, prevented prospective studies of a sample of the general population to explore whether such damage is present prior to onset of the disorder. Recent dynamic studies of differences in brain function in normal and schizophrenic subjects also point to a biological disorder. To a certain extent, this is consistent with the observed deficits of people

⁸⁰ O'Callaghan E, Larkin, C and Waddington, J L. (1990) "Obstetric complications in schizophrenia and the validity of maternal recall." Psychological Medicine. Vol. 20, pp 89-94.

with Schizophrenia.

The fact that neuroleptic medication is effective in most cases in controlling the positive, though not the negative, symptoms of Schizophrenia is also suggestive of a biological disorder, as are the pronounced peaks of age of onset of the disorder and differences in peaks between male and female sufferers. The author also finds compelling the notion that Schizophrenia might be a disorder of modern times, growing both in numbers and virulence in the Nineteenth Century and perhaps gradually declining in the Twentieth Century. The decline and near disappearance of certain subtypes of the disorder such as hebephrenic and catatonic subtypes are also interesting and are suggestive of an epidemic that has run its course.

The problem remains that although all the biological models reviewed above explain some of the phenomena associated with the disorder, no one model completely explains all the findings. This is a problem as long as one assumes that Schizophrenia is, as in Kraepelin's view, a single unitary biological disorder. It is, however, better to view Schizophrenia as a syndrome, a set of symptoms that can have several causes.

It should also be remembered that many of the models reviewed are not mutually exclusive. Intra-uterine infection and obstetric complication may be linked. In the context of retro-viruses, infection and genetic inheritance may also be linked. Dopamine models and variants thereof, and alternative models might all be

accommodated within other models of causation.

Almost as intriguing as the disorder itself is the phenomenon that, for most of the Twentieth Century alternative social and psychological explanations have commanded such an important place despite the indicators that Schizophrenia, be it one or many disorders, is clearly of biological origin. Although much of the research quoted above is recent, and the impact of new techniques such as MRI and CT scan cannot be underestimated, it can also be argued that many parts of the jigsaw have been in place for some time. The most impressive (though, as discussed above, controversial) evidence for a genetic model dates back to 1938. Menninger⁸¹, following his experience of psychosis attributable to encephalitis lethargica, felt that this provided a strong analogue of Schizophrenia and made a viral explanation of the latter disorder quite probable. Bleuler⁸² himself, who more than any one person introduced a psychodynamic explanation of the disorder, accepted that some forms of Schizophrenia were endogenous - of organic origin.

In the next section, the author will explain why, despite the strong evidence against such explanations, social and psychological models did gain such ground. To do this it will be

⁸¹ Menninger, K A. (1994, originally published 1925)"Influenza and Schizophrenia. An Analysis of Post-Influenzal "Dementia Precox," as of 1918, and Five Years Later. Further Studies of the Psychiatric Aspects of Schizophrenia." American Journal of Psychiatry. Vol. 151 Sesquicentennial Supplement.

⁸² Bleuler, E. (1924) Textbook of Psychiatry. Translated A A Brill. Macmillan. New York.

necessary to set out such models in their chronological order and then to place them in their social and historical context.

THE FAMILY AND SCHIZOPHRENIA

Eugen Bleuler's Attempt at Synthesis

To understand how Schizophrenia, an apparently organic disorder, was ever felt to have a psycho-social aetiology and, specifically, a familial aetiology, one must look closely at the work of Bleuler and what he was trying to achieve. The influence of Bleuler has been briefly alluded to above; to his credit, for considering that Schizophrenia may not be one but many disorders, and to his discredit, for developing a definition of Schizophrenia so wide as to be almost meaningless.

Stierlin⁶⁸ has explained how, in the context of Schizophrenia, Bleuler attempted to reconcile two irreconcilable traditions within German speaking psychiatry; Kraepelin's organic model of dementia praecox and the psychoanalytical model of mind as proposed by Freud and his followers. Without the benefit of later scholarship (such as Sand⁶⁹) Stierlin argues that Bleuler was attempting to reconcile the main stream of conventional psychiatry in the form of Kraepelin and the radical new wave in the form of Freud. In reality, as Sand was later to point out, Freud's theory is striking in its un-originality and can be seen

⁶⁸ Stierlin, H. (1967) "Bleuler's Concept of Schizophrenia: A Confusing Heritage." American Journal of Psychiatry. Vol. 123 8th February, pp 996-1001

⁶⁹ Sand, R. (1988) "Early Nineteenth Century Anticipation of Freudian Theory" International Review of Psycho-Analysis. Vol. 15, pp 465-479.

as being merely the continuation of a philosophical-psychological tradition in the German-speaking world. Evidence for this will be reviewed later. Thus, what Bleuler was trying to do was not to reconcile the old with the new, the radical with the traditional, but to reconcile two great traditions of which, if anything, the newest and most radical was Kraepelin's. Let us now look in more detail at both these traditions.

As Berrios and Hauser ⁷⁰ have pointed out: "Psychiatry still lives in a Kraepelinian world..." and this is certainly true within the context of Schizophrenia. Their paper provides a useful insight into the social and philosophical context of Kraepelin's views and methods. As they point out, Kraepelin spent the first forty years of his life in a Germany dominated by the vision of Bismarck. Kraepelin was an admirer of Bismarck and was professionally successful in a world dominated by the new German values. Such values extended into the world of psychiatry, and Pauley⁷¹ has explained the dominance of localisation theories in Germany at that time, as supported by Kraepelin, in terms of mirroring the tidy, organised, bureaucratic Bismarckian state. At the same time, Kraepelin and his colleagues in the latter half of the Nineteenth Century were stung by the twin criticisms of failure to find clear organic traces associated with many mental

⁷⁰ Berrios, G E and Hauser, R. (1988) "The early development of Kraepelin's ideas on classification: a conceptual history." Psychological Medicine. Vol. 18, pp 813-821.

⁷¹ Pauley, P J. (1983) "The political structure of the brain: cerebral localization in Bismarkian Germany." International Journal of Neuroscience. Vol. 21, pp 145-149.

diseases, and the legacy of Kant's dictum that psychology could never be a true science since it could not quantify its subject matter. It is worth remembering that Kraepelin had studied experimental psychology under Wilhelm Wundt and was thus well aware of the emerging methodologies that were being used to refute Kant's views on psychology.

Kraepelin was also influenced by Karl Kahlbaum, who saw a flaw in the static view that psychiatry took of symptoms and disorders. Kahlbaum argued that the course of a disorder was an important factor in classification and diagnosis. He argued for a long-term empirical study of the progress of mental disease and stated that the disease's essence was to be found in its natural history. In fact, this is precisely the plan that Kraepelin was to put into effect, and which led to the development of the concept of dementia praecox. Before we look at the study itself, however, two more chance influences should be examined.

Between 1886 and 1891, when Kraepelin was appointed to the chair at Heidelberg, he held the Chair of Psychiatry at the University of Dorpat, now Tartu, in Estonia (then part of the Russian empire). Under German legislation, all psychiatric patients had to be held under the equivalent of our modern "section"; under Russian law, informal patients could be admitted to clinics and hospitals. As a result, the move to Dorpat exposed Kraepelin to a cohort of patients that included more milder and newer cases than were to be found in German institutions. Additionally, German speakers were in the minority in the area and the

difficulties and frustrations of carrying out psychiatric interviews via an interpreter led Kraepelin to concentrate on the behavioural signs of insanity.

Kraepelin's great longitudinal study was started following his move to Heidelberg. Shortly after admission, all patients at the University clinic were given a diagnosis and prognosis and subjected to follow up study. The results were stored on specially developed file index cards. The results of his study led Kraepelin to conclude that, in a large number of cases, regardless of variety of earlier symptoms, all patients ended in a state of dementia - dementia praecox.

The legacy of Kraepelin to Bleuler and modern psychiatry was one of providing a model of a disorder founded in a tradition that stressed an organic approach to mental disorder and which favoured a localisation of function approach. His research methods were empirical and statistical, and his research demonstrated the importance of the course of the disease as a crucial diagnostic factor, though a course which pointed to therapeutic pessimism. Previous diagnostic categories (e.g. hebephrenia and catatonia) were seen as being part of a temporal continuum.

All this Bleuler⁷² accepted, and he viewed Schizophrenia as being a progressive organic disorder similar to Alzheimer's

⁷² Bleuler, E. (1924) Textbook of Psychiatry. Translated A A Brill. Macmillan. New York.

disease. What Bleuler found difficult to accept from his contact and knowledge of Freud's and Jung's approach was that the content of what he called "autistic thinking" found in people with Schizophrenia was "meaningless", as might be implied by a purely organic model. Unlike Kraepelin in Dorpat, he spoke the same language as his patients and he was struck by the similarities between the content of schizophrenic hallucinations and delusions and the content of experiences of normal people in certain states, most obviously dreaming. Bleuler turned to a psychoanalytical approach to help him make sense of schizophrenic thinking.

Freud's contribution to Bleuler's thinking on Schizophrenia can be divided into the former's views specifically on the disorder itself, limited by Freud's own slight experience of Schizophrenia, and the more important general model of mind that Freud espoused.

What Freud had to say specifically about Schizophrenia has been described by London⁷³, Freeman⁷⁴ and Ping-Nie Pau⁷⁵ and can be briefly summarised as follows. Ping-Nie Pau describes the three

⁷³ London, N J. (1973) "An essay on psychoanalytic theory: Two theories of schizophrenia. Part 1: A review and critical assessment of the development of the two theories." International Journal of Psycho-Analysis. Vol. 54, pp 169-178.

⁷⁴ Freeman, T. (1977) "On Freud's theory of schizophrenia." International Journal of Psycho-Analysis. Vol. 58, pp 383-388

⁷⁵ Ping-Nie Pao. (1973) "Notes on Freud's theory of schizophrenia." International Journal of Psycho-Analysis. Vol. 54, pp 469-476.

phases in the development of Freud's thinking on Schizophrenia.

In the first phase, developed in the 1890's, Freud⁷⁶ stated that both neurosis and psychosis were defence mechanisms against repressed ideas, but the difference lay in the type of defence mechanism used; in neurosis conversion and substitution but in psychosis Paranoia, projection.

In his second phase, from the late 1890's to the early 1920's, Freud^{77,78,79,80,81,82} argued that Paranoia should be considered

⁷⁶ Freud, S (1963). The Neurosis of Defence, Volume 3. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁷⁷ Freud, S (1963) On Narcissism. Volume 14. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁷⁸ Freud, S (1963) The Unconscious. Volume 14. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁷⁹ Freud, S (1963) A Metapsychological Supplement to the Theory of Dreams. Volume 14. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸⁰ Freud, S (1963) A Case of Paranoia Running Counter to the Psycho-Analytical Theory of the Disease. Volume 14. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸¹ Freud, S (1963) Introductory Lectures on Psycho-Analysis. Volumes 15-16. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸² Freud, S (1963) Some Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality. Volume 18. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J

as similar to but separate from Schizophrenia. Both were caused by fixation of libidinal development; in the case of Paranoia at the narcissistic stage but in the case of Schizophrenia at the autoerotic stage. He argued that the fixation was the result of conflict; in the case of Paranoia associated with homosexual wish-fulfilment but in the case of Schizophrenia homosexuality may or may not be implicated. In this model, when conflict occurs in the case of both Schizophrenia and Paranoia, libidinal attachment is withdrawn from people in the environment (and the world in general) and the libidinal attachment is to the ego. In Schizophrenia, the detachment of the libido is equivalent to repression and an attempt is made at reconstruction to bring the libido back. In the case of Paranoia, the process is similar via the mechanism of projection. The hallucinations of Schizophrenia are seen as the process of attempted recovery. As a result of the libidinal withdrawal, Freud argued that in both the cases of Paranoia and Schizophrenia transference could not take place and, therefore, psychoanalysis would prove ineffectual.

In the third phase dating from the early 1920's to Freud's death, Freud^{83, 84, 85, 86, 87, 88, 89, 90, 91, 92} argued that neurosis and

and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸³ Freud, S (1963) The Ego and the Id. Volume 19. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸⁴ Freud, S (1963) Neurosis and Psychosis. Volume 19. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

psychosis have a common origin when the ego is in conflict with the id, superego and reality. If the ego remains dependant on the external world and attempts to silence the id, then neurosis occurs. If, however, the id overcomes the ego then psychosis occurs. Later, Freud modified his views explaining the difference between neurosis and psychosis in terms of splitting, that is the co-existence of contradictory ideas that may be a precondition

⁸⁵ Freud, S (1963) The Loss of Reality in Neurosis and Psychosis. Volume 19. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸⁶ Freud, S (1963) Negation. Volume 19. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸⁷ Freud, S (1963) Inhibitions, Symptoms and Anxiety. Volume 20. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸⁸ Freud, S (1963) the Question of Lay Analysis. Volume 20. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁸⁹ Freud, S (1963) Fetishism. Volume 21. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁹⁰ Freud, S (1963) Moses and Monotheism. Volume 23. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁹¹ Freud, S (1963) An Outline of Psycho-Analysis. Volume 23. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

⁹² Freud, S (1963) The Splitting of the Ego in the Process of Defence. Volume 23. The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

of psychosis.

In all these changing ideas on Schizophrenia, there is one obvious difference between Kraepelin and Freud. Kraepelin talks of the body, specifically the brain, whereas Freud talks of the mind. To Bleuler, the problem of reconciling these two perspectives in the context of Schizophrenia was a real problem. How Bleuler attempted to do so is described below.

It did not pose a problem for Freud that no serious suggestion was made to link the id or the ego or the superego to neuroanatomy. At some unspecified point in the future, the biological basis for his theories would be discovered but the discovery of such biological mechanisms seemed not to be a matter for urgency. At first sight, this may seem strange, bearing in mind that Freud first practised as a neurologist but is less strange if one sees Freud not as the first of a new tradition but one of the last in a long line of philosopher psychologists in the German intellectual tradition. This tradition pre-dates Kraepelin and the new experimental psychology of Wundt, and there is some evidence that this tradition might have been the primary influence on the young Freud long before he studied Neurology.

Peters⁷⁵ has outlined the debt that Freud and post-Freudians, such as Jung, owe to German Romantic psychiatry. He stressed how,

⁷⁵ Peters, U H (1990) Studies in German Romantic Psychiatry: Justinus Kerner as a Psychiatric Practitioner and E T A Hoffman as a Psychiatric Theorist. Bithell Memorial Lectures. Institute for Germanic Studies. University of London.

in that movement, the world of the artist and of the psychiatric physician met and influenced each other. Peters reviews the work of two authors in that tradition, the physician and poet Kerner and Hoffman, the lawyer, who combined a particular interest in forensic psychiatry with musical composition, writing and painting (Hoffmann is now mainly remembered through Offenbach's opera). Both Freud and Jung followed in the tradition of psychiatrist as polymath, as did R D Laing, the talented amateur musician with literary pretensions, whose work is reviewed later and owes much to the Romantic tradition.

Peters considers the origins of German Romanticism to be in English literature, and, in particular, cites the influence of Edward Young's "Night Thoughts"⁷⁶ - a central concept that was to emerge in the German school was "Nachtseite". This concept is difficult to render succinctly into English and Peters uses the term "nocturnal side" and employs the metaphor of that part of the Earth which is turned away from the sun and illuminated by the Moon. In man, the nocturnal side is always present just as that part of the globe illuminated by moonlight is present when the other half is illuminated by sunlight. The Nachtseite was the primal source of all that is creative, but it was also associated with animal magnetism (Kerner was a biographer and supporter of Mesmer), somnambulism, madness, divining, clairvoyance, ecstasy and death and the grave. Freud's concept of the unconscious, and Jung's concept of the shadow self, owe much to the concept of the

⁷⁶ Young, E (1989, first published 1742) The Complaint or Night Thoughts on Life, Death and Immortality. Cambridge University Press. Cambridge, UK.

Nachtseite.

In fact, many of the elements of the Nachtseite predate Young. Yates⁷⁷ has attempted to elucidate the symbolism of George Chapman's poem "Shadow of Night" published in 1594. Yates sees Chapman as attempting to defend the Renaissance occult philosophy of Agrippa and Dee against the attack of Marlowe's "Doctor Faustus" and the wider Catholic Reformation in Europe. In Chapman's poem, melancholia and the saturnine are referred to as the humour of the night but cast in a positive sense, in opposition to the frivolity and sensuality of the day. The night humour is associated with high seriousness and the quest for spiritual and scientific enlightenment. Yates establishes links with Dürer's engraving of Melancholia I and the influence of this engraving on Robert Burton⁷⁸.

The Nachtseite always co-existed with ordinary life and sometimes impinged upon it, but because the Nachtseite was associated with positive as well as negative experiences, the mad - those temporarily or permanently dominated by this side were not viewed negatively from this perspective. Peters quite rightly sees a link between Laing's later view of the transcendental and visionary nature of the schizophrenic experience and the German Romantic view. The German Romantic psychiatrists were also

⁷⁷ Yates, F. A. (1979) The Occult Philosophy in the Elizabethan Age. Routledge and Kegan Paul. London.

⁷⁸ Burton, R. (1977, first published 1621) The Anatomy of Melancholy. J M Dent. London.

influenced by the humane reforms of Tuke and Pinel; the theoretical response, from this perspective, towards the mad would be to cherish rather than reject (though the reality was often different).

The concept of duality was of great importance, as shown by the pre-occupation with shadow or double selves, doppelgangers, and what we would now refer to as multiple personality (immortalised in Stevenson's "The Strange Case of Dr Jekyll and Mr Hyde"). Although it cannot be over stressed that multiple personality (if such a thing truly exists!) is different from Schizophrenia, the idea of a shadow self that occludes the normal self has had an important influence both on German and, later, international psychiatry.

The pre-occupation with Nachtseite and its morbid elements was not without its critics. Goethe condemned the more fanciful works of Hoffmann as likely to lead to madness itself, ironic as Goethe himself had been criticised for romanticising suicide in "Werther". Kant also regarded introspection in pursuit of the Nachtseite to be unhealthy. As Ackernecht⁷⁹, in his introduction to the facsimile reproduction of the 1867 English edition of Griesinger's "Mental Pathology and Therapeutics", points out, the battle raged in German psychiatry between the organic "somaticists" and the romantic "psychicists". Griesinger was exiled, for political reasons, for a period in France and

⁷⁹ Griesinger (1965) Mental Pathology and Therapeutics. A Facsimile of the English Edition of 1867. Hafner. New York.

Switzerland. He proclaimed himself a devout somaticist and anti-romantic, condemning romantic psychiatry as a "brilliant sounding, fantastic swindle." He is most famous for his saying: "mental diseases are brain diseases". Despite these unequivocal statements, his very influential textbook is an attempt to reconcile the two traditions (as Bleuler was also to attempt to do later). Griesinger did this under the influence of Herbart who, in turn, was a significant influence on Freud.

In her paper, "Early Nineteenth Century Anticipation of Freudian Theory", Sand⁸⁰ explores the ideas that could have influenced the young Freud. Sand argues that Freud was probably aware of the model of mind developed by the philosopher/psychologist Johan Herbart (pre-dating Freud's) and which bears, in a number of important aspects, a remarkable similarity to Freud's own. She argues that while still a "Gymnasium" student, Freud may well have come across a book by Adolf Lidner, "Lehrbuch der empirischen Psychologie nach genetischer Method" (Textbook of Empirical Psychology by Genetic Method) published in 1858. This textbook was both approved and authorised for school use in Germany and Austria. The importance of this textbook is that it proposed an essentially Herbartian model of mind. Certainly, Freud was aware of Herbart in later life; Sand refers to a conversation reported between Freud and his friend, Silberstein, after they had both attended a lecture by the philosopher, Brentano, in which Brentano was highly critical of Herbart.

⁸⁰ Sand, R. (1988) "Early Nineteenth Century Anticipation of Freudian Theory." International Review of Psycho-Analysis. Vol. 15, pp 465-479.

Herbart was the successor to Kant in the Chair of Philosophy at Königsberg University; his two major texts on psychology are the "Lehrbuch zur Psychologie" (Textbook of Psychology) published in 1816 and the "Psychologie als Wissenschaft" (Psychology as Science) published in 1825. Although Herbart wrote on philosophy and education as well as psychology, both education and psychology in Germany at that time were seen as being a subset of philosophy and not, in the case of psychology, as a subset of medicine or the natural sciences.

Doerner's⁸¹ detailed study of this period shows the influence of Kant's psychology and how, for instance, Kant saw issues of what we would now regard as forensic psychiatry to be, with few exceptions, an area where philosophers should advise the court and not medical doctors. Doerner argues that the influence of Kant was particularly strong on German psychiatry up to and including the first half of the Twentieth Century. He argues that Kahlbaum, Schüle, Krafft-Ebing and Kraepelin can all be described as neo-Kantian.

In a particularly difficult and obscure section of his book, Doerner outlines the main element of Kant's model of psychopathology. The first is that as Kant believed that one could learn nothing of the physiological basis of behaviour; therefore, the only behaviour that was worth studying was that which resulted from acts of free will. His approach was

⁸¹ Doerner, K. (1981) Madmen and the Bourgeoisie. A Social History of Insanity and Psychiatry. Basil Blackwell. Oxford.

essentially one of faculty psychology, and he held that all disorders and irrationality could be deduced from these faculties. Kant argued that introspection as a means of studying the mind was both fruitless and harmful; fruitless because the act of observation alters the object itself, and harmful because the creative imagination could overwhelm the rational elements and lead to madness itself.

Although Herbart was following in the footsteps of Kant, his aim within psychology was to refute Kant's claim that as psychology could never quantify, psychology could never be a true science.

A crucial component of Herbart's model was the concept of the unconscious and its importance in mental processes. The notion of the unconscious had also received support from early experiments in Mesmerism, where subjects were made to recall memories hitherto unrecallable. What Herbart tried to do was to develop a model of mind in which the process by which associations were made, ideas and perceptions disappeared into the unconscious and re-appeared in the conscious, was governed by rules similar to physics. His approach was consciously Newtonian and he developed a complex mathematical model, a calculus of the mind.

Where the mathematical model failed was that, although elegant in itself, it seemed impossible to insert real values into the model. Herbart's attempt to quantify psychology failed and Kant was not refuted but, as Sand points out, what Herbart left was

a powerful metaphor that dominated German speaking psychology for the rest of the Nineteenth Century.

Sand lists those concepts in Lidner's book, most of which were Herbartian, that could be legitimately claimed as precursors to Freud's thinking and these are as follows: Lidner wrote of the struggle for consciousness involving the concepts of conflict and repression. Herbart's model of mind is spatial in a way similar to Freud's topographical model in which, on the upper level, is the conscious, and underneath is the unconscious. Like Freud, Herbart argued that strong representations could oust weak representations from consciousness, and perceptions could be distorted before being allowed into the conscious. Herbart saw representations as being on a network - trains of thought that crossed at junctions or nodal points, rival trains could inhibit one another - and Freud used a similar metaphor. Implicit in both Herbart and Freud's models is the notion of mind-body duality. Lidner stressed the importance of self-observation as the prime mode of exploration and as is well known Freud's work was heavily influenced by his own self observation. As Sand points out, Lidner and Herbart were using pre-existing concepts when they talked of the ego and non-ego (the "Ich" and "Nicht Ich") although Freud was later to use these terms. Lidner also wrote of ego split and of a concept of the ego-ideal, a destructive drive that could be sublimated, and other drives and instincts.

Sand rightly points out that Herbart's and Lidner's terminology were not always co-terminus with Freud's terminology. Herbart's

starting point was the science of physics, whereas Freud's starting point was the science of biology. Herbart was developing a general model of mind involving cognition and perception whereas Freud, though also stating a general model applicable to the mentally well as well as the sick, started from a point of pathology and emotions. However, with all these caveats in mind, it is clear that Freud's theories were influenced by ideas both commonplace and accepted within the German speaking philosophical psychology tradition.

To return to Bleuler's dilemma, when he was trying to reconcile Kraepelin and Freud he was attempting to reconcile two great traditions within German psychology both of which had as their starting point the same attempt to develop a science of mind. To a large extent, Kraepelin's enterprise was successful and led to an organic model of Schizophrenia. Freud's model, directly or indirectly influenced by Herbart, was doomed to failure as a scientific enterprise and Freud's model remains today what Herbart's model was in Freud's day - at best an interesting metaphor.

Of course, psychoanalysis and its pretensions to science have been soundly criticised by Karl Popper, and his views on what does, and does not, constitute science can briefly be stated as follows: there is an inverse relationship between a proposition's probability of being correct and its usefulness. Thus, the statement that the sun will rise again tomorrow has amongst the highest of probabilities of being correct but the amount of

useful information it carries is minimal. Scientifically useful statements are those that lay themselves open to being proved incorrect, are highly specific and are capable of being tested and thus, perhaps, refuted. The process of refutation and the development of further alternative hypotheses that can also be tested is the only way in which scientific knowledge can evolve. Accumulation of affirmative observations, on the other hand, tell us very little.

The young Popper⁸² had been exposed to the influence of Freudian and Adlerian analysis, as well as Marxism, as a student in Vienna and was later to write as follows on conversion to such creeds:-

"Once your eyes were once opened you saw confirming instances everywhere: the world was full of verifications of the theory. Whatever happened confirmed it. Thus its truth appeared manifest; and unbelievers were clearly people who did not want to see the manifest truth; who refused to see it, either because it was against their class interest or because of their repressions which were still "un-analyzed" and crying aloud for treatment. . . . A Marxist could not open a newspaper without finding on every page confirming evidence for his interpretation of history; not only in the news but also in the presentation - which revealed the class bias of the paper - and especially of course what the paper did not say. The Freudian analysts emphasized that their theories were constantly verified by their 'clinical observations'."

What Popper argued was that because of the circular logic of psychoanalysis i.e. that it could only be fully understood by those who had been fully analyzed, its universality as a total explanation for all psychology and its ability to interpret all phenomena in its favour (in short all the factors that provided

⁸² Popper, K R. (1972) Conjectures and Refutations: the Growth of Scientific Knowledge. Fourth Edition. Routledge and Kegan Paul. London. Page 34.

a comforting sense of certainty and made it so attractive to many people) it was not capable of being falsified and was not, therefore, and notwithstanding Freud's view to the contrary, scientific.

In fairness to both Popper and Freud, it should be added that Popper did not equate being "scientific" or "non scientific" with being useful or useless or sense or nonsense. In saying that Freud's (and Adler's and Marx's) ideas were not scientific he was not consigning them to the rubbish heap of ideas but arguing that they should be more accurately described as metaphysical statements. Metaphysical statements may have within them the seed of scientific statements, thus classical atomistic theories of matter were incapable, at the time, of refutation but modern versions are scientific models. Popper regarded Freud's theories as having a similar potential; it was the misunderstanding of the concept of science amongst Freud and his followers that he objected to.

Bleuler, too, was concerned about the lack of empirical rigour evident in the early psychoanalytical movement. Stierlin⁸³ attributes the rift between Bleuler and Freud to Freud's view that Bleuler was ambivalent and half hearted about his own views. Stierlin seems to suggest that the fault lay with Bleuler. In,

⁸³ Stierlin, H. (1967) "Bleuler's Concept of Schizophrenia: A Confusing Heritage." American Journal of Psychiatry. Vol. 123, 8th February, pp 996-1001.

of all places, Alexander and Selesnick's⁸⁴ history of psychiatry, the authors provide clues to the real nature of the rupture. In a book which is otherwise a paean to Freud and the psychoanalytical movement, they concede that Bleuler, one of the first dissenters, was a man of "supreme integrity" though adding, in the same sentence, that so was Freud. Part of the reason for the rupture was the concern Bleuler expressed at the growing authoritarian nature of the movement. Even more interesting is the letter from Bleuler to Freud, written in 1910, which Alexander and Selesnick quote:-

". . . For you it became the aim and interest of your whole life to establish firmly your theory and to secure its acceptance. . . . For me, the theory is only one new truth among other truths. I stand up for it (psychoanalysis) because I consider it valid and because I feel I am able to judge it since I am working in a related field. But for me it is not a major issue, whether the validity of these views will be recognised a few years sooner or later. I am therefore less tempted than you to sacrifice my whole personality for the advancement of the cause."

For Bleuler, one of the other truths was clearly that of Kraepelin; he needed a bridge between Kraepelin's organic dementia praecox and Freud's explanatory method that had no clear links with the organic. Bleuler⁸⁵ felt he had found the bridge in the associative psychology of Semon.

In Semon's model, the two major components of the psyche are the

⁸⁴ Alexander, F G and Selesnick, S T. (1967) The History of Psychiatry: An evaluation of psychiatric thought and practice from prehistoric times to the present. George Allen and Unwin. London. Pages 212-213.

⁸⁵ Bleuler, E. (1924) Textbook of Psychiatry. Translated A Brill. Macmillan. New York.

engrams and the associative links between engrams. The engrams themselves are stable but the associations, which are formed as a result of experience, are subject to change and form clusters which can be evoked and integrated with other clusters. The capacity for change in associations is necessary, and associations must have the capacity to loosen as a result of later experience. They also need the capacity to change so that they can be streamlined and organised into hierarchies. In this theory, associations are particularly loose and subject to change in certain states such as dreaming, fatigue and lessened attention. Individuals would also vary in their capacity for loosening and re-integration of associations.

Associations constantly competed with each other and the stronger, those with strongest affective charge, would oust the weaker but might also break loose. If there was a weakness or deficit in the switches that co-ordinated the associations then there would be a loss of hierarchy and goal direction. In its severest form, there would be fragmentation of affect and destruction of the unity of the personality, which is what we see in Schizophrenia.

It is understandable that Bleuler saw Semon's model as a bridge between the organic dementia praecox of Kraepelin and psychodynamic psychology. The organic weakness or deficit in the hypothesised switches that kept the associations in bound, and at the same time the loosening of associations, could be seen as the source of "complexes", and the symptoms of Schizophrenia as

the result of either the breakdown of associations or as the result of attempts to regenerate the associations in a way posited by Freud in the second phase of his thinking on Schizophrenia.

However, this attempt to integrate the two major traditions via Semon's model had two unexpected and related consequences for Bleuler. The first of these was that, in the light of Semon's model, he had to restructure the traditional Kraepelinian thinking on the symptoms of Schizophrenia. The loosening of associations now became the primary symptom, whereas the hallucinations, delusions and stereotypical behaviour which so marked out people with Schizophrenia from normal people became merely the secondary symptoms. If the implication that loosening of association was common in certain states in normal people, the schizophrenic state of mind now appeared to be somewhat ordinary. Indeed, the next step was to see loosening of association on a continuum in which the location of the normal mind and the schizophrenic was merely a matter of degree - the difference was one of quantity rather than quality.

Bleuler's position became increasingly untenable. In attempting to integrate Kraepelin and Freud, he developed a view which stated that the difference between the person with Schizophrenia and the normal person was merely one of degree, a position incompatible with Kraepelin's model and which caused criticism from the main stream of psychiatry. At the same time, because of his reservations about the psychoanalytical movement and his

decision not to rejoin it, he was criticised from within the movement for his lack of commitment to their views. The natural concomitant of his model of Schizophrenia was to see it as increasingly wide-spread, even when not attended by the classic symptoms. What causes Schizophrenia to be more or less present may be endogenous factors or psycho-social circumstances that, if positive, would inhibit the development of full blown Schizophrenia or, if negative, would cause the full disease to develop.

The most important psycho-social factor would be the individual's upbringing (the parental background) and it is in this that we see the seeds of the pathogenic parenting model. Later, the history of these pathogenic parenting models will be reviewed, and in the second part of this Thesis their impact on parents will be assessed.

The final irony in Bleuler's career is that while he increasingly viewed Schizophrenia from a Kraepelinian perspective and distanced himself from the psychoanalytical movement, eventually seeing Schizophrenia as being purely organic and probably genetic, his earlier views had been enshrined and, until comparatively recently, were tablets of stone in American psychiatry! It is only in the latest editions of the DSM classification system that the definitions of Schizophrenia, which hitherto had been entirely that of early Bleuler, have been sufficiently narrow to be useful. In the main, this was due to the considerable influence of psychoanalytical thinking on

American psychiatry for most of this century. Before looking at the pathogenic parenting models themselves, the reason why psychoanalytical thinking achieved the dominance it did will be reviewed.

The Ascendency of Psychodynamic Psychology

If, as is suggested above, Freud's theories were based on pre-existing ideas, particularly those of Herbart, than the question arises why was Freud more successful in promulgating his model of mind than Herbart? There is no one single answer to this question. One can point to the fact that as Freud was working from an established and pre-existing theoretical position which facilitated the acceptance of his theories, though this does not account for why Freud's views were more widely accepted outside of this tradition (German speaking psychiatry) than within. It is possible to postulate that familiarity with his sources lessened the impact of his work in the German speaking world but increased the novelty outside of the Germany and Austria. One can point to the single mindedness of both Freud and his followers in promulgating their view but this, of itself, is not a complete explanation.

The two major factors that Freud's work offered were meaning and therapeutic hope. Freud and his followers were very much concerned with finding the hidden meaning in apparently meaningless mental phenomena from dreams, to word associations,



slips of the tongue and jokes. Once again, one turns to Popper⁸⁶ to tease out the importance of Hegelian determinism in Freud's (as well as Marx's) works. In Freud's world, nothing is random and everything has a meaning in a historical continuum.

What is the importance of finding meaning in madness, why should it have driven Bleuler to develop his model and later workers such as R D Laing to devote so much time to making sense of the uttering of people with Schizophrenia? The implications are quite important, and it is worth considering the problem posed by madness to early theologians. If a person was mad, what did it tell one about the state of that person's soul? Was the soul also mad? The general consensus was that the inner soul was not mad but that the disease occluded the sanity of the soul. In a sense, the concept of "mind" can be seen as the secular equivalent of the soul, dwelling somehow, somewhere in the body, in the brain.

In terms of Schizophrenia, one can consider two possible effects of the disease. When a hitherto normal person with a normal personality develops the disorder there is almost always a change of personality and a change in mind. One can either argue that the mind, the essential self is there but is being masked by the disorder or, alternatively, one can argue that the mind and brain are not separate and the partial destruction of the brain now being shown by techniques described above means a partial destruction of mind. The self 'as was' has irrecoverably gone and

⁸⁶ Popper, K R (1977) The Open Society and its Enemies. Volume 2 Hegel and Marx. Routledge and Kegan Paul. London.

all that is left is the self 'as is'. While neurological damage remains irreversible, the best that can be done is remedial work and control of positive symptoms. The situation is even more poignant in those disorders where neural damage is far more catastrophic than in Schizophrenia, such as Alzheimer's Disease, Kreuzfeldt Jacob's Syndrome and Huntington's Chorea.

If one takes the first position, seeing the mind as being the seat of the problem, and the problem being of an essentially psychological nature, then the pessimism implicit in neural damage is not an issue. The mind, the original self, is in there, perhaps struggling to break free and perhaps is sending messages, though these become garbled and confused by the disorder. The skilled interpreter and therapist can make sense of these messages and lead the mind to sanity. This was the hope offered by psychodynamic psychology.

The alternative was not only therapeutic pessimism but a model of man that reduced mind to being no more than brain, a vulnerable organ of the body. In this latter analysis, organic models of Schizophrenia and other disorders reduced human personality and achievement to no more than a function of an organic machine.

Hopes had been raised at the beginning of the Nineteenth Century by the new humane approach to the mad - 'moral therapy'. One immediately thinks of Pinel at the Salpêtrière and Tuke at The Retreat in York, as well as Tuke's imitators in the United States

such as Rush. Why this hope was never fully realised is still a matter of some controversy. If one goes back to Hare's argument for a slow epidemic of Schizophrenia, it may be that the diseases that the moral therapists originally successfully treated were not the disease or diseases that later swamped the asylums. Sederer⁸⁷ accepts that an increase in the number of the insane was a factor, but not the only factor, in the decline of moral therapy. To overcrowding, he adds gatekeeping, the process by which groups with vested interest such as professionals and families vying for power to control admissions. Economic considerations and decline of charismatic leadership were other, equally important, factors. To these he also adds the growth of scientism and the decline in morale amongst moral therapists. He argues for an increase in morale amongst those who practise a psycho-therapeutic psychiatry which he sees as the modern heirs to the humanistic tradition of Pinel and Tuke.

Sederer and other chroniclers of the rise and fall of moral therapy, such as Kosky⁸⁸ and Savino and Alden⁸⁹, raise certain important questions on changes in Nineteenth Century care of the insane. Moral therapy did, undoubtedly, offer a challenge to the relatively newly won medical hegemony of madness. Tuke was not

⁸⁷ Sederer, L. (1977) "Moral Therapy and the Problem of Morale." American Journal of Psychiatry. Vol. 134, No. 3, pp 267-272.

⁸⁸ Kosky, R. (1986) "From Morality to Madness; Reappraisal of the Asylum Movement in Psychiatry 1800-1940." Australian and New Zealand Journal of Psychiatry. Vol. 20, pp 180-187.

⁸⁹ Savino, M T and Mills, A B. (1967) "The Rise and Fall of Moral Treatment in California Psychiatry: 1852-1870." Journal of the History of Behavioural Sciences. Vol. 3, No. 4, pp 359-369.

a doctor (in his youth he had hoped to be but his father declined to let him train) and although he was opposed to bad medical superintendents, he was not opposed to the medical profession per se and employed doctors at The Retreat to care for the physical health of the patients. The crucial point, though, was that the doctor was an employee and was not in control. The fact that The Retreat, the most successful and well publicised (by, amongst others, Charles Dickens) facility for the insane in England, employed doctors in a subsidiary role undoubtedly posed a threat to the medical hegemony of madness.

In a thought provoking essay Cooter (in Scull ed⁹⁰) argues that the rapid rise of popularity in phrenology within the medical profession in the first half of the Nineteenth Century can be attributed to the fact that no matter how preposterous it may seem now, then it offered a coherent, physiological model of mental processes with which to challenge the success of moral therapy.

In other essays Blustein and Clark (both also in Scull ed) chronicle respectively the rise of neurologists in Nineteenth Century America and their rivalry with the asylum doctors, and the decline of psychological approaches to insanity in Victorian England. Both papers point to a move away from psychological therapy as enshrined in both moral therapy and hypno-therapy

⁹⁰ Scull, A. (1981) Madhouses, Mad-Doctors and Madmen
The Social History of Psychiatry in the Victorian Era
The Athlone Press. London.

towards an approach that focused purely on the neurological. Psychological phenomena, such as the content of psychotic delusions and hallucinations, were seen as being of little intrinsic interest beyond being indicators of underlying pathology. Clark's description of the Victorian psychiatric perspective on insanity is one dominated by the concept of dementia. Mental illness was viewed, almost always, as the result of a negative and destructive disease process that stripped away the higher levels of reason and left the sufferer inaccessible to the process of reason itself.

In a sense, as Rosen⁹¹ has pointed out, the growth of a physiological and positivistic approach in Nineteenth Century psychiatry cannot be solely attributed to a negative reaction to the increasing failure of the metaphysical and psychological moral therapy. There were isolated examples of an increase in knowledge, if not in effective treatment, in that century including Cretinism and Pellagra psychoses, that led credence to a physiological perspective.

The problem was that the pendulum swung too far, and with the success of neurology came the fear that science would be impotent to treat insanity. This fear was particularly strong in the context of heredity. Bynum⁹² provides a useful synopsis of the

⁹¹ Rosen, G. (1968) Madness in Society. Chapters in the Historical Sociology of Mental Illness. Routledge and Kegan Paul. London.

⁹² Bynum, W F. (1984) "Alcoholism and Degeneration in 19th Century European Medicine and Psychiatry." British Journal of Addiction. Vol. 79, pp 59-70. Page 61.

importance of the French psychiatrist Morel, already mentioned briefly above, in the development of theories and fears concerning the hereditary taint of madness and the relation between heredity and degeneration. As Bynum points out, in the early half of the Nineteenth Century the importance of heredity and madness was very much a French notion and was less well emphasised in Britain and Germany. Esquirol, amongst others, produced statistics to show how important heredity was in disorders such as melancholia, but it was Morel who combined this theoretical tendency with borrowings from social anthropology and theology (he was a devout Catholic) to develop his theory of degeneration. He defined "degenerations" as deviations from the normal human type which could be inherited. In one sense, this was not new, but what Morel added was the idea of the progressive nature of this process. As Bynum describes it:-

Heredity was cumulative, families caught in the cycle would in fact snowball in the course towards extinction. Thus one generation might be merely 'nervous' and unstable; the next would be definitely neurotic; the third seriously disturbed mentally; the fourth could be idiotic and, through sterility of its members, die out."

Morel's model of inheritance was essentially Lamarckian; one's chosen actions could lead to degeneracy by inheritance of acquired characteristics. One obvious example of the starting point of a family's slide to extinction was the ancestor who drank to excess. Thus, there was a moral dimension to Morel's psychiatry which Clark finds replicated in British psychiatry.

That there should be a moral dimension to Nineteenth Century psychiatry should be no surprise for two reasons. The notion of

inheritance of temperament, including melancholy and insanity is quite old as is the notion of intemperance at the time of procreation causing defects in the child. As Burton⁹³ wrote.

"'And where the complexion and constitution of the father is corrupt' (saith Roger Bacon) 'the complexion and the constitution of the son must needs be corrupt and so the corruption is derived from the father to the son.' Now this doth not so much appear in the composition of the body, according to that of Hippocrates, 'in habit, proportion, scars, and other lineaments; but in manners and conditions of the mind,' Et patrum in natos abeunt cum semine mores (the character of the parents is transmitted to the children through the seed)."

Burton goes on to add.

"I need not therefore make any doubt of melancholy, but that it is an hereditary disease."

and

"He that begets a child on a full stomach will either have a sick child or a crazed son . . . or if a drunken man get a child, it will never likely have a good brain . . . Foolish, drunken, or hairbrain women must bring forth children like unto themselves."

The fact that Morel's moralistic views came from, and took root in France, a country that had made such a significant contribution to a more scientific approach to insanity should also not be seen as necessarily unusual. As Sontag⁹⁴ has pointed out in the context of Nineteenth Century views on Tuberculosis, even the acquisition and course of clearly organic disorders have been thought to have been affected by the character of the sufferer, the disease had a moral dimension. Sontag also points

⁹³ Burton, R. (1977, first published 1621) The Anatomy of Melancholy. J M Dent. London. Pages 211-213.

⁹⁴ Sontag, S. (1979) Illness as Metaphor. Penguin Books. London.

out that we see the modern counterpart in the alternative medicine approaches to cancer.

One should also not be surprised that apparently contradictory views (organic versus moral-psychological) of insanity can co-exist at a given time and place. It is only partisan historians such as Alexander and Selesnick⁹⁵ who write of whole periods of psychiatric history in terms of "either/or". For instance, in an interesting paper that delivers a direct rebuke to Alexander and Selesnick's view of the Middle Ages as an unremitting period of demonology, Kroll and Bachrach⁹⁶ demonstrate that from contemporary accounts it is clear that the medieval mind saw insanity as being caused by organic, humoral, defects as well as sin. Whether the mental illness was seen as an illness, and therefore the sufferer was not to blame, or as a punishment depended on the perceived moral state of the sufferer. One can be forgiven for thinking that very little has changed!

Thus, in terms of Morel's theory, there were historical precedents for a climate of opinion that tolerated the contradictions of both a moral and organic explanation for insanity. According to Bynum, Morel's writings were never translated from the French; in spite of this, his influence was still wide spread. Wilhelm Griesinger was greatly influenced by

⁹⁵ Alexander, F G and Selesnick, S T. (1967) The History of Psychiatry: An evaluation of psychiatric thought and practice from prehistoric times to the present. George Allen and Unwin. London.

⁹⁶ Kroll, J and Bachrach, B. (1984) "Sin and Mental Illness in the Middle Ages". Psychological Medicine. Vol 14, pp 507-514.

Morel and incorporated his ideas in his own work. Amongst Griesinger's pupils was Krafft-Ebing who, in turn, incorporated Morel's perspective into his own writings. Morel's most famous adherent in this country was Henry Maudsley (in Skultans ed⁹⁷), who wrote extensively on the importance of inheritance in psychiatric disorders. Maudsley's view was bleak, he wrote of our genetic destiny as the "tyranny of organisation":-

"No one can escape the tyranny of his organisation; no one can elude the destiny that is innate in him, and which unconsciously and irresistibly shapes his ends, even when he believes that he is determining them with consummate foresight and skill. A well-grounded and comprehensive theory of mind must recognise and embrace these facts."

Then, as now (with less justification), genetic disorders were viewed as being hopeless. Rutter, Bolton, Harrington, Le Couteur, MacDonald and Simonoff⁹⁸ have questioned this fallacy, quoting the well known example of phenylketonuria, a genetic disorder that hitherto had led to intellectual impairment but which is now easily detected in infancy and its worse excess avoided by dietary control. In comparison, and despite the presence of a vast counselling and psychotherapy industry, problems associated with the emotional environment of the individual still seem remarkably intractable.

⁹⁷ Skultans, V. (1975). Madness and Morals. Ideas of Insanity in the Nineteenth Century. Routledge and Kegan Paul. London. Page 207.

⁹⁸ Rutter, M, Bolton, P, Harrington, R, Le Couteur, A, MacDonald, H and Simonoff, E. (1990) "genetic Factors in Child Psychiatric Disorders - I. A Review of Research Strategies." Journal of Child Psychology and Psychiatry. Vol. 31, No 1, pp 3-37.

It was in this climate, both in the United States and this country, dominated by neurology but offering little but pessimism that Freud, himself a neurologist, offered a system that had pretensions to neurological underpinning at a time that was ripe for the pendulum to swing the other way.

That psychoanalysis promised successful therapy has been shown by Rapp⁹⁹ in his study of Freud's reception by the British press between 1920 and 1925. He points to the number of articles about psychoanalysis and by psychoanalysts and, in particular he points to the number of claims, sometimes exaggerated, of the therapeutic efficacy of analysis in the treatment of shell-shock victims after the First World War. This should be seen in the context of the general therapeutic pessimism covering a wide range of disorders.

On a lighter note, Freud's emphasis on sexuality also caught the mood of a post-Victorian, post First World War, public. In a way, the psychoanalytical movement in its widest sense was allowed to both have its cake and eat it on the subject of sexuality. In his paper, Rapp points out that those who were titillated by the sexual content of Freud's teaching could turn to the words of the master himself, but for those too squeamish for such matters the popular press advised turning to the alternative post Freudian theorists such as Jung where they would be free to contemplate

⁹⁹ Rapp, D. (1988) "The reception of Freud by the British press: general interest and literary magazines, 1920-1925." Journal of the History of the Behaviourial Sciences. Vol. 24, pp 191-201.

their collective unconscious rather than their sexuality. Alternatively, there were what Rapp refers to as "bowdlerises" of Freud, those who wrote from within the movement but who did not strive to emphasise the sexual. Either way, the movement in its widest sense benefited.

However, it was perhaps through the newly emerging professions such as social work that psychodynamic thinking, though diluted, was to be most widely dispersed.

The Influence of Psychodynamic Psychology on Social Work and Professional Entrepreneurism

Writers on the influence of Freudian and post-Freudian theory on social work, such as Pearson, Treseder and Yelloly¹⁰⁰ and Howe¹⁰¹, while acknowledging the considerable impact such theory has had on American social work from the 1920's and British social work from the 1940's to the 1970's, are careful in estimating the precise depth and scope of this impact. Pearson et al tend to see the interest in psychodynamic theory in social work as mirroring the interest shown by society as a whole in Freud and the post Freudians. What Pearson et al and Howe both argue is that, for all the theoretical dominance of psychodynamic casework in the education of social workers, in this country,

¹⁰⁰ Pearson, G, Treseder, J and Yelloly, M. (1988) Social Work and the Legacy of Freud Psychoanalysis and its Uses. MacMillan Education. Basingstoke.

¹⁰¹ Howe, D. (1987) An Introduction to Social Work Theory. Wildwood House. Aldershot.

post war, the number of social workers who practised in an exclusively psychodynamic way was always rather small and most social workers adopted a more pragmatic and eclectic approach to their work.

What Howe does stress is that the important impact was not so much in practice but in the general model of development and, most importantly, the hypothesised link between early experience and later behaviour. He lists the central points of Freudian and post Freudian theory that became important and enduring tenets in social work as follows: Freud's theory was, as has already been said, deterministic and also reductionist; deterministic in the sense that all behaviour had meaning and could be interpreted in the light of previous experience and also deterministic in so much as we are all influenced by our biological nature in terms of drives and instincts; reductionist in the sense that all human behaviour and personality could be analyzed in terms of a limited number of biological and psychological mechanisms - the two most important drives were sex and aggression.

Psychosexual development and the problems attendant on faulty development have already been mentioned in Freud's thinking on the aetiology of Schizophrenia, but Freud also considered problems in this area to be responsible for a whole range of character disorders. Fixation at the oral stage would lead in later life to the "oral personality", the impulsive, grasping person who needs instant gratification. The oral personality can also be broken down into two further sub-types, the oral-erotic

and the oral-sadistic personality. Fixation at the anal stage lead to the anal personality with attendant problems of retaining and letting go. Fixation at the phallic stage and problems associated with Oedipal and Electra complexes lead to a personality that can be bossy, competitive and success orientated. The importance of these concepts as well as the concepts of id, ego and superego and the unconscious were that they all placed great stress on early development, particularly the first five years. If the stages of development were not handled well, and the primary responsibility was with the mother, than serious psychic damage could occur.

Social workers were one of a group of professionals working on not just the remedial work of trying to undo the results of alleged bad parenting and poor psycho-sexual development but also the development of a preventative approach. Authors and broadcasters like Bowl by and Winnicott used the insights gained from psychodynamic psychology to advise mothers, who had hitherto been left very much to their own devices, how to do their job as mothers and informed them of the consequences of failure to take the professionals' advice.

The same experts also had a considerable impact on social work, though Pearson at el mourn the lessened impact of such theories on modern social work and in their book suggest ways in which Freud's work, in the light of post-Freudian thinking, might still have meaning and use for social work today. This includes such heady alliances as psychoanalysis and feminism, and

psychoanalysis and Marxism. They point out that Freudian psychoanalysis in its purest form has had a limited impact in terms of the number of practitioners and the persons helped by the techniques. Almost as soon as it was formed, the movement fragmented and sub schools were formed. Pearson et al¹⁰² argue that most forms of psychotherapy and counselling have their ancestry, no matter how remote, with the original psychoanalytical movement. They argue that they all share a common "point source" which they describe as follows.

"And the nature of this 'point source' is probably best defined in therapeutic terms as the discipline of self-scrutiny - or what was described by Phillip Rieff (1959) as the method of 'ruthless talk' by which a person attempts to overhaul the basis of motivation, feeling and action in his or her life."

There is a problem in all this. Pearson et al are right to highlight the full extent of Freud's legacy in an extremely wide range of therapies and perspectives, but both the distance and the ubiquitousness of such ideas from the "point source" mean that the ideas pass into both the lay and the professional perspective as established fact - received wisdom - while the origins are not traced and, therefore, are not necessarily subject to scrutiny. It has become the common wisdom that the first years of the child are important and that, in particular, the mother-child relationship is crucial, but the "point source" for all this is a notion of developmental stages (the oral, anal and phallic) that are as bizarre as they are untestable. Both writers supportive of Freud such as Pearson et al and more

¹⁰² Pearson, G, Treseder, J and Yelloly, M. (1988) Social Work and the Legacy of Freud Psychoanalysis and its Uses. MacMillan Education. Basingstoke. Page 14.

critical authors such as Rojek, Peacock and Collins¹⁰³, point out that not only are psychodynamic theories not scientific in themselves, but when their efficacy as treatment is studied empirically, they generally do not come out very well.

Rojek et al have catalogued how, in the context of social work, Freudian terminology has been misused and misunderstood. They talk of the way such concepts as transference, counter-transference, "acting-out", resistance, "testing out" and manipulation are used to negate and dismiss the experiences of clients. They also discuss how uneasily psychodynamic concepts sit with the core values of social work of respect, individualisation and self-determination (terms that themselves would repay re-evaluation and tightening).

However, despite these pitfalls, psychodynamic theory offered the means for professional entrepreneurship for non-medical professions such as social work, psychology and counselling to claim a central role in the treatment of mental illness as well as more general emotional problems and malaise (the first serious challenge to the medical hegemony in the mental health field since Tuke's regime at The Retreat).

All professions must emerge, to some extent, under market forces by first establishing that they have a service to offer, that there is a need to be met, through the creation of new markets

¹⁰³ Rojek, C, Peacock, G and Collins, S. (1988) Social Work and Received Ideas. Routledge. London.

or by entering pre-existing markets. The new profession must claim an exclusive corpus of knowledge and control of admission to the profession, most often by the formation of a professional association. Next, it is necessary that the emerging profession, if encroaching on an existing professions area of expertise, must demonstrate its pre-eminence in the field. Legislative sanction might be sought to obtain exclusive rights to the area though these rights can be revoked, for example the de-regulation of banking and the building societies, and the change in legislation to allow solicitors the rights to representation in higher courts formerly only granted to barristers.

Such talk of markets and creating niches, entrepreneurship and exclusive rights to markets seems odd language in the context of the caring professions but a closer examination will demonstrate its appropriateness.

Goleman¹⁰⁴ reviews the incursions of psychologists and social workers into areas traditionally the exclusive domain of psychiatrists. At its most extreme, the American Department of Defence were considering training a group of psychologists to prescribe psychotropic medication, albeit under medical supervision. Psychiatry is becoming an unpopular speciality in American medicine as it is near the bottom of the pay league among medical specialisms being only more remunerative than general medicine and paediatrics. The number of psychiatrists is

¹⁰⁴ Goleman, D. (1990) "New Paths to Mental Health Put Strains on Some Healers." New York Times. 17th May.

declining and, at the same time, in areas of work that are open to other professionals, such as psychotherapy, medical insurance companies are finding it cheaper to pay for psychologists and social workers to do the work. In a similar vein a court case was pending in California (outcome not known) over the granting of the legal right to psychologists to admit psychiatric patients to hospital.

The situation in this country is not quite the same and the ramifications of the National Health Service reforms have still to be fully felt and evaluated. However, certainly within psychology, in general, and clinical psychology in particular, there is strong sense of a profession under pressure to safeguard its existing areas and to expand into others. Clinical psychology does not enjoy the limited statutory involvement that social work does, in the form of the approved social worker, in mental health cases. Like social work, its efficacy in the major psychoses must be limited where the major treatment is by medication. In an increasingly cost conscious Health Service, important work that can legitimately be done by non-medical specialists (in the context of Schizophrenia work on reducing high expressed emotion in the family immediately springs to mind) might suffer unless it is recognised that this is vital to prevent even more costly re-admission.

Any cursory examination of the popular journals of social work and psychology will show articles on new areas where these disciplines attempt to gain a role such as disaster or Aids

counselling. Indeed, "The Psychologist", published by the British Psychological Society, has a regular "Media Watch" column chronicling when psychologists have appeared in newspapers, magazines, television or radio; the British Psychological Society's own Press Committee offers media training to the Society's members. The appearance is of a serious and organised marketing of a profession.

Summary of the Professional Impact of Psychodynamic Psychology

We have seen how Bleuler attempted to reconcile the two great traditions in German speaking psychology in the context of Schizophrenia. On the one hand was Kraepelin's purely organic model that implied therapeutic pessimism; on the other hand were the new/old ideas of Freud, very probably based heavily on Herbart's model of mind. The Freudian approach offered both therapeutic optimism (though Freud himself was pessimistic about the efficacy of psychoanalysis in the context of Schizophrenia) in that it was a psychological rather than an organic model and also, it was felt, provided a way to make sense of schizophrenic thought.

For a number of reasons psychoanalytic thinking gained an ascendancy in American psychiatry, and was not without impact in Britain. Though the psychoanalytic movement began to fragment almost as soon as it was formed, the legacy of its theory is still widespread and considerable in social work and a whole

range of therapies that, to some degree, owe their ancestry to Freud.

As has been described above, one of the central tenets in Freud's theory is the importance of early experience and the legacy of psychological damage that can accrue within the first five years. In his view, a whole range of character disorders could occur as a result of fixation at given periods of development and he believed that Schizophrenia and Paranoia, which he regarded as separate, owed their aetiology to such a process.

In all this, the parents and specifically the mother were central players who had it in their gift to produce a normal individual or an individual ruined for life; it is against this background that we can now review, in detail, some of the pathogenic parenting models of Schizophrenia.

Psychodynamic Pathogenic Parenting Models

Adolf Meyer

Adolf Meyer was a pivotal figure in American psychiatry in the first half of this century and his work and theories have had an important impact on thinking on Schizophrenia at a number of different levels. Although he did not directly implicate the family in the aetiology of Schizophrenia, his work undoubtedly prepared the ground for those who did.

His Swiss origins facilitated contact with the German speaking traditions in psychiatry and it was Meyer who reviewed the 5th edition of Kraepelin's "Manual" for the American Journal of Psychiatry while he was a guest of Kraepelin in Heidelberg (Peters¹⁰⁵). Meyer was instrumental in publicising Kraepelin's work, at least through his own interpretation of it. In fact, he was experiencing increasing reservations about Kraepelin's perspective which centred on Meyer's view that mental illness should be viewed from the perspective of the whole being - the individual - and not on the almost cellular level of the German somaticists. Meyer's perspective and its philosophical origins are set out in the Fourteenth Maudsley Lecture he gave entitled "British Influences in Psychiatry and Mental Hygiene" (in Lief

¹⁰⁵ Peters, U H (1998) "Die Deutsche Scizophrenielehre und die psychiatrische Emigration." Fortschritte der Neurologie Psychiatrie. Vol. 56, no 11, pp 347-360. (translation C Bell).

ed¹⁰⁶).

The key components in his thinking were that practitioners needed to see the whole situation of the patient and his/her history to make sense of the disorder, and to be aware of the environment the patient came from, and would return to, to effectively treat and maintain the patient. This, in turn, led to the development of the concept of "psychobiology" - that what we *think* can impinge on how we *function*, down even to the cellular level, and that, conversely, changes at all biological levels can impinge on thinking.

Meyer's attitude to psychodynamic psychology mirrored his attitude to Kraepelin's work. While welcoming the new ideas and, indeed, facilitating their spread, he disagreed on a number of levels with Freud's approach, thinking that Freud's foci on instincts and the unconscious were limiting. His view on Schizophrenia was that it could result from deterioration in habit pattern, including habits of thinking, and was not, therefore, necessarily of organic origin and might be ameliorated by psychotherapy.

At a stroke, almost, he invented the task of the psychiatric social worker and, indeed, his wife can claim to be the first psychiatric social worker. He stressed the importance of the psychiatric social history, and his comments on the content of

¹⁰⁶ Lief, A ed. (1948) The Commonsense Psychiatry of Dr Adolf Meyer. McGraw-Hill. New York.

reports and record keeping (see "Case Work in Social Services" in Lief ¹⁰⁷) are views still held today within the profession.

At the same time, if there was an environmental, ie social or familial content to Schizophrenia then the poor prognosis inherent in Kraepelin's conceptualisation was not axiomatic. Indeed, Meyer's attitude to Schizophrenia was by no means as pessimistic as Kraepelin's. With Meyer's development of the concept of "Moral Hygiene", came an implicit hope of a preventative approach to mental illness in general and to Schizophrenia in particular.

Harry Stack Sullivan

The crucial factors in Harry Stack Sullivan's thinking were that early interaction between child and parent was crucial in the development of personality and, in particular, crucial in the aetiology of Schizophrenia. To Sullivan, the concept of "anxiety" was central; anxiety was the discomfort that a child felt in the presence of significant adults. Anxiety is the principal tool that adults use to coerce children into acceptable behaviour. Sullivan accepted the existence of the Oedipus complex but disagreed with Freud's view that it was of biological origin and universal. Sullivan regarded the Oedipus complex as an artifact of Western civilisation. This highlights the crucial difference between Sullivan and Freud. Sullivan's model of man is that of

¹⁰⁷ Lief, A ed. (1948) The Commonsense Psychiatry of Dr Adolf Meyer. McGraw-Hill. New York.

a social animal who, from the earliest stage, is both object related and relationship seeking. The child develops through a process of successive awareness of itself in relationship with others of which the most important dyad is that of the mother-child. Sullivan saw anxiety as the source of all psychopathology but not a natural part of the child. Anxiety was imparted to the child via an anxious parent who was usually the mother.

Anxiety could be experienced on three levels by the child: low anxiety (a good me), high anxiety (a bad me) and intolerable anxiety (a not me) and it is the latter which is seen in the end-of-the-world panic experiences of people with Schizophrenia.

For Sullivan, the origins of Schizophrenia are to be found in an overly anxious mother who imparts her anxiety to her child who, in turn, over compensates by disassociation. Emerging sexuality puts pressure on the self system in adolescence and the defence of selective inattention begin to break down; developmentally primitive states of mind come to the fore and the self-system collapses. Sullivan regarded Schizophrenia not only as a disorder but as an adaptive process for the avoidance of panic and terror. Although he accepted that in some cases and types of disorder organic and genetic processes might be implicated, he saw Schizophrenia, in general, as being a psycho-social process.

Frieda Fromm-Reichmann

Fromm-Reichmann's approach to her work may well be more well

known to general readers than her name. According to Peters¹⁰⁸, she is the thinly disguised therapist-heroine of Hannah Green's book¹⁰⁹ and under the pen name of Virginia Axline¹¹⁰ wrote her own description of the intense and intimate style of psychotherapy she developed at the Chestnut Lodge Clinic where she met Harry Sullivan. Her work has a theoretical importance beyond "faction" accounts of therapy.

Fromm-Reichmann's paper of 1948¹¹¹ is important as it was the first to actually classify and give a name to a sort of parent and a sort of parenting that, from the perspective of the psychoanalytic movement, was felt to induce Schizophrenia in later life. In her paper, Fromm-Reichmann fully acknowledged the influence of Harry Stack Sullivan. The bulk of her paper is devoted to the proposition that, notwithstanding Freud's view to the contrary, it was possible to carry out effective psychoanalysis with people with Schizophrenia. However, within the article she states the following:-

"The schizophrenic is painfully distrustful and resentful of other people, due to the severe early warp and rejection he encountered in important people of his infancy and childhood, as a rule, mainly in a schizophrenogenic mother. During this early fight for

¹⁰⁸ Peters, U H (1998) "Die Deutsche Scizophrenielehre und die psychiatrische Emigration." Fortschritte der Neurologie Psychiatrie. Vol 56, no 11, pp 347-360. (translation C Bell).

¹⁰⁹ Green, Hannah (1964) I Never Promised You a Rose Garden. A Novel. Rinehart and Winston. New York.

¹¹⁰ Axline, V (1964) Dibs, In Search of Self. Pelican. London.

¹¹¹ Fromm-Reichmann, F. (1948) "Notes on the Development of Treatment of Schizophrenics by Psychoanalytical Psychotherapy." Psychiatry. Vol. 11, pp 263-273. Page 265.

emotional survival, he begins to develop the great interpersonal sensitivity which remains his for the rest of his life. His initial pathogenic experiences are actually, or by virtue of his interpretation, the pattern for a never-ending succession of subsequent similar ones. Finally he transgresses the threshold of endurance. Because of his sensitivity and his never-satisfied lonely need for benevolent contacts, this threshold is all too easily reached. The schizophrenic's partial emotional regression and his withdrawal from the outside world into an autistic private world with its specific thought processes and modes of feeling and expression is motivated by his fear of repetition rejection, his distrust of others, and equally so by his own relative hostility, which he abhors, as well as the deep anxiety promoted by this hatred."

Fromm-Reichmann's model of Schizophrenia incorporated the two essential elements of maternal overprotection and maternal rejection. Not only was she influenced by Sullivan but also by a number of studies carried out during the 1930's, for example Levy¹¹², Kasanin, Knight and Sage¹¹³ and Despert¹¹⁴, which seemed to show unusual patterns of relating in parents of people with Schizophrenia. Levy looked at maternal overprotection, Kasanin et al claimed reported that they had found both maternal overprotection and maternal rejection and Despert reported a significant pattern of subdued fathers and overanxious, aggressive and unsollicitous mothers in his sample of people with Schizophrenia. This research is reviewed in more detail below.

¹¹² Levy, D M. (1931) "Maternal overprotection and rejection." Archives of Neurological Psychiatry. Vol. 25, pp 886-889.

¹¹³ Kasanin, J, Knight, E and Sage, P. (1934) "The parent-child relationship in schizophrenia." Journal of Nervous and Mental Diseases. Vol. 79, pp 249-263.

¹¹⁴Despert, L J. (1938). "Schizophrenia in Children." Psychiatric Quarterly. Vol 12, pp 366-371.

The British Object-Related Theorists

This term loosely refers to a group of British post Freudian theorists who, like Sullivan, stressed the importance of man as social animal. The three major figures in this group were Melanie Klein, Fairbairn and Winnicott who has already been mentioned as an important influence on psychodynamic social work.

Klein's development and divergence from Freud (both Sigmund and Anna) has been described by Sayers¹¹⁵ who sees her as one of the four important women psychoanalytical theorists (the others being Anna Freud, Deutsch and Horney) who helped to place the maternal on the agenda in the, essentially, patriarchal world of psychoanalysis.

Important factors in Klein's approach were the stress on love versus hate in relationships (as opposed to wish versus reality in the conventional Freudian approach) and the importance of fantasy. Fantasies were centred on relationships with others and these relationships are referred to as internal object relationships. Of particular importance in the context of psychosis are Klein's concepts of splitting and projective identification. In normal childhood development both these mechanisms come into play; but if they occur in later life they are significant in psychopathology, which she associated with an

¹¹⁵ Sayers, J. (1992) Mothering Psychoanalysis. Penguin Books. London.

excess of aggression, envy and hate in relationships.

Whereas classical psychoanalysis sees human development as a series of phases, Klein saw development in terms of a hierarchy of relational positions. Two of the earliest positions the infant encounters are the paranoid and the depressive. In the paranoid, aggressive interpersonal experiences are split off and projected on to significant others, who are then seen as threatening and anxiety provoking. In the depressive position, the infant realises its own aggression and feels guilty about it. According to Klein these positions are normal in the child but pathological if they are not negotiated through in later life.

In Klein's model of Schizophrenia, the child has intense, sadistic, envious impulses that lead to the overuse of withdrawal, splitting and projective identification. Because of the strength of these feelings and the mechanisms used to cope, the infant never develops to the depressed position which requires recognition of its own feelings and remains fixed at the paranoid position to which it will regress, in later life, when faced with stress.

Thus, what Klein was saying was that the seeds of Schizophrenia were in significant relationships in childhood. Contemporary and later theorists, either independently or influenced by Klein, were to argue that the seeds of Schizophrenia were in the pathological relating of the mother to the child. It must be stressed, as Sayers points out, that this is not necessarily the

position adopted by Klein herself. In Klein's view, the significant other would probably be the mother but this need not necessarily be so. Sayers argues that followers of Klein, Horney, Deutsch and Anna Freud, in celebrating their successful challenge to the patriarchy of conventional psychoanalysis, have tended to see the mother-child relationship as the only significant relationship and, as he quite rightly argues, the time has come to redress this balance to something closer to what Klein was actually stating. The risk of an entirely mother centred theory is to see all psychopathology in terms of bad mothering, although Klein's analysis, particularly her child analysis, often involved the development of a maternal relationship with the patient as a "good enough" parent, to use the phrase of her long term supporter, Winnicott, which did not presuppose that the child had been subjected to bad parenting. Herein lies the importance of fantasy. In Klein's view, it is not what the significant adult, the parent, actually did that was important - more what the child fantasised about that relationship.

Fairbairn's model of Schizophrenia owes much to Klein and to Sullivan. Fairbairn regarded human behaviour as being centred on contact with others, regardless of whether the contact was pleasant or unpleasant. He regarded all mental illness as a consequence of poor object relationships in infancy. Like Bleuler, he regarded Schizophrenia as being a point on a continuum rather than a discrete illness, a point more extreme than the schizoid personality which, in turn, was more extreme than the normal personality. The origins of Schizophrenia and the

schizoid personality were in maternal absence or withdrawal, which the infant interprets as meaning that its own love is bad. This leaves the infant in a state of conflict in which it wants its mother to be present to love but feels that that very love is a repellent to the mother. Eventually, the infant's only recourse is to withdraw from relationships.

Both Klein and Fairbairn shared a common perspective on Schizophrenia that saw its roots in early childhood experience of relationships with significant others, but in Klein's model the key factor was a heightened constitutional factor, a capacity for aggression and other negative emotions, whereas for Fairbairn the key factor was in the mother's behaviour - her physical or emotional withdrawal from the child. In this sense, Fairbairn was closer to Fromm-Reichmann.

However, what Fairbairn and Klein had in common was a view of the infant as being shaped by external and internal forces, of being passive. Winnicott said that the infant, from the earliest stage, took a more active part. The mother and child enjoyed a dyadic relationship in which the mother catered for the needs of the child and the child signalled that needs had to be met. The mother did not impinge on the child to meet her own needs when the infant was quiescent. The infant develops feelings of control over its mother and the environment and to a feeling of omnipotence. Later the infant realises gradually that its mother cannot, or will not, always meet its demands.

The model of Schizophrenia that arises from Winnicott's developmental views is as follows: the natural process of the infant learning the limits of its omnipotence is interrupted because of exposure to the realities of the real world, to a degree and extent that is beyond the stage of development of the infant to cope with. The mature self fails to develop and a false, compliant, self develops instead, which is geared to meeting the needs of others. Fantasy, which is always present and normal, takes on more importance and finally, in full Schizophrenia, fantasy replaces reality.

American Post-Freudian Theorists

McGlashan (in Kaplan and Sadock¹¹⁶) has reviewed the major American post-Freudian theorists. Margaret Mahler postulated three stages in development, autism, symbiosis and separation-individuation. In this model, Schizophrenia is seen as the result of failure to form a symbiotic relationship with the mother, leading to an inconsistent image of the mother by the child. In adolescence, when individuation should occur, the subject becomes vulnerable to regression back to the first, autistic stage and this is what we see in Schizophrenia.

Both Arieti and Giovacchini regarded Schizophrenia as being the result of abnormalities in the child's environment. Giovacchini regarded trauma in the earlier stages of development as the cause

¹¹⁶ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

of fixation, preventing the development of coherent object relations. Regression later leads to incoherent and chaotic states. Arieti believed that the logical conclusion of such fixation was a state in which it became impossible to empathise with other persons and which led to an emotional deadness.

Ping-Nie Pau, like Bleuler, believed that Schizophrenia occurred in at least two forms, one of which was almost certainly biological and probably genetic in origin and the other of which was probably social-developmental in origin. His model of Schizophrenia concentrates on the phenomena of extreme panic states which paralyse the ego and lead to the fragmentation of the sense of continuity of the self. The ego marshals primitive defence mechanisms against this unbearable sense of loss of safety, and the psychotic personality is the result of attempts to re-integrate the sense of self. The cause of these states are ordinary psychodynamic stresses, as experienced by everybody, but in the case of the Schizophrenia-vulnerable subject the reaction is not normal anxiety but an extreme form of panic. The reason why people with Schizophrenia react to ordinary stress in this extraordinary way is because inappropriate mothering has led to failed emotional cuing, which in turn leads to repeated distress in the infant. This repeated distress leads to poor emotional development and the use of these primitive defence mechanisms. Such tendencies lie dormant until the stresses of adolescence.

Grotstein's model of Schizophrenia also postulated three stages of development, the autistic, the symbiotic phase (or paranoid-

schizoid position) and the separation and individuation phase. The schizophrenic subject is born with constitutional defects of sensory perception; added to this is maternal failure to protect the infant from sensory confusion and a sensory overload. This is compensated for by raising the sensory threshold which, in turn, leads to relative sensory deprivation. The gaps in normal perception are filled with hallucinatory phenomena. All this occurs at the autistic stage and leads the infant to enter the next stages in a psychologically deformed state, developing a schizoid personality. Later stresses lead to full blown Schizophrenia.

Psychoanalysis and Women

Freud's work and his influence present us with a series of paradoxes. As has been described above, Freud's thinking is presented as being novel and revolutionary when, in fact, it is the continuation of a much older tradition. Psychoanalysis is seen as a tool of personal liberation when, in fact, it requires total submission to a particular world view. In its claim to biological universality it is seen as being above, or beyond, the ephemera of political and social conflict yet it is very much a creed of its own time and place.

Doerner¹¹⁷ has attributed the emphasis on introspection in German Romanticism and the "Sturm und Drang" school as, itself, being a reaction to the political repression in Prussia and the mid German states following the French Revolution and the fear of that Revolution spilling over into other European states. With open debate of the most significant social and political event of the epoch stifled, there was nowhere else for the intellectual mind to go but inwards to a sometimes morbid introspection.

Freud was influenced by those who were, in turn, influenced by this political and philosophical climate. His theory was based on introspection and claimed to be universal because of its, supposed, biological basis. The use and reuse of biological metaphors (without adequate biological underpinning) reinforced

¹¹⁷ Doerner, K. (1981) Madmen and the Bourgeoisie. A Social History of Insanity and Psychiatry. Basil Blackwell. Oxford.

the theories universal, timeless a-politicality. Although psychodynamic writers were to address the subject of fascism the movement's response to the rise of fascism was slow and, one might argue, reluctant with a number of members of the movement, including Freud, only just escaping persecution (Sayers¹¹⁸). Earlier, members of the movement such as Wilhelm Reich had been discouraged (on both sides it should be added) from having dual membership with the Communist Party (Rycroft¹¹⁹). What Freud and his followers aimed at was to adjust their patients to life as it was and, in their view, always would be, not offering a critique of modern society, let alone attempting to change it.

Writers from the feminist position such as Ward ¹²⁰ and apostates such as Masson¹²¹ have argued that Freud attempted to explain away uncomfortable accounts of real incest. By developing the concept of the "seduction theory", Freud made incest easier to cover up by denying the victim the validity of her experience.

In a sense, the subject of incest is a subset of the influence of Freud's views on women in general and, for the purposes of this study, mothers in particular. This had a pernicious influence both within the field of psychodynamic psychology and

¹¹⁸ Sayers, J. (1992) Mothering Psychoanalysis Penguin Books. London.

¹¹⁹ Rycroft, C. (1971) Reich. Fontana. London.

¹²⁰ Ward, E. (1984) Father, Daughter, Rape. Woman's Press. London.

¹²¹ Masson, J M. (1985) The Assault on Truth. Penguin Books. London.

the lay world.

Friedan¹²² has argued that in the earlier days of the influence of psychoanalysis in the United States it was part of a liberating and liberalising influence on women, at least as far as sexual restrictions were concerned. Friedan's book is both an interesting and an important one. Friedan was educated originally as a psychologist and researched in psychology, but after marriage and children she developed a second career in journalism. She considered herself a beneficiary of that first wave of feminism in this century that allowed women an opportunity to be educated and develop professional careers. She saw this position being eroded substantially after the Second World War and her book is an attempt to explain this state of affairs, and the damaging and frustrating effect this was having on American women. Her book, at the time of its publication, was very influential in what can be thought of as the second wave of feminism.

What is also interesting about her book is that it was written towards the end of a period when Freud and psychodynamic psychology held hegemony not only over psychiatry and abnormal psychology but over the social sciences in general. While at times showing understandable reticence and paying due homage to Freud's "genius", she launched a devastating critique on Freud's image of women quoting from letters he wrote to his fiancée,

¹²² Friedan, B. (1963) The Feminine Mystique. Victor Gollanz. London.

Martha (later his wife) and from his biographer, Ernest Jones¹²³

who wrote:-

"Whatever his intellectual opinions may have been in the matter, there are many indications in his writing and correspondence of his emotional attitude. It would certainly be going too far to say that he regarded the male sex as the lords of creation, for there was no tinge of arrogance or superiority in his nature, but it might perhaps be fair to describe his view of the female sex as having as their main function to be ministering angels to the needs and comforts of men. His letters and his love choice make it plain that he had only one type of sexual object in mind, a gentle feminine one . . .

There is little doubt that Freud found the psychology of women more enigmatic than that of men. He said once to Marie Bonaparte: 'The great question that has never been answered and which I have not yet been able to answer, despite my thirty years of research into the feminine soul, is, what does a woman want?'"

Friedan¹²⁴ further amplifies Freud's incomprehension in the face of feminine psychology in the following quotation, this time from Freud himself:-

"A man of about thirty seems a youthful, and, in a sense, an incompletely developed individual, of whom we expect that he will be able to make good use of the possibilities of development, which analysis lays open to him. But a woman of about the same age, frequently staggers us by her psychological rigidity and unchangeability . . . There are no paths open to her for further development; it is as though the whole process had been gone through and remained unaccessible to influence for the future; as though, in fact, the difficult development which leads to femininity had exhausted all the possibilities of the individual . . . even when we are successful in removing the sufferings by solving her neurotic conflict."

¹²³ Jones, E. (1953). The Life and Work of Sigmund Freud Vol 1. Basic Books. New York. Page 101.

¹²⁴ Friedan, B. (1963) The Feminine Mystique. Victor Gollanz. London. Page 104.

The key to Freud's attitude to women is to be found in his background. Friedan points out that Freud was brought up in a traditional Jewish patriarchal family where ". . . men said the daily prayer: 'I thank Thee, Lord, that Thou has not created me a woman,' and women prayed in submission: 'I thank Thee, Lord, that Thou has created me according to Thy will'". Freud's own father was an autocrat and his mother was submissive. In turn, this Jewish culture was part of a wider central European autocratic and patriarchal society. From this perspective women would be seen as being the inferior sex, less than men. Due to Freud's own lack of insight into the cultural relativity of his perspective on women, he transformed his own view of the innate inferiority of women to "fact" by the use of a biological metaphor.

The metaphor in question is "penis envy" which, Freud stated, was the mainspring of feminine psychology. Briefly stated, the young girl realises that she lacks something all boys have, a penis, and from this comes a realisation that as a woman she is something less than a man. She sees herself as castrated and is wounded in her self love, she depreciates both herself and all other women, including her mother. The consequences of this are several. The "normal" girl will attempt to gain a penis of her own, first through the love of her father, then her husband and finally gaining a penis of her own through giving birth to a male child on whom her ambitions can be expressed. In the "abnormal" girl the penis envy will lead to sexual inhibition or neurosis or, crucially, to a masculine complex. What Freud means by a

masculine complex is the desire by women to do things which, by Freud's cultural standards, were seen as being the prerogative of men. At a stroke, Freud confines all women's political, economic, professional and creative ambitions (outside of the home) as symptoms of a diseased psychological development. Women who are not content with "Kinder, Kucher und Kircher" are, in Freud's judgement, sick. Of course, this view did not go unchallenged and attempts to develop a more positive psychodynamic psychology of women have been chronicled by Sayers¹²⁵ but still the views of Freud dominated.

The period which particularly interests Friedan in her study of the plight of women in the United States is from the 1940's to the early Sixties when the first edition of her book was published. During that period she saw the erosion of women's hard won progress into traditionally male dominated areas such as education and the professions gained after the First World War. She saw many women abandoning their educational and professional ambitions in favour of becoming wives and mothers. They did so under pressure not only from the popular press but from professional advisors in schools and colleges who argued that it was not normal to entertain "masculine" ambitions. These same able women then became frustrated at the limitations of their lives and abandoned ambitions, and it was this widespread malaise amongst American women that was the starting point of Friedan's study, a similar malaise to that of the Viennese women patients

¹²⁵ Sayers, J. (1992) Mothering Psychoanalysis. Penguin Books. London.

seen by Freud whom he so profoundly failed to understand! The advice to women about what was femininely appropriate was both fed by and, in turn, re-enforced the conventional Freudian view.

As has been mentioned above, psychoanalytical theory dominated not only the fields of psychiatry and abnormal psychology in America and at that time, but also other areas of social science, and we are left with two questions: why did it achieve such a dominating position there and why the first wave of the impact of Freudian thinking did not seem to impede the advancement of women in America after the First World War but did so after the Second World War?

It is impossible to answer either of these questions with absolute certainty but the following factors seem to be important. Reference has already been made to Doerner's view on the relationship between the flourishing of Romanticism and introspective psychology in Prussia and the mid German states at the beginning of the Nineteenth Century and the use of political repression in those states in an attempt to contain the contagious infection of the ideas spawned by the French Revolution. The intellectually curious and critical could not engage in a critique of their own society and the only arena for exploration was the personal, not the political. As has already been stated Freud was very much the heir to this tradition. America during the "Cold War" was in a not dissimilar position. It, too, was attempting to contain the contagion of revolution, though of a Marxist kind, and therefore had to define itself in

terms of what it was opposed to. Marxism and Socialism, once a potent force in America, had been in decline for some time before the Second World War (Shannon¹²⁶) but during the "Cold War" few attempted to criticise the American State from a Marxist perspective. Like the Soviet Union, America saw itself as the ideal type of a society but also, like the Soviet Union, it had its fair share of social problems that ideal type societies should not have. The solution, in the United States at least, was to couch these problems in terms of individual psychology, and Freudian analysis was an ideal tool. It was pseudo-scientific, pseudo-biological and, as stated above, considered itself above or beyond the political. It offered no critique of society and was only concerned with reform of the individual to fit society. In the context of the role of women, it presented what was essentially a Nineteenth Century, bourgeois, capitalistic model of women as a universal truth, a model ideal for America defining itself, in part, in a romantic view of its own past.

Women, especially mothers, found themselves the focus of scrutiny during this period that sometimes bordered on misogyny based on their role as the most significant person in the development of psychologically healthy children, and, conversely, as the cause of the disturbed and deviant child. As Neill¹²⁷ points out :-

¹²⁶ Shannon, D A. (1967) The Socialist Party of America. Quadrangle Books. Chicago.

¹²⁷ Neill, J. (1990) "Whatever Became of the Schizophrenogenic Mother?" American Journal of Psychotherapy. Vol. 44, No. 4 pp 499-505. Page 503.

"Women seemed to be very powerful. To professionals, and we must bear in mind that the public avidly sought professional advice on child care, mothers had failed to some degree. They had failed to produce healthy well-adjusted children but were powerful enough to produce pathological ones.

If women seemed to be powerful or dominant in the postwar years, men seemed to be less so. Much popular literature was given over to the theme of the decline of the male. The bureaucratization of work, the rise of the corporate "man in the grey flannel suit," the demise of individualism, were all forces of emasculation in the public world. This same literature warned that at home waited the "castrating woman." How much this state of affairs contributed to (mostly male) professionals' belief that a mother was powerful enough to cause schizophrenia we cannot know."

Finally, Neill provides a chilling quote from Donald Jackson¹²⁸, writing in 1957:-

". . . perhaps the next phase will include a study of schizophrenia as a family-borne disease involving a complicated host-vector recipient cycle that includes much more than can be counted by the term, schizophrenogenic mother. One could even speculate whether schizophrenia as it is known today would exist if parthenogenesis was the usual mode of propagation of the human species or if women were impersonally impregnated and gave birth to infants who were reared by state nurses in a communal setting."

The demonisation of mothers was complete. It should be remembered that is the same Donald Jackson who, with Bateson, Haley and Weakland, developed the Double-Bind theory of Schizophrenia and that Haley of the same team later went on to develop family therapy techniques with Salvador Minuchin!

¹²⁸ Jackson, D D. (1957) "A Note on the Importance of Trauma in the Genesis of Schizophrenia." Psychiatry. Vol. 20 pp 181-184. Page 501.

Psychodynamic Theories of Schizophrenia, an Overview

There are a number of minor variations in all the psychodynamic models of Schizophrenia reviewed above. Nevertheless, what most, if not all, have in common are the following: development is seen as a series of stages that are either successfully or unsuccessfully negotiated. Unsuccessful negotiation will lead to problems in later life including Schizophrenia. The cause of unsuccessful negotiation of the stages is trauma, frequently, if not always, caused by poor or inadequate mothering.

McGlashan (in Kaplan and Sadock¹²⁹) has pointed out that such theories have failed to stand the test of time for several reasons. As already stated, nearly all the theories above talk in terms of discreet stages of development, though these stages may vary between theorists. McGlashan argues that despite investigation, there is no empirical evidence for the existence of such stages. He also argues that these models, with a few exceptions such as Winnicott, picture the infant as a helpless, passive recipient of experience, including psychologically traumatic experiences, whereas all the evidence seems to point to infants as being active, seeking beings. McGlashan states that many infants who have suffered severe trauma do not go on to develop Schizophrenia and that many people with Schizophrenia experienced apparently relatively normal and uneventful childhoods. What the theories also fail to explain is why such

¹²⁹ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

alleged traumatic childhoods were never observed at the time or seemed to have no immediate consequence. In short, why does it sometimes take as much as two decades for the psychological damage to manifest itself. McGlashan also adds that there is scant evidence for a process of regression.

The Evidence for Pathogenic Parenting of People with Schizophrenia

In what is probably the most thorough review of research on the subject of the schizophrenogenic mother, Parker¹³⁰ concludes that most of the studies that seemed to demonstrate a correlation between a certain type of maternal personality (and to a lesser extent a paternal personality) and the aetiology of Schizophrenia were too flawed to be useful. Parker's paper reviews the two major strands in thinking on the relationship between parenting and parenting type and Schizophrenia, the first being the relationship between parenting type and the cause of Schizophrenia and the second being the relationship between parenting type and the course of Schizophrenia. The latter is reviewed in more detail below in the section on Expressed Emotion Theory.

As has been mentioned above, one of the earliest studies was by Kasanin, Knight and Sage¹³¹; they examined the childhood histories as recorded in hospital case histories of forty-five people with Schizophrenia. On the basis of these records, they concluded that there was evidence of maternal over protection in thirty-three cases and maternal rejection in two cases using the criterion of maternal over protection and rejection developed by

¹³⁰ Parker, G. (1982) "Re-Searching the Schizophrenogenic Mother." Journal of Nervous and Mental Diseases. Vol. 170, pp 452-462.

¹³¹ Kasanin, J, Knight, E and Sage, P. (1934) "The parent-child relationship in schizophrenia." Journal of Nervous and Mental Diseases. Vol. 79, pp 249-263.

Levy¹³². Kasanin et al recognised certain caveats in attributing a direct causal relationship. They accepted that over protective mothers might make better and more detailed informants for the purposes of hospital records, and therefore might be over represented in their sample. They also accept that Schizophrenia might be part of a wider biological inferiority; that people with Schizophrenia might have a higher probability of having other physical defects that may elicit an over protective response from the mother. Schizophrenia itself might elicit an over protective response and, in its more deviant behavioural form, a rejective response. However, despite these sensible caveats, Kasanin et al's research was used as supportive evidence for the existence of the schizophrenogenic mother.

Despert¹³³ reported a study of twenty-nine schizophrenic children admitted to a New York hospital. He found a consistent pattern in nineteen cases where the father was very subdued and the mother was aggressive, overanxious and oversolicitous. However, the sample was biased as nineteen of the twenty-nine cases were from one ethnic group (Jewish) and the results might just as easily be attributed to cultural patterns.

Hadju-Gaines¹³⁴ claimed to have replicated Despert's findings in

¹³² Levy, D M. (1931) "Maternal overprotection and rejection." Archives of Neurological Psychiatry. Vol. 25, pp 886-889.

¹³³ Despert, L J. (1938) "Schizophrenia in Children". Psychiatric Quarterly. Vol 12, pp 366-371.

¹³⁴ Hajdu-Gaines, L. (1940) "Contributions to the aetiology of schizophrenia." Psychoanalytic Review. Vol 27, pp 421-438.

a study, but had only four patient families. He also conceded that the pattern of parenting observed might be just as relevant for neurotic cases.

As Parker points out, there followed a series of uncontrolled studies that seemed to validate the hypothesis of the schizophrenogenic type mother. Tietze¹³⁵ studied twenty-five mothers of people with Schizophrenia. The sample was biased, as all the mothers were of at least average intelligence, and concluded that they tended to be overanxious, obsessive and domineering but there was also a subtype of the subtly domineering mother who, if anything, was more dangerous than the overtly domineering type. Tietze argued that all the mothers only felt secure if they were in control of their relationship with their child.

Reichard and Tillman¹³⁶ concatenated the results of a number of previous studies with thirteen cases of their own, and concluded that the parents of people with Schizophrenia were characterised by an ineffectual, withdrawn father dominated by an aggressive, sexually frigid mother. They further concluded that there were two important mothering subtypes; an overtly rejecting mother and a covertly rejecting mother both of whom were dominating and controlling of the schizophrenic child. In the latter case, the

¹³⁵ Tietze, T. (1949) "A study of mothers of schizophrenic patients." Psychiatry. Vol. 12, pp 55-65.

¹³⁶ Reichard, S and Tillman, C. (1950) "Patterns of parent-child relationship in schizophrenia." Psychiatry. Vol. 13, pp 247-257.

dominance was expressed as over protection.

Clardy¹³⁷ classified half the families of thirty people with Schizophrenia as overprotective and rejecting. Wahl¹³⁸, in a study based on hospital case records of three hundred and ninety-two people with Schizophrenia, concluded that a third had experienced rejection and seventeen per cent over protection from one or both parents. In a later study, Wahl¹³⁹ examined the hospital records of five hundred and sixty-eight people with Schizophrenia admitted to a US Navy hospital and concluded that thirty-four per cent had been subject to parental rejection and nine per cent subject to over protection.

Lidz, Cornelison and Singer's (Lidz, Fleck and Cornelison ed¹⁴⁰) study of seventeen families of people with Schizophrenia led them to support the model of the schizophrenogenic mother. Their work developed into the family imbalance model of Schizophrenia which is examined in more detail below.

¹³⁷ Clardy, E R A. (1951) "A study of the development and course of schizophrenic children." Psychiatric Quarterly. Vol. 25, pp 81-90.

¹³⁸ Wahl, C W. (1954) "Some antecedent factors in the family history of 392 schizophrenics." American Journal of Psychiatry. Vol. 110, pp 668-676.

¹³⁹ Wahl, C W. (1956) "Some antecedent factors in the family history of 568 male schizophrenics of the U.S. Navy." American Journal of Psychiatry. Vol. 113, pp 201-210.

¹⁴⁰ Lidz, T, Fleck, S and Cornelison, A R. (1964) Schizophrenia and the Family. International University Press. New York.

As Parker has pointed out, all the above studies are flawed to some degree. Some studies used sample sizes that were too small to justify their generalisations, while other studies, though more than adequate in sample size, were biased in their sampling of subjects. They relied on retrospective histories and case records. Most of the studies relied on the American criteria for diagnosing Schizophrenia which, by British and Continental standards, would be likely to over-include those suffering from other forms of disorder including neurotic and personality disorders. However, the single flaw that unites all the above studies is their lack of control groups. Later researchers have tried to use control groups in their studies but, as Parker points out, these later studies have not greatly clarified the issue.

Gerard and Siegel¹⁴¹ compared open-ended interviews of relatives of hospitalised people with Schizophrenia with a control group of relatives of high school students and found a more intense relationship between people with Schizophrenia and their mothers compared to the control group. They found a pronounced degree of contact, prolonging of maternal relationship and relationships that precluded other social contact. Also, in the Schizophrenic group there was a higher rate of disinterested fathers. However, the choice of families of high school students introduced a potential class bias element that may have affected the results.

¹⁴¹ Gerard, D L and Siegel, J. (1950) "The family background of schizophrenia." Psychiatric Quarterly. Vol. 24, pp 47-73.

Mark¹⁴² compared the mothers of a hundred hospitalised people with Schizophrenia with the mothers of a hundred general medical patients in terms of a child rearing attitude scale. He found significant differences between the two groups. The mothers of people with Schizophrenia were more restrictive and over protective and they also displayed both excessive devotion and detachment in comparison with the mothers of general patients. However, Zuckerman, Oltean and Monashkin¹⁴³, in a study that itself can be criticised for its eccentric choice of controls - mothers of hospitalised people with Schizophrenia compared to mothers attending school, church and social meetings - found little difference between the two groups in terms of three scales: authoritarian-control, hostility-rejection and democratic attitudes. These could equally well be accounted for by social class differences.

In another flawed controlled study, Freeman and Grayson¹⁴⁴ compared mothers of children who had Schizophrenia with a control group of mothers who were the acquaintances of student volunteers. Their findings were that the mothers of children with Schizophrenia tended to be more possessive and ignoring of their children.

¹⁴² Mark, J C. (1953) "The attitudes of the mothers of male schizophrenics towards child behaviour." Journal of Abnormal and Social Psychology. Vol. 48, pp 185-189.

¹⁴³ Zuckerman, M, Oltean, M and Monashkin, I. (1958) "The parental attitudes of mother of schizophrenics." Journal of Consulting Psychology. Vol. 22, pp 307-310.

¹⁴⁴ Freeman, R V and Grayson, H M. (1955) "Maternal attitudes in schizophrenia." Journal of Abnormal and Social Psychology. Vol. 50, pp 45-52.

Kohn and Clausen¹⁴⁵ did attempt to match relatives of people with Schizophrenia with controls using criteria of age, sex and paternal occupation. They found that it was only amongst the higher social class that there was a difference in terms of rating the mother as playing a strong and the father a weak authoritarian role. Lane and Singer¹⁴⁶ also found a significant class difference in a study of forty-eight families of people with Schizophrenia matched demographically with the families of forty-eight general hospital patients. They found that although people with Schizophrenia rated themselves as more dependant on their mothers than the controls, this could be accounted for by the fact that middle class people with Schizophrenia made more negative judgements of their parents than lower class people with Schizophrenia, who tended to overidealise their mothers and deny hostility towards their parents.

Lu¹⁴⁷ compared the attitudes of fifty patients with Schizophrenia with the attitudes of their non-Schizophrenic sibling to their parents. Lu's findings were that people with Schizophrenia tended to have both stronger positive and negative feelings to their parents than their siblings. The people with Schizophrenia tended to view their mothers as being dominating

¹⁴⁵ Kohn, M and Clausen, J A. (1956) "Parental authority behaviour and schizophrenia." American Journal of Orthopsychiatry. Vol.26, pp 297-313.

¹⁴⁶ Lane, R C and Singer, J L. (1957) "Familial attitudes in paranoid schizophrenics and normals from two socioeconomic classes." Journal of Abnormal and Social Psychology. Vol. 59, pp 328-339.

¹⁴⁷ Lu, Y-C. (1964) "Mother-child role relations in schizophrenia." Psychiatry. Vol. 24, pp 133-142.

and authoritarian. Lu came to the conclusion that the submission and dependence as a result of the Schizophrenia may elicit the dominating and authoritarian response from the mother.

In an important paper, McGhie¹⁴⁸ argued that terms such as "over protective" were often ill defined, and acknowledged that research in this area may raise anxiety in the parents of people with Schizophrenia who may feel that they are to blame for their child's disorder. He argued that the research methodology should include reassurance for the subjects. His own study of twenty mothers of people with Schizophrenia, twenty mothers of people with Neurosis and twenty controls found nothing to support the hypothesis that mothers of people with Schizophrenia were over protective, though there was some evidence to show that this was so in the mothers of people with Neurosis.

Even if it were possible to demonstrate that the parents of people with Schizophrenia behaved differently towards their offspring, this is still far from establishing a causal connection. There is, of course, the question of why some children of allegedly schizophrenogenic mothers develop Schizophrenia and their siblings do not. As has been stated above, having a sibling with Schizophrenia does increase the probability of Schizophrenia but this is just as easily explainable by a biological mechanism e.g. genetic or viral mechanisms. More importantly, and as researchers such as Lu have

¹⁴⁸ McGhie, A. A. (1961) "A comparative study of the mother-child relationship in schizophrenia." British Journal of Medical Psychology. Vol 34, pp 195-208.

pointed out, one must tease out if the alleged aberrant behaviour of parents of people with Schizophrenia is cause or effect.

O'Neal and Robins¹⁴⁹ explored this difficult area by attempting to follow up five hundred patients seen in child guidance clinics thirty years previously. Eventually, they were able to compare twenty-eight families with a child disturbed enough to attend child guidance clinic, who had no symptoms of Schizophrenia at the time but who later developed the disorder, with the families of ex-patients who had no current psychiatric disorder. The rationale of this research was that if the mothers were showing signs of pathogenic parenting prior to the onset of the disorder, then this may be evidence for a causal rather than a re-active link. What they did find was a higher rate of dependence noted at the child guidance clinic among the subjects later to develop Schizophrenia than the controls, a ratio of thirty-six per cent to two per cent. However, this evidence is less impressive than it seems. Classical psychodynamic models of Schizophrenia, as well as many biological models, postulate that the damage that causes Schizophrenia happens at an early stage of development. How early depends on the model, but all would predate the age that these children were seen at the child guidance clinic. The problem has always been to explain the period of latency, less of a problem in the biological models than the psychological. As has been mentioned above, there is anecdotal evidence to suggest that there are certain oddnesses of behaviour observed in people

¹⁴⁹ O'Neal, P and Robins, L. (1958) "Childhood patterns predictive of adult schizophrenia: A 30-year follow-up study." American Journal of Psychiatry. Vol. 115, pp 385-391.

who later go on to develop Schizophrenia and it might be argued that these early signs of the disorder can account for the over dependence observed in much the same way as the full symptoms of the disorder may elicit an over dependant relationship from the mother.

In a similar study, Waring and Ricks¹⁵⁰ examined the records of a hundred children who had attended a child guidance clinic, fifty of whom later developed Schizophrenia and a matched group of fifty who had not been admitted to psychiatric hospital. The records showed that the mothers of people with chronic Schizophrenia had been described in terms unlike that of the schizophrenogenic mother i.e. shy, inadequate, fearful and nervous but neither dominating nor controlling. Although some mothers of discharged, non-chronic schizophrenics did meet the criteria of the schizophrenogenic mother, more mothers in the control group were so described. Waring and Ricks' study was replicated by Gardner ¹⁵¹.

Finally, Wender, Rosenthal, Zahn and Kety¹⁵² compared matched groups of natural parents of people with Schizophrenia, adoptive

¹⁵⁰ Waring, M and Ricks, D. (1965) "Family patterns of children who become adult schizophrenics." Journal of Mental and Nervous Diseases. Vol. 140, pp 351-364.

¹⁵¹ Gardner, G G. (1967) "The role of maternal psychopathology in male and female schizophrenics." Journal of Consulting Psychology. Vol. 31, pp 411-413.

¹⁵² Wender, P, Rosenthal, D, Zahn, T and Kety, S. (1971) "The psychiatric adjustment of the adopting parents of schizophrenics." American Journal of Psychiatry. Vol. 127, pp 1013-1018.

parents of people with Schizophrenia and adoptive parents of children who did not have Schizophrenia. Case abstracts from parents' interviews were rated blind, but the raters could draw no conclusion about child rearing practices from the information supplied. What they could rate was parent psychopathology, which was found to be highest in the natural parents of people with Schizophrenia, next highest in the adoptive parents of people with Schizophrenia and least present in the adoptive parents of normal children. The results are suggestive of the impact of the child's Schizophrenia on the parent's psychopathology rather than the reverse, particularly in the context of adoptive parents who should have passed basic screening for psychopathology prior to adoption.

It would seem that after nearly sixty years of research, much of it methodologically flawed, there is little conclusive evidence for psychopathology of parents being a causal factor in Schizophrenia. What there does seem to be is evidence for the impact of having a schizophrenic child on parents. The subject of the impact of Schizophrenia on the reciprocal child-parent relation is examined in more detail below in the context of the concept of Expressed Emotion.

Family Transaction Models of Schizophrenia

The Double Bind Hypothesis

Bateson, Jackson, Haley and Weakland¹⁵³ saw the origins of Schizophrenia in the parents placing the child in a position where whatever it said or did would be construed as being wrong, the so called "double bind". Eventually, the child will withdraw from a situation in which it can never win. Bateson and his colleagues brought a variety of backgrounds to their approach to Schizophrenia; only Jackson was a psychiatrist, Bateson was an anthropologist and philosopher, Haley's background was in communication theory and Weakland's in engineering and anthropology.

Atkinson¹⁵⁴ defines five factors that must exist for the double bind to have its pathological impact in Bateson et al's model and these are: the need for two or more people to be involved, the person(s) giving the contradictory directions to be of importance to the child, the repetition of the double bind, that there must be an implied or explicit punishment awaiting the child for the inevitable wrong choice and that the child cannot escape from this situation or point out the inherent contradiction in the double bind. As Atkinson points out, in Bateson et al's model,

¹⁵³ Bateson, G, Jackson, D, Haley, J and Weakland, J. (1956) "Towards a Theory of Schizophrenia." Behavioural Science. Vol. 1, p 251.

¹⁵⁴ Atkinson, J M. (1986) Schizophrenia at Home. A Guide to Helping the Family. Croom Helm. London.

Schizophrenia appears less as an illness than as a pattern of communication or reaction to a pattern of communication.

In reality, there appears to be very little evidence to support anomalous communication patterns as described in the model between parents and the schizophrenic child, a finding no doubt exacerbated by very real problems in defining what does actually constitute a double bind, since this need not refer to verbal messages only.

Ringuette and Kennedy¹⁵⁵ compared letters of parents to their schizophrenic child with letters to non-schizophrenic siblings while the latter were patients in general hospitals. They also studied letters written by volunteers asked to simulate correspondence to their child as if in hospital. They found no significant differences in the correspondence.

Haley¹⁵⁶ compared patterns of instruction giving between parent and child in three groups: children with Schizophrenia, Neurosis and normal children. In the first part of the experiment the instructions were given over a microphone, with the communication in one direction only - from parent to child. In this phase the normal children and children with Neurosis performed markedly better on the instructed task than the children with

¹⁵⁵ Ringuette, E and Kennedy, T. (1966) "An Experimental Study of the Double Bind Hypothesis." Journal of Abnormal Psychology. Vol. 71, pp 136-144.

¹⁵⁶ Haley, J. (1968) "Testing parental instructions to schizophrenic and a normal children: a pilot study." Journal of Abnormal Psychology. Vol. 73, pp 559-565.

Schizophrenia. In the second phase, communication was two way and the performance of the children with Schizophrenia improved considerably. All the parents were asked to instruct normal children, not known to them, and this time there was no significant difference between the groups of parents. The results, in total, seemed to indicate that though there were clear communication problems between children with Schizophrenia and their parents it was likely that the problem was with the child with Schizophrenia and its perception of the parent's communication.

Family Imbalance Theory

Lidz developed his theory of family imbalance on the basis of the research he and his co-workers (Lidz et al¹⁵⁷ mentioned above) carried out on seventeen atypical families of people with Schizophrenia (they were all members of socio-economic groups I and II). From this somewhat limited data set, he and his co-workers postulated that Schizophrenia is the result of a disturbed triadic relationship between the mother, father and child. In this theory, certain patterns such as "schism" and "skew" occur. In schism, one parent is hostile, cold or destructive to the other, and in a "skewed" family one parent is inadequate and the other dominant. Sometimes, the generational boundaries may become blurred and the child is expected to play the role of adult friend or even parent to his or her father or

¹⁵⁷ Lidz, T, Fleck, S and Cornelison, A R. (1964) Schizophrenia and the Family. International University Press. New York.

mother. Other important concepts are the schizophrenic child as a scapegoat for the family's ills and the child as "identified patient". These notions have passed into common use in the wider field of family therapy.

Family Imbalance Theory has two things in common with the Double Bind hypothesis. The first is that they share the view of Schizophrenia being less of an illness and more a malfunction of communication, and the second is an almost total lack of evidence for their assumptions! A series of experiments by Ferreira and Winter¹⁵⁸ (and with Poindexter in 1966¹⁵⁹) has failed to find any supporting evidence for significant differences in family patterns as hypothesised by Lidz in the families of people with Schizophrenia compared with families of children suffering from other disorders and normal families. Despite this, Lidz, in an interview in 1972, (Orrill and Boyers¹⁶⁰) claimed that:

"one thing is clear: there has never been a schizophrenic who came from a stable family - at least we cannot find any".

Fragmented Family Communication Theory

Based on a study of four families only, Wynne, Ryckoff, Day and

¹⁵⁸ Ferreira, A J and Winter, W D. (1965) "Family Interactions and Decision Making." Archives of general Psychiatry. Vol. 13, pp 214-223.

¹⁵⁹ Ferreira, A J, Winter, W D and Poindexter, E. (1966) "Some interactional variables in normal and abnormal families." Family Process. Vol. 5, pp 60-75.

¹⁶⁰ Orril, R and Boyers, R. (1972) Laing and Anti-Psychiatry. Penguin. Harmondsworth.

Hirsch¹⁶¹ suggested that in Schizophrenia the whole family was disturbed in terms of the family's attempt to maintain mutuality where no mutuality appears to exist. Such a state was characterised by communication between family members which was fragmented, disjointed and lacking in continuity. Wynne et al characterised two main types of faulty communication on a continuum between, at one extreme, an amorphous style and, at the other extreme, a fragmented style. Wynne et al also hypothesised that roles in the families of people with Schizophrenia are also of importance, being either rigid and stereotyped or loose and ambiguous.

Wynne et al further hypothesised that the impact on the child was to affect its cognitive development, and that feelings of emptiness and pointlessness are conveyed to the child. If the family develop rigid roles, then the child cannot develop any sense of self-identity and cannot function outside of the family, which leaves it ill equipped to cope with the developmental transitions of adolescence.

Singer and Wynne (in Cohen ed¹⁶²) compared the generated speech from comments on the Rorschach test from parents of children with schizophrenia, neurotic and normal children. They developed categories which allowed them to claim a seventy-five per cent

¹⁶¹ Wynne, L C, Ryckoff, I, Day, J and Hirsch, S. (1958) Pseudo-mutuality in the family relations of schizophrenics." Psychiatry. Vol. 21, pp 205-220.

¹⁶² Cohen, I M ed. (1966) "Family structure dynamics and therapy." Psychiatric Research Reports of the American Psychiatric Association. No 20.

accuracy in identifying which group a parent came from. However, when the mothers and fathers were compared separately, the mothers of schizophrenic children did not score significantly differently in these categories compared to mothers of normal or neurotic children. The variance was only found in the speech of the fathers, with the highest scores for fathers of people with Schizophrenia the lowest for fathers of normal children and the fathers of neurotic children in between.

Hirsch and Leff^{163,164} attempted to replicate these findings in Britain. They did find differences between parents of schizophrenic, neurotic and normal children and, once again, this was accounted for by the scores for the fathers only. However, the degree of overlap between groups was much greater than Singer and Wynne's American sample, which seems odd if one considers the tighter definition of Schizophrenia used in this country compared to the United States (if anything the greater overlap should have been in Singer and Wynne's study). However, as Atkinson points out, a more likely explanation is that Singer and Wynne's subjects constituted a biased sample, being subjects referred to them for special study by colleagues who knew their interest in faulty communication theory. Hirsch and Leff's subjects were recruited from consecutive hospital admissions. When re-analysed, Hirsch and Leff also found that the higher score of the fathers

¹⁶³ Hirsch, S R and Leff, J P. (1971) "Parental abnormalities of verbal communication in the transmission of schizophrenia." Psychological Medicine. Vol. 1, pp 118-127.

¹⁶⁴ Hirsch, S R and Leff, J P. (1975) "Abnormalities in Parents of Schizophrenics." Institute of Psychiatry Maudsley Monograph. No 22.

of Schizophrenia sufferers also correlated with a higher rate of utterances: could it simply be that they scored higher because they spoke more?

The Rise of Family Therapy

Although the development of family therapy in a general context pre-dates the work of Bateson et al and Lidz et al, it is undoubtedly true that the work of these two groups had a powerful impact on the development of the movement in general. Lidz's concept of the scapegoat or "identified patient" has passed into general use. The general philosophy of rejecting the individual sufferer/deviant as the key to the problem in favour of the family system as a whole has an enormous attraction in a wide range of arenas beyond the treatment of Schizophrenia.

Although there are a number of different forms of family therapy and the literature on the subject is truly vast, certain key points emerge as crucial. As stated above, the alleged problem person in the family is not the focus, that person's problem is seen as part of the disfunction of the family as a whole. The family is seen as the central unit, for good or ill, and what is under investigation in family therapy are patterns of communication, verbal and non verbal, which are the only indicators of how the family is functioning. The whole - the family - is seen as being greater than the sum of the parts; the individual family member, and indeed, in a sense, the family member as an individual, almost ceases to exist under this

scrutiny. As with classical psychoanalysis, the content of communication, or non communication, is scrutinised in great detail as all communication is viewed as being meaningful and significant.

As Howe¹⁶⁵ has pointed out, family therapy has been adopted with great enthusiasm within social work in this country for three reasons.

Since as early as the Nineteen Fifties there had been concern about problems suffered by children, and problems caused by children; this led to an increasing focus on the family as an arena for both political and social concern and action. This was reflected in Parliament in the Ingleby Committee set up in 1956. The Committee reported in 1960 and its recommendations were, in the main, accepted in the Children and Young Persons Act, 1963. The Committee also reported that some of the problems identified were not being acted upon because of the specialist and fragmented nature of the existing Social Services. This criticism led to the Government White Paper: "The Child, the Family and the Young Offender"¹⁶⁶ which argued for a unified, family centred, social services. Finally, the Seebhom Report¹⁶⁷ of 1968 which

¹⁶⁵ Howe, D. (1989) The Consumers' View of Family Therapy. Gower. Aldershot.

¹⁶⁶ The Child, the Family and the Young Offender. (1965) HMSO. London.

¹⁶⁷ The Seebhom Report (1968) HMSO. London.

(together with the "Local Authority Social Services Act", 1970¹⁶⁸) shaped Local Authority Social Services Departments as we know them today.

The key factors associated with this political and social climate have been summarised by Howe as a rejection of an individual symptom based approach in favour of a community and familial approach. Society and Government were stating both their interest, legitimacy and right to intervene in the family through its agents. The essence was also on preventative as well as remedial action, but there was also a recognition of the lack of existing expertise and the need to develop new skills. As Howe¹⁶⁹ wrote:

"Thus, social work in the 1970's and 1980's was well placed to view the family as (i) an acceptable entity of welfare concern, (ii) an appropriate context for understanding individual behaviour, and (iii) a proper subject for professional concern."

In social workers' need to develop new skills, family therapy (mainly developed within psychology and psychiatry) had clear advantages. Its area of work was the accepted area of concern - the family. Its jargon was purposeful and "scientific" and, indeed, its supposed scientific basis was part of its appeal to social workers unaware of the lack of evidence behind much of its seminal work. At a time when conventional individual psychodynamic influenced case work seemed to deliver explanations

¹⁶⁸ The Local Authority Social Services Act. (1970) HMSO. London.

¹⁶⁹ Howe, D. (1989) The Consumers' View of Family Therapy. Gower. Aldershot. Page 5.

but few prescriptions for treatment, or at best only protracted treatment, the focused, finite term approach of family therapy naturally appealed.

Family therapy appealed to the new breed of managers who were emerging in the new social services. They were able to offer to their subordinates a focused, finite and quantifiable way of working. The interest of social workers attracted to family therapy therefore coincided with the interest of management.

Thus, a form of therapy developed with a significant input from those committed to exploring the family context of Schizophrenia became a popular vehicle for exploring a whole range of problems and problem behaviours. Family therapy's influence waxed as the influence of traditional individual casework waned in much the same way as individual psychodynamic explanations of the origins of Schizophrenia were also replaced by family models.

However, both in the case of Schizophrenia and the wider domain of family therapy, this approach was not without criticism. As has been said, the basis of some of the concepts is somewhat slender. The notion of the family as being the most important system to the exclusion of all other systems may be open to question in individual cases. The denial of the validity of the individual family member's experiences and indeed the denial of the family members' individual autonomy is also somewhat questionable (as is the role of the therapist, who is both a member but detached from the family system, as the only one

within the system who can interpret properly how the system is functioning or mal-functioning). Family members are part of the system but, unlike the therapist, cannot step outside to view it.

The author also questions the validity of applying, naively, concepts from one area of science into another, or into social science. Researchers within the physical sciences are aware that when examining systems with anything more than the most limited number of variables, prediction becomes impossible. If this is true in the realm of the non-sentient and the non-organic how much more so must this be true of human interaction in the family and, therefore, how much more difficult must it be to draw up typologies of reaction, unless one resorts to the grossest oversimplification?

It can be argued that in intervening in families we are using models of what families should be, divorced from the reality of what families are. It can also be argued that the reality of family life is plastic and non absolute. The criteria for what constitutes what is correct in families are created by society, often within the political arena, but these are presented as eternal, absolute values. Currently, there is still a view that the family is responsible for causing the deviant behaviour of the child, including mental illness. There is a lack of evidence to support this, either in the general or the particular.

Finally, it should be said that there is an inherent and unfair

one way nature to the analysis implied by family therapy. It is accepted that family problems lead to social problems, bad parenting to child delinquency etc, but it is not so strongly stressed that social problems lead to family problems, for example, that family breakdown and stress may be the result of economic and social structures.

The Radical Critics of Psychiatry

If, indeed, the concept of the family and what constitutes family values are relative, mutable over time and space, then is the concept of madness, of Schizophrenia, built on similar shifting sand? Since the 1960's a number of authors have argued just this albeit from varying and sometimes contradictory positions. In this section, the works of five of these theorists, Laing, Goffman, Szasz, Scheff and Foucault will be examined.

Laing and Anti-Psychiatry

Laing's work is important not just because of his impact as a major British theorist in this country, or because his work enjoyed a certain transient popularity outside of the mental health field, but because the changes in his thinking, and there appear to be at least three stages, highlight important positions in thinking about Schizophrenia. The word "appear" is used because, like Foucault, Laing's writings were sometimes obscure and polemical.

In Laing's first phase (see Laing¹⁷⁰), he both continues and extends the thinking of the family transaction theorists by saying that the family causes madness, but not just specific families with specific communication pathologies. In his view, at that time, the nuclear family itself was seen as pathogenic,

¹⁷⁰ Laing, R D. (1960) The Divided Self: A Study of Sanity and Madness. Quadrangle. Chicago.

and Schizophrenia was a strategy that individuals used to cope with the impossible situation created by the family. However, Laing did accept, at this first stage, that Schizophrenia as described by his fellow psychiatrists, did exist as a phenomenon. What his theory failed to explain is why all siblings of people with Schizophrenia did not develop the disorder and, for that matter, why all children in all nuclear families were not also schizophrenic.

In Laing's second phase (see Laing and Esterson¹⁷¹), he seemed to be arguing that Schizophrenia, though still a state with negative connotation, was not a disorder as such but a form of interpersonal functioning. In his final stage, he seemed to be arguing (see Laing¹⁷²) that Schizophrenia was not a disorder but existed only as a social and political label. Further to this, Laing described the state of mind known as Schizophrenia as being the true sanity with the dissolution of the normal ego. Schizophrenia here becomes a transcendental state, a state of grace - a breakthrough rather than a breakdown. From this point of view, the notion of "treatment" becomes unthinkable.

Oelbaum¹⁷³ has pointed out the problems and confusion that Laing created for himself in his changing views on Schizophrenia.

¹⁷¹ Laing, R D and Esterson, A. (1970) Sanity, Madness and the Family. Penguin. London.

¹⁷² Laing, R D. (1967) The Politics of Experience and the Birds of Paradise. Penguin. London.

¹⁷³ Oelbaum, L R. (1972) "Clinical and moral views of madness: Laing and Goffman compared." Bulletin of the Menninger Clinic. Vol. 36, no 5, pp 487-504. Page 492.

"Perhaps much of the ambiguity of Laing's writing is the result of his effort to deal with madness both phenomenologically and prospectively - or teleologically. In this sense, madness is not only (1) a mode of being in the world that is primarily a reaction to social forces pressing on the individual but also, (2) a purposive-willed effort to reinstate oneself as an intact human being. It is in this second sense that madness acquires its special moral force.

But there is, I think, another source of ambiguity and equivocation in Laing's writing: he alternates, it seems, between considering madness to be the outcome of a special kind of social plight over which the individual can exercise no control, and a course of action that he might choose or refrain from choosing."

In his 1967 book¹⁷⁴, Laing used the metaphor of the squadron of aircraft flying in formation. By analogy, the schizophrenic flies out of formation and it is being "off course" that defines the schizophrenic as such. As Laing points out, what is not necessarily clear is if it is the squadron, the schizophrenic, or indeed anybody who is truly on course! The person with Schizophrenia may choose to leave the formation as a self willed act because he feels that he knows what the right course is. In this sense, the behaviour of the person with Schizophrenia may be constructed as an act of social and political protest.

Laing was also very concerned with the issue of madness and responsibility and how, subsequent to diagnosis, all meaning and responsibility for past and perhaps deviant acts are taken away from the mad. Although Laing did not regard the insane as being responsible for their plight, he deplored the way in which madness is used to subtract meaning from their actions and,

¹⁷⁴ Laing, R D. (1967) The Politics of Experience and the Birds of Paradise. Penguin. London.

therefore to deny their humanity.

Writers from within the mainstream of psychiatry such as Clare¹⁷⁵ have been more scathing in their criticism of Laing, a criticism that it must be said Laing invited by his own harsh polemicism.

"Now elsewhere Laing recognises how easy it is to keep shifting the "blame" for the condition from the patient to the patient's biochemistry, the patient's mother, the parental marriage, the nuclear family, the social environment, the capitalistic system, the Total World System. It is not, as he puts it, "a matter of laying the blame at anyone's door". But, unfortunately, such caveats as he and others enter live somewhat wanly and uneasily beside the gigantic insistence which emerges from his and his colleagues' writings that it is the family who has driven the schizophrenic mad, that the illness is the only "intelligible" response to the situation, and that psychiatrists, in seeking to alleviate the schizophrenic's sufferings, are merely furthering the family's destructive interests. So it is that Mary Barnes describes her "abnormally nice family" (though it is never stated in what way they were abnormal) and the reader of that much-read book is left in no doubt that the colourful variety of Mary's family interactions and experiences caused her illness and that of her brother."

Irving Goffman

Goffman's views on madness, though no less radical and perhaps, even, more radical than Laing's, are more consistent and straightforward. Goffman simply argues that there is no such thing as psychotic behaviour. He argues that all of the behaviours, the delusions and hallucinations etc., observed as

¹⁷⁵ Clare, A. (1980) Psychiatry in Dissent. Controversial Issues in Thought and Practice Second Edition. Tavistock Publications. Page 194.

being symptomatic of psychoses and Schizophrenia exist in the world of the non-psychotic. What marks out the mad from the sane is that the mad show these common behaviours in addition to social and/or legal rule infraction. Thus, if one displays the alleged psychotic behaviours but one does not infringe social and legal rules one will be judged to be normal. Break the rules but show no "psychotic" behaviour and one will be judged a criminal or other form of deviant. To be judged mad one must both show the behaviour and break the rules. Goffman deals with the question of those who are mad but not deviant and volunteer for treatment by saying that such persons have inculcated society's models of madness and have been taught that their "normal" experiences are abnormal.

While Laing was clearly troubled and unsure on the issue of insanity and responsibility for one's acts, Goffman is quite clear. We are all, including the alleged mad, responsible for our own acts and when the legal system colludes by the use of the insanity defence it is clearly wrong.

However, Goffman does accept that, for instance, the organically brain damaged are in a different category to the functionally insane. He regards the former as, perhaps, not being able to act within societal norms, whereas the latter should be able to. Goffman's distinction is both over simplistic and inaccurate. As has been explained above, there is increasing evidence in the context of Schizophrenia for some degree of brain damage

associated with the disorder. It is no longer tenable to draw hard and fast boundaries between organic and non-organic psychosis. It is also very difficult to say when organic damage can be said to impinge on an individual's capacity to follow societal rules.

Goffman's most significant contribution is in describing the "rites of passage" by which the newly judged insane are processed into the role of being mad. In his most well known book (Goffman¹⁷⁶), the process of humiliation and degradation and the stripping away of personal autonomy is described. Attempts to retain a sense of individual identity, and indeed all other acts, are re-interpreted within the context of the diagnosis. Goffman's view of this re-interpretation received confirmation in Rosenhan's¹⁷⁷ famous experiment in which "pseudo-patients" i.e. non-psychotic volunteers, trained to offer one psychotic symptom on admission, were admitted to unsuspecting psychiatric facilities. Their normal behaviour, including note taking on the behaviour of staff and other patients was re-interpreted as symptomatic of their psychotic condition.

¹⁷⁶ Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Doubleday. New York.

¹⁷⁷ Rosenthal, D L. (1973) "On being sane in insane places." Science. January, pp 281-288.

Szasz and the "Myth of Mental Illness"

The central thrust of Szasz' argument (see Szasz¹⁷⁸) is that the concept of "mental illness" is a metaphor, a myth, that has incorrectly gained the status of established fact. He argues that the language and terms of scientific medicine are entirely appropriate in the context of organic disorders, but are used inappropriately in the context of deviance in human conduct, of which the conduct of the so called schizophrenic would be an example. There are several consequences of this mistaken approach to human conduct.

Szasz does not dispute that there are a large number of persons ill at ease with themselves and society who, from the traditional psychiatric perspective, are deemed to be suffering from functional psychiatric disorders. These people often request and require help, but the help they should receive should, according to Szasz, be predicated on a science of human conduct not a science of medicine. In real terms this would mean a humanistic, psychotherapeutic approach. What it specifically would *not* mean is a pharmacological approach.

More than this, Szasz argues that the pseudo science of psychiatry is appropriated by society, or allows itself to be appropriated, in a number of unacceptable ways. It has been used in the past to provide spurious scientific credibility to the

¹⁷⁸ Szasz, T. (1962) The Myth of Mental Illness. Secker and Warburg. London.

persecution of allegedly deviant groups, for example the explanation of homosexuality as a form of sickness. Alternatively, it has been used, in Szasz own words (Szasz¹⁷⁹), to "bootleg" humanistic values into the legal and other social systems. What he means by this is that just as the bootleggers provided alcohol (at some considerable profit) during Prohibition, providing a product that society wanted in the face of legislation that was both unpopular and unworkable, so psychiatry provides "under the counter" humanism in the context of legal and social systems that would otherwise be intolerably repressive and inoperable. An example of this would be abortion on the grounds of the mother's psychiatric health. The central flaw in psychiatry providing such a service to society, beyond the intellectual flaw of psychiatry staking claim to areas beyond its remit, is that in doing so, politicians and society itself are allowed to avoid facing up to the central moral issues that must be resolved. While psychiatry papers over society's cracks, the foundations are never repaired.

In all this, Szasz divides what conventional psychiatry would regard as psychiatric disorders into three categories. He agrees with Goffman's basic acceptance of a category of the clearly organically brain disordered e.g. those suffering from GPI or toxic psychoses where the concept of disease is appropriate but the disease is of the brain not the mind. The second category includes the functional psychiatric illness where there is

¹⁷⁹ Szasz, T S. (1962) "Bootlegging humanistic values through psychiatry." Antioch Review. Vol. 22, pp 341-349.

disease only in the metaphorical senses. The third category consists of anti-social acts that are social deviations only. It is only in the first category that psychiatry should intervene.

With the benefit of hindsight, the same criticism can be made of Szasz as of Goffman ie that in Schizophrenia there is sufficient evidence of organic abnormality to place the disorder in the category that is the legitimate province of a medical based approach. However, to digress slightly beyond the strict bounds of this thesis, Laing and Goffman and Szasz still leave important questions to be answered concerning responsibility for one's actions, even for the clearly mad, and the dangers of professions stepping beyond their boundaries to fill voids left by politicians and the state.

Thomas Scheff and Societal Reaction

Scheff¹⁸⁰ argues that the major problem in psychiatric diagnosis is that it is decontextualised, that it fails to take into account the social situation in which the alleged suffer from mental illness finds him or herself. In a sense, this decontextualisation is implicit in the notion of mental illness. The medically trained specialist does not look for the social context of the behaviour and therefore does not find it. The problem is further compounded by the possibility that the

¹⁸⁰ Scheff, T J Being Mentally Ill. A Sociological Theory. Aldine. Chicago.

diagnosis is often made in a rushed and pressured situation and can sometimes be somewhat perfunctory.

Scheff supports this argument by reference to Laing and Esterson's¹⁸¹ lengthy interviews, which seemed to show rational explanations for the alleged sufferer's irrational behaviour in terms of a reaction to the bizarre behaviour of other family members. Up to a point Scheff is right, but as many examples of over emphasis and over interpretation of context can be found as under emphasis. It could be argued that the above average rates of Schizophrenia in Afro-Caribbeans can be, in part, attributed to poor, rushed and decontextualised diagnosis. This may result in the misdiagnosis of reactive or endogenous affective disorder as Schizophrenia or even culturally appropriate sane behaviour as insanity. At the other extreme are the sorts of criticism made by Clare¹⁸² of Laing and Esterson and their followers, of over exhaustive scrutiny of family background which in itself was bound to turn up some nugget of deviant behaviour as it would of any family that did not have a mentally ill member (remember Mary Barne's "abnormally normal family"). However, Scheff usefully reminds us that writers such as Lemert have argued that the family is not the only group situation where an individual's behaviour can lead to him or her being excluded and labelled as deviant and, perhaps, mentally ill; it is a characteristic of all

¹⁷⁷ Laing, R D and Esterson, A. (1970) Sanity, Madness and the Family. Penguin. London.

¹⁸² Clare, A. Psychiatry in Dissent. Controversial Issues in Thought and Practice. Second Edition. Tavistock Publications. London.

groups of which the family is just one type.

On a deeper and more philosophical level, Scheff argues that no behaviour can be defined as being deviant outside of a social context, and that those who are mentally ill can end up playing the role of the mentally ill within the social milieu. As has been said, the psychiatrists and doctors must define a certain sort of deviance known as mentally illness as an "illness", an individual and internal and not a social disorder because their whole education and thinking must lead them to that conclusion. Lay society, for want of an alternative, agrees and colludes with this model, and one presumes that as, in Goffman's approach, those who show no obvious signs of mental illness but report themselves as sufferers do so because they too have internalised medical values and perspectives. Scheff also argues that by decontextualising "mad" behaviour and seeing it purely in terms of the organic, the meaning of the behaviour becomes lost and denigrated by being defined as meaningless.

In the context of the times in which Scheff was developing his theories, his criticisms had some validity. As has been mentioned above, there have been very real problems of diagnosis and there continues to be problem of how effectively even good diagnostic criteria can be applied in the context of an overworked and overstretched health service. However, events have overtaken Scheff as they have Laing, Goffman and Szasz, and diagnostic criteria, and evidence for the appropriateness of an organic approach have advanced in the intervening decades. With

hindsight, the supporting evidence from Laing and Esterson seems slim and partial. For every "identified" patient whose bizarre behaviour is explicable in terms of the family's bizarre behaviour there are many more people who suffer delusions and hallucinations, sometimes, if not often, in social isolation. Given the current levels of funding of community care, more people will be left to be tortured by hallucinatory voice in isolated bed-sitters.

Michel Foucault

Foucault's contribution was an attempt to link philosophy and history, in the modern French literary-philosophical style. Though regarded as one of the leading structuralists he frequently denied this ascription, and has also been described as a post-structuralist.

He argued that we are living in a period of thought that started at the end of the Eighteenth Century and from which we are yet to emerge. Our current pattern of thought is so radically different from the previous, the "Classical Age" (in Foucault's understanding, the Seventeenth and Eighteenth Centuries), that we find it difficult to explore thinking beyond the beginning of our era, beyond the point of rupture and disruption.

Foucault attempts to explore these changes in a range of areas but, for the purposes of this thesis, his most important work is the change in attitude to madness at the end of the Eighteenth

Century described in the abridged, English translation as "Madness and Civilization" (Foucault¹⁸³). He argues that during the "Classical Age", lunatics were not expelled from society but were confined with other deviants, such as criminals and paupers: madness was an idle illness. Foucault argues that before this, during the Renaissance, madness was not feared and had a meaning beyond reason. Madness had a functional role in exposing the folly of the sane world. The "Classical Age" ushered in an era, not just of confinement but of harsh treatment - of torture as therapy. In the Renaissance, madness was not an illness and had a meaning; in the "Classical Age" madness was an illness fraught with moral undertones.

The "Classical Age" gave way to our current period, and the transition to a psychiatric perspective was characterised by the liberation of the mad by reformers such as Tuke and Pinel. Foucault argues that these reforms were, in reality, a long way from liberal and humane position they seem. A tyranny of the body was replaced by a tyranny of the mind. Hitherto, no matter how badly patients may have been physically treated in the "Classical Age" their minds, dreams and fantasies had been left untouched. In the modern period, the asylum, mirroring the authoritative nature of bourgeois society, confined unreason itself. It is during our current period that the medical model of madness achieved its dominance and, as such, we find it difficult not to see madness in terms of tissue and disease, to see the world

¹⁸³ Foucault, M. (1971) : Madness and Civilization: A History of Insanity in the Age of Reason. Tavistock. London.

through the eyes of those living in periods when medicine did not have the hegemony over madness.

There are several problems with Foucault's history that go beyond his extravagant and sometimes impenetrable prose style. In a brief but thorough survey of Foucault's critics, Merquior¹⁸⁴ points out the many shortcomings in Foucault's history. Foucault was later to argue that Nietzsche was correct in saying that historians can never be objective and that their pretensions to objectivity were false. In his later writings, Foucault claimed to be writing a new form of history but when he wrote "Madness and Civilization" he was writing a radical history of psychiatry from the position and technique, however, of conventional historicity. As such, it fails as good, historical scholarship, and Merquior quotes many examples. Cruelty to and imprisonment of the mad can be found in the Mediaeval and Renaissance period, and organic, medical models of madness date back at least as far as Hippocrates and were very important in the Mediaeval and Renaissance periods. Though not so humane as their most strident supporters argue, Tuke, Pinel and the moral therapists' reforms were significant and humane reforms. Contrary to Foucault's opinion (as has been argued earlier) Tuke's reforms were seen as a threat, not a support, to medical hegemony at the time. Where Foucault saw medical interference in the Nineteenth Century, more accurate historical analysis sees medical passivity in the face of the perceived incurability of insanity (for instance Maudsley's "tyranny of organization"). The reader is referred to

¹⁸⁴ Merquior, J G. (1991) Foucault. Fontana. London.

Merquior and the authors he cites for a full catalogue of Foucault's inaccuracies.

What remains of Foucault's ideas? He was, of course, correct in arguing that notions on madness are products of their age, and that we experience difficulty in seeing the world through the eyes of our ancestors, but this is both trite and obvious. A phrase used by Foucault to describe his studies was: "archaeology of medicine". Certainly, psychiatry and allied fields often seem curiously a-historical in their view. However, there is an increasing amount of good scholarship, good "archaeology", in this field, one thinks of the work of Doerner and Scull for example. In comparison to this good "archaeology", Foucault appeared as something of an Eighteenth Century antiquarian or Twentieth Century treasure hunter with a metal detector, digging bright objects from the earth and making hopelessly inaccurate and extravagant claims about the worth, dates, provenance and context of the objects he has found.

VULNERABILITY-STRESS MODELS OF SCHIZOPHRENIA

McGlashan (in Kaplan and Sadock ed.¹⁸⁵) regards vulnerability-stress model as the third major class of psycho-social theories of Schizophrenia, the other two classes being psychodynamic and family-transactional. He traces the origins back at least as far as Freud, quoting from Freud¹⁸⁶ as follows:

"Disposition and experience are here linked up in an indissoluble aetiological unit. For disposition exaggerates impressions which otherwise have been completely commonplace and have no effect, so that they become traumas giving rise to situations and fixations; while experiences awaken factors in the disposition which, without them, might have long remained dormant and perhaps never have developed."

Vulnerability-stress models imply that the underlying basis of Schizophrenia is biological but includes an environmental trigger factor that could be social and/or psychological that has to be present for the disease to emerge. In this way, nurture interacts with nature to either inhibit or facilitate the expression of the disorder.

This compromise position between the biological and psycho-social approaches has an immediate appeal as an explanation for the inadequacies of purely biological or purely psycho-social explanations. For instance, many vulnerability-stress theorists,

¹⁸⁵ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

¹⁸⁶ Freud, S. (1957) On the History of the Psycho-Analytic Movement. Hogarth Press. London.

such as Sandor Rado, see the vulnerability as being genetic. As reviewed above, the evidence for a genetic component in Schizophrenia or genetic aetiology in a significant number of cases is impressive but not sufficient to indicate that genetics is the sole answer. A present or absent trigger factor might explain the lack of full Mendelian inheritance patterns seen in Schizophrenia.

Rado¹⁸⁷ saw the inherited component as being "anhedonia" the incapacity to experience pleasure which in turn leads to the inability to develop initiative, overdependence on others and thought patterns that are convoluted but lacking in emotion. The individual will develop a stable if schizoid personality in a family environment that is relatively stress free and supportive, but in a less favourable background full Schizophrenia will occur.

Meehl¹⁸⁸ also believed that the underlying predisposition to Schizophrenia was inherited, but in this case an inherited defect of neural integration. The family environment and social learning would determine, once again, whether full Schizophrenia developed.

Vulnerability-stress models have also been used to explain differing rates of occurrence in Schizophrenia between social and

¹⁸⁷ Rado, S. (1956) Psychoanalysis of Behaviour. Grune and Stratton. New York. Page 963.

¹⁸⁸ Meehl, P. E. (1962) "Schizotaxia, schizotypy, schizophrenia." American Psychologist. Vol. 17 p 1.

also ethnic groups. The argument runs that even if the vulnerability is evenly distributed throughout the population, the stresses of poverty, and/or being on the receiving end of racism, results in higher than average rates of Schizophrenia in the lower socio-economic groups and certain ethnic minorities. However, the "social drift" argument explains the higher rates in the lower socio-economic groups without recourse to vulnerability-stress. Simply put, Schizophrenia, associated as it is with poor motivation and volition, is an impoverishing disease, and, over generations, those families with the genetic predisposition are likely to drift into the lower social classes. This would also lead to a higher concentration by marriage within such classes. In effect, poverty becomes a result, not a cause, of Schizophrenia.

Investigators in this area are also interested in comparing chronic versus acute stress and the onset of Schizophrenia. Chronic stresses include those mentioned above, the long slow grind of poverty for instance, whereas acute stress models are interested in the role of life events, bereavements, loss of relationships etc and the onset of the disorder. The problem with a life event theory approach is that we all experience at one time or another significant and stressful life events but we do not all develop Schizophrenia. Even amongst those predisposed to the disorder by, say, family history and sharing a common life event, say the death of parent, there may be one sibling who develops the disorder and one who does not. It can be argued that the meaning and psychic pain of a common life event may be

experienced differently by individuals, but at this point such an approach is in danger of becoming empirically meaningless. Without an objective measure of the psychic distress caused by a life event, and it is hard to see how one could measure such a thing, it is impossible to correlate life events with onset of Schizophrenia or to compare with non-schizophrenic controls. The matter is further confused if, before the onset is noticed, the disorder is present at a sub-clinical level sufficient to influence the affective reaction to the life event. In short, the early stages of the illness may pre-dispose the sufferer to react to a life event to a more heightened or lessened degree.

Perhaps the most significant, enduring and potentially most useful of the vulnerability-stress models is the theory of Expressed Emotion (EE). The origins of the Expressed Emotion approach are in a paper by Brown, Carstairs and Topping¹⁸⁹ that showed that people with Schizophrenia discharged to hostels, lodgings, siblings and distant relatives survived longer in the community than those discharged to live with parents or spouses.

Expressed Emotion is a measure of the rate of negative and hostile reactions by family members to the person with Schizophrenia. Tape recordings are made of samples of the family's conversations and scored by a standardised methodology

¹⁸⁹ Brown, G W, Carstairs, G M and Topping, G. (1958) "Post-hospital adjustment of chronic mental patients." Lancet. Vol. II, pp 685-689.

(see Brown, Birley and Wing¹⁹⁰ and Vaughn and Leff¹⁹¹). Families are rated as either High EE or Low EE and the research seems to indicate that relapse is more common in High EE families than Low EE families. This approach postulates a psycho-social element to the course of the disease but not to the cause. Falloon¹⁹² concludes from a large body of research that Expressed Emotion remains one of the most powerful predictors of the course of Schizophrenia available.

However, there still remains confusion as to the meaning of these findings. It seems likely that rates of EE do not represent a genetic link with Schizophrenia. As rates of EE correlate with relapse in both the case of spouses and parents, it is unlikely that high EE in parents is the manifestation of an inherited disorder expressing itself as Schizophrenia in the child.

It is interesting to note that this approach, certainly by workers in this country, was seen as being very much a reaction against the more condemning approach of Laing and his followers. It was recognised that the predicament of family carers of people with Schizophrenia was a difficult one and emotionally highly

¹⁹⁰ Brown, G W, Birley, J L T and Wing, J K. (1972) "Influence of family life on the course of schizophrenic disorders: replication." British Journal of Psychiatry. Vol. 121, pp 241-258.

¹⁹¹ Vaughn, C E and Leff, J P. (1976) The measurement of expressed emotion in the families of psychiatric patients." British Journal of Social and Clinical Psychology. Vol. 15, pp 157-165.

¹⁹² Falloon, I R H (1988) "Expressed emotion: current status." Psychological medicine. Vol. 188, pp 269-274.

charged. The focus of work, albeit frequently from a family therapy approach, was basically a humane one, that of helping families cope with the bizarre and difficult behaviour and thus reduce EE.

Even so, the focus was, in the early research, family pathology related. More recent research (see, for example, Leff, Berkowitz, Shavit, Strachan, Glass and Vaughn¹⁹³) has shifted the focus yet again seeing the high EE families as being normal in an abnormal situation. The beneficial work is found in teaching coping strategies and explaining the disorder, rather than a traditional family therapy approach with its implications of parental pathology. This new attitude has been summarised by Falloon¹⁹⁴ in a passage which offers an appropriate conclusion to the arguments raised in this chapter.

"Despite three decades of careful research on the association between household stress factors and the clinical outcome of schizophrenia the precise nature of this association remains obscure. This should not surprise research scientists for whom the precise links between, genetic, biochemical and other psychosocial factors and the pathogenesis of schizophrenia have yet to be unravelled. However, the "expressed emotion" hypothesis has focused attention on the plight of the family members who are increasingly expected to cope with the confusing, frightening behaviour of their relatives. Efforts to support the family unit in their efforts to cope with mental disorders are now considered a crucial part of the community management of schizophrenia. Unlike the early efforts that focused on the deficits noted in the families under stress, recent developments have

¹⁹³ Leff, J, Berkowitz, R, Shavitt, N, Strachan. A, Glass, I and Vaughn, C (1989) "A trial of family therapy v a relatives' group for schizophrenia." British Journal of Psychiatry. Vol. 154, pp 58-66.

¹⁹⁴ Falloon, I R H (1988) "Expressed emotion: current status." Psychological medicine. Vol. 188, pp 269-274. Page 273.

attempted to build on the strengths of family coping. The family remains unrivalled in the care of the mentally ill, and is arguably the most valuable resource in promoting the long-term health and welfare of its members. Such an important resource deserves our utmost respect."

PART TWO

THE PARENTS' PERSPECTIVE

THE EXPERIENCES OF FAMILIES OF PEOPLE WITH SCHIZOPHRENIA

In the previous sections the author reviewed the conventional psychiatric definitions of Schizophrenia and the problems inherent in this concept. Schizophrenia was viewed from an historical context and the three major perspectives on Schizophrenia were reviewed - Schizophrenia as a biological disorder, psycho-social models of Schizophrenia, focusing particularly on family models, and finally a brief review of the major interactionist group of models, the vulnerability stress approach.

As has been reviewed above, there is a little or no evidence to support psycho-social explanations of Schizophrenia and, in particular, pathogenic parenting models. This leaves the secondary question of why, despite the considerable biological tradition, despite the pre-existing evidence for biological explanations and despite the lack of evidence for psycho-social explanations, they gained the currency they did, and still endure to some degree today.

The answers to this question are many and cover both the laudable and not so laudable. The key is Freud and psychodynamic psychology and his pre-cursors. Despite claims and terminology to the contrary, what Freud presented was a concept of disembodied mind, a mind with no clear or coherent attachment to the neuro-physiological, a mind but a few steps removed from the concept of the soul. Based on philosophical-psychological

tradition that pre-dated the pessimistic view of Kraepelin, Freud, or more accurately the post-Freudian thinkers on Schizophrenia including Bleuler, found acceptance for their ideas for a number of reasons.

At the end of the Nineteenth Century and the beginning of the Twentieth Century, psychiatry, although greatly increasing its knowledge base, had reached a state of therapeutic impotence, particularly in the context of dementia praecox/Schizophrenia. Inheritance was held to be a major factor if not the sole factor in insanity and as such the outlook was bleak. The early optimism of Tuke and Pinel's approach and moral therapy had also died. Schizophrenia was a disease of the brain and as such untreatable.

What psychodynamic psychology offered was Schizophrenia as disease of mind and a method of treatment (though Freud himself felt that psychoanalysis might not be an effective treatment for Schizophrenia). In rejecting nature, such an approach had to implicate nurture and this has led not only to numerous therapeutic blind alleys but also to a great injustice towards the parents of people with Schizophrenia who found themselves unfairly blamed.

Thus far, the author has reviewed Schizophrenia and the family from the perspective of the professional. In the second half of this thesis the perspective of the parents will be reviewed. By way of an introduction to the study of the experiences of parents of persons with Schizophrenia, a review of recent

material is presented to give a context to the questions which the study explores.

The Burden of having a Child with Schizophrenia

Atkinson¹⁹⁵ lists several types of emotional burden found in families of people with Schizophrenia. She writes :-

"Inevitably, relatives of chronic schizophrenic patients are worried about the present and the future, in terms of the patient's treatment and management. The past may also be of concern to them and provide an additional source of worry. Not infrequently there is a "search after meaning" as relatives try to understand why this should have happened to their family. Many parents will feel that it is something they have or have not done that is at the root of the problem. They may search for anything in the ill child's upbringing that distinguishes him from his siblings, and will recall anything from traumas and illness, to real or imagined rejection by other family members as being of possible significance."

Reactions of guilt and blame would be likely if the family was being directly held to blame by mental health care professionals in terms of the pathogenic parenting models reviewed in Part One of this thesis or if those models have spread out to the wider lay view of the aetiologies of the disorder.

Authors such as Creer and Wing¹⁹⁶ have also reported that parents of people with Schizophrenia often felt that professionals held them to blame for their child's illness and: "Many parents recalled some doctor or social worker who implied

¹⁹⁵ Atkinson, J M. (1986) Schizophrenia at Home. A Guide to Helping the Family. Croom Helm. Beckenham. Page 101.

¹⁹⁶ Creer, C and Wing, J. (1975) "Living with a Schizophrenic Patient". British Journal of Hospital Medicine. Vol. 14, p 73.

or stated unambiguously that it was their fault the patient was ill". Also Creer and Wing report anecdotes from families of responses from professionals that were prompt, sympathetic, appropriate and efficacious. The problem, as Creer and Wing found it, was that the best sort of services, from the family's point of view, were not always available and evenly distributed.

The picture Creer and Wing paint of the plight of families of people with Schizophrenia at the time of their study was of a group of people who were sometimes helped and sometimes hindered by the responses of the professionals, but who were, in the main, left to their own devices to work out their own solutions.

On the whole, the major sources of distress and disruption for the families were not violent and aggressive behaviour but more often the effects of negative symptoms of the disorder, such as frustration at the apathy or slowness of the sufferer. They shared the distress of their family member's social incapacity and were unsure whether to acquiesce with the sufferer's desire for social isolation or whether it would be therapeutically better to encourage or coerce the sufferer into social situations. Scant help or advice seemed available from the professionals.

Some positive symptoms were both common and distressing, particularly bouts of over activity and distress caused by, and in response to, auditory hallucinations. Many families had worked out coping strategies such as advising their family member to

pace up and down the garden rather than the road outside. Families said that unless one had lived under such circumstances, it was impossible to appreciate the strain and stress of it all. There was fear of rapid mood changes, unpredictable behaviour and the fate of the schizophrenic child when the parents died or were too old to cope.

Thompson and Doll¹⁹⁷ usefully differentiate between objective and subjective burden to the family of having a mentally ill family member at home. Subjective burden was defined as the feelings engendered by the experience, objective burden of the disruptions caused by having the member at home. In a survey of 125 relatives in the Cleveland, Ohio they found the following: in terms of objective burden, 38% of the subjects reported a financial burden, 30% role strains, 30% disruption of everyday routines, 50% required to supervise and 20% problems with neighbours. In all, 26% of subjects reported no objective burden items, 46% reported two or more object burden problems and 27% three or more problems. In terms of subjective burden, 46% reported feelings of embarrassment, 72% feelings of overload, 42% feelings of entrapment, 27% moderate resentment, 13% severe resentment, 21% feelings of moderate exclusion and 6% feelings of severe exclusion. In all, 23% reported no subjective burden items, 62% one or two items and 15% three or more items.

Thomson and Doll found no demographic correlates of types of

¹⁹⁷ Thompson, E H and Doll, W (1982) "The burden of families coping with the mentally ill: An invisible crisis." Family Relations. Vol. 31, pp 379-388. Page 385.

emotional burden and concluded that:-

"... the emotional burdens of coping with a mentally ill kin appeared to be universally found in this sample, with no respect to differences in social classes, race, education, the age or sex of the relative or of the former patient."

A similar lack of correlation was found in terms of objective burden with the one, obvious, exception that the lower the socio-economic group of the relative, the more likely they were to report the mentally ill family member as a financial burden.

In a similar study, Hatfield¹⁹⁸ had surveyed the burden to families of people with Schizophrenia in the Greater Washington area. Of the 89 usable questionnaires she received, she noted emotional burdens of stress (65%), anxiety (30%), resentment (24%), grief and depressions (22%) and the problems of causing hardship for siblings (27%), threat to the parent's marriage (20%), disruption of family social life (17%), disruption of the personal life of family members (14%) and placing the burden on one member of the family (12%). She concludes:-

"The study found that the families of the mentally ill risk deterioration of their psychological and physical resources to the point that their personal efficiency may be reduced and the organization and stability of their family life threatened. Humane considerations require that society take notice and create services to minimize this distress."

"People generally fear most what they do not understand. Therefore, the families of schizophrenic patients would be greatly helped by a knowledge of schizophrenia and practical techniques for managing patients with this disease. Also needed are professional relationships that include families as

¹⁹⁸ Hatfield. A B (1978) "Psychological costs of schizophrenia to the family." Social Work. September, pp 355-359. Page 358.

well as patients and in which family members are considered part of the treatment team and are assisted to understand the nature of schizophrenia and its prognosis and treatment. A recent study reported that care-givers who were asked what kind of help would most reduce their stress gave first priority to an understanding of schizophrenia and practical management techniques.

They also expressed dismay that such help had been so persistently denied them by professionals to whom they had turned. A different type of professional may be needed in this area and literature of a nontechnical nature should be widely distributed."

Other Family Members and Schizophrenia

The literature on the family and Schizophrenia tends to concentrate on parents of people with Schizophrenia but having a Schizophrenia sufferer in the family can have an impact on siblings.

Dearth, Labenski, Mott and Pellegrini¹⁹⁹, in their review of the experiences of members of the Families of the Mentally Ill Collective in the USA, look in some detail at the plight of brothers and sisters of sufferers. They found that the following reactions were typical.

Siblings may fear that they too may become mentally ill or that their own children might inherit the disorder; they may be the first member of the family to guess that something is wrong (particularly if they share a bedroom with the sufferer) and may meet with initial incredulity from their parents or suffer guilt

¹⁹⁹ Dearth, N, Labenski, B J, Mott, M E and Pellegrini, L M (1986) Families Helping Families: Living with Schizophrenia. W W Norton. London.

because they did not make their fears known. Before, or after, family and professional realisation of the existence of the disorder they may bear the brunt of their ill siblings disruptive behaviour and this may affect their own education and social life. The behaviour of their schizophrenic sibling may lead to embarrassment and shame. Hospitalization can be a point of shock as siblings are unlikely to be familiar with the ambience of the mental hospital and the impact of medication and this will compound the stress of visiting. In turn, siblings sometimes feel guilt at leaving their brother and sister in hospital - that they can walk away - and guilt that they can lead a normal and enjoyable life. They might also feel that their behaviour and comments are being scrutinised by mental health care professionals for evidence of deviancy.

Some siblings experience a sense of loss, akin to a sense of death, about their mentally ill brother or sister, a feeling that their sibling is irrevocably lost. They may also become prematurely aware of their mother and father's fallibility and vulnerability as their parents try to make sense of the family cataclysm, perhaps not too successfully. Indeed, the illness may generate disputes within the family. Finally, siblings of people with Schizophrenia frequently experience a premature sorrow and responsibility. This can lead to a psychological maturity and wider vision in advance of chronological years but it can also lead to resentment and be destructive.

As Schizophrenia often becomes manifest before the time when one would expect the sufferer to form permanent relationships and have children, and the illness itself is associated with impaired social functioning and ahedonism, people with Schizophrenia, on the whole, have a lower than average rate of spouses and established partners and children (leaving to one side the speculative argument that Schizophrenia may, in itself, be associated with lowered fertility). For these reasons, the literature on partners and children of people with Schizophrenia is not rich, though the early work of Deasy and Quinn²⁰⁰ has already been mentioned.

Schizophrenia may destroy a relationship. Through its combination of negative and positive symptoms, the person with Schizophrenia can be difficult to live with. The children of such relationships may suffer neglect or become the supportive adult in the family. They, like the siblings above, may fear inherited mental illness, feel resentment at premature responsibility and embarrassment at their parent's eccentric behaviour. The impoverishment that often is the result of the disorder will affect material standards in the home.

²⁰⁰ Deasy, L C and Quinn, O W (1955) "The Wife of the Mental Patient and the Hospital Psychiatrist" Social Issues. Vol. 11 pp 49-60.

Family Therapy and Schizophrenia

In an open and honest paper, Terkelsen²⁰¹, a family therapist working with families of people with Schizophrenia of many years' standing, has dramatically reviewed and rethought his past work. He admits that as a therapist who started from a position that Schizophrenia was a disorder of social and familial origin his therapeutic sessions with the families were often negative, fruitless and left him, and one presumes the family, with the feeling of an unhappy and pointless experience.

Terkelsen has reviewed his position and now accepts that the evidence for a family aetiology of Schizophrenia is at best scant, and at worst deeply flawed. On that basis, he now assumes that most of his past therapeutic work must have, in turn, been at best unhelpful and at worst destructive. Reviewing previous studies such as Schaffer, Wynne, Day, Rycoff and Halperin²⁰² he now sees the family therapy approach as being characterised, from the families' point of view, as an experience that was either overtly or passively blaming. The sorts of questions that the therapist would ask might lead the family to believe they were being blamed for the sufferer's disorder, as indeed they were since the theoretical position of the therapist was just that.

²⁰¹ Terkelsen, K (1983). "Schizophrenia and the Family: II Adverse Effect of Family Therapy". Family Process. Vol. 22, pp 191-200.

²⁰² Schaffer, L, Wynne, L C, Day, J, Rycoff, I M and Halperin, A (1962) "On the nature and sources of the psychiatrist's experience with the family of the schizophrenic." Psychiatry. Vol. 23, pp 32-45.

Perhaps the family entered the therapeutic arena with its own burden of guilt, and the passive position of the therapist failed to alleviate this. Certainly, no information was given that might have demonstrated that the family were not to blame.

Terkelsen now finds explicable the hostility and aggression sometimes expressed, particularly by parents, towards the therapist, seeing it in terms of the clash of two alien and incompatible cultures where it is almost impossible for either side to see the other point of view. The therapist will see the family as unit, a system, and the patient or identified patient as the one to be rescued from this situation. The therapist cannot help but see things this way as this is the perspective in which he or she has chosen to work, has been taught and chosen to be trained. Within this tradition, manipulation of the situation is seen as being legitimate (for example see Minuchin²⁰³). In turn, the family sees the therapist as being partial and manipulative and, as such, he/she poses a potentially destructive threat to individual family members and the integrity of the family unit. In a family that may be reacting extremely, but normally, in the context of the abnormal behaviour of the schizophrenic member, further extreme reaction might occur as the family reacts to the abnormality of the therapist's behaviour and the therapeutic situation. In turn, the therapist may become defensive and interpret the family's or family member's reaction as further proof of the family's pathology. The courage in

²⁰³ Minuchin, S (1983) Families and Family Therapy. Tavistock Publications. London.

Terkelsen's paper lies, not least, in his realisation that for years, as a family therapist, he was part of the problem and not part of the solution!

Terkelsen's position is supported by Howe's²⁰⁴ study. This followed a small group of family therapists working in Social Services through a series of cases and then carried out detailed interviews of the families involved to find out how they experienced the therapy. He interviewed ten families who had declined the offer of family therapy and twenty-two who had accepted and taken part in family therapy. Howe's study is quite damning. Only three families who had accepted family therapy were relaxed and satisfied with the experience. Problems were encountered with the process itself which included the obtrusive use of video camera equipment and knowledge that observers were sitting in on the process. Families found that the distant approach of the therapist was off putting, particularly when they had known the therapist as a social worker or had known other social workers who, by comparison, seemed more human and approachable. The drop-out rate was quite high and many of the families' verdicts were that the process had been a waste of time, though a few appreciated the opportunity it gave for the family to take stock of their situation. A minority of families felt so negatively about the experience that they would not return to social services for future help.

²⁰⁴ Howe, D (1989) The Consumers' View of Family Therapy. Gower. Aldershot.

Finally, as Jules Henry²⁰⁵ has said.

"I wonder whether family therapists would find any families lacking all of the following "pathogenic features". A mother's great emotional dependence on her daughter, the need of mother to feel superior, self protection through acquiescent "symbolic" attachments among members of the family, pressure (excessive pressure) to maintain the subculture of the family, emotional divorce, ie, husband and wife lead outwardly tranquil and conformal lives but do not give each other what they need, a parent cares largely for himself as reflected in his child, children are rewarded when they believe as the family wishes and are punished for being independent, parents keep much of what goes on secret from the children, two members of the family form an alignment, etc, etc, etc."

The Evolution of the Family Response

Terkelsen (in Hatfield and Lefley ed.²⁰⁶) attempts to map out the typical stages that the family might go through with their mentally ill member.

In the first phase, the family see only minor symptoms, perhaps as minor variations in the subject's normal behaviour. Terkelsen argues that, as there is a dread of mental illness in society, there will be an inclination in the family to minimise such signs or hope that the subject will grow out of them. Even when family members do seek early and prompt assistance, it is not usually with any suspicion of a serious disorder.

Terkelsen does not explore in detail the debate as to whether the

²⁰⁵ Henry, J. (1973) Pathways to Madness. Vantage Books. London. Page 455.

²⁰⁶ Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London.

closeness of the relative hinders rather than facilitates the recognition that precedes acceptance of the illness though Kreisman and Joy²⁰⁷ do explore the issues more fully.

The next phase is characterised by an event or events that disrupt the pattern of the family's adaptation to the subject's mental state. This can be a sudden escalation of deviant behaviour, an outside person bringing home the reality of the situation, or the more concerned family member seeking the help of a professional. The family may either seek help themselves or do what they can to make the subject change - to "pull him/herself together".

Terkelsen describes the third stage as stalemate, as the sufferer is not usually as advanced in realisation that something is profoundly wrong as the family. The family itself may be split as to the extent of the problem, indeed, mental health care professionals may themselves tend to minimise the problem or may concentrate on the family, now confused and anxious, as the seat of the problem. The family may well diverge, some to retreat from the problem, others to focus on the sufferer at the expense of other family members, while normal family problems and stresses get pushed to one side.

In the fourth stage, the family may still be experiencing anxiety but are not yet aware of the poor prognosis and outlook. This

²⁰⁷ Kreisman, D E and Joy, V D (1974) Family response to mental illness of a relative: a review of the literature." Schizophrenia Bulletin. Issue 10, pp 34-57.

stage is characterised by various mechanisms for circumscribing the problem including: withdrawal, minimising the problem, denying the problem or defining it terms of character problems of the sufferer or, recognising that the sufferer is ill but being hopeful that a cure will be forthcoming and the sufferer will revert to normal before long.

Then, usually, an incident occurs. The sufferer is violent to others, attempts suicide etc, and the authorities now take cognisance of the sufferer who now becomes a patient. The meaning of mental illness for the family can no longer be ignored. At this point, the family or individual family members will embark on a search for the cause of the disorder. This search for a cause can take many forms. Echoing (and perhaps with half a knowledge of) pathogenic parenting models, there may be recriminations concerning the ill member's upbringing or the family may look to recent life events as aetiological factors. They may look at ancestry to detect supposed inherited insanity and, of course, this can be divisive as to whose side the taint of insanity comes from! Siblings and children may express anxiety, and issues of genetic counselling emerge. The family may consult scientific literature and, at this point, may be made aware that the world of psychiatry may not have many certainties to offer. The family may well split on aetiological lines.

Associated with the search for cause will be the search for cure or treatment and at this point the family may be exposed, for many for the first time, to the world of the hospital and the

clinic. This world includes not just issues of psychotropic medication but the whole panoply of issues: ward and hospital routines, mental health legislation, professional roles and boundaries, psychological based treatments, welfare rights and services in the community.

Where do the families gain this knowledge from? Frequently the staff seem too busy to do any more than answer direct questions, and though formal induction programmes and packs are becoming increasingly common for new patients to a hospital, clinic or other facility they are less common for patients' families.

The next phase Terkelsen describes as the collapse of optimism, in which over weeks, then months, then years it becomes obvious that cure and reversion to the pre-morbid state is unobtainable. Some benefits may be noticed such as control of positive symptoms by medication and the return of limited ability to lead a normal life, to maintain perhaps basic self care or sheltered work. All this may be characterised by remission and reoccurrence of the illness, of steps backward and forward. Some family members may see the patient as a total invalid and over solicitous of his or her needs; other family members may be repelled by the patient and his or her behaviour and avoid contact. Any imbalance in the family, where individual family members may focus so much on the sufferer that other family members needs go unmet, may also be a source of lasting resentment.

The penultimate phase Terkelsen calls "surrendering the dream"

and it is at this point that grief at what might have been becomes important. In the case of Schizophrenia, the illness frequently manifests itself in early adulthood, and the family have memories of a normal childhood. Inevitably, there is a tendency to extrapolate as to what might have been, careers, families and so on, and the contrast between what is and what might have been is a poignant one. In this sense, the fluctuations in the disorder, the remissions and improvements, hinder rather than help in this process. A sudden improvement may offer tantalising hope of those dreams coming true and can lead to constant uncertainty. Conversely, professionals often complain that families react inappropriately or unenthusiastically to improvements in the sufferer's mental state. This may be explicable in terms of the family having seen the cycle of improvement and decline before. They will have a longer temporal perspective than that of the professional.

For the family, respite periods in residential care are highly desirable or the sufferer may be placed outside of the family home altogether and family contact managed at a tolerable level. But, as Terkelsen points out, the reality is that for many families compartmentalisation, the prerequisite for the wellbeing and normality of the individual and the family in the face of the catastrophic nature of the disorder, is incompatible with care at home.

Analogues with Learning Disability

The reaction of grief, of sense of loss within the family of the person with schizophrenia, has already been mentioned. A debate has ranged within the field of learning disability about the appropriateness of professionals' responses to similar grief reactions in parents of the learning disabled and this debate has importance for the way mental health care professionals see the parents of the mentally ill.

Some workers in the field of learning disability, influenced by the work of Kübler-Ross and her investigations into the emotional responses to death and dying, have attempted to plot similar patterns and stages of grief in the parents of the learning disabled. In some ways, this has been a sensitive and useful approach but when applied too rigidly has led to notions of "appropriate" and "inappropriate" grieving which have not been helpful. As a result, there has been a wide ranging debate as to how similar the two events, death of a loved one and birth of a handicapped child, really are.

The centre of this debate is whether the grief associated with handicap should be seen as acute or chronic. The adaptation of the Kübler-Ross model sees the grief at its greatest at around the time of first realisation and diagnosis but diminishing over time to a point of "acceptance" by the parents, just as grief, supposedly, diminishes over time and one accepts the loss of a loved one. The model, in both cases, is an acute grief one and

the therapeutic goal is a state of "acceptance".

This approach has been criticised on two levels. Within the thanatological context grief can be chronic and may vary in intensity over time in a way that is different from the neat and tidy acute grief model. Anniversaries and other cues may evoke severe grief reactions long after the event and to view this as being pathological is wrong.

From the learning disability perspective, the acute grief model may be even more inappropriate. Death is final but a handicapped child presents itself as a constant reminder, possibly for the whole of the parent's life. On the positive side, a handicapped child can be a source of joy and pleasure to the parents, like any other child, and the picture need not be one of unrelieved sadness. However, the grief may be accentuated at special times of rites of passage when the "differentness" of the child is contrasted, such as change of school or marriage of contemporary children. In these senses, the grief is more rightly described as chronic though this is not always rightly understood by the professionals, as Kornblum and Anderson²⁰⁸ point out.

"In a recent study investigating the validity of parental feeling of chronic sorrow, the feeling of parents of mentally retarded children were found to be quite different from the feelings and reactions social workers expect from them. The clinical findings from parental interview suggested that "chronic sorrow" does not seem to be an abnormal response; rather it is a normal reaction to an abnormal situation. This view, however, was held by only a minority of social workers

²⁰⁸ Kornblum, H and Anderson, B (1982) "'Acceptance' Reassessed - A point of View" Child Psychiatry and Human Development. Vol. 12, No 3. pp 171-178. Page 172-173.

questioned. Most social workers did not assume that parental sorrow is a periodic phenomenon and therefore did not expect that parents have reoccurring feelings of grief."

The term "acceptance" has also been justly criticised in the context of learning disability and there is confusion and ambiguity about what precisely does "acceptance" mean. Most parents of the learning disabled, like most parents of the mentally ill, soon accept the disorder as an established fact. However, often the term "acceptance" is used by professionals in a wider sense to encompass not just the diagnosis but the implications of the disorder, the limitations it will place on the life of the sufferer. Such a perception ignores the fact that the parents may be genuinely unaware of the repercussions, or not as aware as the professionals. As Kornblum and Anderson have also said:

"As we have pointed out, however, parents cannot know the ramifications and implications of their child's handicap. This inability to foresee the full impact of the child's problem must be distinguished from denial. In other words, if the parents cannot know the implications of the condition, they cannot accept the child's handicap. This does not mean, however, that they are denying it. Their reaction is not pathological."

Olshansky²⁰⁹ goes further and argues that denial itself may be understandable and not necessarily pathological.

"The reality faced by the parents of a severely retarded child is such as to justify his chronic sorrow. When the parent is asked to "accept" mental deficiency, it is not clear just what he is being asked to do. The great stress professional workers tend to place on "acceptance" may suggest to the parent that he is expected to perceive his child from

²⁰⁹ Olshansky, S. (1962) "Chronic Sorrow: A Response to Having a Mentally Defective Child." Social Casework. Vol 43, pp 190-193. Page 191.

the point of view of the professional helper. This expectation may make him both resentful and resistant. In our clinical experience, we have seen relatively few parents so neurotic that they deny the fact that the child was mentally defective. We have seen relatively few parents who did not recover enough, after the initial shock of discovery, to mobilise their efforts on behalf of the child. It is understandable that some parents move slowly and erratically towards recognition of the mental defect and toward meeting the child's special needs. Some of them even "regress" to the point of denying at certain times the reality of the child's defectiveness. On other occasions, they become unduly optimistic about the child's potentialities. In our view such regression may help the parents to tolerate better the terrible reality that confronts them each day.

Why does the professional worker become so impatient with the parents' slowness or occasional regression, why does he feel such a great sense of urgency to do something about it? After all, the parent has a lifetime in which to learn to deal with the needs and problems of the mentally defective child. In most cases, one can ask what would be lost if the parent is unable for several years to view his child as mentally defective?"

The attraction for the mental health care professional of the acute grief model is that it postulates a tidy model of grief that has a beginning, a middle and an end. When "acceptance" has been achieved the case can be closed. The reality in both learning disability and mental illness is that the grief and sorrow of the parents will vary enormously, one day barely visible and the next extremely painful. This may present problems of service delivery for the professional trying to help the parents, but is not evidence of pathology.

The View from the Professions

Terkelsen's view, discussed previously, represents only his own perspective and his own account of how he once held the family

accountable for their family member's illness. Is there any evidence that such a view is still widespread?

There is much anecdotal evidence to suggest that parents felt that they were being blamed (for instance Creer and Wing's research discussed earlier). Sometimes the antagonism of the professional to families per se is only too evident. In his book "The Death of the Asylum"²¹⁰ Professor Talbott is dismissive of parents and parents' groups.

"Parents and relatives groups overtly have the same purpose as that of the mental health administrator-optimal care and treatment of the patient. Under optimal circumstances they can be of invaluable help. Some groups and some relatives, however, are so bent on the negative approach to all issues that they actually hamper, rather than assist the change process. For example, some persons take a stance that hospital or program staff are ipso facto in the wrong, and it is not an explanation but an expurgation that is desired whenever contact is made with the administration. In addition, as is inevitable, those active in such groups frequently use their relationship with key administrators to seek preferential assistance for their relatives. This, of course, results in a VIP syndrome, which is demonstrably bad for the patient care."

In this "Doctor knows best" statement, no account is taken of a possible parent's perspective. Individual parents lobbying for their own child may be an additional burden or nuisance, but it is entirely understandable from the family's (and the individual patient's) point of view. Has Professor Talbott never used his personal relationships with his own administrators in the furtherance of his own causes or projects and if so should this

²¹⁰ Talbott, J A (1978) The Death of the Asylum: A Critical Study of State Hospital Management, Services, and Care. Grune and Stratton. New York. Page 63.

be medicalised with a "syndrome" label?

In Professor Talbott's splenetic utterances we are reminded of the earlier findings of Deasy and Quinn²¹¹ who, among other things, asked psychiatrists to characterize a "good" wife and a "bad" wife of a psychiatric patient. Their composite findings were that the "good" wife was a person who;

" . . . is aware of her own feelings about her husband and can express them; is sincere, honest, straightforward, mature. Has insight. She lets the doctors alone, accepting the authority of the hospital. She feels the hospital is helping the patient, that the patient should be in hospital, and she cooperates with the hospital's plans for the patient."

In contrast the "bad" wife is characterised as follows:

"She exhibits signs of emotional disturbance or immaturity and is not approving of the hospital. She is insecure, selfish, dominating, has poor judgement. She has no insight into the patient's illness, will not see that she can help or has faults; is incapable of understanding or controlling her own hostility. She expects a quick recovery, thinks the doctors should do more for the patient and get him out faster; she pushes the doctors, maintains a critical attitude toward the hospital, tries to thwart the hospital, and takes up a great deal of the doctor's time."

The inference is clear - unquestioning support of the hospital, the treatment and the doctor is associated with a healthy personality, and the converse.

More recent research in the United Kingdom by Cape, Antebi,

²¹¹ Deasy, L C and Quinn, O W (1955) "The Wife of the Mental Patient and the Hospital Psychiatrist" Social Issues. Vol. 11, pp 49-60. Page 56.

Standen and Walden²¹² provides a useful insight on current thinking among practising psychiatrists on the aetiology of Schizophrenia. Cape et al sent questionnaires to 156 psychiatrists in the South West Region Health Authority area and 119 responded. The questionnaire asked them, among other things, to rate ten models of aetiology of Schizophrenia on a five point scale from "no importance" to "prime importance". The ten models of aetiology included: five psycho-social models (family imbalance, schizophrenogenic mother, double bind, fragmented family communications and scapegoating), four biological models (structural brain pathology, neurotransmitter dysfunction, viral infection, genetic predisposition) and the final model of life events. The results showed that the highest ratings were for genetic predisposition and neurotransmitter dysfunction, and were significantly higher than life events or the psychosocial explanations. Life events had a significantly higher rating than the psychosocial explanations. However, there was an interesting age difference in responses, in so much as the older psychiatrists tended to be more accepting of a psychosocial approach and the younger psychiatrists were more committed to a biological approach.

In a discussion the author of this thesis had with the senior author of the paper, Dr Gavin Cape, differing views were put forward to explain this age difference. Dr Cape, a young psychiatrist, goes against the trend he has found by supporting

²¹² Cape, G S, Antebi, D, Standen, P and Walden, C (1994) "Schizophrenia - The views of a sample of psychiatrists". Journal of Mental Health. Vol. 3, pp 105-113.

a psychosocial approach. He explains the results of the age difference found in he and his colleagues' work as attributable to the fact that as psychiatrists grow older they inevitably grow in wisdom, insight and knowledge and that this is why, with age, they see a dimension beyond the biological in Schizophrenia. As an alternative, the author suggested a "critical periods" approach, that the theories one learns as a student or newly qualified are the ones that tend to stay with us for most of our professional lives, if for no other reason that when in practice it becomes increasingly difficult to keep on top of new developments and to become aware of ideas that refute previous assumptions. Thus psychiatrists who trained when Laing, Lidz and other family theorists held sway are more likely to countenance such views than their more biologically trained younger colleagues.

It is interesting to compare these results with a recent study in Germany. Angemeyer and Matschinger²¹³ reported the results of a large, general population survey (over 3,000 subjects) carried out in East and West Germany at the time of the reunification. They presented subjects with a vignette of a person with Schizophrenia (by DSM-III criteria) and presented a number of causative explanations. Subjects rated psycho-social stress explanations highest, followed by biological explanations, followed in score order by intrapsychic factors, socialisation,

²¹³ Angermeyer, M C and Matshinger, H. (1994) "Lay beliefs about schizophrenic disorder: the results of a population survey in Germany" Acta Psychiatrica Scandinavica. Vol. 89 (supplement 382), pp 39-45.

state of society and, the lowest rated, supernatural explanations.

The German study showed a first and second ranking for psychosocial stress and biological explanations. It should also be noted that within their study Angermeyer and Matschinger found neither significant differences in opinion between the sexes nor was age or educational level a significant factor. In only three of the models were there significant differences between West and East German subjects. These were: "work difficulties" (scored significantly higher by East German subjects), "constitutional weakness" and "lack of will" (both scored significantly higher by West German subjects). Overall, though, ranking of causation was not significantly different for subjects raised in the capitalist West or marxist East.

In another, comparatively recent study, Castaneda and Sommer²¹⁴ sent out questionnaires to a large number of mental health care professionals in California and received replies from 195 social workers, 78 psychologists, 43 psychiatrists, 25 nurses, 21 rehabilitation therapists and 40 other mental health care professionals. Of the total respondents, 64% felt that mental health care professionals in general had a tendency to blame parents for their son or daughter's mental disorder while 32% said that this was uncommon or non-existent.

²¹⁴ Castaneda, D and Sommer, R (1989) "Mental Health Professionals' Attitudes Toward the Family's Role in Care of the Mentally Ill." Hospital and Community Psychiatry. Vol. 40, no 11, pp 1195-1197.

Community Care and the Family

Katschnig and Konieczna²¹⁵ looked at the different perspectives of self help groups for patient's families and professionals working from within the family therapy tradition. They saw self help groups for families as being at the opposite end of a power gradient to traditional family therapy. In family therapy, the power is with the therapist and by their presence the family acquiesce with this.

The growth of such organisations as the National Schizophrenia Fellowship and SANE (Schizophrenia: A National Emergency) can be seen as the inevitable consequence of the gradual process of deinstitutionalisation of psychiatric patients in this country that, itself, was part of a world wide trend. This process of deinstitutionalisation was the result of a number of factors including the development of major tranquillizers and other medication from the 1950s to date, that allowed, in the majority of cases of Schizophrenia, for the control of the worst excesses of the disorder. Of equal importance was public revulsion at the long confinement of patients in dispiriting and understimulating asylum environments and pressure from groups such as MIND who represent the constituency of the mentally ill themselves. In addition, the success of the Italian Democratic Psychiatry Movement (very much the outcome of an alliance between radical psychiatry and the, then, powerful Italian Communist Party) acted

²¹⁵ Katschnig H and Konieczna, T. (1989) "What Works in Work with Relatives? - A Hypothesis". British Journal of Psychiatry. Vol. 155 (Supplement 5), pp 144-150.

as a much trumpeted model for organisations such as MIND. In the United Kingdom, the humanitarian arguments for deinstitutionalisation combined with a hypothesised cost saving in transferring psychiatric patients to what is, euphemistically, known as Community Care, formed an almost overwhelming argument for the rundown of the old, monolithic mental hospitals.

The inevitable outcome of such a process had already been foretold by Doll²¹⁶. Following the close down of long stay psychiatric hospital facilities in Cleveland, Ohio, Doll undertook a study of a group of families who now had the care of their mentally ill family member. He found that although, on the whole, the families were quite tolerant of unusual or deviant behaviour, and were often very reluctant to rehospitalise the ill family member, the pressures on the family were quite severe. In this case, what might seem on paper as a successful programme of de-institutionalisation was paid for by a good deal of pain and misery within the family. The lack of respite and emergency short term facilities has been an enduring source of concern.

In the United Kingdom there has been a growing groundswell of complaint about how the mentally ill have been left to fend for themselves, have committed violent and dangerous acts and how the families have been abandoned to cope for themselves under the "community care" programme. Journal and newspaper articles carry harrowing accounts of families' and sometimes professionals'

²¹⁶ Doll, W (1976) "Family coping with the mentally ill: an unanticipated problem of deinstitutionalization." Hospital and Community Psychiatry. Vol. 27, no 3, pp 183-185.

experiences under community care (for example Willis²¹⁷, Woodall²¹⁸, Salmon²¹⁹ and Chadwick²²⁰). In this seeming state of crisis, organisations like NSF and SANE have sharply questioned the wisdom of community care but this in turn has led it into conflict with MIND who were among the architects of the policy. This dispute (reviewed by Bartlett²²¹) mirrors not only the differences of constituency between the groups and views on treatment, but shows fundamental differences of view of aetiology, with MIND, on the whole, supporting the sufferers from mental illness against the "medical model" and over reliance on medication in favour of a more socio-psychological approach.

As early as 1963, Grad and Sainsbury²²² had investigated the burden on families of mental illness and compared two catchment areas one of which offered a hospital based approach (Salisbury) and the other of which offered a community based service (Chichester). They interviewed the families of 410 psychiatric patients who had had contact with the services in both areas. Not

²¹⁷ Willis, M J (1982) "The Impact of Schizophrenia on Families: One Mother's Point of View." Schizophrenia Bulletin. Vol. 8, no 4, pp 617-619.

²¹⁸ Woodall, R (1992) "Why my son went to live in a cave." The Independent. 7th of April, p 19.

²¹⁹ Salmon, T (1992) "It's our son who is ill. Why won't doctors consult us?" The Independent. 6th of October, p 15.

²²⁰ Chadwick S (1992) "My patient wants to kill himself. Hospital, help!" The Independent. 7th of April, p 19.

²²¹ Bartlett, N (1989) "Agreeing to differ." Community Care. 20th of July, pp 17-19.

²²² Grad, J and Sainsbury, P (1963) "Mental illness and the family." The Lancet. Vol. 1, pp 544-547.

all the patients suffered from Schizophrenia; the initial patient referrals included organic, psychotic, neurotic and personality disorders. The burdens on both groups of having mentally ill members were rated in terms of the effect on the family, and in terms of the behaviour that the family found worrying. The mental health of the closest relative was deemed to be disturbed in 60% of the families and the physical health in 28%. The social and leisure activities of the family were said to be disturbed in 35% of families, children disturbed in 34% of families, domestic routine disturbed in 29% of families, income of family disturbed in 23% of families and employment of family members disturbed in 23% of families.

The aspects of the patient's behaviour that the family found most troublesome were: complaints about bodily symptoms (38%), self danger (that is suicide or accident) (34%), importunate and demanding behaviour (34%), behaving oddly or expressing peculiar ideas (27%), uncooperative and contrary (26%), constantly restless or over-talkative by day (23%), troublesome at night (21%), threatening the safety of others (12%), objectionable, rude or embarrassing behaviour (9%) and causing trouble with neighbours (7%).

Grad and Sainsbury's key interest was in reviewing the relief of burden as a result of intervention and comparing, in relief of burden terms, a hospital versus a community based service. They found that the hospital based service offered more relief on the whole, but families who rated their burden as heavy were equally

relieved in both service conditions. They argued that when clinical features of the patient and social context of the family were taken into account, a community based service could offer relief equal to a hospital based one. Grad and Sainsbury²²³ conclude that:-

"Schemes for treating patients outside the mental hospital will have to take account of the health and economic peculiarities of families; and, in deciding whether treatment inside or outside the hospital is preferable, family attitudes will have to be considered."

Berhheim (in Hatfield and Lefley²²⁴) has traced the salient issues in the growth in power of the National Alliance for the Mentally Ill (NAMI) in the USA, an umbrella organisation of 430 state and local affiliate organisations that represent the patient and the patient's family. Their growth has been quite rapid. Their membership consists mainly of educated, white, middle-class parents of mentally ill children and they have enjoyed considerable success as a lobbying group. Among their aims is the right to have information and involvement in planning for the mentally ill on both an individual and a general level. They wish the family to be seen as part of the solution and not part of the problem and, as such, generally resent and reject the family therapeutic approach with its implications of family pathology. They will provide both information and advice on referral. In a country that has a market led health system, this

²²³ Grad, J and Sainsbury, P (1963) "Mental illness and the family." The Lancet. Vol. 1, pp 544-547. Page 547.

²²⁴ Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London.

latter point becomes very important. Professionals who are known to be sympathetic to families, who understand their plight and work *with*, rather than *against*, or independently of, the family are the professionals whom the organisation recommends. The converse is true of professionals who adopt a family pathology perspective or who cannot or will not work with the family. NAMI has, on the individual practitioner level, become a powerful force in the market and is in the position to shape professional opinions and attitudes by dint of hard economics.

This has undoubtedly caused a culture shock in the world of American health care professionals and those who cannot adapt try to shelter behind confidentiality or the patient as the single and only client as a way of avoiding the inevitable. One can sense some of the tetchiness of the old guard in the quotation from Professor Talbott above. As the National Health Service moves slowly to a more consumer led approach with market forces increasingly intruding into traditional practices, at some point in the future we might well see a similar development at the hospital and clinical team level in parallel with the increasing power of the voices of campaigning organisations like SANE and the National Schizophrenia Fellowship at national level.

A positive view of professionals can be found in the survey of Castaneda and Sommer²²⁵. They note an increasing respect and

²²⁵ Castaneda, D and Sommer, R (1989) "Mental Health Professionals' Attitudes Toward the Family's Role in Care of the Mentally Ill." Hospital and Community Psychiatry. Vol. 40, no 11, pp 1195-1197.

valuing by professionals of self-help groups for the families of the mentally ill. More than 81% of their respondents who were willing to offer opinions on family organizations expressed approval or strong approval of such groups, and all felt that there was a role for professionals in relation to such groups, though they tended to favour education and consultation over political alliances. Of those who were undecided or did not respond about such groups, the highest proportion were psychiatrists (37% of the responding psychiatrists) and psychologists (22%). Rehabilitation and occupational therapists were the groups most open to respond. The inference is that it is psychiatrists and psychologists who probably have the most reservations about family groups.

What and Whom Families Find Helpful and Unhelpful

Lewis and Zeichner²²⁶ interviewed the families of 109 patients admitted to three state mental hospitals in Connecticut. Of the 109, 90 acknowledged that their family member was mentally ill while five families denied that the member was ill at all and a further fourteen said that the illness was physical. Of the 90 who acknowledged mental illness, 26 had thought their family member had been mentally ill for two years or more before admission.

Lewis and Zeichner then went on to categorise the families'

²²⁶ Lewis V S and Zeichner, A M (1960) "Impact of admission to a mental hospital on the patient's family." Mental Hygiene. Vol. 44, pp 503-509.

attitude to the ill family member as follows: sympathetic understanding (50), fear (12), puzzlement (15), hostility (7), ambivalent (24) and persistent denial (1). They further categorised the way families dealt with the ill family member as: no change (32), expected less (44), made dependent (19), provoked (8) and appeased (6).

Lewis and Zeichner asked the families about professionals, and asked them to rate the professionals as: helpful, partly helpful, not helpful or no opinion. The professional the families had most turned to was the physician (72 instances of which 19 were rated not helpful), followed by psychiatrist (50 instances of which 18 were not helpful), hospital (27 instances of which 7 were not helpful), clergy (16 instance of which 5 were not helpful), police (9 instances but none judged not helpful) and finally social work agencies (5 instances of which two were not helpful).

McElroy (in Hatfield and Lefley ed.²²⁷) has said that the family and the professional "march to the beat of a different drummer" and the main thrust of her argument is the need for professionals to change their view of the family and family members from that of an object of therapy to that of "adult learners". Her views are usefully informed by the accounts of individuals who straddle the two worlds - who are mental health care professionals and members of families where there is a mental illness sufferer (see

²²⁷ Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London.

Turnbull and Turnbull²²⁸, Wasow²²⁹). In these, and many other accounts, the therapeutic attempts of professionals on the family have been seen as harmful and counterproductive.

McElroy argues that the perceptions of the family by the family and the professionals are often hopelessly at odds, that even the language of discourse is incompatible. Professionals often underestimate, or fail to register at all, the catastrophic nature of the experience of having a mentally ill family member. They often fail to realise that a chronic illness such as Schizophrenia, because it so drastically alters the essential selfhood of the sufferer, differs radically from the impact of other chronic illnesses. Families and family members may go through a period of grief that is both like in some ways, and unlike in others, the grief concerning a family member who has died. It is like grieving for the dead in the sense that the person that was has gone but of course, in the corporeal sense, the person is still there. The pattern of remission and relapse is a form of cruel resurrection followed again by death. In that sense, the grief of the family members for the sufferer can be worse than grief for the dead.

McElroy argues that what families both want and need is information and education. However, even when this is recognised, in a general sense, by professionals the conception of the

²²⁸ Turnbull, A P and Turnbull, H R (1978) Parents Speak Out. Merrill. Columbus, Ohio.

²²⁹ Walsh, M (1985) Schizophrenia: Straight Talk for Families and Friends. William Morrow. New York.

informational and educational needs can be at odds with what the family thinks its own needs are. The implications are of importance, as it is the mental health care professionals who must provide much of the education and information.

McElroy²³⁰ carried out a questionnaire survey of the educational needs of family members drawn from the Alliance of the Mentally Ill (AMI) in Greater Baltimore and registered psychiatric nurses in a psychiatric hospital in the same area. In the family group 52 (37 mothers, 11 fathers and the rest siblings). Family members responded in full and sixty nurses completed the questionnaire. Among other things, the questionnaire asked the respondents to rate the priority for the family of educational needs and also to rate behaviours of the sufferer that might concern the family.

The results showed major discrepancies between the perceptions of the families' needs between the nurses and the families themselves. For instance, the families rated an update on research on the major mental illnesses as high priority whereas the nurses felt this to be a low priority. There was some concordance on treatment, with the families rating information on psychotropic medication as the highest priority and the nurses viewing knowledge about forms of treatment for the major mental illnesses as a priority. Nurses rated how to handle mental health care professionals as a low priority.

²³⁰ McElroy, E M in Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London.

In terms of challenging behaviour, the nurse felt that the following behaviours gave most problems for the family: the ill member's inability to achieve potential or prepare for a career or to work or to adhere to, or develop, a predictable schedule, and lack of motivation. The families felt their biggest problems were suicidal and homicidal behaviour, verbal and physical aggression, creating scenes in the neighbourhood, and unusual and strange behaviour.

McElroy argues that professionals will need to undergo much rethinking if they are to service appropriately the needs of the families, and these needs must be serviced if care in the community is to work. McElroy²³¹ states:-

"For professionals to gain understanding of the family perspective, as well as for the development of mutuality, regard and viable collaborative treatment goals, examination of their own attitudes; of the validity of theories of practice espoused; of practical behaviour implemented, and of semantics used to describe families are essential."

Holden and Lewine²³² surveyed family groups in five states in the United States and received 203 replies. As they point out, their sample was not necessarily representative of relatives of the mentally ill as the majority of respondents were white, middle-class and educated and most of the respondents were women

²³¹ McElroy, E M in Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London. Page 239.

²³² Holden, D F and Lewine, R J (1982) How families evaluate mental health professionals, resources and effects of illness." Schizophrenia Bulletin. Vol. 8, no 4, pp 626-633. Page 627-628.

and mainly the sufferer's mother. In terms of the diagnosis of the sufferer, 71% suffered from Schizophrenia.

The survey showed a large groundswell of discontent with the services on offer to the family and the sufferer. Comments included:-

"To proceed on the assumption that the illness is caused by malparenting is very damaging because these attitudes are transmitted by innuendo if not directly. This results in increased guilt felt by the parents and decreased ability to accept diagnosis and impairment."

In addition to these sins of commission, the lack of information provided was another significant complaint:-

"Each doctor seemed to make a different decision, and I was never helped to understand why. I'm not sure what to think. I was left in the dark. Everything was frightening because unexplained."

The families were asked what their primary response was after working with mental health care professionals. The positive responses included: confidence (8%), understanding of Schizophrenia (9%) and learning of coping strategies (9%). Against this, just under three quarters of the respondents reported primarily negative responses: guilt (3%), powerlessness (13%), frustration (38%), anger (4%) and 33% said that they had found contacts with professionals not helpful. When asked to rate their satisfaction with mental health professionals, 2% were very satisfied, 24% were generally satisfied but 32% were generally dissatisfied and 42% were very dissatisfied. At the same time, mental health professionals were viewed by 53% of the sample as the primary resource at time of crisis.

Diagnosis was a central area of complaint and contention. Professionals sometimes comment that they do not regard labels, i.e. diagnosis, as helpful. This is a response that Holden and Lewine's subjects found unhelpful. To be vague or reticent about a diagnosis that has already been made does not advance the position of the family, and if a diagnosis has not been made because the situation is genuinely unclear, why not say so? Where a diagnosis has been made and the family are made aware of it, they are in a better position to find out more about the disorder, including the problems inherent in diagnosing something like Schizophrenia, for themselves. The diagnosis is the first piece of information to give the family, and from this the family can gain more information for themselves. Having stated the diagnosis the professional has, in fact, stated a hypothesis, and with knowledge the family may verify or falsify it. In the hackneyed phrase: "knowledge is power", and one can only speculate whether this is the reason why some professionals are so reticent about "labelling" their patients. In Holden and Lewine's study, explanation of diagnosis was completely avoided in 6% of cases, felt too vague in 35% of cases, not thorough enough in 31% of cases and too technical in only 4% of cases. Sixty-eight percent of the respondents were told the diagnosis within the first two years of the illness, 32% between the second to the eleventh year or not told at all. In terms of satisfaction of the adequacy of information provided about diagnosis, of those informed by a mental health professional, 75% felt the explanation was inadequate. There was a general lack of satisfaction with the medication used on the family member and

a lack of information on medication and its side effects.

Holden and Lewine²³³ have considered that the sample of family members may have been atypical and a criticism could be that the families' expectations of professionals were unreasonable. Holden and Lewine have concluded that this was probably not so:-

"We might speculate that family members' expectations for professional help are unrealistically high and that no matter what the professional response, families would be dissatisfied. However, the families' comments were inconsistent with this interpretation. Generally, the respondents had a realistic picture of the illness and its prognosis. Repeatedly, families reported a need for realistic and practical guidance. They were seeking information and support, not simply looking for reassurance or easy answer. Although families reported being frustrated by their contacts with professionals they continued to look to professionals for help and desired a closer working relationship."

In another study, Grell and Grusky²³⁴ found, once again, a pattern of dissatisfaction with services as offered to the families of the mentally ill. Their subjects were 56 families from a North Western state of the United States that had, according to the authors, an extensive and well coordinated mental health system focusing on the community. Using a family service satisfaction scale they found high levels of dissatisfaction. These levels of dissatisfaction seemed unrelated to family background variables, though the gender of the

²³³ Holden, D F and Lewine, R J (1982) How families evaluate mental health professionals, resources and effects of illness." Schizophrenia Bulletin. Vol. 8, no 4, pp 626-633. Page 632.

²³⁴ Grell, C E and Grusky, O (1989) "Families of the seriously mentally ill and their satisfaction with services." Hospital and Community Psychiatry. Vol. 40, no 8, pp 831-835.

respondent was significant - female respondents were more dissatisfied than males. Grell and Grusky consider this explicable in terms of female members of the family, particularly mothers, taking on the role of primary carer and therefore having more contact with professionals. There seemed to be a relationship between length of time after onset of the illness and satisfaction with the service. This may indicate that satisfaction, or lack of dissatisfaction, increased with exposure to the service. Also, late onset of illness seemed to be another factor associated with more satisfied response. However, one factor that clearly emerged as affecting rates of satisfaction and dissatisfaction was interaction with the case manager and the supportive role of the case manager.

In a recent study Tessler, Gammache and Fisher²³⁵ investigated the experiences of 274 relatives or close friends of 168 psychiatric patients in three centres in Ohio and collected information on 1,198 contacts with mental health care professionals. They found that the importance and extent of contact with a given type of professional varied with the point in the patient's psychiatric career. For instance, contact was more frequent with the psychiatrist during acute episodes but about the point of discharge contact with social workers increased. Also, the familial closeness of the respondent to the patient was related to the contact with the professional. Parents

²³⁵ Tessler, R C, Gammache, G M and Fischer, G A (1991) Patterns of contact of patient's families with mental health professionals and attitudes toward professionals." Hospital and Community Psychiatry. Vol. 42, no 9, pp 929-935.

or spouses were more likely to have contact with professionals higher in the hierarchy, psychiatrists for instance, than friends or siblings. However there may have been formal and legal reasons for this.

Pleasingly, Tessler, Gamache and Fisher report a higher rate of satisfaction with services than previous studies and it is interesting that they note that recency of contact with professionals correlated with satisfaction, leading them to hypothesise that professionals really are changing their approach to families in line with past criticism and, perhaps, those who were dissatisfied in this study are remembering older incidents.

Tessler, Gamache and Fisher measured degree of alienation by presenting five statements and asked the respondents to state whether they strongly agreed, agreed, disagreed or strongly disagreed. Their results, in rounded percentage terms, were as follows: to the statement "Professionals were interested in what I could tell them about the patient's condition", 20% strongly agreed, 59% agreed, 7% disagreed and 14% strongly disagreed. To the statement: "Professionals gave me detailed information about the patient's illness", 11% strongly agreed, 35% agreed, 15% disagreed and 39% strongly disagreed. To the statement: "Professionals consulted me as they planned services and medication for the patient", 10% strongly agreed, 26% agreed, 23% disagreed and 41% strongly disagreed. To the statement: "Professionals assured me that I was not to blame for the patient's illness", 19% strongly agreed, 42% agreed, 11%

disagreed and 11% strongly disagreed. Finally, to the statement: "Professionals showed that they understood the problems I faced in caring for the patient", 16% strongly agreed, 45% agreed, 12% disagreed and 27% strongly disagreed.

There is a limited comfort in these figures. They seem to indicate that significantly more of the subjects experienced the professionals as being interested in what they said and that more respondents felt that the professionals understood their problems with the patient than not. However, the majority felt that they were not being consulted about services and medication nor were they being given detailed information. The majority did feel that professionals assured them that they were not to blame for the patient's illness, but the fact that 40% still disagreed with the statement is a cause for concern.

Psychiatrists were the professionals making up the largest group of contacts (27%), next social workers (31%), then care managers (17%), psychologists (7%) and nurses (5%). The respondents were most satisfied with their contact with psychologists and care managers and least satisfied with their contacts with psychiatrists. This may be as much a function of the differing tasks and responsibilities of the different professions as of the training and quality of staff. Psychiatrists were most involved in issues of medication and hospitalisation. Psychologists, interestingly enough, were most involved in family therapy and patient behavioural problems. Social workers were most involved in housing and day care. Care managers were most involved in

employment, education and housing and nurses were involved home care and medication.

Among the more fascinating results of this study is an overall higher rate of satisfaction than hitherto found and also that psychologists, the professionals rated the highest in satisfaction, were most involved in family therapy. This seems to run counter to previous research and opinions on the family's response to family therapy. It might be explicable as a statistical aberration: the number of encounters with psychologists was, with the exception of nurses, the smallest in the study and not all encounters were connected with family therapy and therefore a few good experiences of family therapy may have been atypical or family therapy as defined by the respondents may not have been strictly family therapy at all. Another possibility is that in parallel with what seems an improvement in attitude by professionals to patients' families, there has also been an improvement in attitude within family therapy. For the families, this may be becoming a kinder and more constructive experience.

How Should Families Deal with Professionals?

Dearth, Labenski, Mott and Pellegrini²³⁶ give an account of the experiences of members of the Families of the Mentally Ill Collective in the United States. The book contains a chapter on

²³⁶ Dearth, N, Labenski, B J, Mott, M E and Pellegrini, L M (1986) Families Helping Families: Living with Schizophrenia. W Norton. London.

dealing with professionals and outlines some of the problems that families find; it offers advice on how these problems can be solved. They acknowledge the problems associated with doctor-patient confidentiality but point out that many professionals are committed to working with the family and have instigated joint family-patient-professional meetings that help with this problem. They also advocate that another professional should act as an intermediary or advocate on behalf of the family when dealing with the psychiatrist. Joint family and professional seminars are also useful and they are vehicles for exchanging and making known differing perspectives.

Dearth, Labenski, Mott and Pellegrini's advice to families when working with professionals can be summarized as follows: be wary of any doctor offering a cure; if you do not instinctively like or trust the doctor choose another one; do not be embarrassed to discuss cost of treatment; before a meeting with a professional spend some time devising an agenda and stick to it; do not be intimidated by a professional and if what is being said is not understandable ask for clarification. Also, do not be afraid to ask for things to be written down. Ask about the nature of any treatment and alternatives. Be honest with the professional and look for the best in them but if the professional won't talk, change him or her. Don't put the professional on the defensive by being rude or aggressive but at the same time, where necessary, be assertive; insist that you are treated with respect. Ask how you can help and how you can monitor progress; remember the limits of the professional's own knowledge and power

and remember that working with professionals can be a process of change, sometimes painful, on both sides. If necessary, go over the head of the professional. Finally, choose a doctor who can be reached.

Summary

In the first part of this thesis, the author stated the reasons why biological explanations represent the most plausible explanations of the aetiology of Schizophrenia. The author examined, in detail, the genesis of the pathological parenting approach and reviewed the evidence for and against such an approach. Such evidence as there ^{was} _^ deeply flawed or unimpressive and led the author to conclude that the long hegemony of such an approach was only explicable in terms of historical, social and political factors.

As the pathogenic parenting approach appears less and less credible, there needs to be a serious rethink in our attitudes and approaches to working with the family. As Hatfield has said above, perhaps we even need a new type of professional. There is an increasing body of research on the impact of mental illness, and in particular Schizophrenia, on the family and also the real, as opposed to professionally assumed, needs of the family members.

Such research cannot be ignored for the reasons outlined above. Both in the United States and the United Kingdom, as the process

of closing the old mental hospitals continues, the burden of looking after the mentally ill falls on the community and, in particular, the family. The burden of looking after the mentally ill can be so great that it can be done only at the cost of individual members of the family becoming identified carers and the life of the family suffers. Other problems are left unattended or unaddressed, and tensions and divisions within the family frequently occur. Not only is this destructive to the family, but we know through work on expressed emotion that it has a negative effect on the sufferer. The traditional route of maintaining the integrity of the family and individual family members, by placing the sufferer in residential care, becomes increasingly unavailable.

Through the work of pressure groups both here and in the USA, it is becoming clear that breaking point is being reached. We must develop new ways of working with families that do not add to their burden of stress but alleviate it. In the USA, the force behind such an approach is increasingly coming through the market. As a market based approach has been introduced into the National Health Service and the Social Services we are likely to feel this force here.

In the writer's own experience of conversations with patient's families, both Rampton patients and patients elsewhere and families of the learning disabled as well as the mentally ill, their experiences of mental health care professionals has been mixed and often extreme. The families have told anecdotes of well

handled encounters by professionals even when they had to tell bad news - pessimistic diagnoses and poor prognosis. At the opposite extreme were anecdotes of being mishandled and being treated badly.

The existing research, reviewed above, covers a long period of time and is drawn from across the world but principally from the United States. In order to establish how far these issues will apply to the UK at the present moment the following study was carried out. The next three chapters describe the method, results and discussion of research on the impact on parents of having a son or daughter with Schizophrenia in terms of their views and knowledge of the disorder, the burden and stress of having a son or daughter with the disorder, and the parents' views on their encounters with mental health care professionals. In order to explore issues of guilt and blame, the research also explores what information the parents received about the disorder and how they perceived they were treated by mental health care professionals.

METHOD

The Subjects

Originally it had been planned to carry out this research only on the parents of patients in Rampton Hospital, where the author works. This plan was modified by adding a second group of subjects who were parents of patients who had Schizophrenia and were being treated either as in patients or out patients at Bassetlaw District General Hospital, Department of Psychiatry. It was felt, on reflection, that the experiences of parents of patients in Rampton may be atypical, and that it would be useful to compare and contrast these experiences with the experiences of parents of patients who had not been involved with the forensic psychiatry services.

Bassetlaw Hospital is in Worksop and its catchment area (including the area where Rampton Hospital is located) covers North Nottinghamshire. It is typical of a District General Hospital serving a small town and rural area.

Formal approval was required and obtained from both Rampton Hospital and Bassetlaw District General Hospital Local Research Ethics Committees before interviewing could commence.

Rampton Group

All the subjects selected were the biological parents of patients

detained in Rampton Hospital and whose son or daughter suffered from Schizophrenia as their only significant mental disorder. Because of the controversy over the diagnosis of Schizophrenia in the black community all subjects were white. All but one subject had English as their first language, the exception being a subject originally from Finland but who had lived in this country since the mid 1940s and who was fluent in English. All subjects were free from any significant mental disorder

The method of identifying potential subjects was to select, using the Social Work Department's Patient Database, all patients whose legal classification under the Mental Health Act 1983 was Mental Illness. All those who suffer from Schizophrenia only in Rampton should, in theory, be classified as Mentally Ill, though not all the Mentally Ill suffer from Schizophrenia, for instance a significant minority suffer from affective psychosis.

The database was used to generate an individual checklist for each Mentally ill patient (Appendix A) addressed to the patient's Responsible Medical Officer (their consultant psychiatrist). The checklist asked the Responsible Medical Officer if the named patient suffered from Schizophrenia. If the answer to that question was "Yes" then the question was asked if Schizophrenia was the only significant psychiatric problem. If the answer was again "Yes" then they were asked to classify the patient's type of Schizophrenia in terms of the World Health Organisation

International Classification of Diseases system, Ninth Edition²³⁷ (at the time of commencement of the research the Tenth Edition was not available). If the Responsible Medical Officer had reservations about such classification in general, or with regard to the specific patient, they were invited to describe, in their own words, the type of Schizophrenia.

All Responsible Medical Officers at Rampton who had Mentally Ill patients on their caseload were approached and all co-operated with the survey. From an original 272 patients classified as being Mentally Ill, 200 patients were deemed to be suffering from Schizophrenia and 147 were felt to have Schizophrenia as their only significant psychiatric disorder. This information was put into a specially constructed research database and this was used to generate a second checklist (see Appendix B), referring to patients deemed only to be suffering from Schizophrenia, but this time addressed to the patient's social worker. The checklist asked if the patient's mother was still alive, and if she was, whether she was capable of taking part in the research project. If she was not, the social worker was asked to give the reason why. If she was capable of taking part, the social worker was asked if she was aware of the diagnosis (approaching subjects who were unaware of their son or daughter's diagnosis would have raised both technical and ethical problems) and finally, the social worker was asked to supply her address and telephone number. Identical questions were then asked concerning the

²³⁷ The International Classification of Diseases. Ninth Edition. (1979). World Health Organisation.

patient's father.

As with the Responsible Medical Officers all social workers approached co-operated with the process though one social worker specified that she felt that it was inappropriate for the author to contact potential subjects directly but that she would make the initial contact. This was readily agreed to.

In the event, 57 of parents were still alive and of these 26 were felt to be not capable of being interviewed. Examples of the reasons given were victim of the index offence, lives abroad, wishes no contact regarding son or daughter, too elderly or ill, too traumatised by the experience.

Of those potential subjects left, a further two were eliminated from the study because they were not thought to be aware of the diagnosis of Schizophrenia.

This left a core group of potential subjects of 29 of whom 4 were couples to be interviewed together and 18 were subjects to be interviewed individually because they lived alone. Only in seven cases did the subject decline to take part in the research at all.

Subjects were approached and invited to take part by telephone or if this was not possible by letter (as stated above, one social worker approached the parents of her patients herself).

The parents were told that the research was to find out about their experiences of being a parent of a son or daughter with Schizophrenia, that the information they gave would remain confidential, but in case they had any fears that this might have an impact on their child's progress at Rampton the interview would be confined to the period between their first noticing that something was wrong with their child up to, but not including, admission to Rampton Hospital.

Bassetlaw Group

The criteria for selecting subjects in the Bassetlaw group were the same as for the Rampton Group. That is to say subjects had to be the natural parents of persons who had Schizophrenia as their only significant mental disorder, the parents had to have no significant mental disorder themselves and all were white. With one exception all had English as their first language (the exception being a subject originally from Rumania who had lived in this country for forty years and was fluent in English).

Identifying subjects from Bassetlaw proved more problematic than the Rampton Group. It was a condition of ethical approval that the initial contact with potential subjects would be by Bassetlaw staff. Dr Kingdom, at that time a consultant psychiatrist at Bassetlaw, provided a list of current patients who had been diagnosed as having Schizophrenia. Unlike the Rampton group, it was not possible to subdivide by sub types of Schizophrenia. Initial co-operation had been offered by the social work team but

after a long period they finally reported that they could not identify suitable subjects prepared to take part. A similar approach by the community psychiatric team also failed, resulting in a further delay. The author was put in touch with Dr Larne, who as well as being senior registrar in psychiatry at Bassetlaw Hospital was also carrying out research into diet in infancy and risk of Schizophrenia. Part of this research involved making telephone contact with parents of patients who had Schizophrenia and asking them questions about diet in infancy. He agreed to ask his subjects if they would be prepared to discuss the possibility of being subjects in this research. In the event, Dr Larne was able to provide the names and telephone numbers of ten parents, eight of whom agreed to take part in the research.

Instruments and Procedure

Rampton Group

All subjects in this and the Bassetlaw group were interviewed in their own home.

The interview with parents fell into two halves, the first of which was a series of structured components, the second involved a semi-focused life story approach. This part of the interview was tape-recorded. Subjects had been informed in advance that tape-recording would be necessary but their written consent (see Appendix C) was required before the interview commenced.

The main form for the questionnaire is reproduced in Appendix D and includes the formal statement, the protocol, read out to all subjects.

The first part of the questionnaire was used to collect demographic data as described above. The second part concentrated on the parents' knowledge of Schizophrenia. It asked the age of their child when they first noticed something was wrong, the age of earliest treatment or hospitalisation for Schizophrenia and whether they had known anybody else who had suffered from the disorder.

The subjects were then asked to describe, in their own words, what they thought caused Schizophrenia. However, the author felt it would also be useful to adopt a more structured approach to ascertain the subjects' views on causation. An instrument to establish subjects' knowledge and views on Schizophrenia already exists in the form of the "Knowledge About Schizophrenia Interview (KASI)" (see Barrowclough, TARRIER, Watts, Vaughn, Bamrah and Breeman²³⁸) but it does not explore in sufficient detail views on causative models. Instead, the following strategy was used.

Subjects were asked to rate a series of ten models of causation of Schizophrenia in terms of importance as an explanation for the

²³⁸ Barrowclough, C, TARRIER, N, Watts, S, Vaughn, C, Bamrah, T S and Breeman, H L. (1987) "Assessing the functional value of relative's knowledge about schizophrenia. A preliminary report." British Journal of Psychiatry. Vol. 151, pp 1-8.

disorder. The models were a mixture of organic and psycho-social explanations namely: genetic theory, family imbalance theory, viral theory, schizophrenogenic mother, neurotransmitter disorder, structural brain pathology theory, life event theory, fragmented family communication theory, scapegoating theory and the double-bind theory. This part of the research was partly based on a method developed by Cape, Antebi, Standon and Walden²³⁹ (previously referred to in the Introduction to Part Two) who surveyed a sample of psychiatrists to ascertain their views on the diagnosis, aetiology, management and prognosis of Schizophrenia. In Cape et al's study they asked the psychiatrists to rate the importance of these ten theories on a five point scale from "no importance" to "prime importance" as an explanation of Schizophrenia's aetiology.

In this research project, however, it could not be assumed that the subjects would be familiar with these theories and a more elaborate approach was developed. The author drew up brief descriptions of the above theories of roughly equal word length varying from a minimum of 71 words to a maximum of 100 words and an average of 81.5 words (sd 9.01). In the descriptive text, every effort was made to de-contextualise the descriptions. No reference was made to supportive research, or lack of it, for the theories, nor were original authors and dates included to try and avoid any biasing between theories. These explanations were drawn

²³⁹ Cape, G S, Antebi, D, Standen, P and Walden, C (1994) "Schizophrenia - The views of a sample of psychiatrists". Journal of Mental Health. Vol. 3, pp 105-113.

from Kaplan and Sadock 1989²⁴⁰ and were shown to one of the authors of the paper, Dr Gavin Cape, then Senior Registrar at Ramptom Hospital. He agreed that these were accurate explanations of the theories with one exception, on family imbalance theory, preferring the explanation in Clare²⁴¹ and this text was amended accordingly. The descriptions are reproduced in Appendix E.

The descriptions of the theories were printed onto individual sheets of A5 paper which were pasted on card, then laminated. Two such sets of cards were produced. The theories were referenced numbered from one to ten and a small program was written in BASIC to generate random numbers in this range. Before each interview the program was run to set the random order of presentation at that interview.

During the interview, the author read out the name of the theory of causation and asked the subject(s) if they had heard of that theory and their response was noted. They were then given a card with the description of that theory while the author read out the description from the duplicate card. If a couple were being interviewed, the second card would be passed on to the other partner to read after it had been read out. The subject was then asked if they could now remember hearing of that theory and their response noted. The subject was then asked to rate the theory in

²⁴⁰ Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry. Volume 1. Fifth Edition. Williams and Wilkinson. Baltimore.

²⁴¹ Clare, A. (1980) Psychiatry in Dissent. Controversial Issues in Thought and Practice. Second Edition. Tavistock Publications. London.

terms of importance as an explanation of the cause of Schizophrenia as follows, no importance, some importance, moderate importance, very important, prime importance and don't know. As in Cape et al's study, the questionnaire allowed space for the subject to add other theories to this list and to rate their importance though this option was never used. The author was, sometimes, asked for clarification of the descriptions but confined himself only to explanations of the text and did not given any additional information on the theories nor did he express any opinion on them.

After all ten theories had been rated, the subjects were asked if they had gained any information on Schizophrenia from books, TV or radio programmes and if they had could they supply details.

The third section of the interview concentrated on the degree of burden presented by having a son or daughter suffering from Schizophrenia, and who helped.

The first part, based in part on Lewis and Zeichner's²⁴² study, asked the subjects to rate the following groups of people in terms of being helpful, partly helpful and not helpful or don't know or no contact:- psychiatrists, GPs, social workers, psychologists, nurses, clergy, police, neighbours, family, friends, self help groups and any other group defined by the subject. The second part concatenated a degree of burden scale

²⁴² Lewis, V S and Zeichner, A M. (1960) "Impact of admission to a mental hospital on the patient's family." Mental Hygiene. Vol. 44, pp 503-509.

based on research by Thompson and Doll²⁴³ and a checklist of behavioural problems sometimes associated with Schizophrenia. The subjects were required to answer yes, no or don't know to these items.

The fourth and final section of the interview was a focused life story interview, and it was this section that was tape recorded. The life story approach, as described by Tagg (in Brenner, Brown and Canter²⁴⁴), in spite of its methodological problems, seemed the only approach to gain the necessary information. The focused approach, as described in Kidder, Judd and Smith²⁴⁵ seemed particularly appropriate at this point.

"In the focused . . . interview the main function of the interview is to focus attention on a given experience and its effects. Interviewers know in advance what topics or what aspects of a question they wish to cover. This list of topics or aspects is derived from a formulation of the research problem, from an analysis of the situation or experience in which the respondent has participated and from the hypotheses based on psychological or sociological theory. This list constitutes a framework of topics to be covered, but the manner in which questions are asked and their timing are left largely to the interviewer's discretion. Interviewers have freedom to explore reasons and motives and to probe further in the directions that were unanticipated. Although respondents are free to express completely their own line of thought, the direction of the interview is clearly in the hands of the interviewer."

The subjects were given the following instructions:

²⁴³ Thompson, E H and Doll, W (1982). "The burden of families coping with the mentally ill: An invisible crisis." Family Relations. Vol. 31, pp 379-388.

²⁴⁴ Brenner, M, Brown, J and Canter, D (1985) The Research Interview: uses and Approaches. Academic Press. London.

²⁴⁵ Kidder, L H, Judd, C M and Smith, E R. (1986) Research Methods in Social Relations. CBS Publishing Japan Ltd. Page 274.

"Now we come to the main part of the interview.

As I explained at the beginning I would like you to tell me what were your experiences in general, but in particular, in dealing with mental health care professionals, from the time you first felt that something was wrong with your son/daughter to admission to Rampton.

I have a checklist of topics that I feel are important and from time to time you may see me making a note on this sheet of paper. This is to provide a record that you have just mentioned one of the topics on the checklist. If at the end some areas have not been covered I will ask you directly. Apart from this, and when I would like a few more details, I will leave you to tell your own story in your own time.

However, as a tip I would suggest that most people find it easier to tell their story in chronological order."

The checklist was generated from the literature on the experiences of parents of people with Schizophrenia reviewed in the Introduction and contained the following themes: guilt, blame, shock, fear, confusion, stress, grief, loss of self esteem, behaviour problems, emotional burden, financial burden, anger (against mental health care professionals), neglect (by mental health care professionals), reliability (of mental health care professionals), information, psychiatrist, social worker, psychologist, nurse, GP, hospital, clinic, diagnosis, medication, voluntary group, neighbours, siblings, family, friends, church, police, prison and court. In addition, the checklist contained a note to the author as interviewer to probe for "who, where, when" details of person, place and time when a given event occurred.

Bassetlaw Group

The instruments and procedure for the Bassetlaw group were nearly identical to the Rampton group except that where reference was made to the subjects' experience "up to admission to Rampton" the Bassetlaw group were asked for their experiences to the date of interview (see Appendix G).

Data Analysis

As mentioned above, a database had been specifically developed to contain the information necessary to select those patients at Rampton Hospital who suffered from Schizophrenia only, and from there to identify parents who would be suitable interview subjects. This database was constructed in Microft Aspect®, a fourth generation, relational database language and is the language used to construct all Rampton Hospital Social Work Department database applications. As the research database was in the same environment as the main patients' databases it was also possible, in the case of the Rampton group, to access information concerning patient characteristics including gender, date of birth and index offence and date of admission to Rampton.

All this information related to the patient and not the subject, the patient's father or mother. A separate database was constructed to contain the information collected from both groups of interview subjects, a separate record for each subject. The second database contained the information from the first three

sections of the interview, which, as those sections were structured, were relatively easy to code and the data easy to interrogate. A third database contained the analysis of the tape recorded interview.

The information from the tape recorded component of the interview was scored using the score sheet in Appendix F. The interview was divided into two sections, where the subject was unprompted and where, at the end, the subject was prompted for any reference on the cue sheet that had not been referred to. The duration of both sections was recorded. Both sections required scoring on two separate sheets, identical in both sections. Sheets one and three recorded when the subject referred to a person (psychiatrist, GP, social worker, psychologist, nurse, staff or volunteer from self help group, clergy, police, neighbour, patient sibling, other family member or friend) who appeared to blame them for the disorder, neglected them, angered them, were unhelpful or were unreliable in the context of their son or daughters disorder. The opposites, of being absolved from blame, not neglected, not feeling angry toward, being reliable or helpful were also recorded. Sheets two and four recorded references to dates or age when the subject's child was first professionally seen about the disorder, hospitalised and, in the Rampton group, first contact with courts and prison. Instances of being given information, or conversely not being given information, on the diagnosis, treatment and medication and nature of the disorder by psychiatrist, GP, social worker, psychologist, nurse or self help group staff or volunteers were also recorded. Reactions in terms

of guilt, shock, fear, stress, grief, loss of self esteem, sense of loss, general emotional and financial burden were recorded as well as behavioural problems.

Where particularly illustrative anecdotes occurred, these were transcribed into a word processing environment. To make the accounts anonymous, personal names, names of institutions and location references were deleted.

HYPOTHESES

The purpose of the research was to gain a wide range of information on the experiences of parents of people with Schizophrenia but also to test out certain specific hypotheses.

If there is still a legacy of the pathogenic parenting models today then one might expect that the subjects would report the following:

Hypothesis 1. There would be a significant awareness of the existence of at least some of the earlier pathogenic parenting models.

Hypothesis 2. That there would be a significant number of reports by subjects that they felt that mental health care professionals blamed them for their son or daughter's disorder.

Hypothesis 3. That there would be a time factor to reports of feeling being blamed. That is to say, subjects who were parents of children who developed the disorder more recently might be less likely to have been exposed to professionals and literature sympathetic to pathogenic parenting theories than subjects whose children developed the disorder some time ago.

Hypothesis 4. That there would be a significant number of reports by subjects of feelings of guilt that they may have caused the disorder.

Hypothesis 5. That these feelings of guilt would be significantly related to feelings of being blamed.

Finally, Hypothesis 6 would be that the subjects would show a high degree of burden as a result of their experiences with their schizophrenic son or daughter.

RESULTS

The report of results has been divided into two sections. The first section consists of quantitative data and statistical analysis. The second section focuses on qualitative data, and on selected quotations from the transcripts of the tape recorded part of the interview that are particularly illustrative of the concepts and reactions referred to in the qualitative analysis.

Quantitative Analysis

The analysis of the interviews can be grouped under four main headings: demographic data about the subjects and their son or daughter (the patient at Rampton or in Bassetlaw), the subjects' views on Schizophrenia and its origins, the burden of having a son or daughter who has Schizophrenia in the family and finally the views of the subjects on their contact with mental health care professionals. The data has been extrapolated from both the structured and unstructured components of the interview and is also broken down by group ie Rampton or Bassetlaw.

Demographic Data

In all, twenty-two interviews were carried out with parents of patients in Rampton (at the time of interview) and eight interviews were carried out with parents of patients in Bassetlaw. The interviews in the Rampton group took place between

the 17th of November 1992 and the 8th of May 1996. The interviews in the Bassetlaw subgroup took place between the 14th of October 1994 and the 19th June 1996.

As stated in the Method, all subjects were natural parents of patients diagnosed as suffering from Schizophrenia as their only significant mental disorder. All subjects were white and, with the exception of two subjects, all were born in the UK and had English as their first language. As mentioned in the Method, the exceptions were a subject (Rampton group) who was born and brought up in Finland and a subject born in Rumania (Bassetlaw group). Though their son or daughter had Schizophrenia, none of the subjects were known to be suffering from Schizophrenia or any other significant mental disorder including learning disability.

Parent Type

Table 1 shows the parent type interviewed in both groups.

Table 1 Parent Type

Parent Type	Rampton	Bassetlaw	Total
Mother	12	3	15
Father	6	-	6
Mother and father	4	5	9
Total	22	8	30

Subject Ages (at time of interview)

In both the Rampton and the Bassetlaw groups, the fathers were, on average, older than the mothers and, in terms of all subjects, the Bassetlaw group was slightly older than the Rampton group. With an overall age range of 41 to 79 years old, the total subject group might be considered to be quite old. The ages of the subjects are shown in Table 2, in integer years.

Table 2 Subject Age

Rampton		Bassetlaw	
Mothers	Fathers	Mother	Fathers
41	49	56	62
47	49	56	65
49	54	58	70
49	59	59	73
50	64	64	75
52	67	65	
54	72	66	Range = 62-75
55	72	75	Mean = 69.00
57	73		Sd = 5.43
61	79	Range = 56-75	
63	79	Mean = 62.38	
63		Sd = 6.48	
66	Range = 49-79		
68	Mean = 65.18		
71	Sd = 11.08		
79			

Range = 41-79
 Mean = 57.81
 Sd = 10.10

Occupation

Tables 3 and 4 show the subjects' occupations (current or prior to redundancy/retirement). In comparison to national statistics²⁴⁶ there was a higher percentage of "professional" persons in the combined subject group; in all there was a lower rate of white collar and higher rate of blue collar workers in both groups. Table 5 shows the occupation classification for both groups and also the percentage breakdown for the general population in the 1991 census. Note: In the 1991 Census "Housewife" is not recognised as an occupation and has not been

²⁴⁶ Office of Population Census and Survey (1994) 1991 Census Economic Activity for Great Britain, Volume 1 and 2. HMSO, London.

included in the table.

Table 3 Subject's Occupation

Rampton Group

Mothers

Ballet teacher and examiner
Clerical assistant
Hotel worker
Housewife
Housewife
Housewife
Housewife
Live in carer
Nurse
Process worker
Retailer
Social Services Manager
Self employed manufacturer
Shop worker
Textile worker
Wool Dyer

Father

Bookkeeper
Centre lathe turner
Educationalist
PCV driver
Policeman
Retailer
Site agent
Steel erector
Steel worker
Self employed manufacturer

Table 4

Bassetlaw Group

Mothers

Domestic worker
Grocer
Housewife
Language teacher
Receptionist
Resident warden
Psychiatric nurse
Teacher

Fathers

Concrete worker
Grocer
Miner
Minister of religion
Policeman

Table 5 Subject's Occupation in terms of the OPCS Classifications

	Rampton	Bassetlaw	Total (%)	1 9 9 1 Census (%)
Managerial and Admin Professional	1	0	1 (3%)	16%
Associate Professional & Technical	2	3	4 (12%)	8%
Clerical & Secretarial	1	1	2 (6%)	9%
Craft & Related Occupations	2	1	3 (9%)	16%
Personal & Protective	5	0	5 (15%)	15%
Sales Occupation	2	2	4 (12%)	9%
Industrial Plant & Machine Operators	3	2	5 (15%)	7%
Other Occupations	5	1	6 (18%)	11%
	2	2	4 (12%)	9%

Level of Education

The subjects' educational level, in terms of age at leaving full time education, is shown in Tables 6 and 7.

Table 6 Mother's Education

	Rampton	Bassetlaw	Total
Left school at 14	4	2	6
left school at 15	6	3	9
Left school between 16-18	4	0	4
Went on to higher education	2	2	4
Total	16	7	23

Table 7 Father's Education

	Rampton	Bassetlaw	Total
Left school at 14	3	3	6
left school at 15	2	1	3
Left school between 16-18	3	0	3
Went on to higher education	2	1	3
Total	10	5	15

Direct comparisons with national statistics are difficult but Social Trends²⁴⁷ does offer some indication. Chart 3.14 in that publication shows adults with qualification at or above GCSE Grades A-C or equivalent, by gender. In 1975, 30% of males had achieved this level and 21% females. By 1992 these figures had risen to 55% for males and 50% for females. In comparison, half the Rampton group fathers had left full time education at 16 or over and one in five of the Bassetlaw fathers. Six out of sixteen (37%) of the Rampton mothers stayed on in education over the age of sixteen and two out of seven of the Bassetlaw mothers (29%). Overall, these figures bear reasonable comparison with the earlier national averages, and if it were possible to extrapolate back the trend, bearing in mind the subjects are comparatively elderly and the national trend shows an increase in educational

²⁴⁷ Office of Population Census and Survey (1995) Social Trends CD. HMSO, London.

attainment over time, this might show that the subjects are of at least average educational level judged by their school leaving age.

Religious Beliefs

The subjects were asked what their formal religious affiliations were (present or baptised or initiated into) and to rate their strength of religious beliefs in terms of not at all religious, not very religious, moderately religious, very religious and don't know.

Table 8 Mother's Religious Affiliation

	Rampton	Bassetlaw	Total
Church of England	8	3	11
Church of Scotland	1	0	1
Roman Catholic	1	3	4
Jehovah Witness	1	0	1
Mormon	1	0	1
Pentecostal	1	1	2
Christian (non denominational)	1	0	1
Methodist	1	0	1
Lutheran	0	1	1
Agnostic	1	0	1
Total	16	8	24

Table 9 Father's Religious Affiliation

	Rampton	Bassetlaw	Total
Church of England	3	3	6
Church of Scotland	1	0	1
Church in Wales	1	0	1
Roman Catholic	1	1	2
Mormon	1	0	1
Pentecostal	0	1	1
Buddhist	1	0	1
Agnostic	1	0	1
Atheist	1	0	1
Total	10	5	15

If we add the father and mother church membership figures (discounting agnostics and atheists, who, by definition would not be church members) we can compare our subjects with the 1992 church membership figures in Social Trends²⁴⁸, Table 13.14.

Of the 39 subjects, 21 were members of the Anglican and Methodist community, 6 were Roman Catholics and 5 belonged to other Trinitarian churches. A further 3 subjects belonged to non-Trinitarian churches (Mormon and Jehovah Witness) and one subject was a member of a non-Christian religion (Buddhist).

²⁴⁸ Office of Population Census and Survey (1995) Social Trends CD. HMSO, London.

Table 10 Church Membership - Subjects Compared to National Statistics

	Subjects Number	Subject % (of 36)	National %
Anglican and Methodist	21	58	27
Roman Catholic	6	17	25
Other Trinitarian	5	14	29
Non Trinitarian	3	8	6
Non Christian	1	3	13
Total	36	100	100

Although the subject group had over double the percentage of Anglican and Methodist members, the overall membership of Trinitarian churches as a whole was only slightly higher in the research group than the national ratio, 89% compared to 81%. The ratio of non Trinitarian church membership was not greatly different, 8% and 6%, but the membership of non Christian churches was 10% lower though this is not surprising in an all white subject group.

Tables 11 and 12 show subjects' reported strength of religious belief.

Table 11 Mothers' Strength of Religious Belief

	Rampton	Bassetlaw	Total
Not at all religious	1	0	1
Not very religious	10	1	11
Moderately religious	5	6	11
Very religious	0	1	1
Total	16	8	24

Table 12 Fathers' Strength of Religious Belief

	Rampton	Bassetlaw	Total
Not at all religious	2	0	2
Not very religious	4	1	5
Moderately religious	3	3	6
Very religious	1	1	2
Total	10	5	15

Subject's Area of Residence

Table 13 shows the subject's area of residency.

Table 13 Subject's Area of Residence

	Rampton	Bassetlaw	Total
Nottinghamshire	3	7	10
South Yorks	5	0	5
North Yorks	3	0	3
West Yorks	2	0	2
Kent	2	0	2
Lincolnshire	1	1	2
Greater London	2	0	2
West Midlands	2	0	2
Berkshire	1	0	1
West Glamorgan	1	0	1
Total	22	8	30

Rampton Hospital's current catchment area is the Eastern half of England and this is reflected, in the main, in the area of residence of the Rampton subjects. Bassetlaw being in the County of Nottinghamshire, it is not surprising that seven out of eight of the interviews were with subjects who lived there.

DATA ON THE SUBJECT'S SON OR DAUGHTER WHO AT THE TIME OF INTERVIEWING WAS A PATIENT

Gender of Patient

Table 14 shows the gender of the patients.

Table 14 Gender of Patient

	Rampton	Bassetlaw	Total
Male	20	7	27
Female	2	1	3
Total	22	8	30

Tables 15 and 16 show the ages when the subject first suspected something was wrong, age at first treatment/hospitalisation, and, in the Rampton group, age at admission to Rampton and age at date of interview.

Event Age Data

Table 15 Rampton Patients Event Age Data

Interview Number	1 Something Wrong	2 Treat./ Hospital	3 Admission Rampton	4 Age at Interview	Difference 4 - 3
1	17	18	31	41	10
2	10	15	26	43	17
3	25	25	31	34	3
4	28	28	29	31	2
5	18	29	30	32	3
6	23	28	29	29	1
7	19	20	30	34	4
8	24	30	36	42	6
9	18	19	32	46	4
10	15	15	36	41	5
11	21	22	27	31	4
12	15	16	26	32	6
13	15	16	27	32	5
14	14	23	25	28	3
15	18	19	27	48	21
16	17	19	30	37	7
17	18	18	23	24	1
18	17	17	32	35	3
19	13	14	19	31	12
20	8	14	24	27	3
21	28	29	39	42	3
22	15	20	21	22	1
Range	8-28	14-30	19-39	22-48	1-21
Mean	18.00	20.73	28.55	34.64	5.64
SD	5.18	5.46	4.85	7.04	5.14

Table 16 Bassetlaw Patients Event Age Data

Interview Number	1 Something Wrong	2 Treat./ Hospital	3 Age at Interview
1	18	21	30
2	29	29	36
3	15	15	38
4	21	22	29
5	16	16	28
6	18	23	28
7	30	30	44
8	30	30	31
Range	15-30	15-30	28-44
Mean	22.13	23.25	28.40
SD	6.49	5.99	4.15

In both groups it can be seen that the interviews represent many years of cumulative experience of living with the disorder. What is also of note is the average ages for first noticing something was wrong to first treatment, is greater in the Rampton Group than the Bassetlaw - just over two years compared to just over one year. One can only speculate as to why this difference might be so.

A simple explanation may be in terms of the earlier age at which parents first noticed something was wrong in the Rampton group. With hindsight they may have thought something was wrong but at the time may have regarded it as an adolescent crisis. Table 17 shows the subtype of Schizophrenia, in terms of ICD9, as diagnosed by the patient's responsible medical officer. This information was only available for Rampton patients. If there was a higher rate of paranoid Schizophrenia in the Rampton group than the Bassetlaw group, this might be a factor. Generally speaking, people with paranoid Schizophrenia suffer less damage to the integrity of their personality than those with other forms of Schizophrenia. The nature of their paranoid delusions may also lead them to conceal their symptoms. Thus, if there was a greater rate of paranoid Schizophrenia in the Rampton patient group this may account for the longer time for first treatment contact to take place.

Alternatively, one might speculate that the increase in delay in obtaining first consultation/treatment may have had an impact on the ultimate seriousness of the illness. At this stage it is not

possible to say whether Special Hospital patients with Schizophrenia have spent longer with the illness before receiving first treatment and whether there is any relationship between delay in treatment and outcome in terms of seriousness of the disorder.

Table 17 Subtype of Schizophrenia (Rampton patients only)

	Number
Catatonic	2
Paranoid	13
Residual	1
Unspecified	6

The high rate of paranoid subtype Schizophrenia should not, of itself, be any surprise bearing in mind that Table 18, below, shows that just over three quarters of the patients have committed crimes against persons. Authors such as McNeil and Binder²⁴⁹ have argued that symptomatology is more important than clinical diagnosis in terms of predicting violence by the mentally ill. The diagnosis of Schizophrenia, of itself, will not predict violence, but hostile-suspiciousness associated with Paranoia might. DePauw and Szulecka²⁵⁰ have pointed out the relationship between well developed delusions (in particular of misidentification) in the mentally ill and violence.

²⁴⁹ McNeil, D E and Binder, R L (1994) "The relationship between acute psychiatric symptoms, diagnosis and short term risk of violence." Hospital and Community Psychiatry. Vol. 45:2, pp 133-137.

²⁵⁰ DePauw, K W and Szulecka, T K (1988) "Dangerous Delusions. Violence and the Misidentification Syndromes." British Journal of Psychiatry. Vol. 152, pp 91-96.

Table 18 Index Offence (Rampton patients only)

	Number
Manslaughter	6
Sexual offenses	0
Other crimes against persons	11
Arson	1
No index offence	4

Length of Interview

The duration of the tape recorded interviews, in minutes and decimals of minutes, can be seen in Tables 19 and 20. The Bassetlaw interviews lasted longer than the Rampton interviews. This could be a function of the fact that in some cases in the Bassetlaw group the patient was still living at home or returned home on a regular basis and the experiences of this group were therefore more immediate and more detailed. It could also be true that the circumstances that led to the Rampton patients' admission may have led parents in that group to be more reserved or inhibited in their accounts.

Table 19

Rampton

	Unprompted	Prompted	Total
Range	10.00-84.66	4.45-30.53	15.75-91.75
Mean	32.17	13.61	45.86
SD	18.28	7.15	18.36

Table 20

Bassetlaw

	Unprompted	Prompted	Total
Range	22.95-94.00	15.00-40.60	45.66-130.66
Mean	58.22	24.83	81.56
SD	31.75	9.83	35.30

Summary of Demographic Data

Altogether 30 interviews were carried out, twenty two interviews with parents of patients in Rampton Hospital and eight of parents of patients in Bassetlaw. Fifteen of the interviews were with mother only, six with father only and nine with mother and father.

The subject groups were relatively elderly with a total age range of 41 to 79. The mean age of the fathers was greater than that of the mothers and Bassetlaw group was slightly older in both sexes than the Rampton group.

In terms of occupation (present or past), although the percentage in the professional occupation category was higher in the combined subject groups than in national percentage figures, overall there was a lower percentage of white collar and higher percentage of blue collar occupation compared to national figures.

There was an obvious difficulty comparing the educational level of the subject group with current statistics of educational level but it was not unreasonable to assume that, in comparison with their contemporaries, the educational level of the subjects was not low.

In terms of religious belief, the percentage of members of Trinitarian and Non Trinitarian churches was slightly higher in

the subject group compared to national statistics and the membership of non Christian churches was lower, though this is not surprising in an all white subject group.

All but one of the interviews in the Bassetlaw group were carried out with parents who lived in the county of Nottinghamshire. Rampton group subjects resided throughout the UK though the majority lived in eastern part of the UK, from Yorkshire to Kent, Rampton Hospital's current catchment area.

Of the son or daughter who had Schizophrenia, twenty seven were male and three were female. On average, the Rampton patients were older than the Bassetlaw patients. The length of time between first noticing something was wrong to the date of interview was much greater in the Rampton group, a mean of 16.64 years than the Bassetlaw group, a mean of 6.27. The length of time between first noticing something was wrong to first treatment was twice as long in the Rampton group than the Bassetlaw group, 2.73 years compared to 1.12 years.

Information on subtype of Schizophrenia was only available on the Rampton patients and over half were diagnosed as having paranoid Schizophrenia. Information on index offence was only relevant to the Rampton patient group and six out of twenty had an index offence of manslaughter, a further eleven had an index offence of other offenses against the person and there was one patient with an index offence of arson. Four patients had no index offence at all.

The length of the tape recorded component of the interview was much longer in the Bassetlaw group than the Rampton group, a mean of 81.56 minutes compared to 45.86 minutes.

The Subject's Views on Schizophrenia

Knowledge of Schizophrenia

The subjects were asked if they knew anybody else who had Schizophrenia. Table 21 shows the Yes/No responses (mother, father and mother and father responses have not been differentiated in this table). Table 22 shows who the person was who had Schizophrenia, if the response had been "Yes".

Table 21 Subject knew anybody else who had Schizophrenia?

	Yes	No	Total
Rampton	9	13	22
Bassetlaw	3	5	8
Total	12	18	30

Table 22 Person known who also had Schizophrenia

Rampton

Friend's two daughters
Friend's son
Patient's girlfriend
Neighbour
Day centre users
Mother & Grandfather
Uncle & cousin
Cousin
Other family members

Bassetlaw

Patient's wife
Friend's son
Hospital patients

When asked if the subjects had read any books, seen any TV programmes or heard any radio programmes on the subject of Schizophrenia the responses were as follows:-

Table 23

Rampton

	Number
No	5
Nothing specific	3
Book by Arieti and TV and radio	1
Book by Gwen Howes and TV	1
Books and encyclopedia	1
Article in "Woman's World"	1
Books and TV	1
TV programme	4
Nick Ross, Channel 4 Documentary, 27/3/93	1
TV and radio	2
National Schizophrenia Fellowship material	1
NSF meeting with Professor Leff and Dr Weller	1

Table 24

Bassetlaw

	Number
"Divided Self", TV Programmes	1
"Divided Self" and book on Schneider	1
NSF literature, TV programmes	1
Books TV "Trouble in Mind"	1
TV, radio, hospital leaflet	1
TV programmes	1
Old medical dictionary	1
From when mother worked in hospital	1

On the whole, subjects in both groups were not very specific about their sources of information, but where they were able to name specific books or other sources they present a mix of older, pathogenic sources and more modern family orientated approaches in sympathy with the family's predicament. In the Rampton group, as well as more psychodynamic theorists such as Arieti, there were references to National Schizophrenia Fellowship literature, talks given by Professor Leff (who has published on Expressed Emotion) and Gwen Howes who, on the whole, writes from a position in sympathy with the broad aims of the National Schizophrenia Fellowship. In the Bassetlaw group, there was a reference to NSF

literature, to the comparatively recent TV series "Trouble in Mind" but also two references to R D Laing's "The Divided Self". The reference to Schneider might be a reference to a text book on Schneider's symptomatic system.

Subject's Views on Etiological Models

Subjects were asked, prior to the model rating procedure, what, in their view, was the cause or causes of Schizophrenia. Some subjects gave more than one reason.

Table 25 Rampton Subjects. What Causes Schizophrenia?

	Number
Don't know	12
Chemical imbalance	2
Biological vulnerability but illicit drugs as a trigger factor	2
Inheritance	2
Dopamine imbalance	1
Biological vulnerability but trauma as a trigger	1
Inheritance and stress	1
The burden of looking after younger siblings	1
Worry, overwork and too much studying	1
Low self esteem	1
Brain malfunction leading to dreaming while awake	1
Depression	1

Table 26 Bassetlaw Subjects. What Causes Schizophrenia.

	Number
Don't know	2
Drugs	2
Stress	2
Chemical imbalance	1
Inheritances	1
Isolation	1
Disappointment	1
Adolescence	1
Upbringing	1

As described in the Method, subjects were asked if they had heard of various models of Schizophrenia (the same models used by Cape,

Antebi, Standen and Walden²⁵¹) in their study of what psychiatrists thought were important etiological factors in Schizophrenia). They were then shown brief descriptions of the models and asked whether the model was now familiar to them and their responses noted. This enabled the constructions of a basic familiarity rating system in which, if the subject was familiar with the model prior to seeing the description the model scored two points, if it was familiar after being shown the description, one point, and no points if the model was still unfamiliar after the description. The total score for all interviews, in the rank order, from most familiar to least are set out in Table 27.

Table 27 Familiarity of Models

Model	Rampton	Bassetlaw	Total
Genetic Theory	36	12	48
Neuro-transmitter Disorder Theory	21	7	28
Life Event Theory	17	11	28
Viral Theory	13	3	16
Structural Brain Pathology Theory	11	4	15
Scapegoating Theory	7	1	8
Family Imbalance Theory	6	1	7
Double Bind Theory	4	1	5
Schizophrenogenic Mother Theory	4	1	5
Fragmented Family Communication Theory	3	1	4
Note: Maximum possible score per theory	44	16	60

After the presentation, the subjects were asked to rate each model, as had Cape et al's subjects, in terms of importance in explaining the cause or causes of Schizophrenia. They were asked to rate in terms of: don't know, no importance, some importance, moderately important, very important and prime importance.

²⁵¹ Cape, G S, Antebi, D, Standen, P and Walden, C (1994) "Schizophrenia - The views of a sample of psychiatrists". Journal of Mental Health. Vol. 3, pp 105-113.

Subjects were informed that these models may not be mutually exclusive and therefore it might be possible to judge several models as being of prime importance. Using a simple scoring system of zero points for don't know and no importance, one point for some, two points for moderately, three point for very and four point for prime importance it was also possible to construct a basic score for each model and to rank order the scores. The results are shown in Table 28.

Table 28 Subjects' Ranking of Importance of Model

Model	Rampton	Bassetlaw	Total
Life Event Theory	47	12	59
Neuro-transmitter Disorder Theory	51	7	58
Genetic Theory	38	3	41
Structural Brain Pathology Theory	29	3	32
Viral Theory	15	0	15
Family Imbalance Theory	15	0	15
Schizophrenogenic Mother Theory	12	0	12
Double Bind Theory	9	0	9
Scapegoating Theory	5	0	5
Fragmented Family Communication Theory	3	0	3
Note: Maximum possible score per theory	88	32	120

Table 29 shows the ranked ordered median score for ratings of the same model by Cape et al's subjects.

Table 29 Cape et al's Subjects

Model	Score	Rank Order
Genetic Theory	3.5	1
Neuro-transmitter Disorder Theory	3.3	2
Life Event Theory	3.0	3
Structural Brain Pathology Theory	2.3	4
Fragmented Family Communication Theory	2.1	5
Double Bind Theory	1.7	6
Scapegoating Theory	1.6	7
Family Imbalance Theory	1.5	8
Viral Theory	1.4	9.5
Schizophrenogenic Mother Theory	1.4	9.5

From these tables it was possible to perform further analyses.

The first was to see whether there was a correlation between familiarity of models and rating of importance of models in the combined groups. Applying the Spearman Rank Correlation Test yielded a value of 0.8563 which is significant at the 0.02 level indicating a positive relationship between familiarity of model and rating of importance in this group of subjects.

The second was to see if there is any correlation between the combined group subjects and Cape et al's subjects in terms of rating of importance of the ten models. Spearman's Rank Correlation Test was applied to Cape et al's results and the subject scores. The computed value was 0.5762 which is significant at the 0.081 level indicating a degree of concordance between what Cape et al's psychiatrists and the subjects in this research thought were the causes of Schizophrenia.

Finally, Spearman's Rank Correlation Test was applied to the two separate groups ranking of importance. The computed value was 0.8731, significant at the 0.001 level, indicating a high degree of concordance between the Rampton and Bassetlaw group subjects in their views on the models.

Summary of Subjects' Views on Schizophrenia

In nine out of the twenty-two Rampton interviews and three out of the eight Bassetlaw interviews the subjects said that they knew somebody else who had Schizophrenia.

The subjects named a number of sources of information: TV and radio programmes, books and magazines though frequently they could not remember specific titles. Where they could, there was a mixture of sources that could be said to be pro-family such as National Schizophrenia Fellowship material but also, in the Bassetlaw group, there were two references to Laing's "Divided Self".

When the subjects were asked the open-ended question, "what they thought were the cause or causes of Schizophrenia?" subjects in twelve of the twenty-two Rampton interviews and two out of the eight Bassetlaw interviews said that they did not know. Where subjects did offer an explanation, the most frequent type of explanation was a biological disorder, but stress explanations, either in conjunction with biological vulnerability, or entire of itself was also felt to be important. To a lesser extent, inheritance and illicit drug use was felt to be important and in only one interview was upbringing felt to be a cause.

When the family were asked to rate familiarity of ten etiological models, biological models and life events were the most familiar. The familiarity scores for the older pathological parenting

models were low. When asked to rate the importance of the models, once again, life events and biological models were rated as most important. There was a positive correlation between the familiarity scores and the importance scores: models that the subjects were most familiar with were deemed the most important. There was also a positive correlation between subjects in this study and the psychiatrists interviewed in Cape, Antebi, Standen and Walden's²⁵² study in terms of ranking of importance of models. There was also a positive correlation in the ranking of importance of models between the Rampton and the Bassetlaw group.

Hypothesis 1 stated that there would be a significant awareness of the existence of at least some of the pathogenic parenting models. The results indicated that this was not the case and that the subjects, on the whole, had little awareness of such models and treated them with a good deal of scepticism, when made aware.

²⁵² Cape, G S, Antebi, D, Standen, P and Walden, C (1994) "Schizophrenia - The views of a sample of psychiatrists". Journal of Mental Health. Vol. 3, pp 105-113.

The Burden of Having a Son or daughter who has Schizophrenia

The information in this section was derived from both the structured and the unstructured tape recorded sections of the interview. It contains the responses to the behavioural problem checklist and also a list of behavioural problems mentioned in the tape recorded interview. As in all the analyses of this second section, the scores are in three figures; where a reference has been made without prompting, where the reference has been made after prompting and finally the sum of the two. The scores for the degree of burden checklist are included as well as an analysis of references to the following emotional responses in the tape recorded interview: emotional burden, financial burden, sense of guilt that the subject may have caused the disorder, sense of shock, fear, confusion, stress, grief, negative self esteem and a sense of loss at what the son or daughter may have become. Additional emotional responses beyond these categories are also included.

Behavioural Problem Checklist

Table 30 shows the results of the behavioural problem checklist in the structured component of the interview.

Table 30 Behavioural Problems - Number of "yes" responses

	Rampton	Bassetlaw	Total
Withdrawal	19	7	26
Verbal Aggression	18	4	22
Violence	17	4	21
Undue Suspiciousness	16	4	20
Poor Self Care	13	5	18
Rapid Mood Change	14	3	17
Suicidal Behaviour	15	4	17
Destructiveness	10	5	15
Obsessions	11	3	14
Self Injurious Behaviour	11	2	13
Phobias	4	1	5
Sexually Inappropriate Behaviour	3	1	4
Maximum per problem	22	8	30

Once again, Spearman's Rank Correlation Test was applied to see if there was a concordance between the ranking of behavioural problems between the Rampton and Bassetlaw groups. The computed value was 0.6184, significant at the 0.032 level. However, it is worth drawing attention to some of the ratio similarities and difference between the groups. In terms of the most frequent and least frequent behaviour problems, "withdrawal" and "sexually inappropriate behaviour" the ratio is roughly the same in both groups. In between there is quite a difference in ratio, with the Bassetlaw group showing an overall lower rate of behavioural problems than the Rampton group.

In the tape recorded interviews the subjects referred to the following problems and Tables 31 (Bassetlaw group) and 32 (Rampton group) show the number of interviews where that problem was mentioned. The second column are figures where subjects had not mentioned problems and were asked if there were any problems

with their son or daughter. The third column is the sum of the unprompted and prompted columns.

Table 31 Bassetlaw Subjects. Behaviour Problems with patient

	Unprompted	Prompted	Total
Paranoid Ideation & other Delusions	5	2	7
Apathy	2	1	3
Verbal Aggression/Swearing	2	0	2
Asleep During Day and up at Night	1	1	2
Hallucinations	1	1	2
Violence	1	0	1
Withdrawal	1	0	1
Self Neglect	1	0	1
Illicit Drug Taking	1	0	1
Destructiveness	1	0	1
Inappropriate Laughter	1	0	1
Obsessions	1	0	1
Restlessness	1	0	1
Aggression	1	0	1
Wandered	1	0	1
Rapid Mood Changes	1	0	1
Crying	1	0	1
Elation	1	0	1
Erratic	1	0	1
Poor eating habits	1	0	1
Out late	1	0	1
Mixing with bad company	1	0	1
Weight loss	0	1	1

Table 32 Rampton Subjects. Behaviour Problems with Patient

	Unprompted	Prompted	Total
Violence	12	3	15
Suicidal	9	0	9
Asleep During Day and up at Night	6	2	8
Paranoid Ideation & other Delusions	6	1	7
Verbal Aggression/Swearing	5	2	7
Withdrawal	5	1	6
Drinking to Excess	4	0	4
Self Neglect	4	0	4
Hallucinations	4	0	4
Illicit Drug Taking	3	0	3
Self Injurious Behaviour	3	0	3
Problems at School - Truanting/Refusal	3	0	3
Destructiveness	3	0	3
Inappropriate Laughter	3	0	3
Stealing	3	0	3
Thought Disorders	2	0	2
Loss of Employment	2	0	2
Depression	2	0	2
Obsessions	2	0	2
Rages/Temper	2	0	2
Restlessness	2	0	2
Aggression	2	0	2
Wandered	2	0	2
Unable to Cope	1	0	1
Frightened	1	0	1
Demanding	1	0	1
Negative Self Esteem	1	0	1
Set Fires	1	0	1
Hid Knives in the House	1	0	1
Non Compliance with Medication	1	0	1
Picked on Siblings	1	0	1
Disruptive	1	0	1
Needed Supervision	1	0	1
Rapid Mood Changes	1	0	1
Gambling	1	0	1
Immature	1	0	1
Crying	1	0	1
Morbid Interests	1	0	1
Difficult to bring friends home	0	1	1
Easily led	0	1	1

Because the types of problems vary and because the frequency counts are both low and there are many tied scores, it was not felt to be safe to perform a statistical analysis between Tables 31 and 32. However, it is worth making one or two observations. In the Rampton group, violence is the most frequently referred

problem but in the Bassetlaw group it is paranoid and other delusional beliefs. If we compare the top five categories (in the Bassetlaw group, after the first five the scores are all one) three out of five are to be found in both groups. These categories are paranoid ideation and other delusional beliefs, asleep during day and up at night and verbal aggression/swearing. The two high scoring categories that appeared in the Rampton group and not the Bassetlaw were violence and suicidal behaviour and the two that were scored high in the Bassetlaw group and not in the Rampton group were apathy and hallucinations.

Degree of Burden

Table 33 shows the scores for the degree of burden scale. They represent the number of interviews, out of twenty, in which the subject respond yes to the question about their son or daughter with Schizophrenia.

Table 33 Degree of Burden

	Rampton	Bassetlaw	Total
Behaviour at times more than could be coped with	18	5	23
Difficult to know how to respond to	16	6	22
Feeling of being trapped by the way things were	17	4	21
Upset every day routine	15	4	19
Needed supervision	13	3	16
Behaviour was embarrassing	9	3	12
Felt shut off from normal life	9	3	12
Felt resentful because of the situation	7	4	11
Caused problems with neighbours	5	2	7
Maximum score per burden item	22	8	30

Spearman's Rank Correlation Test was applied to Table 33 to see

if there was a concordance in the ranking of burden type between the Rampton and Bassetlaw subjects. The computed value was 0.7449, a positive correlation significant at the 0.021 level showing a high degree of concordance between the Rampton and the Bassetlaw group in terms of burden.

Emotional Responses

The unstructured interview was analyzed for any reference to the following reactions to having a son or daughter with Schizophrenia in the family: emotional burden, financial burden, sense of guilt (that the parent may have caused the disorder), shock, fear, confusion, grief, negative self esteem and sense of loss. Once again, three figures are presented referring to a positive response without prompting, with prompting, and the total of these two scores. All scores, once again, are out of twenty-two in the Rampton group and eight in the Bassetlaw group, each point signifies an interview where the positive response occurred.

Table 34 Rampton Subjects' Emotional Response

	Unprompted	Prompted	Total
Stress	7	15	22
Sense of loss	3	17	20
Emotional burden	17	10	17
Fear	7	10	17
Grief	1	15	16
Shock	2	12	14
Guilt	3	9	12
Confusion	3	8	11
Negative self-esteem	2	8	10
Financial burden	1	9	10
Maximum possible score	22	22	22

Table 35 Bassetlaw Subjects' Emotional Response

	Unprompted	Prompted	Total
Stress	5	3	8
Guilt	3	4	7
Shock	2	4	6
Emotional burden	4	2	6
Confusion	2	4	6
Sense of loss	1	5	6
Fear	3	2	5
Financial burden	2	3	5
Grief	1	4	5
Negative self-esteem	0	2	2
Maximum possible score	8	8	8

Table 36 consists of the total scores in Tables 35 and 34.

Table 36 All Subjects' Emotional Response

	Rampton	Bassetlaw	Total
Stress	22	8	30
Sense of loss	20	6	27
Emotional burden	17	6	23
Fear	17	5	22
Grief	16	5	21
Shock	14	6	20
Guilt	12	7	19
Confusion	11	6	17
Financial burden	10	5	15
Negative self-esteem	10	2	12
Maximum possible score	22	8	30

Again Spearman's Rank Correlation Test was applied to see if there was any concordance between the ranking by the Rampton and the Bassetlaw subjects. A positive correlation of 0.5004 was computed but at a level of 0.141 this would not be regarded as significant. However, if one looks at the two scores there are some interesting observations to be made. All the families, in both groups, reported stress and both groups ranked lowest a sense of negative self-esteem. Twenty out of twenty^{two} of the Rampton

interviews and three quarters of the Bassetlaw interviews referred to a sense of loss of what might have been. Fear was a significant reaction in both groups (seventeen of the Rampton and five of the Bassetlaw interviews).

Sense of Guilt

A sense of guilt for causing the disorder was recorded in twelve of the twenty-two Rampton interviews and seven out of eight of the Bassetlaw interviews. The Fisher Exact Probability Test²⁵³ was applied to these results but there was no significant difference between the groups.

A Chi Square Test was carried out on the data to see if length of exposure to the disorder had any impact on presence or absence of guilt. The data for both groups were pooled and the length of time between noticing something was wrong with their son or daughter to time of interview was calculated in integer years. The mean was then calculated and interviews divided into two groups, length of exposure less than or greater than the mean. These groups were further sub divided into presence or absence of guilt to create the matrix below.

²⁵³ In this and subsequent analyses where the expected frequency in a two by two matrix falls below 5, the Fisher Exact Probability Test has been used in preference to Chi Square, as recommended in Daley, L E, Bourke, G J and McGilvray (1995) Interpretation and Uses of Medical Statistics. Blackwell Science. Oxford.

Table 37. Sense of Guilt and Length of Exposure to the Disorder

	Sense of Guilt		Total
	Yes	No	
Less than Mean	8	8	16
Greater than Mean	10	4	14
Total	18	12	30

There was no significant relationship between length of exposure and sense of guilt.

Summary of Behavioural Problems and Degree of Burden Analysis

With nineteen out of thirty interviews where subjects reported that they experienced a sense of guilt for, in some way, causing the disorder, there was clear support for the fourth hypothesis.

The sixth hypothesis was also supported by the high levels of burden and stress that the subjects have experienced, in both groups.

There are, however, some apparent inconsistencies in the results between the structured components of the interview and the analysis and the tape recorded interviews. Where the same behavioural problem or burden category was measured by both methods, there was a tendency for the score to be higher when measured by the structured approach. For instance, seventeen out of the twenty interviews recorded violence as a problem in the behavioural problem checklist but in only 15 out of 22 tape recorded interviews was violence mentioned. It is unlikely that the subjects would be deliberately inflating the scores in the structured component and this apparent discrepancy is most likely attributable to the fact that in the structured interview the prompts to memory were highly specific, as in the example above, "was your son or daughter ever violent", whereas any prompting in the tape recorded component was non-specific, "did you experience any behavioural problems with your son or daughter".

There was a significant positive correlation between the ranking

of the behavioural problem checklist between the both groups, indicating a degree of concordance in the sort of problems found in both the Rampton and the Bassetlaw subjects. The highest ranking problems (occurring in two thirds or more of all the interviews) were, in order: withdrawal, verbal aggression, violence, undue suspiciousness and poor self care. The two least frequently occurring problems (occurring in less than a third of interviews) were phobias and sexually inappropriate behaviour, though in the latter case subjects might have been reticent in revealing this. In the tape recorded interview, violence was the most frequent problem mentioned in the Rampton group and paranoid ideation and other delusional beliefs in the Bassetlaw group. However, in both groups three problem categories occurred in the top five ranked scores: paranoid ideation and other delusions, asleep during the day and up at night and verbal aggression/swearing.

There was a significant positive correlation in terms of the Degree of Burden checklist between the ranking of the Rampton and Bassetlaw groups indicating a concordance in the burden felt by both groups of subjects. In over two thirds of the combined interviews, subjects reported that their son or daughter's behaviour was, at times, more than could be coped with, found it difficult to know how to respond to him or her, and felt trapped by the way things were. Only one burden category occurred in less than a third of the interviews and this was that their son or daughter caused problems with the neighbours.

The tape recorded interviews were scored for references to the following responses: stress, sense of loss of what might have been, fear, grief, shock, guilt, confusion, negative self esteem, emotional burden and financial burden. It should be noted that there was not a significant correlation between the two groups in their ranking of these reactions, although both groups ranked stress as the most frequent, being referred to in all the interviews, and negative self esteem the least frequent. All the scores were high and half of the ten reactions measured were recorded in two thirds or more of the combined groups' interviews. In order of frequency these were: stress (as mentioned above), sense of loss, emotional burden, fear and grief. Even the least frequent reaction, negative self esteem, was found in 12 out of 30 interviews.

The disparity between the groups in guilt was not statistically significant though it is worth remembering that the Bassetlaw group tended to have more contact with their son or daughter and it could be that proximity exacerbated this sense of guilt. Although the Rampton group had, on average, a longer experience of their son or daughter's disorder there was no significant relationship between exposure to the disorder and sense of guilt in the combined groups.

Subjects' Responses to Contact with Mental Health Care Professionals

Who has proved helpful?

Subjects were asked to rate categories of persons on how helpful they had been in the context of their schizophrenic son or daughter. They were asked to rate in terms of very helpful, helpful, not helpful, don't know or no contact. In terms of contact, the following scores show the number of interviews where contact had occurred, out of 22 for the Rampton group and out of 8 for the Bassetlaw group, with rank ordering from most to least contact.

Table 38 Contact with Professionals and Other Persons

	Rampton	Bassetlaw	Total
Family	22	6	28
GPs	21	7	28
Friends	21	4	25
Psychiatrists	19	6	25
Neighbours	19	2	21
Police	16	5	21
Nurses	13	5	18
Social Workers	11	5	16
Clergy	9	3	12
Self Help Groups	3	3	6
Psychologists	5	0	5
Maximum possible score	22	8	30

Spearman's Rank Score Correlation Test was applied to the scores for both groups and a value computed of 0.673, a positive correlation significant at the 0.039 level, indicating a concordance of which sorts of lay and professional people the

Rampton and Bassetlaw groups had contact with. It is, perhaps, more interesting to note the low scores rather than the high, the relatively low contact rates for social workers and even more so for self help groups and psychologists.

Using a simple scoring system of two points for very helpful, one point for helpful and zero points for not helpful or don't know or no contact, it was possible to construct a table of scores of helpfulness and to rank order the results.

Table 39 Who has Proved Helpful?

	Rampton	Bassetlaw	Total
Family	31	7	38
Friends	25	3	28
Police	20	4	24
Psychiatrists	14	8	22
GPs	16	5	21
Neighbours	15	4	19
Nurses	13	4	17
Social Workers	7	5	12
Clergy	7	4	11
Self Help Groups	4	2	6
Psychologists	3	0	3
Maximum possible score	44	16	60

Once again, Spearman's Rank Correlation Test was used to see if there was any concordance between the Rampton and the Bassetlaw subjects but the computed value was 0.440 which was not significant. Both groups ranked psychologists as lowest in helpfulness, though as described below this may be as much a function of lack of contact. There does seem to be some indications that the Bassetlaw group found certain professional groups more helpful and lay persons less helpful than the Rampton group when the scores are expressed as percentages of the maximum

possible scores (see, for instance, the scores for psychiatrists, social workers, family and friends).

Finally, the Spearman's Correlation Coefficient was computed for the combined scores of the two groups for both contact and helpfulness scores. A value of 0.9016 was computed indicating a highly significant correlation between the type of person who the subjects had had contact with and the subjects' perceptions of their helpfulness.

Analysis of the Structured and Unstructured Sections of the Tape Recorded Interview in Terms of Blame, Neglect, Anger to, Reliability and Helpfulness.

Both parts of the tape recorded interview were scored for the presence or absence of the above factors. The factors also included their antonym and the scores were further broken down as to who evoked or was responsible for the factor from a list of the following: psychiatrist, GP, social worker, psychologist, nurse, staff/ member of self help group, clergy, police, neighbour, family member, patient sibling, and friends. The scores are all out of twenty. The full scores are shown in Appendix H (blamed/not blamed), Appendix I (neglected/not neglected), Appendix J (anger towards/no anger towards), Appendix K (reliable/unreliable) and Appendix L (helpful/unhelpful).

For presentation here these Tables have been summarised. Table 40 shows the overall ranked scores for the reaction factors. The maximum score for each reaction in the Rampton Group is 264 that is to say that if in all 22 interviews the subjects had said that a member of all the 12 professional or lay groups listed had evoked the reaction then the score would therefore be 22 times 12. The equivalent maximum score for the Bassetlaw group is 72, 8 times 12. The maximum Total score is 336.

Table 40 Overall Ranked Score for Reaction Factor

	Rampton	Bassetlaw	Total
Helpful	36	16	52
Not Helpful	36	7	43
Neglected	13	6	19
Anger To	12	3	15
Unreliable	6	7	13
Blamed	8	1	9
Not Blamed	3	5	8
Reliable	0	3	3
No Anger To	2	1	3
Not Neglected	1	1	2

Spearman's Rank Correlation Test was applied to the Table to see if there was a concordance between the Rampton and the Bassetlaw groups in the rank order of their reactions. A positive correlation coefficient was found of 0.6657 significant at the 0.036 level.

At first sight, the figures in Table 40, though mixed, might seem altogether not too negative. The highest score for any reaction is feelings of being helped and although the next six reactions are all negative, if expressed as a percentage of the maximum possible score could still be seen as not too excessive. Thus calculated, the scores for Not Helpful is only 12%, Neglected 5%, Anger to 4%, Unreliable 3.6% and, most importantly, being blamed at only 2.5%.

However, these encouragingly low negative figures may be misleading as the real impact of the numbers of negative responses may be being diluted by the range of persons who might have evoked that reaction. If we recast the figures by negative or positive reaction and by person evoking the response group,

the figures become both more telling and worrying for mental health care professionals. Table 41 shows the total number of interviews, Rampton and Bassetlaw combined, where subjects reported a negative response against a person group. The maximum score per cell is the same as the total number of interviews, that is 30, and the Table is ranked in terms of row Total (out of a maximum possible score of 150 per row of 5 cells).

Table 41 Negative Response to Person Group

	B	N	A	U	U	T
	l	e	n	n	n	
	a	g	g	r	h	
	m	l	e	a	e	
	e	e	r	b	p	
	d	d	t	l	f	
			o	e	u	
					l	
Psychiatrist	3	10	7	5	15	40
Nurse	2	5	4	3	11	25
GP	1	4	3	5	8	21
Social Worker	1	2	0	0	5	8
Self Help Group	0	0	0	0	5	5
Psychologist	1	0	0	0	2	3
Family	1	0	0	0	2	3
Patient's Sibling	1	0	0	0	0	1
Clergy	0	0	0	0	0	0
Police	0	0	0	0	0	0
Neighbours	0	0	0	0	0	0
Friends	0	0	0	0	0	0
Total	10	21	14	13	48	106

It can be clearly seen that it is the professionals rather than the lay persons who evoke the most negative responses, with psychiatrists leading the Table with perceived negative encounters. In 1 in 10 interviews the subject(s) felt that the

psychiatrist was blaming them for their son or daughter's disorder; in 1 in 3 interviews the subject(s) felt neglected by the psychiatrist, in 7 out of 30 interviews the subject felt anger towards a psychiatrist, in 1 in 6 they felt the psychiatrist was unreliable and in half the interviews a psychiatrist was felt to be unhelpful.

Care must be taken in interpreting the column totals, as in some cases the same response was recorded against several person groups. For example, in one interview, where the subject had been invited to attend family therapy with her son, she felt that she was being blamed for her son's disorder by a psychiatrist, nurse and a psychologist; thus one interview alone accounts for 3 out of ten of the column score for blame.

Could these negative scores be as much a function of level of contact as of quality of contact? This could be tested in two ways. One might expect that if negative scores were related to rate of contact, not quality, then the same groups who scored highly on negative contact might also score highly on positive contact. Table 42 shows the results for positive responses, and as in Table 41 the groups are rank ordered by row total.

Table 42 Positive Response to Person Group

	N o t B l a m e d	N e g l e c t e d	N o A n g e r o	R e l i a b l e	H e l p f u l	T o t a l
Psychiatrist	6	1	1	1	3	12
Nurse	2	1	1	1	6	11
Police	0	0	0	0	8	8
Patient's Sibling	0	0	0	0	7	7
Social Worker	0	0	0	1	5	6
Self Help Group	0	0	0	0	4	4
Family	0	0	0	0	4	4
Clergy	0	0	0	0	4	4
Neighbours	0	0	0	0	4	4
Friends	0	0	0	0	4	4
GP	0	0	1	0	1	2
Psychologist	0	0	0	0	0	0
Total	8	2	2	2	52	66

Table 42 is interesting in showing that for positive and negative responses the psychiatrist and nurse hold positions which are first and second in both Tables, after that the police and patient's siblings, followed by social workers, evoke the most positive comments. Also of interest is that the overall total of positive score is much lower than the negative overall score, 66 as opposed to 106.

Two further test strategies were applied to try and resolve this issue. The first was to combine the row columns totals of Table 38, rate of contact with person group recorded in the structured

component of the interview with Tables 41 and 42, negative and positive responses. By applying Spearman Rank Correlation Test it would be possible to see if Negative responses by group were correlated with positive responses by group (thus indicating a contact effect) and also to see if either or both negative and positive scores by group were correlated with contact recorded in the structured interview. Please note that the structured questionnaire did not specifically refer to contact with patient's siblings but 27 out of the 30 families were known to have a brother and/or a sister to the patient and this is the rate of contact that has been assumed. Table 43 shows the combined results.

Table 43 Negative Responses, Positive Responses and Contact

	Negative	Positive	Contact
Psychiatrist	40	12	25
Nurse	25	11	18
GP	21	2	28
Social Worker	8	6	16
Self Help Group	5	4	6
Psychologist	3	0	5
Family	3	4	28
Patient's Sibling	1	7	27
Clergy	0	4	12
Police	0	8	21
Neighbours	0	4	21
Friends	0	4	25

Applying Spearman's Rank Correlation Test showed that there was no significant correlation between the ranking of person groups in terms of negative and positive response, between negative response and contact and between positive response and contact.

In a final test strategy to resolve the issue, negative and positive scores were aggregated into two groups - professional and lay persons involved with the subject. The professional grouping consisted of scores for psychiatrist, nurse, GP, social worker and psychologist. The lay group consisted of scores for family, patient's sibling, neighbours and friends. The three problem groupings were self help group, clergy and police. Although both clergy and police were professionals they were included in the lay group as their professional training was not focused on mental health issues. Although contact with self help groups (principally the National Schizophrenia Fellowship) might well be with lay members and volunteers, the degree of knowledge on the disorder placed this category of persons more in the professional grouping. The National Schizophrenia Fellowship represents and is sympathetic to the plight of the family, and by including the self help group scores in the professional grouping should have, if anything, the impact of diminishing the negative and enhancing the positive overall score for the grouping.

The matrix for total positive and total negative scores for the professional and lay groups are shown below in Table 44. Chi Square Test was applied to the matrix and the expected frequency scores are shown in brackets.

Table 44 Total Negative and Positive Scores for Lay and Professional Groups

	Negative	Positive	Total
Professional	105 (87)	33 (51)	138
Lay	4 (22)	31 (13)	35
Total	109	64	173

The matrix yielded a value for chi square of 47.3412 and at a degree of freedom of 1 this value is significant at the 0.001 level.

In summary, blaming, neglect, anger towards, reliability and helpfulness, positive responses and negative responses, by person group, are not correlated and are not likely to be mediated by rate of contact. Moreover, contacts with professional groups are rated significantly more negatively than lay groups. These results should sound a note of warning in the way mental health professionals conduct their contact with parents and families of persons with Schizophrenia. In the Qualitative section of the Results are verbatim accounts of such encounters showing both badly and well handled examples.

Detailed Analysis of Feelings of being Blamed for the Causing the Disorder

The number of interviews where subjects reported feeling being blamed by others for causing the disorder was lower than was expected, six interviews in all, and therefore the second Hypothesis was not supported.

The third Hypothesis, that blaming would be less likely to be reported by subjects whose children had developed the disorder more recently, was tested by splitting the combined group in two in terms of being less than or greater than the mean length of exposure to the disorder and further dividing by presence or absence of reference to being blamed. The following matrix was constructed.

Table 45. Sense of Being Blamed and Length of Exposure to the Disorder

	Sense of Being Blamed		Total
	Yes	No	
Less than Mean	2	14	16
Greater than Mean	4	10	14
Total	6	24	30

The matrix was subjected to the Fisher Exact Probability Test but there was no significant relationship between length of exposure

and feeling of being blamed, and therefore there was no support for Hypothesis 3.

Hypothesis 5 was tested by constructing a matrix of interviews subdivided by presence or absence of feelings of being blamed and presence or absence of sense of guilt.

Table 46. Feeling of Being Blamed and Sense of Guilt for Causing the Disorder

	Feeling of Being Blamed		Total
	Yes	No	
Sense of Guilt	4	14	18
No Sense of Guilt	2	10	12
Total	6	24	30

The Fisher Exact Probability Test was applied and it was found that there was no significant relationship between feeling of being blamed and a sense of guilt and therefore there was no evidence to support Hypothesis 5.

It was also decided to see if there was any relationship between being specifically counselled not to blame oneself and a sense of guilt. The following matrix was constructed.

Table 47. Counselling that Not to Blame and Sense of Guilt for Causing the Disorder

	Counselled not to Blame		Total
	Yes	No	
Sense of Guilt	4	14	18
No Sense of Guilt	1	11	12
Total	5	25	30

Interestingly the Fisher Exact Probability Test indicated that there was also no significant relationship between being absolved from blame and sense of guilt.

Who Gave Information to the Subjects?

The tape recorded component of the interview was analyzed for any reference to information being given to subjects in the three categories of information on diagnosis, medication and treatment and information about the disorder itself. The information given was further categorised by who gave it in terms of psychiatrist, GP, social worker, psychologist, nurse and Self Help Group staff. The scoring was very liberal and ignored entirely the quality of that information. For instance, a subject reported that he had asked his son's GP what Schizophrenia was and the GP, according to the subject, said "Oh it's like a Jekyll and Hyde". Inaccurate and unhelpful as this statement, is it was recorded as an instance of a GP giving information on the nature of the disorder. If a subject did not mention being given any information he/she was prompted.

Tables 48, 49 and 50 show the results.

Table 48 Who gave Information on Diagnosis?

	Rampton		Bassetlaw		Tot
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	7	2	3	0	12
GP	4	0	1	0	5
Social Worker	2	0	1	0	3
Psychologist	0	0	0	0	0
Nurse	1	0	0	0	1
Self Help Group	0	0	0	0	0

Table 49 Who gave Information on Medication/Treatment?

	Rampton		Bassetlaw		Tot
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	4	1	2	1	8
GP	0	0	0	0	5
Social Worker	0	0	0	0	3
Psychologist	0	0	0	0	0
Nurse	1	0	1	1	3
Self Help Group	0	0	0	1	1

Table 50 Who gave Information about the Disorder?

	Rampton		Bassetlaw		Tot
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	0	2	0	1	3
GP	2	0	0	0	2
Social Worker	2	0	0	0	2
Psychologist	0	0	0	0	0
Nurse	0	0	0	1	1
Self Help Group	1	0	1	1	3

Spearman's Rank Correlation Test was applied to all three Tables to see if there was a concordance between the Rampton and Bassetlaw groups as to which professional groups gave information. With relatively low figures present, caution must be observed in interpreting the results, but there was a positive correlation (0.9393, significant at the 0.005 level) between groups in diagnosis information, a positive correlation (0.8980 significant at the 0.015 level) between groups in medication/treatment information and no significant correlation for information about the disorder.

Spearman's Rank Correlation Test was also applied to the combined scores for both groups to see if there was a correlation between information category by professional group. Only one correlation

was significant, there was a positive correlation between who gave information on diagnosis and information on medication/treatment, a calculated value of 0.9706, significant at the 0.001 level. There were no significant correlations between who gave information on diagnosis and information on the disorder and between information on medication/treatment and information on the disorder.

Overall, what is surprising is the relatively low levels of information giving. If we combine the three tables and rank by professional group, psychiatrists are by far the most informative professionals (33) followed, at some distance, by GPs (12) and social workers (8). Even so, psychiatrists are reported to have only given information on diagnosis in twelve out of thirty interviews, on medication/treatment in eight out of thirty interviews and on the disorder itself in three out of thirty interviews.

It might be argued, on one hand, that even after prompting, the subjects' memories may be at fault and the scores under report the extent of information giving. On the other hand, the liberal scoring undoubtedly tends to inflate the impression of information giving. What we are seeing is a group of patients' parents who are intentionally or unintentionally being deprived of essential information.

Qualitative Analysis

This section of the Results can, itself, be further sub-divided into two sections. The first will look at the more personal responses of the subjects to their situation, focusing on the emotions of stress, guilt, shock, fear, grief, sense of loss, emotional and financial burden. Inevitably, these emotions sometimes overlap: a violent outburst by the son or daughter can leave the parent shocked and afraid. An emotional category can also stand for several things: guilt was originally defined in terms of guilt for causing the disorder and this is what has been scored in the quantitative analysis but guilt can also be felt for the consequences of the son or daughter's behaviour. The second part will look at the parents' reaction to the professional and lay persons they have been involved with, focusing on the issues of blame, neglect, feelings of anger to, reliability and helpfulness. All quotations will be identified by their group and interview number. Some subjects have been quoted more frequently than others (and some subjects not quoted at all). The choice of subject and quotation was decided by the illustrative power of what the subjects had to say.

Personal Reactions

Stress

Stress can be difficult to disentangle from many of the other reactions listed below, but emotional stress can often be associated with psychosomatic reaction and be a causative factor in organic disease. A father of a patient in Rampton tells of his experience of visiting his son while he was at the local psychiatric hospital:

" . . . still suffering with this ulcer, stomach ulcers through worry. When I used to go to visit him (son) I used to walk up the drive towards the hospital and in anticipation, just as you go through the gate, and it happened every time, I get like a knife in my stomach. And every time I went up through that gate that knife would come there because at that point I used to think has he done anybody any injury?"

Rampton Group, Interview 2

The disruption to everyday routine can be a considerable stress factor. The following quotation highlights some commonly found themes including the tendency of many people with Schizophrenia to substitute day for night - to sleep during the day and be active during the night. Whether there is a biological explanation for this behaviour or whether people with Schizophrenia find the stimulation of others aversive and adopt a lifestyle that deliberately avoids contact with others is not known, but many parents and families find the experience very disruptive and has an impact on their own sleep patterns. Also of note is that anticipation of untoward events can be as much a stress factor as the event itself. The mother quoted below

talks of: " . . . living at the edge of a volcano, waiting for it to erupt".

"Although he didn't do a lot to harm anyone at (local Psychiatric Hospital), you know, then they said could you have him at home for the weekends, so we said we'd try. So we used to have him home, when he first went in, for the weekends, but we had to stop because he'd play the radio all night and he'd walk about with the radio all night and smoke so we never ever slept. From Friday night bringing him out to Saturday tea time we never, ever slept. We were absolutely shattered and this went on every weekend so we got to the stage where we said we can't put up with this any longer, you know, so we said look, we can't have him out at weekends any more, but we'll fetch him out Sunday. So that's what we did. At least we got our rest in. So we had him out on Sunday. But that was disastrous when he had him out on Sunday because he used to shut himself in that room. He wouldn't talk to anybody. If you asked him any questions it was always yes, no, I don't know. That was all we ever got out of him in conversation. Nothing other than that. "Have you seen the Doctor". "Yes". "What did you say to him". "I don't know". And this is the sort of things, you see, you could never make a conversation with him at all. And then, when he was in that room he'd fallen down quite a few times. We could never, we always used to stay in the kitchen when he was in that room so that we could hear. It was like living at the edge of a volcano, waiting for it to erupt. We were always listening for something happening, because we knew something was going to happen, so we were just virtually listening."

Rampton Group, Interview 13

Guilt

Although for quantitative analysis purposes guilt was defined in terms of a sense of guilt at doing, or not doing, something that may have caused the illness, quotations have been included about other aspects of guilt. A father talks of walking away from the local psychiatric hospital where his son was and the sense of guilt for just leaving him there:

"That's the worse thing. You even feel guilty when you are accepting it more. You feel that that's wrong like you shouldn't even feel that way."

Rampton Group, Interview 9

Others experience a sense of guilt about the course of the disorder, that had the parent detected the signs and arranged for treatment earlier things might not have turned out as bad as they had. A mother says:

"The only sense of guilt we had to that was, did we ought to have seen signs of him.....could we have picked it up earlier so, you now, like, avoided him becoming an acute schizophrenic? You know."

Rampton Group, Interview 13

Some subjects report a sense of guilt for the, sometimes very serious, consequences of their son or daughter's illness and actions. An intelligent and articulate father of a son with Schizophrenia had both witnessed and been a victim of serious assaults by his son. Eventually, the son attacked his mother with a motorbike padlock chain, nearly killing her and leaving her severely brain damaged. She has multiple handicaps and the father now cares for her. Two weeks prior to this incident another serious incident had occurred and mother and father had debated whether the police should be called. The mother felt the police should not be involved and her view prevailed. The father contemplates his mixed feelings about guilt:

"We should have reported, I should have reported him to the police that night but he came down while we were talking may be 15 - 20 minutes after I had left him upstairs. And he had boots on with a steel toecap and he had all this. He was almost like a soldier who had got ready for battle. He had like different clothes on and he had these boots on and he had some kind of a belt round his vest and he had this chain

with a big lock on the end of it and he was swinging it and marching up and down. In a way I feel that it's possible that I let him get away with it that time. I feel guilty about, but I don't feel guilty about it, because I think there would have been a next time though."

Rampton Group, Interview 7

But above all else, parents sense guilt that in some way they are causal agents of the disorder. In the absence of information from professionals, parents frequently embark on a "search for meaning" and a lay explanation of some amorphous stress model often emerges. The parent then looks for ways in which they might have stressed their child. A father encouraged his son's academic aspirations and now wonders whether the illness was a consequence.

"I used to encourage him because I felt he was looking for a worthwhile thing and things like that and also knowledge is always a good thing. I used to encourage him and, you know, sometimes you feel I wonder if I've overdone it and things like."

Rampton Group, Interview 9

A mother and father interviewed described how shortly before the onset of their daughter's illness the family underwent a number of significant life events. The family moved from council to owner occupied housing, changed religious affiliation and the parents started their own small business which meant that they had to work on Saturdays. The mother contemplated whether there might be a link with the illness:

"At first you wonder what have I done? What have I done wrong in bringing her up? She used to look after her brother on a Saturday while we had to go to Market. She always did alright. She grumbled some Saturdays because she wanted to go out. We used to say she used to grumble about looking after (her brother) and we used to say it's not right sometimes. It sort

of got into that way, that she, you know, looked after (her brother) when they first took her into (local psychiatric hospital) and she got worse you think well we must have done something wrong so you look back at what have you done. Well, we left her to look after (her brother)."

Rampton Group, Interview 1

Despite the flaw in the lay model that, in this and many other families' cases, all the other brothers and sisters were subject to the same stresses but did not go on to develop the disorder, this mother was still left with a pervading sense of guilt.

"I wondered if there was something that set it off, that started it off? But we've looked back and said well we did the same with all of them they, all had the same amount of presents, they all had the same thing at Christmas, you know what I mean. As far as you know you've not treated (her) any different to the others."

"Well we stopped her going out on a Saturday perhaps that had something to do with it, you know. You well I did look back and wonder what went wrong? Why aren't the others like it? What have I done? And I thought I'd done pretty much the same with all of them, so why aren't they ill? You know you do that and think well it must have been in some way in which we treated her."

Rampton Group, Interview 1

Another mother contemplated divorce from her second husband in case her remarriage might have been a precipitating factor in the disorder:

"I just thought where have I gone wrong, what have I done to him, why should it happen, you know, and I tried, I tried to compare to my other son, you know when you've got two, I thought what have I done wrong, why should this have happened to him . . . I mean I even got to the pitch where (step father) has been marvellous, I mean, he puts up with a lot from (son), I mean he does disrupt our lives, he has disrupted our lives a lot and I even went to these group meetings at the hospital and I said, "is it because I've married again"? Because if it is I'll leave (step father) if it'll make (son) better. I even got to that pitch, you know."

Guilt may continue despite reassurance to the contrary:

"I felt all the way along that, even though different ones I've spoken to, friends of mine that I've known for years, and they've all said to me nobody could have been a better mother, you know. But you still feel, maybe I've done something or something's happened. I don't feel it so much now because, since his illness was diagnosed for sure and it was no longer behaviour and it helped a bit, but prior to the actual illness being diagnosed I thought maybe it's something I've done."

Rampton Group, Interview 20

"People have said don't blame yourself since it's not your fault. Nevertheless you still look back and you think what did we do? Did we do something wrong? Because you think it must have been something you've done wrong to start it. Probably . . . I don't know? They said it wasn't our fault. Nothing we've done could have caused it."

Rampton Group, Interview 1

On other occasions a parent will accept that there is no point in feeling guilty, even in the face of genetic explanations where issues of which side of the family the taint of insanity may come from.

"I think I dismissed it, it wasn't our fault and it's not our fault, you know, even if it's in our genes we didn't make the genes. It's just unfortunate."

Rampton Group, Interview 7

Shock and Fear

Shock, as originally defined for the purposes of quantitative analysis, referred to the shock of awareness that the subject's son or daughter had a mental illness or shock at being told the diagnosis itself. A father says:

"It was a shock to me I never expected that, I mean he's an invalid more or less."

Rampton Group, Interview 8

A mother says:

" . . it's sort of a big shock to you when you find out that there's something wrong with your daughter. And when it's that kind of illness you thought it must be something we've done."

Rampton Group, Interview 1

But a sudden and unexpected violent outburst is also a shock and such incidents are not confined only to the Rampton group. A mother in the Bassetlaw group describes just such an outburst.

"You've got to get out of bed," I said, "and have this hot meal," and, he'd got his back to me, and I said "or are you going to have it in bed" and there was I picking up this money and picking up more of his cigarette ends. I've got a biscuit tin for an ashtray and he still misses it. And I said to him, "now come on (son), look at all your money on this carpet and the carpet with all these burn holes in it," and I bent down to pick up the cigarette ends and I had a plate of chili con carne come crashing down over my head. Hot chili con carne. I can laugh now but I didn't then. It was an awful shock. It was a terrible shock. Red hot chili all over my head. And I turned round, it was such a shock because, you don't, I don't think any mother ever expects her son to use violence with them and he punched me straight in the head. He's got a great big dent in his bedroom wall. My head bounced off the wall and he did that twice. He was poised, honestly, as if he was fighting off someone that was going to kill him. You know, it happened that quickly that it didn't hurt me. I had awful black eyes but I didn't hurt at the time. But he looked terrified. He looked as if he was fighting for his life, you know, he was just going to punch me again and I was screaming, "don't do it" because I really thought he was going to kill me and I was screaming at the top of my voice. And I did get through to him and he immediately calmed down and it had shaken me, knocked my glasses flying and I thought I've got to get out and I sort of grabbed my bag and I said, "you make yourself a cup of tea". He said, "oh Mum there's blood all over my hands". I said, "never mind you'll wash that". I said, "have a nice cup of tea and I'll come back later". And I drove home and my glasses I'd left there but I did manage to drive home. Clean up all this chili. My eyes. He punched me there and there but the bruising went to there. I did look a mess. I looked terrible. I looked shocking.

Bassetlaw Group, Interview 28

Another mother describes a similar violent attack where she too presented a normal face after the incident:

"When he threw me across the floor and I injured all my back, and he was completely out of it just because I'd asked him to do something, somebody in another room came out and sort of asked me if I was alright and I said I was. But I was really quite frightened because he's so strong, and he's a lot stronger when he's ill. And I had (other son) with me as well. So I just carried on as if nothing had happened because the landlord was waiting downstairs and I took (son) with me in the car. But all the time, I could almost feel this anger. You know. I thought any minute now he's going to turn on me and really hurt me."

Rampton Group, Interview 20

The violence of such outbursts can be inexplicable and terrifying. The father of the son who had attacked his mother leaving her severely brain damaged gives the following account:

"When he attacked me with the bar he would have killed me. I wouldn't have been able to get him off me and when he finally did attack me here, in the house, he was much more violent than when he attacked me earlier, out in the yard. It was like he was upset and it was like there was no maliciousness in his attack. But when he attacked me the last time he was intent on hurting me. He was hitting me as hard as he could and he suddenly stopped. But it started when I was actually walking out of the room when he grabbed me. . . . He dragged me out of the room to the top of the stairs and I thought he's going to throw me down the stairs. I thought I'm not going to be thrown down the stairs. I let him drag me there but when we get there I was going to have him down the stairs. He's going to have to go head first down the stairs and if it kills him that's it. But he's not throwing me down the stairs . . . he just let me go and ran back into the room. And then, later on, he came down. He expected me to ring for the police, because he came down. I came down here and I was talking to his mother and we were still shaking and deciding what to do about it. And his mother didn't want him to be reported to the police and I was sympathetic towards that and didn't do that. I decided we'd do it her way and that was a mistake and it was a mistake that she paid for"

Rampton Group, Interview 7

The same subject makes the important point that families can

sometimes get used to the violence and fear, and not fully at the time appreciate how dangerous the situation is:

"The thing is we've been dealing with this for 8 years and you're getting used to it. First you're frightened and thinking, "Oh God he's a maniac". Now the second time he attacked me was 10 times more severe than the first attack but he didn't frighten me as much and I soon got over it whereas the first time he attacked me he really upset me. I mean it was like probably two weeks before I actually realised, I had this feeling, that if he'd actually managed to knock me down with that bar he would have pounded on me until I was dead. And it was a real nasty feeling and it only came afterwards. It didn't come at the time whereas when he knocked me down he was kicking the shit out of me I didn't feel like that afterwards at all. I forgot about it, sort of. I didn't forget about it but it didn't leave any traces so if the professionals fell down it was because their professional bodies are not fighting to actually exercise their professional skills in this area, you know, and have their opinions recognised. And it's because they don't warn you against it. I imagine that what happened to us we became sort of blasé about it. It happens to lots of people and I imagine that's statistically recorded too. And they don't say to you how he's going to become."

Rampton Group, Interview 7

He goes on to make the point that family members themselves do not always bring to attention the violent or dangerous behaviour:

"He would abuse his mother physically and verbally and his sisters, like holding (mother) up against a wall and shouting at her to eventually actually hitting her. This, again, was very difficult for me because I was living over at the other place so I didn't come down here all the time. I was working, you know, we had the phone and I'd pop in sometimes. I guessed at the time that if there were any problems she'd ring me up but I'd come in and it would only be in conversation later that I discovered that his mother had been abused. It was too late to do anything about it. The neighbour next door actually occasionally caught (son) dragging his mother outside and banging her against the wall and the neighbour next door this side intervened a couple of times. . . . Yes, it was shortly after that. He'd arrived and he'd been here about 10 days and (his sister) and his mother had been out one night and they were in a friend's house (of sister) and we were discussing it. (Sister) and his mother suddenly said to me, said do you know he had an

axe under the bed and I said "alright how long had he had that" and (sister) said he'd brought it with him. So I was really annoyed about it. As I said, it had been in the house for 10 days, this axe under the bed, so I waited until he was out and took the axe. I can't remember what I did with it but I got rid of it, put it out the house. And the following morning when I came downstairs he produced a metal rod. I could actually show you a piece inside it was aluminium, inch diameter aluminium. It was a very serious weapon and he produced from behind the fridge and went for us with it, (sister) and I. I pushed (sister) through (dining room) and told her to get out the front door. I opened the back door and went out into the yard, rather rapidly, and he came out and I wrestled with him and got this thing off him."

Rampton Group, Interview 7

He goes on to point out how brief and unpredictable can be the most serious attacks:

"You've got these personal reasons, manageable, difficult, I mean very difficult but manageable and everything. And they go like that and what happened to (his) mother probably didn't take longer than 3 minutes so what you're dealing with is someone who is like for 6 months it's difficult but manageable for 3 minutes they're not and you can't forecast when that 3 minutes is going to happen but when that 3 minutes does happen it can result in serious or fatal injuries. (Mother's) injuries were basically fatal. It was only because she had immediate treatment and (son) would stop before he finished. If there had been no one there and she had been left for a while she would have died. But she was on a life support machine, it was like 13 or 16 days before her stomach would accept water. She was on a life support machine for 11 days. I mean she was dead, she would have suffocated, all her functions had stopped. I mean the reason she was on a life support machine was that her brain was so badly damaged that it couldn't make her breath. That had stopped so a machine made her breath. . . . And in most places in this world she would have died.

Rampton Group, Interview 7

The same subject refers to an almost supernatural quality in his violent encounters with his son.

"A terrifying experience, you're shaking or it's just the sense of the energy that's there and it's malevolent but like if you keep still nothing is going to happen you just got to keep it calm. So we kept it calm. And eventually he went off upstairs. I should have gone straight down to the police station and reported it. It was shortly after that, it was two weeks after that, I think, when he attacked his mum."

Rampton Group, Interview 7

A feeling echoed by another mother and father.

Father: I've never seen such evil, such.....

Mother: Evil's a good.....

Father: Well, I've never been so afraid of anyone as I was then. It wasn't so much the fear or anything, it was that you couldn't reason, there was absolutely nothing, whatever you said, he would accuse you of things like torturing him, holding him down in a cold bath, burning him with hot spoons and then cold spoons, all this kind of thing, but no matter what you said you couldn't reason. There was no reasoning with him at all. The more you said the more agitated he became, the more aggressive he became.

Rampton Group, Interview 22

Families may have to take extra security measures to protect themselves but the stress of maintaining this security could be quite considerable.

" . . . it was a bit frightening every one locked their bedroom door. I actually made wedges for them to put under their doors so they wouldn't open."

Rampton Group, Interview 7

"They'd (siblings) had more than enough. They used to lock their doors on a night. I mean, it was like Fort Knox, you know what I mean, it was locked doors every night, all the doors used to go, you know, like, because they was all getting nervous. He was kind of walking around, like I said, like a zombie, when they were drugging him up with the depixol, he was dribbling, I mean he was just like a big zombie, like, walking around the house."

Rampton Group, Interview 12

"And the fact that (son) did get out of the hospital twice that night and we had to get up and leave,

(other son), because he was young, he wouldn't even go in the garden because he thought (son) would come in. I mean I was having nightmares, but I used to go to sleep and then I'd wake up and I'd remember I hadn't locked one of the doors and I'd run and lock the kitchen door and then I'd, by the time I'd run round to lock the patio door he would be in and I used to get dreams like that."

Rampton Group, Interview 20

"You were expecting to find him. When I was going up the top of the stairs at the house and then I'd get to the top stair and then just throw myself down onto the landing just in case anybody was, you know. We were expecting trouble. Silly really, he could be waiting down the street waiting there couldn't he. Oh you imagined him everywhere. I mean, you just couldn't sleep, I had some of the most awful dreams. Mind you they were nothing as regards what was to come afterwards."

Rampton Group, Interview 22

But fear can be mixed. It can be fear of the person with Schizophrenia and fear of the consequences for them. One mother expresses both emotions:

"It's taken a terrible lot. It's always at the back of your mind. You try to live a normal life but she's always there back of your mind. You feel so helpless. You know you want to help her and you feel (after) what she's done you're frightened. So mixed emotions. I mean you love her, she's your daughter you can't help but love her. I'm frightened to have her home. I don't know what she might do. I couldn't live through that again and it's that sort of thing you know."

"The police were quite sympathetic really. I mean they must have got fed up with bringing her back. But the danger that (daughter) was in when they let her out, as they (nursing staff) said - to have a bit of sex. They (nursing staff) thought it would do her good. To me that was absolutely frightening. It wasn't the hospital, it was the sisters or the nurses. When I took her back they'd say: "we let her out because we thought it would do her good to go and have a bit of sex somewhere". To me I was horrified. And they (nursing staff) used to phone me up at 12.00 (midnight) - "Is (your daughter) there?" and I'd say "no she's not here. "Oh right. Why isn't she there. No she's gone out again". And to me I used to be awake, kept waking up, thinking I wonder where she is? I wonder if she's alright? It was torture for me, that. And not one night, this was done many nights to me.

And I used to think they'll find her one morning dead, you know. This is how it used to make me feel about it."

Rampton Group, Interview 1

Grief and Senses of Loss

At times it can be difficult to differentiate between grief and a sense of loss. In terms of this research, grief may be thought of a deep sorrow at the seemingly irrevocable loss of the son or daughter as was, in his or her pre-morbid state. As has been described in the Introduction in the context of learning disabled children, this sense of grief is, in important ways, both like but unlike the death of a loved one. One father likens having a child with Schizophrenia to having a child with any other serious and incurable disorder:

"It's like a sick child that you can't cure. That was it, you know, there was no point in weeping and wailing and carrying on, you know. It was just like real sad, frustrating and helpless. You couldn't do anything you couldn't make it better and we gradually realised that, you know, reality. Nothing will make him better. It was a bit depressing and then we saw him deteriorate and that was sad."

Rampton Group, Interview 7

A sense of loss implies a feeling of sorrow at the loss of what the child might have been or done had he or she not had the disorder. The feeling can be very generalised:

"Like the saying goes the world was his oyster, as far as he was concerned, and then he seemed to have everything he was a perfect physical specimen as well at the time and then he started having problems . . . first we had to get a doctor then he was crying a lot of the time."

Rampton Group, Interview 9

It can also be specifically evoked by comparison with other people's children:

"A friend of (son's), I mean the father's a friend of mine, and the father's son is a farmer just down in the village there and his son is (son's) age a bit younger than (son). It's like his son has got an agricultural contracting business he operates. His father actually does a similar sort of thing. His father farms and does contracting too and he sometimes works for his son or sometimes the son works for the father but the son is doing very well he's a very jolly lad fit and healthy and I sometimes look at him and I think shit, where's my son going?"

Rampton Group, Interview 7

"He's lost all his teenage years. His illness started from 15 to 21. Lost all them years.

And when I used to go on holiday it never bothered Andrew. He didn't think like us. He never mentioned it. He never said, "oh I wish I was like them". He never mentioned it but I used to think it. I used to think, I used to feel hurt that he was stuck with us and we could see other young lads in his age group all playing on the beach with the girls, kicking."

Bassetlaw Group, Interview 27

"It's only during these later years I have been thinking that my friends have had children who have done very well at school and gone to university and found spouses, got married, and are living happy lives and why is it that our life is completely sort of destroyed, not really destroyed but different, just making it very difficult to invite friends here when (son) was here at home. We hardly had any friends visiting us and we couldn't go out very much, but I'm not really regretting it but I've sort of wondered in my mind, why?"

Rampton Group, Interview 10

On other occasions, the loss can be of the parent's very specific expectation of what the child would grow up to be like:

"I know that I've lost the person that was, I mean prior to 14, I mean, he was the type of person that, when my father died he said "don't worry Mummy, I'll always be here to look after you". I mean he never failed to buy a present on Mother's Day or make a card, or, be fully supportive and caring and loving. I mean he was never, even into his 20's, never the type to not say "I love you Mum" and he still does when he calls me now. I mean I never leave the hospital after a visit without him saying he loves me.

He's always been that type of person, you know. I mean, we do it as a family. We kiss each other when we're coming and going and I think we have a fairly warm, secure, family life. . . . And also the fact that the person I see now is not the person I expected him to be. That he would mature from the child he was and the partial adolescent he was to the adult that I expected. I expected the adult as, I suppose, my husband is, because he was that type of person that I felt he would be like his father."

Rampton Group, Interview 14

Emotional Burden

The term emotional burden is used here to describe other long term emotional reactions that may have occurred and represent a chronic burden to the family. A mother talks of the reaction of others to her daughter with Schizophrenia who displays problem behaviours:

"Awful thing to happen to your child, something like that (schizophrenia). I mean in a physical illness people are sympathetic. When it's a mental illness and especially when people have come to the house and they've (daughter) done queer things or they've done, I mean, she's sent people away from this house."

Rampton Group, Interview 1

At other times the stress that the schizophrenic family member puts on the family as a whole can lead to distress anger and resentment.

"It's bound to, you're bound to feel helpless and useless, you know I certainly do. I get angry with him you know. I feel I want to give him a good shake sometimes, I do. What I'm saying is like (sister) says she remembers him, how (patient) keeps writing letters. He'd loved to see her. She just broke down. She said, "I can't go and see him I remember him as a child," and you know to me I thought you're crucifying all your family."

Rampton Group, Interview 8

Financial Burden

The financial burden that may fall on parents of persons with Schizophrenia can take many forms. In the United States, under a largely private health care system, the major financial burden is often the cost of medical treatment and hospital residential costs. In this country, the financial burden is more likely to be importuning for money by the son or daughter or the cost of subsidising community care by furnishing and supporting their son or daughter in independent accommodation. This, in an adult child, means the financial obligation may continue into the parents' retirement and to the end of the parents' life. Where the son or daughter lives at home and is destructive, the repeated costs of replacing broken windows and door panels can be quite a burden. Two quotations from one parent illustrate many of these points:

"He demanded money from (mother). (Mother) comes from a family that's quite well off and he expected that she could always give her money whatever he wanted. And many times she did, you know, but she reached a point when she began to say no, so he was a burden in that way. He was also a burden in as much as he regarded this house as his base you know."

"Yes, so it went on, like, you know (mother) really tried to help him and she behaved as a mother ought to do and she felt she needed to help with the problems, getting his things, furnishing his flat and doing all that stuff you know. And he'd lose the key, do things like that lose the key, so he'd break the door in so then she'd come round to me and I'd go round and rebuild the door for him so he didn't have to call the council people in to do it. I must have done that half a dozen times."

Rampton Group, Interview 7

Parent Reactions to Professional and Lay Persons

Blame and Absolving from Blame

There was only one recorded instance where a subject stated that a mental health care professional had explicitly stated that she was responsible for her son's behaviour. Although, with hindsight, this incident occurred after the initial onset of the disorder, the visit to see a child psychologist, in this case, preceded any formal diagnosis of Schizophrenia:

"He'd been a keen, bright, student and suddenly he wouldn't do his homework or anything else. The doctor then recommended we take him to a child psychologist. I had by that time discovered in his bedroom a box of magic mushrooms. I didn't know what they were at the time but I was told what they were and I threw them out and he went completely haywire about this, because I'd thrown them out. I also found bits of tinfoil which I told the child psychologist about, who told me very politely, he'd interviewed us as a family and told me very politely that I'd no place to go in (son's) bedroom, that his room was his own, if he wanted tinfoil and it to be a tip he was allowed to do that and that I was causing the problem, the disruptive behaviour, with him by invading his territory. I thought that living under my roof as my child at that time of 14, that I had a right for him to respect our home and himself, and he wasn't doing that and so I have to say I didn't go back."

Rampton Group, Interview 14

The same subject also links being given the impression that professionals might be blaming her with a lack of information giving by professionals:

"He then diagnosed him, but when I asked what he thought was wrong with (son) he said, "we don't want to put labels on. . . ." They asked me to go for an interview which I did. I spent a full afternoon giving all my life history and still getting no feedback about what was happening with (son) and what they were going to do. . . . My husband and I had one case conference with the Social Workers, the Doctor and a couple of nurses, case nurse and another nurse who, we

gained absolutely nothing from that interview. It was asking questions more about us, our backgrounds, our relationship with (son), had we spanked him, had we this, had we that, had we the other. It was more to do with what we might have done to (son), which I found pretty offensive really. I answered because if it helped . . ."

Rampton Group, Interview 14

For other subjects, the feeling of being blamed was felt to be implicit in the questions being asked and the unforthcoming nature of the professionals that they met. The professionals so described did little to allay the subjects' own sense of guilt, and by their line of questioning led the subjects to believe that they were being blamed:

"And we told these people, doctors and so forth, they had (son) in first and they must have been asking him a lot of questions that he couldn't answer, when he come out he was upset and crying. And then we had to go in. And they asked us all personal questions: was our family life alright, were me and my husband alright, did we get on, did we fall out, which we didn't, I mean everybody has an argument. We did fall out, all sorts of personal questions. I can't remember everything but it was all personal, to do with our personal life and we couldn't understand why they were asking us all these things . . . We were told nothing."

Bassetlaw Group, Interview 25

At other times, the blaming was not explicitly or implicitly from the professionals but from the family or other lay persons:

"Well in the early days when (son) first became ill my mother and aunty sometimes sort of said that it was my fault, that I had brought (son) up in a different way, but I couldn't see it myself and my husband, because he was reading all these books about psychiatry and he said that in some of these books there was this theory about it was the mother's fault. I felt it was wrong to blame me."

Rampton Group, Interview 10

However, there were examples of professionals who specifically attempted to alleviate any sense of guilt in the patient's

parents.

"They were very nice at (local Psychiatric Hospital) as well. We saw another young fellow that was a Psychiatrist and I said, well I wonder, I sit and wonder all day why it's happened. He said, "look, I have 4 children of my own and it could happen to one of mine." He said it comes as a bolt out from the blue. He said, "don't think you're to blame."

Rampton Group, Interview 15

Though, in one case, even reassurance from professionals was not sufficient to prevent a mother suspect critical life events as a causative factor.

"The one I went to see at (local psychiatric hospital), the lady psychiatrist. She told me not to blame myself, it was nothing I'd done. And she said, "you mustn't blame yourself, it's not your fault. It would have come on anyway. It was an illness that would have come on sometime. Might not be teenage. It might be later on, even, in her life. It would have come on anyway." Why? Why would it come on anyway if it's nothing that happened in her life?"

Rampton Group, Interview 1

Neglecting and Not Neglecting

The boundaries between neglect, unreliability and unhelpfulness can sometimes be difficult to define but, as scored in the analysis of the tape recorded interview, neglect refers to the failure of professionals and others to take cognizance and address the problems that the families were experiencing with their mentally ill family members or to involve them in information sharing:

"It's, I feel as though I've been, let's just say completely ignored over the last eight to ten years, like as if I didn't exist. It's just like as if he never had a mother and father, he never had us at all, because they wouldn't listen to a word I said. It's like, if you got a Doctor listened to you and believed in what you said then it would have been half the, I wouldn't have had half the problems I've had. It's been going on since he's been 15 and they've been completely ignoring what I've said and they've just carried on as if you just don't, they carry on as if you don't exist."

Rampton Group, Interview 12

Subjects also report neglect of the patient.

"I thought that was terrible. I felt that he had been unsupported all that time, they knew he had an illness and then they decided just to leave him to his own devices and one of the staff did say to him that if he carried on he'd either end up, we'd read in the paper one day found he was dead in the gutter, or else he'd end up in hospital. He said that to him because of his lifestyle, because of his dependency on drugs."

Rampton Group, Interview 20

These accounts of neglect of patients also include allegations of not just neglect but failure of care. The mother of a daughter with Schizophrenia said.

" . . . I went down, she'd got one cabbage in the cupboard (in her flat). That was all she'd got and I said look give me the money I'll look after the money

for you. You can have some money every day for food. It's food that is but they didn't like (me) helping her and doing it for her. She'd got to do it herself and she couldn't do it herself. She couldn't buy anything. She didn't know what to buy did she? She wasn't capable of buying food. She couldn't do it because I took her (to the supermarket) and bought her food. She'd pick it up and put it back. She didn't know what to buy. She couldn't do it, so to me to put her out in a flat when she couldn't even look after herself with food even, you know. And then she got a couple of boyfriends and they were after money (for) drinks and she'd go in the pub herself and she got thrown out of the pub near the church. She got thrown out of that and you know she couldn't look after herself. To us it was a ridiculous thing to do to put her out you know in a flat like that."

" . . . she had two miscarriages you know. Yes, she had two miscarriages. That was through them letting men into that place that wasn't patients, and they'd go in that day place (local Day Centre) wherever it was where they all used to go in and have a cup of tea or whatever. And these men had been patients but had been discharged but they used to go back to the women who were in there and she went with somebody, didn't she, in there. And then the second time she went she left the hospital and went with somebody and she was sleeping in a car. This fellow had a got a car and then she got another fellow, he was an Indian or something. They raped her. She said two Indians raped her and she had a baby with one of them and she, six nearly six months was it? Five and a half month or six month miscarriage. She had an abortion, I mean, not miscarriage. She had an abortion and she really suffered and we went to the hospital with her and everything. But she used to have such terrible language, you know, because none of the nurses or anybody would bother with her because she was swearing, you know."

Rampton Group, Interview 1

The same subject went on to say:

"She had nothing. (Professionals) wanting to put responsibility on you but not helping you in any way. . . . Nobody advising and when they used to let her out of (local psychiatric hospital) and I'd take her back in the car. As I say it used to happen many, many nights the police would bring her here. Police bring (daughter) here."

Rampton Group, Interview 1

At times, parents report specific neglect and negligence,

particularly in the context of professionals who refuse to respond to a crisis.

"He was another Psychiatrist, I think he was of equal standing but he wasn't (son's) Psychiatrist and I said he's threatening to kill us, I feel that he's going to and I want him admitted because he's dangerous to himself and to others. I said he's completely off his head and he said "My dear, if we took in all patients just because a mother or somebody thinks they're ill," he said "the hospital would be full up". He said "you've got to make an appointment for next week and he can come and see us at the clinic then". And that's all he said. And I mean I've heard of cases where a family have phoned up hospital begging them to admit them and I think the family knows the state of the person more than anybody else, they know when they're really ill, and I feel that, you know, this is a silly system, that they take no notice."

Rampton Group, Interview 20

At other times, there is a recognition that it may not be the fault of individual professionals but of a system, and in the following quotation, the legal system that prevents prompt and appropriate action:

"And then she said: "we couldn't hold him because we've got no backing to hold him or keep him. We couldn't get the Doctor out. The Doctor wouldn't come out and sign anything". She said, "we tried our best to hold on to him till the Doctor could give him....but we haven't been able to hold him, we're not allowed to hold him without the GP saying so". And she said "I'm just warning you because he might be down to you".

Rampton Group, Interview 20

Unreliability

Failure of the appropriate services to be available is a not uncommon criticism. Two mothers tells of their difficulties in getting the GP to come out to see their sons.

"One of our GPs was very reluctant to come home later in the evenings, even if it was between eight and 10.00 o'clock. And he was sort of saying he had done

his day's work and he was tired and he was not coming out and you will have to cope yourself with your son. He can't do anything."

"So the doctor wrote out another prescription without saying anything to me and he just went really over the top with his medication. . . . And I called, there's someone you call and we were waiting, waiting, waiting, an hour and a half, maybe longer, and each time I called back she said, you know, he's on his way, and then when I called again she said, "he's been to your house and no-one needs a doctor". I said "nobody's been to this house and we do need a doctor" and I got the address from her, it was up (District), there's a hospital or something another up there, and he had gone there. So I got through again, I waited about another half hour and I got through again to this service and unbeknown to me she put me through to (GP's) actual home. I didn't ask to be put through to that, she did that. And well, I got a mouthful and I says "well can you come out?" "No, the doctor will be there". I said "I've waited a hell of a long time for a doctor and he's very ill, my son's in pain here, he needs a doctor". No! He wouldn't turn out. Somebody would be there."

Rampton Group, Interview 11

Another mother tells of the problems of getting a duty (approved) social worker to get her son "sectioned" for treatment:

"There was no-one, he needed another doctor's signature and a Social Worker's, but there was no Social Worker available at the time. It must have been a weekend. And he wanted me to sign these papers. He did say and it was only supposed to be for 48 hours but it ended up a week and, anyway, I signed the papers. I thought, well if he needs to be there he needs to be there, but when a Social Worker came later on to see me at home she said that they didn't like that happening because it can turn, you know, it could have turned (son) against me, because I was the one that committed him."

Rampton Group, Interview 11

Failure to maintain undertakings, particularly of contact, are also a source of grievance:

"And I didn't like his (CPN's) attitude. That sounds awful but he said to me, "I'm Mr so and so". I said, "yes". He said "I'm from the hospital". I said, "who sent you?" Because I'd had no help until then and he sort of looked a bit, you know, "strange woman". He

said, "well I've been sent," you know he changed his tone. He was rather big headed, quite large, and I said, "look", I think this must have been before I saw (Consultant), I can't remember exactly, I said, "look I'm trying to cope with my son, he's laughing and doing all these things, you know, rocking". I said, "I just cannot cope with this, being left in ignorance," so obviously it was before I saw (Consultant). Well anyway he said "where is he now?" I said, "he's in bed". I said "do you want to go upstairs to see him or shall I bring him down?" He said, "bring him down". Brought (son) in they had a chat together, the fellow went and then again into bed. He did say to me look, he said, "your son, I am sure has got Schizophrenia". I said, "well thank you for telling me". I said, "now for God's sake" I said, "don't go from here and never come back and leave me alone to cope with this". I've never seen the man since. Just never seen him since. He promised, he's changed town altogether. He said "oh I will come back," he said, "you don't believe it, I will come back". I've never seen him since. I have actually, I've seen him in the distance at the hospital."

Bassetlaw Group, Interview 25

Unhelpfulness and Helpfulness

The analysis of the tape recorded interviews revealed a number of examples of professionals being unhelpful but also of professionals being deemed to be helpful. Sometimes the comments were very general.

"You know you need more, you need a lot of help from other people. I mean you don't want words you want more direct help."

Rampton Group, Interview 7

"If we'd have had more help with her, well we tried seven years, we tried at least seven years with her wasn't it? While she was a patient. If we'd have had more help with her we probably could have coped."

Rampton Group, Interview 1

"It's difficult because (mother) can't actually tell her story. It's like every thing else, it's like fifty fifty, she was getting help but she wasn't getting all the help she wanted. People recognised that (son) had Schizophrenia but they didn't recognise, you know, the

effect it was having on (mother), didn't recognise, they didn't acknowledge the dangerous situation she was in. I think that was the case, you know, people just don't know how to deal with it. (Mother) went to the doctors two weeks before (son) attacked her actually. The last time (mother) went to the doctors about him and the doctor prescribed valium, so she would be unconscious when he attacked her, which she didn't take, I mean.

Rampton Group, Interview 7

" . . . we were all extremely worried but (sister) actually wrote to people asking for help saying that if we didn't get help now (son) was going to kill her mother."

Rampton Group, Interview 7

or referred to specific areas where help was needed, in this case hospitalisation:

" . . . it used to worry me you know (the) stress of it. I used to think "Oh God". You know I felt he needed help and I just couldn't get it, you know. I couldn't get the help I felt that (son) did need. (The) help he did need (was) hospitalising. I knew I felt deeply about it and it was getting somebody to believe me that he did (need hospitalising)."

Rampton Group, Interview 2

Or in terms of follow up and monitoring:

"It is important and he was just fobbed off from, I don't know whether they were relief psychiatrists or what, but during that interim period (son) did have a difficult time because his medication, nobody knew him and he didn't get the follow-on and the support and things, his medication was chopped and changed."

Bassetlaw Group, Interview 26

A father raises the issue of confidentiality and open recording. He had told the psychiatrist confidential information not expecting the information to be passed on to his son only to find that the unit operated an open recording system. The father said that he was not made aware of this at the time and the disclosure

caused a breach between he and his son:

"I wasn't happy with her (nurse) explanation and I wanted to discuss it with (Consultant) so I discussed it with him and he said that he had this policy of complete openness, that (son) could see his files at any time he wanted to, that he didn't keep anything from his patients. And that I found, with a mental patient, really surprising, particularly in view of the confidential information that we'd given him about (son). We certainly wouldn't have wanted (son) to have known what we said and assumed that when we were talking to a doctor that is, with a doctor that you've got confidentiality, because that's what you do."

Rampton Group, Interview 22

A father comments on what he sees to be the impotence of a voluntary organisation to provide the help that is really needed:

"(Patient's mother) and (sister) founded the local branch of the National Schizophrenia Fellowship. But they are like a friendly society, like I mean, the Women's Institute is stronger than the National Schizophrenic Fellowship to me. They have these meetings and they all cry on each others' shoulders and they do support and help each other but they actually can't do anything. They can't say, you know, have this specialist look at him, give a definitive word, and then he'll be taken away or he'd get the proper treatment or whatever. You know they are not interested in doing anything like that which is what you need."

Rampton Group, Interview 7

When professionals are felt to have been helpful it is often quite simple things that have left a positive impression:

"I have to know that he's alright before I can settle. I had a week away in March because I was not having a very good time, (Social Worker) went to him three times a week, which is marvellous . . . put my mind at rest. He said "go away and we will look after him. And all the staff at (Day Centre) are very good with him."

Bassetlaw Group, Interview 26

(Psychiatrist) sort of treated the family as a whole, you know, she included me in everything with (son), and (father) and everybody. She eventually got him to move into (Hostel)."

Bassetlaw Group, Interview 26

"He was on one time, he has, I mean I know that sounds silly and infantile to anybody else, but (son) had difficulty swallowing tablets and (Psychiatrist) understood this and said "(son) it's alright, if you crush them, that's fine".

Bassetlaw Group, Interview 26

"She (CPN) was very good and she listened to me. I could tell her things about (son) and talk to her and she really did help me because I was at my wits' end. I was really at my wits' end but she could relate back to (Psychiatrist) and then things started to improve."

Bassetlaw Group, Interview 26

At other times, professional "helpfulness" can be dubious. A father alleges that the police charged his son with rape, knowing full well that he was innocent, as the police claimed that this was the only way he would get proper psychiatric treatment.

"You don't know what was in that statement. And I even said to him "what do you want to do a thing like that for?" I said "you know (son) hasn't done it". I had a word, I stood there, I mean they know me because I was forever down the Police Station every night picking (son) up from when he was about 13 onwards and one time I was down there three nights on the trot. He was doing silly things. He was always doing something wrong so I was always down the Police Station picking him up and I said to them, "what do you want to go and do him for rape for?" I said, "you know he never done it". I said he couldn't hurt anybody, he couldn't push himself on to anybody. So he says, well he says, "if we don't do him for that he's never going to get any help is he? He's not well, the boy's not well". Now this is what he told me, I mean, the coppers turned round and said to me, which is right, they're trying to help out, I'm not saying they're doing wrong, they was trying to help out in their own way, but they was trying to help themselves as well by getting him out of the district because he was driving them round the bend. Because he was getting on their nerves. They said, "we're going to do him for it because he said he done it". I said, "you know he never done it." And they wouldn't, you know, they knew, the Police knew he never done it but they had to get him for something to get him out of the way. So that's what they done. So he went down for rape."

Rampton Group, Interview 12

Feelings of Anger Towards Professionals

Transcripts of tape recordings often lose the vehemence of the statements made but a mother spoke with anger and incredulity at the position taken by a senior person in her local Social Services.

"(Senior Manager) did say to us it was better to keep him at home even if he was violent towards us because he knew of instances where a boy was always beating his mother up, practically every week and that was better because they were together, rather than be separated, taking him into Care."

Rampton Group, Interview 20

The same mother had seen her son thrown out of Social Services accommodation:

"I felt it was wrong that (son) was just turned out of the halfway house where he was getting his medication, he was getting support, they were keeping an eye on him, he was being taught on how to do his own washing, ironing, shopping, cleaning. And because he couldn't stop taking cannabis they just turfed him out. I had to find him a room and he was left to his own devices and I had to more or less keep an eye on him."

Rampton Group, Interview 20

She expressed anger that the same organisation would throw her son out of their accommodation for smoking cannabis yet their representative felt it quite appropriate that her schizophrenic son should stay at home to violently abuse his family.

Another mother also expressed anger and incredulity, this time at nurses she alleged deliberately left her daughter at risk:

"I was angry with her (nurse). I was angry when they said they'd let her out for a bit of sex. To me it was disgusting. I mean, I think it was pathetic thing to say. I used to protect her and take her back and make sure she was safe and I never knew if she was safe or

not. I never knew what might happen to her. She'd get in any man's car, you know, to come home and has done and told me what she'd done to get here. She has, I mean, to me she was in shocking danger really."

Rampton Group, Interview 1

The anger can also be non-specific, directed at a "system" that is negligent of both the person with Schizophrenia and the family:

"Mental Health professionals, the doctors, the psychiatrists and psychologists, psychiatric social workers and so on and like the professionals on their professional bodies should be putting pressure on the legislators and saying, "look it's alright these lawyers and MIND, and we admit there are people locked away who shouldn't be there, but we also have to take care of this." So what the legislation needs, should allow us to take care of, before these people should be out they should be processed before release. They should have a right to demand that that processes be carried out. The least possibility really should be investigated. But at the same time if we know a schizophrenic is carrying an axe then we need to take him out of the way because he's going to chop somebody's head off with it. And researchers and the records show that this is the definite pattern of behaviour of schizophrenics. They carry a weapon and use it. That's what I read in this article. If that's true, people need to deal with that. People need to deal . . . professionals through their professional bodies and legislation and that's not surprising all that's not been done and that could have prevented what happened. So I'm sort of angry about that but I can't point at anyone.

Rampton Group, Interview 7

A mother recalls an incident when she was angered by what she felt was the insensitivity of a nurse:

"And a nurse came up and asked him what was wrong and he says, "don't you want to see your mother? (son's name) and (son) said "no". He says, well ask her to leave," which I thought was very cruel. . . The nurse said, "well tell your mother and ask her to leave," you know, and I thought well that's a bit cruel, you know. And, anyway, I says, "alright (son)," I knew he was upset and I says, "I'll see you tomorrow" and then, I'm not sure if it was that night, or the next day, it's so long ago, but I was told that he had attacked another patient, tried to strangle her."

Another mother talks of her encounter with a psychiatrist, with some humour now, but she was clearly angry at the time:

" . . . and he (psychiatrist) said, "but I've interviewed your son and he's told me the reason that he stabbed his mother, she has men in the house, men come to the house." Blooming men, and I'd got a blooming house full of folks here! I thought. His dad said to him, ridiculous. But fancy a psychiatrist saying that! If my husband had have been a bit loopy, or a jealous man, he could have done me in. Now what, can you understand a psychiatrist talking to an husband like that in front of his wife? My husband said, "ridiculous,". He said she's never been a woman who went out.....You see, basically it was (son) that didn't know what he was saying and he was prattling away and the silly man was taking notice of what he was saying, you know."

Rampton Group, Interview 15

In one case, the subject had initiated legal action against his son's psychiatrist. He alleges that his son was prescribed medication known to increase aggression and it was as result of this that his son was eventually placed in Rampton. The father was less angry about the alleged original mistake in medication than what he claimed was the dishonesty of the psychiatrist.

"We began to try and find out. We got solicitors to try and find out about the depixol, why he hadn't mentioned it (in court) and all that. And they were working for us for about a couple years or more. And during this time they were looking into it they found out from the Barrister that had represented our son that they had asked (consultant psychiatrist) for a list of the drugs that he was on and the depixol wasn't one of them. That's why he (barrister) hadn't mentioned it. So I took it that they didn't bother to check. He (consultant psychiatrist) was a professional man. We were just one of the public and we took his word for it. However, the solicitors were going to try and get hold of the records to prove it and after lots of letters and considering many cases eventually he (consultant psychiatrist) said he would send the records and things like that but the trouble was that they had disappeared. He was supposed have sent them up to (another psychiatric unit) that's just practically across the road and they disappeared in between.

But it was pretty clear that the solicitors couldn't do anything without the records to prove that he was on this drug and that (consultant psychiatrist) had told lies to the Barrister. But it left really one thing that our MP (name) put us in touch with the Welsh Office. And after 18 months of intensive checking they found where the blame was, over a 21 page report that disappeared whilst in this doctor's care. He had retired and not much could be done in any case without the actual records and they weren't any where to be found before this. The Welsh Office (under then Secretary of State for Wales) asked every hospital in the area, seven different hospitals, to check their records and cross check them. And they were still not found. Each one of these hospitals had to change the system of recording from then on. But none of this did us any good because nothing would be done without proving by the records that he (consultant psychiatrist) had been telling lies."

Rampton Group, Interview 2

A mother expressed similar anger at what she perceived to be the lies of a psychiatrist in court. In this case her son had been discharged from hospital and shortly afterwards fatally stabbed a complete stranger. She confronted the psychiatrist who had discharged her son.

"When I spoke to (psychiatrist), he never even came to speak to us and I went and searched him out and asked him why he had let (son) out within six weeks when I had gone from him being fourteen to twenty four (years old) trying to get him in. Ten years and within 6 weeks he'd decided that he was fit to be let out, without any supervision. I discovered then that he should have had a Day Nurse calling. He should have had a Social Worker, he should have had follow-up appointments, he should have been sectioned if he didn't take the medication, but none of these things had happened and psychiatrist's only answer to that was, "according to their records (son) had never showed any violent behaviour". The fact that he had attacked two nurses in there, pierced himself all over with pins, was not showing violent behaviour, well it was a total lie. (Son) had shown violent behaviour during the six weeks he was in (local hospital).

Rampton Group, Interview 2

Information Giving

Subjects complained that they were not given information about

the disorder and about what to expect:

"I think they were the people that could have talked to me and explained the illness to me and made me understand how it would manifest itself and maybe how I could have helped him and what I should be doing, you know, to help him. Instead we were kind of treating him like kid gloves and a child and trying to be protective with him because he seemed as though that's what he needed."

Rampton Group, Interview 14

"No, I didn't get much information at all much help when I look back."

Rampton Group, Interview 2

"I mean, anything that I, I was kind of fobbed off as if I was a lay person and couldn't possibly understand medical terms about mental illness."

Rampton Group, Interview 14

Even when information is given it can often be of poor quality.

" . . . I must have gone away bit confused first time so I said, "well what it is Schizophrenia?" So he (GP) says, "oh, its like a Jekyll and Hyde," like he says sometimes he's alright and sometimes he's not he says. He may have explained in a bit more detail but basically them were his words. Jekyll and Hyde like."

Rampton Group, Interview 2

"It was someone at (probation office). That was in the early stage. Personality disorder. Yes first of all it was diagnosed, well he was diagnosed, as a personality disorder. Then he was diagnosed as being schizophrenic. And I went to see the probation officer. "What is a schizophrenic, you know, every one keeps using these words and you know what is a schizophrenic?" And he said to me at the time, "a schizophrenic, most people build castles in the air, a schizophrenic builds them and lives in them you know."

Rampton Group, Interview 2

"It was during some time when he was in (local psychiatric unit) because I remember when the social worker who came here to see us. And they told us that it (Schizophrenia) would leave a person normally about 15 years. Well that of course never did come with him so he didn't say normally he said in some cases it seems to leave them after about 15 years."

Rampton Group, Interview 2

Withholding of diagnosis was another source of complaint.

"At that time he did attack two of the nurses in (local hospital) but they said, "well this does happen with this illness," and I said, "what illness?" And they said "we don't like to put labels on".

Rampton Group, Interview 14

A father complains that the information on Schizophrenia and dangerousness is there but is not being acted upon and in his case he found out too late:

". . . What really sticks in my memory is that after this happened to people gave me these reports and I've still got them upstairs about paranoid schizophrenic cases which have been reported in professional journals and things like that. . . . I mean the reports were there, all (son's) behaviour was down in that report and there were things, if a schizophrenic starts to carry a weapon then inevitably he will eventually, or she will eventually, use it on someone. And this was like, this was the pattern of behaviour of all schizophrenics. It was there on record. And it seemed to be like if you knew a schizophrenic, and you knew that schizophrenic carried a weapon, if you were a professional dealing with these things then you should have the right to take that person out of circulation and treat them because if you didn't someone was going to get seriously hurt or even killed. (Son) always carried a knife . . . he always carried a knife with a 3½" blade one of those butterfly french folding knives with a wooden handle. He always carried one of those and he spent a great deal of time sharpening it."

Rampton Group, Interview 7

However, another subject reports being kept informed and how this has proved helpful:

"I have a great deal of respect for (consultant psychiatrist at the local psychiatric hospital). I found it easy to go along with him. I was remembering like if people explain and keep you informed things are a lot easier."

Rampton Group, Interview 2

DISCUSSION

Certain clear themes emerge from the Results. The subjects' views on causation of Schizophrenia, prior to the model rating procedure, encompassed both biological models and stress/life events explanations. When asked to rate the specific models, they rated life event theory the highest, followed by biological models. There were few references to specific sources of information on Schizophrenia, but those that were referred to included books from the pathogenic parenting position and also sources in opposition to pathogenic parenting models.

It is interesting to compare these findings on parents' ideas about causation with those presented in the relatively sparse literature on views of aetiological models. The work of Cape et al²⁵⁴ has already been mentioned. There was a significant degree of concordance in ranking of aetiological models between the psychiatrists in Cape et al's study and subjects in this study.

One must be careful when comparing the results of this study and Angemeyer and Matschinger's²⁵⁵ large, general population study in Germany, mentioned in the literature review above. As has been shown in the first part of this thesis, there is a distinct and

²⁵⁴ Cape, G S, Antebi, D, Standen, P and Walden, C (1994) "Schizophrenia - The views of a sample of psychiatrists." Journal of Mental Health. Vol. 3, pp 105-113.

²⁵⁵ Angermeyer, M C and Matshinger, H. (1994) "Lay beliefs about schizophrenic disorder: the results of a population survey in Germany" Acta Psychiatrica Scandinavica. Vol. 89 (supplement 382), pp 39-45.

different philosophical tradition in psychiatry in the German speaking world which may, in turn, mean that lay perceptions in Germany are different to lay perceptions in the English speaking world. Also, unlike this study, many and perhaps most of the subjects in the German research would have had little or no exposure to the disorder, though such was the size of the study that one would expect, by chance, that some subjects would have been relatives and/or carers of person with Schizophrenia or perhaps were persons with Schizophrenia themselves.

However, bearing in mind these caveats, the results of the German study show interesting similarities with the results in this study, showing a first and second ranking for psycho-social stress and biological explanations in both studies.

In line with the seeming lack of information sources reported by subjects is a lack of information giving by mental health care professionals, and even when information is given it is often scant, insufficient, poor and sometimes inaccurate. The observations by Deasy and Quinn²⁵⁶, previously referred to, might still be true today: "They never tell you anything. It looks like after all the training they've had they'd be able to give you some definite answers." "The doctors never have time to talk to you."

The levels of stress that the parents experienced as a result of their son or daughter's disorder is also worthy of note. Subjects

²⁵⁶ Deasy, L C and Quinn, O W. "The Wife of the Mental Patient and the Hospital Psychiatrist" Social Issues. Vol. 11, pp 49-60 1955.

in both the Rampton and the Bassetlaw groups reported high rankings (reported in two thirds or more of the interviews) for the following problems: withdrawal, verbal aggression, violence, undue suspiciousness and poor self care. Also, in more than two thirds of the interviews, subjects reported that their son or daughter's behaviour was, at times, more than could be coped with: they found it difficult to know how to respond to him or her and felt trapped by the way things were.

A sense of guilt for in some way causing the disorder was expressed in a significant number of the interviews. Although there was a difference between the two groups, with the Bassetlaw group showing greater frequency of guilt this was not statistically significant.

These results should also be considered with the results on parents' experiences of being blamed. There were only ten instances of subjects reporting that they felt they were being blamed by a professional or other significant persons. Of these ten instances, two were examples from non-professionals (sibling and other family member) and three of the instances were from one subject. Unknown in the remaining instances are the number where the professionals were not knowingly blaming, or not blaming at all but the subject misinterpreted the situation. In the context of the long history and considerable impact of pathogenic parenting models, and the instances and claims of professionals blaming families as reviewed in the Introduction to the second

part of this thesis (Terkelsen²⁵⁷, Creer and Wing²⁵⁸, Castaneda and Sommer²⁵⁹, Holden and Lewine²⁶⁰, Bernheim and McElroy in Hatfield and Lefley ed.²⁶¹), the actual level of blaming in this research seems lower than was expected. One must also take into account that there were nearly as many instances of parents reporting being counselled not to blame themselves. Of the eight instances, six were advised not to blame themselves by psychiatrists and two by nurses. It is worth remembering that in Tessler, Gammache and Fisher's²⁶² study in response to the statement: "Professionals assured me that I was not to blame for the patient's illness" 61% of their subjects (relatives or close friends of psychiatric patients) expressed some degree of agreement.

The paradox that we are left with is that in this study we are seeing subjects experiencing guilt in the absence of blame, and

²⁵⁷ Terkelsen, K (1983) "Schizophrenia and the Family: II Adverse Effect of Family Therapy". Family Process. Vol. 22, pp 191-200.

²⁵⁸ Creer, C and Wing, J. (1975) "Living with a Schizophrenic Patient". British Journal of Hospital Medicine. Vol. 14, p 73.

²⁵⁹ Castaneda, D and Sommer, R (1989) "Mental Health Professionals' Attitudes Toward the Family's Role in Care of the Mentally Ill." Hospital and Community Psychiatry. Vol. 40, no 11, pp 1195-1197.

²⁶⁰ Holden, D F and Lewine, R J (1982) "How families evaluate mental health professionals, resources and effects of illness." Schizophrenia Bulletin. Vol. 8, no 4, pp 626-633.

²⁶¹ Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London.

²⁶² Tessler, R C, Gammache, G M and Fischer, G A (1991) "Patterns of contact of patient's families with mental health professionals and attitudes toward professionals." Hospital and Community Psychiatry. Vol. 42, no 9, pp 929-935.

sometimes in the context of being specifically counselled not to blame themselves.

The final, important overall finding is the low rating that subjects gave professionals, particularly in terms of perceived unhelpfulness and neglect; and this was felt not to be mediated by degree of contact with a professional group. Professionals were rated significantly more negatively than lay persons, once again echoing Deasy and Quinn's²⁶³ subjects' statements.

The Parent as Secondary Victim and the Relevance of Attribution Theory

There are consistencies of views between the subjects in this study, the subjects in Angermeyer and Matschinger's study and the psychiatrist subjects in Cape et al's study. However, this is in the absence of consistent sources of information for the subjects, and sometimes of any information at all. It is as if the stress/life event followed by biological models reflect the current common sense view, despite the fact that, from the 1940's to the 1970's, pathological parenting models informed the professional zeitgeist. There is also the central paradox that although there is scant evidence of unequivocal blaming of parents by others, only slightly more records of assumptions of being blamed (though whether the professionals did hold the parents to blame will probably never be known) and only slight

²⁶³ Deasy, L C and Quinn, O W. "The Wife of the Mental Patient and the Hospital Psychiatrist" Social Issues. Vol. 11, pp 49-60 1955.

exposure to pathogenic parenting theories, there were high levels of searching for meaning in terms of self-blame and guilt, despite instances of professionals counselling specifically that the parents were not to blame. This is shown most poignantly by Subject 1, quoted above, who despite being told by a psychiatrist not to blame herself still wondered if burdens and duties she placed on her teenage daughter may have caused the illness.

Is there an explanation for this phenomenon? If one takes into account the high levels of stress reported by subjects in this study, and one views the parents as, in some sense, a victim of their situation, then Attribution Theory may well provide an explanation for what has been found.

Attribution of self-blame has now been investigated in a whole range of areas including self-blame for spinal injury and self-blame in mothers of developmentally disordered children for their children's disorder. A key early study looked at the reactions of victims of rape. Janoff-Bulman²⁶⁴ surveyed three groups of women: depressed female college students, non-depressed female college students and rape victims at a rape crisis centre. Janoff-Bullman found that when the two college student groups were compared, the depressed group expressed notions of characterological self-blame, that is they felt that there was something intrinsic within them that led them to feel that they

²⁶⁴ Janoff-Bulman, R. (1979) "Characterological Versus Behavioral Self-Blame: Inquiries into Depression and Rape." Journal of Personality and Social Psychology. Vol. 37, No. 10, pp 1798-1809. Page 1808.

had failed. Some rape victims also expressed ideas of self blame but this was behavioural self blame, "if only I hadn't taken the short cut home" or "if only I hadn't accepted that lift". In many instances the self blame was counterfactual, but it also seemed to be helpful in constructing a behavioural hypothesis by which the victim felt that she might avoid a repetition of the assault. In contrast, rape victims who adopted a characterological self-blame approach, "I'm the sort of woman who gets raped", had no such buffer against the future. Janoff-Bullman concludes that behavioural self-blame may be very important in allowing rape victims to regain control of their lives but if this is the case there are important implications for therapists and counsellors.

"One counselling technique for rape victims includes repeatedly telling a woman that there is nothing she could have done to avoid the rape, that it was entirely the rapist's doing and outside of her control. Although meant to be reassuring, these statements could conceivably be not at all helpful, in the light of the proposition that the women are seeking to re-establish control. Rather, counsellors should perhaps recognise the functional value of behavioural self-blame and concentrate on enabling the victim to re-establish a belief in her relative control over life outcomes (eg, discussing possible ways of minimising the likelihood of a future rape). Too often, behavioural self-blame is regarded as detrimental to mental health. Rather, it may serve as an indicator of the victim's psychological needs at the time."

Affleck, McGrade, Allen and McQueeney²⁶⁵ compared a survey of attitudes of mothers of 57 developmentally disabled children and literature on accident victims that seemed to show that victims

²⁶⁵ Affleck, G, McGrade, B J, Allen, D A and McQueeney, M. (1985) "Mothers' Beliefs About Behavioral Cause for Their Developmentally Disabled Infant's Condition: What Do They Signify?" Journal of Paediatric Psychology. Vol. 10, No 3, pp 293-303.

who assumed behavioural responsibility for their accident had better outcome than those who blamed it on others. Affleck et al hypothesise that what is happening when victims blame themselves for their own or their child's fate is the application of a "Just world" model. In the "Just world" model people, ultimately, get what they deserve and persons who become victims may both morally re-evaluate themselves or be re-evaluated by others who hold a similar, primitive causal model.

Gulotta and de Cataldo Neuberger²⁶⁶ describe the "Just world" model as follows:-

"According to this theory, if a disaster befalls an individual, more fault is attributed to the respectable than to the less respectable victim because the intrinsic characteristics of the victim do not qualify him for his fate. Thus, the lay person, to maintain his belief in a just world, must invent some justification for the tragedy which he can lay on the victim."

Why should such unjust and punitive causal models be held today? The alternative is to see the world as being, on a personal level, a-causal and for some people perceiving a spurious causality may be preferable to the anarchy of a-causality.

On a more important level one can see the implications for the rape victims where the catastrophic event may well have occurred in the context of an everyday circumstance or environment, on the way to or from work or the victim's own accommodation. If the victim's primary fear is a future attack there is little she can

²⁶⁶ Gulotta, G and de Cataldo Neuberger, L (1983) "A Systematic and Attributional Approach to Victimology." Victimology: An International Journal. Vol. 8, No. 1-2, pp 5-16. Page 14.

do to avoid the context in which the first attack took place and to gain control of the situation except by counterfactual thinking.

Similar processes have been observed in the families of homicide victims. Getzel and Masters²⁶⁷ describe the reactions of such families in New York and these reactions include rage, guilt and yearning for the dead. They also include shock terror, apathy and evinced helplessness. Such a sudden and profound event as homicide in the family, particularly if unprovoked, particularly if by a stranger, can be profoundly disabling as it evokes feelings of the randomness of life and meaninglessness of the action, for the victim and his or her family, at least.

Rosenthal, Sadler and Edwards²⁶⁸ develop the argument further in the context of post-traumatic stress disorder in explaining the reactions of catastrophe victims. These reactions include loss of equilibrium in daily functioning, sense of insecurity, pervasive sense of danger and self questioning. The authors believe these reactions too result from the collapse of three assumptions that people normally hold: perception of personal invulnerability, belief in the world as a meaningful and comprehensible place and positive self view.

²⁶⁷ Getzel, G S and Masters, M (1984) "Serving Families Who Survive Homicide Victims" Social Casework: The Journal of Contemporary Social Work. Vol. 65, Part 3, pp 138-144.

²⁶⁸ Rosenthal, D, Sadler, A and Edwards, W. (1987) "Families and Post-Traumatic Stress Disorder." Family Therapy. Vol. 22, pp 81-95.

Tennen, Affleck and Gershman²⁶⁹, reviewing work in a number of areas of self blame including serious illness, illness in children and being a victim of rape, make an important distinction between perceived control of repetition of the key catastrophe (eg rape or birth of a defective child) or perceived control on the course of illness (eg development of the child, course of illness or recovery from spinal injury). The terms they use are "recurrence" and "sequelae". They conclude, after reviewing a number of studies, that when self-blame is associated with perceived control over recurrence this may help bolster adaptation. In this context, they find the reticence of staff to discuss issues of causation or to attempt to alleviate guilt in terms of "act of fate" explanations may be counter productive:

"In this vein, it is interesting that none of the mothers reported being told by their child's treating physician or nurse that their personal behaviour was responsible for their child's condition. In fact, professionals involved in their child's care typically discouraged behavioural attributions and encourage attributions to chance. Such encouragement is probably in large part responsible for the high magnitude of chance attributions in the sample (see also Bulman and Wortman (1977)). It is unclear whether such reticence on the part of the treatment staff to accept behavioural causes stem from a belief that such ascriptions are inaccurate or a belief that they are associated with emotional distress and maladaptation. We do suspect that many professionals are swayed by arguments that parental self-blame signals poor coping (eg Cramer 1976; Schild 1971). But Wortman (1983) offered poignant examples of how professionals' attempts to console patients by telling them that they were not responsible for their circumstances often met with visible signs of depression. Such interventions are probably even more common when the illness is severe and members of the victim's support system wish to relieve him or her of the burden of blame. Our results

²⁶⁹ Tennen, H, Affleck, G and Gershman, K. (1986) "Self-Blame Among Parents of Infants With Perinatal Complications: the Role of Self-Protective Motives." Journal of Personality and Social Psychology. Vol. 50, No. 4 pp 690-696. Page 695.

demonstrate that behavioural self-blame emerged despite the communications of treatment staff. Self-blame was more likely with increasing severity, and its association with positive mood state was mediated by the belief that a recurrence could be avoided in future children. This pattern of findings point to the defensive underpinnings of self-blame in this group of mothers and its potential healing role for some victims of aversive life events."

As Affleck, McGrade, Allen, and McQueeney²⁷⁰ point out, an absence of professional explanations or a statement such as: "we may never know what caused your baby's disability" may pose a threat to a "Just world" model making self blame a more attractive possibility. Blaming others, or fate, implies that one may be vulnerable, again, to fate. Self blame, at the behavioural level, implies that one can modify one's behaviour to avoid an unjust world. The authors conclude that their study shows that self blamers adjust better than other blamers and cautiously conclude that self blame, rather than being maladaptive may be adaptive.

Before looking at the psychoeducational implications of applying Attributional Theory to the parents of people with Schizophrenia, it is necessary to clarify certain definitional issues first.

The author has been asked (personal communication with Professor Digby Tantom) whether the subjects in this research are experi-

²⁷⁰ Affleck, G, McGrade, B J, Allen, D A and McQueeney, M. (1985) "Mothers' Beliefs About Behavioral Cause for Their Developmentally Disabled Infant's Condition: What Do They Signify?" Journal of Paediatric Psychology. Vol. 10, No 3, pp 293-303.

encing guilt or shame. Gilbert, Pehl and Allen²⁷¹ have developed a useful taxonomy to differentiate between shame and guilt, a taxonomy based on earlier work by Lewis (in Rutter, Izard and Read eds²⁷²). At its simplest, shame is associated with powerlessness whereas guilt is about having power and either misusing it or failing to use it. The two authors look at both phenomena in more detail in terms of the self and the other. In context of rape, the self is the victim and the other the perpetrator: in the context of a family where there is Schizophrenia, the self is the parent, the other is the son or daughter who has Schizophrenia.

In terms of shame, the perception of the self is as unable, as an object of scorn, disgust, ridicule and humiliation. The person feels paralysed, helpless, passive, and inhibited. They also feel inferior, smaller, and weaker. Physical reactions may include involuntary body response, rage, blush, tears, and gaze-avoidance. The person may be functioning poorly, their mind may go blank, there is a desire to hide, to conceal oneself and the self is seen as the focus of other's awareness. In shame, the perception of the other is of able, the source of scorn, contempt, ridicule, humiliation. The other is laughing, rejecting, active, uninhibited and free, superior, bigger and stronger. The other is also adult and in control, functioning well but experiencing contempt.

²⁷¹ Gilbert, P, Pehl, J and Allen, S. (1994) "The phenomenology of shame and guilt: An empirical investigation." British Journal of Medical Psychology. Vol. 67, pp 23-36.

²⁷² Rutter, M, Izard, C E and Read, P B eds. (1986) Depression in Young People: Developmental and Clinical Perspectives. Guildford Press. New York.

The other is in focal awareness.

In contrast, in the context of guilt the self is seen as able, the source of hurt, let down or failure. The self is intact and capable. The focus on self is in actions, behaviour and feeling. The self makes efforts to repair. In guilt it is the other who is unable, injured, incapable, needful and hurt. The focus is on let down or injury done to the other and the efforts to elicit reparation.

Couched in these terms, it is possible to understand how the victims of rape may feel *shame* but the term *guilt* more accurately describes the reaction of parents of the disabled including those disabled by a mental illness such as Schizophrenia.

Shaver and Drown²⁷³ are critical of the confusion in the literature about the terms causality, responsibility and self blame in literature on Attribution Theory. They argue that these terms are not interchangeable and may naturally vary between groups of victims, for example rape victims may not see themselves as causing the perpetrator to rape but may blame themselves for finding themselves in the predicament where they were the one who was raped.

Conversely, victims of domestic violence may blame themselves for being the one who elicited their partners' violence, if they were

²⁷³ Shaver, K G and Drown, D (1986) "On Causality, Responsibility, and Self Blame: A Theoretical Note" Journal of Personality and Social Psychology. Vol. 50, No 4, pp 697-702. Page 701.

different their partner might not be violent. They point out that the difference between blame and responsibility is well known to politicians who may accept responsibility but do not accept the blame. They argue that:-

"Rephrased in this way, the notion (represented in the examples reviewed) that some self-attributions can lead to positive adjustment to various life calamities loses some of its paradoxical quality but gains construct validity. Self-attribution of causality for the production of negative outcomes ought to be highly related to the reestablishment of perceived control over future outcomes; this reestablishment seems important in successful coping with victimization. Self-attribution of responsibility for poor character or faulty judgement would be expected to increase both the present pain produced by the suffering, and the expected likelihood of future suffering. Self-attribution of blame (non veridical in the absent of intent) could add an intropunitive aspect to this personal burden."

Attribution Theory and Expressed Emotion

In the first part of this thesis, the author examined the one family theory that has seemed to have stood the test of time. This is Expressed Emotion (EE), in which the quality of family, and in particular parental relating to the schizophrenic family member is correlated with the course of the disorder and relapse. Authors such as Bebbington and Kuipers²⁷⁴ have argued that aggregated research presents an overwhelming case for the relationship between high EE and relapse and that this relationship can be found world wide. Despite this, objections to Expressed Emotion theory have been voiced from two opposing

²⁷⁴ Bebbington, P and Kuipers, L (1994) "The predictive utility of expressed emotion in schizophrenia: and aggregate analysis." Psychological Medicine. Vol. 24, pp 707-718.

positions.

Although the theory was originally conceived in opposition to the prevailing pathogenic parenting models, the theory itself has changed over time and its proponents couch their arguments in pro family terms. Some family members of persons with Schizophrenia still find the EE approach objectionable and Hatfield²⁷⁵ has articulated some of these arguments. She maintains that whatever their stated position, professionals rarely have any empathy or understanding of what it really feels like for the family or appreciate the extent of the burdens. Hatfield argues that no matter how the theory is couched, families cannot help but see themselves as being judged as being good (low EE) or bad (high EE) family members. She also argues that professionals may underestimate the element of the patient's free will in events or that other powerful persons in the patient's environment, such as professionals involved in his or her treatment, may be equally responsible as casual agents in the patient's relapse. Indeed, authors such as Sorensen Snyder, Wallace, Moe and Liberman²⁷⁶ have sought to demonstrate that Expressed Emotion by staff in residential facilities for people with Schizophrenia can be an important factor in relapse. Finally, Hatfield fears that a psychoeducational approach may be used as a cheaper alternative

²⁷⁵ Hatfield, A B (1987) "The Expressed Emotion Theory: Why Families Object." Hospital and Community Psychiatry. Vol. 38, No 4, p 341.

²⁷⁶ Sorensen Snyder, K, Wallace, C J, Moe, K and Liberman, R P (1994) "Expressed Emotion by residential Care Operators and Residents Symptoms and Quality of Life." Hospital and Community Psychiatry. Vol. 45, No 11, pp 1141-1143.

to investing in proper residential facilities in the community.

At the opposite extreme are writers such as Johnstone²⁷⁷ who, though writing from a position that the writer does not necessarily agree with in terms of the authenticity of Schizophrenia as an illness and the role of the family in the origins of the disorder, has produced a stimulating and provocative critique of the whole Expressed Emotion position. Her article should also be read in conjunction with Leff and Vaughn's²⁷⁸ reply and Johnstone's²⁷⁹ subsequent reply to Leff and Vaughn.

Johnstone sees historical parallels between the development of moral therapy and the development of family interaction models today. She argues that, initially, both models were radical challenges to the medical dominance of the treatment of mental illness but that both were appropriated by the medical profession, thus neutralising the threat. She argues that family interaction models of Schizophrenia were appropriated by psychiatry through the development of Expressed Emotion theory. Johnstone sees certain elements in the mainstream Expressed Emotion literature as being key indicators of this conspiracy. The family is not to blame because the illness is biological and

²⁷⁷ Johnstone, L. (1993) "Family management in "schizophrenia": its assumptions and contradictions." Journal of Mental Health. Vol. 2, pp 255-269.

²⁷⁸ Leff, J and Vaughn, C. (1994) "Critics of family management in schizophrenia: their assumptions and contradictions." Journal of Mental Health. Vol. 3, pp 115-116.

²⁷⁹ Johnstone, L. (1994) "Reply to Leff and Vaughn." Journal of Mental Health. Vol. 3, pp 117-118.

the importance of medication is stressed.

Johnstone agrees with Hatfield that the messages sent out in this form of therapy are contradictory in the context of blaming the family. In her own words "not entirely facetiously" she compares the communication between Expressed Emotion therapists and the family with the deviant parent communication styles hypothesised by various family interaction models, the most obvious of which is the "double bind" of saying the family is not to blame (for starting the illness) but is to blame (for maintaining it).

Johnstone points out that the proponents of Expressed Emotion, to maintain their anti "anti-psychiatry" position, must repudiate any attempt to see family interaction as the precipitator of the disorder itself. She argues that there is evidence of pathogenic relating prior to breakdown but Leff and Vaughn²⁸⁰ present reasoned arguments why research in this area is problematic and firm conclusions premature. The author would add to Leff and Vaughn's arguments that there is evidence of the "differentness" of children who later develop Schizophrenia (Grimes and Walker²⁸¹) and this is supportive of biological models and may provide an explanation of pre-morbid high EE levels in terms of family members reacting to subclinical levels of the disorder.

²⁸⁰ Leff, J and Vaughn, C. (1994) "Critics of family management in schizophrenia: their assumptions and contradictions." Journal of Mental Health. Vol. 3, pp 115-116.

²⁸¹ Grimes, K and Walker, E F (1994) "Childhood Emotional Expressions, educational attainment, and Age at Onset of Illness in Schizophrenia." Journal of Abnormal Psychology. Vol. 103, No. 4, pp 784-790.

Johnstone is sceptical of the whole concept of Schizophrenia as an "illness" in arguments already reviewed in the first section of this thesis. The sort of arguments she uses include those put forward by Marshall (in Bentall²⁸²) and seem predicated on the notion of a single monolithic biological model of Schizophrenia which was always likely to prove improbable and presents an easy target. She is suspicious of medication (or, more correctly, the ubiquitous use of standard anti-psychotic medication), she speculates that some, and perhaps many, patients would get better without medication and that medication may make matters worse rather than better. There is a germ of truth in all this. As long ago as 1926, Menninger²⁸³ speculated that a minority of cases of Schizophrenia were characterised by acute onset, short duration of the disorder and good outcome with few or no future relapses. This was written at a time when there was no drug treatment for Schizophrenia. Menninger speculated that this variant of Schizophrenia may, like the epidemic of encephalitis lethargica, have been a legacy of the Spanish Influenza epidemic of 1919.

Perhaps her most important and deceptively simple argument is to ask what are we seeing in high EE anyway? Barrowclough, Johnston

²⁸² Bentall, R. ed. (1990) Reconstructing Schizophrenia Routledge. London.

²⁸³ Menninger, K A. (1994, originally published 1925)"Influenza and Schizophrenia. An Analysis of Post-Influenzal "Dementia Praecox," as of 1918, and Five Years Later. Further Studies of the Psychiatric Aspects of Schizophrenia." American Journal of Psychiatry. Vol. 151 Sesquicentennial Supplement.

and TARRIER²⁸⁴, in attempting to answer this question, find the simple binary model of either high EE or low EE as being too simplistic. They looked at both the amount of attributions that relatives made about their schizophrenic family member's disorder and consequent behaviour, and also the quality of these attributions. What they found was that low EE relatives made fewer attributions than high EE relatives but that on a qualitative level, high EE relatives fell into a further two groups, over-protective or over critical. They found that these two sorts of high EE relatives also differed in the attributions they made. Over critical style was associated with attributions of the schizophrenic family member's illness and behaviour as being under his or her control to some degree. Over-protection was associated with attributions of being beyond and outside the person's control.

At first sight, these results seem like verification of what common sense should tell us anyway but the results have important implications. If attributions, the models that a family member might have about their mentally ill relative or the illness itself, mediate not only their sense of guilt and a just world as has been hypothesised in the first part of this Discussion but also levels of Expressed Emotion, does this argue for a "state" rather than "trait" model of EE? While acknowledging that a person's traits may predispose them to certain beliefs rather

²⁸⁴ Barrowclough, C, Johnston, M and TARRIER, N. (1994) "Attributions, Expressed Emotion and Patient Relapse: An Attributional Model of Relatives' Response to Schizophrenic Illness." Behaviour Therapy. Vol. 25, pp 67-88.

than others, Barrowclough et al's model does lend itself to a "state" perception of the attributional model. Rather than an inherent emotional lability, the model lends itself to a traditional one of the family member as would be envisaged by George Kelley: as hypothesis generator.

The Psychoeducational Model

Traditional family intervention in Expressed Emotion work is a psychoeducational model helping to shape the family's view of the disorder, to put into context the schizophrenic family members behaviour and to develop coping skills. In short, such an educational programme should have a powerful influence on the family's attributional style and content. If all the above is true, it should work, but does it?

We have an authoritative overview of this question in Mari and Streiner's²⁸⁵ paper. The authors of this meta-analysis worked within the framework of the Cochrane Schizophrenia Group and, as such, had access to the most sophisticated literature search facilities available. As a Cochrane Collaboration, the authors, by definition, only incorporated Random Controlled Trials (RCTs) in their analysis (currently the Cochrane Groups regard RCTs as the only research strategy to consistently provide results of sufficient rigour - in their terms the "gold standard"). Their inclusion criteria were all RCTs with a:

²⁸⁵ Mari, J J and Streiner, D (1996) "Family intervention for those with schizophrenia." The Cochrane Library (CD), 1996 Issue 3. Page 7.

" . . . focus on families of people with Schizophrenia or schizoaffective disorder receiving any psychosocial intervention that required more than five sessions and was not restricted to an in-patient context/environment."

Did they find the intervention worked? The answer was a highly qualified "yes". Perhaps the most significant finding was that where the families did receive intervention, the member with Schizophrenia relapsed less. This positive news is overshadowed by the analysis showing that one had to work with seven families to prevent relapse in one at one year, raising issues of cost benefit. Where the intervention did prove effective, it seemed to do so by increasing medication compliance. There was no effect, either way, on suicide rates. Interestingly, there was, overall, a differential response in terms of reduction in EE in high EE family members:

Overall, levels of expressed emotion were somewhat lowered by the family interventions. There was a suggestion that over-involvement, one element of expressed emotion, was decreased to a greater extent in families that had treatment and that little or nothing happened to the levels of criticism - another key element of expressed emotion."

This finding might be of particular importance if one sees in the psychoeducation of family members who are over critical, a process by which the family member sees his or her character as being blamed for the potential relapse. Two unwanted consequences may be a resentment of the intervention as yet another critical pathogenic parenting model or the negative hopelessness seen in other forms of characterological self blame. In contrast, to change over involvement and associated over protectiveness requires the reevaluation by other family members of qualities in the schizophrenic family member, perhaps a less threatening

and more positive process for the family.

What is not immediately apparent from Mari and Streiner's paper is what the content of the educational programmes are. They talk in general terms of the common elements but one has to look at the original papers to find what little detail there is. Not all of the original papers were available to the author but eleven papers covering a sample of six of the twelve studies were obtained (some studies generated more than one paper, for instance one and two year follow ups). This sample contained one study from the USA, two from China and three from the UK.

The study in the USA is described in Hogarty, Anderson, Reiss, Kornblith, Greenwald, Javna and Madonia²⁸⁶ and Hogarty, Anderson, Reiss, Kornblith, Greenwald, Ulrich and Carter²⁸⁷. Their study looked at the impact of family intervention and social skills training for the patient, separately and combined. They explicitly reject both the terminology and the approach of family therapy using the term "family treatment" to describe their family intervention. They employed various education and discussion groups and refer to providing "Concrete data on

²⁸⁶ Hogarty, G E, Anderson, C M, Reiss, D J, Kornblith, S J, Greenwald, D P, Ulrich, R F and Carter, M. (1986) "Family Psychoeducation, Social Skills Training, and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia. I. One-Year Effects of a Controlled Study on Relapse and Expressed Emotion." Archives of General Psychiatry. Vol. 43, pp 633-642.

²⁸⁷ Hogarty, G E, Anderson, C M, Reiss, D J, Kornblith, S J, Greenwald, D P, Ulrich, R F and Carter, M. (1991) "Family Psychoeducation, Social Skills Training, and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia. II. Two-Year Effects of a Controlled Study on Relapse and Adjustment." Archives of General Psychiatry. Vol. 48, pp 340-347.

Schizophrenia" and "Concrete management suggestions". Neither paper gives any firm indication of what model, or models, of Schizophrenia their education programme was predicated on, or what the families were specifically being told.

Neither of the Chinese studies, Xiong, Phillips, Hu, Wang, Dai, Kleinman and Kleinman²⁸⁸ and Zhang, Wang, Li and Phillips²⁸⁹, describe in any detail the syllabus of their educational programmes although in Xiong et al there is a reference to: "the importance of thinking of the patient's symptoms as manifestations of an illness, not the result of a 'bad personality' or 'fate'".

The UK study described in Leff, Kuipers, Berkowitz, Eberlein-Vries and Sturgeon²⁹⁰ and Leff, Kuipers, Berkowitz, and Sturgeon²⁹¹ only refers to this description of the educational content in their study:

²⁸⁸ Xiong, W, Phillips, M R, Hu, X, Wang, R, Dai, Q, Kleinman, J and Kleinman, A. (1994) "Family-Based Intervention for Schizophrenic Patients in China. A Randomised Controlled Trial." British Journal of Psychiatry. Vol. 165, pp 238-247.

²⁸⁹ Zhang, M, Wang, M, Li, J, Phillips, M R. (1994) "A Randomised-Control Trial of Family Intervention for 78 First-Episode male Schizophrenic Patients. An 18-Month Study in Suzhou, Jiangsu." British Journal of Psychiatry. Vol. 165 (suppl. 24), pp 96-102.

²⁹⁰ Leff J, Kuipers, I, Berkowitz, R and Sturgeon, D. (1985) "A Controlled Trial of Social intervention in the Families of Schizophrenic Patients: two Year Follow-up." British Journal of Psychiatry. Vol. 146, pp 594-600.

²⁹¹ Leff J, Kuipers, I, Berkowitz, R, Eberlein-Vries, R and Sturgeon, D. (1982) "A Controlled Trial of Social intervention in the Families of Schizophrenic Patients." British Journal of Psychiatry. Vol. 141, pp 121-134. Page 122.

"This consisted of four lectures on the aetiology, symptoms, course and treatment and management of Schizophrenia. We put a lot of thought into the writing of these lectures, which incorporated our consensus opinions on the above topics, couched in everyday language with a strict avoidance of jargon. The lectures were read out from a typescript to each relative in his or her home. . . . Following each lecture we allowed unlimited time for the relative to ask questions."

We are not told what the authors' consensus opinions are and it would also have been interesting to know what the subjects' questions were.

In the second UK study, described in Falloon, Boyd, McGill, Williamson, Razani, Moss, Gilderman and Simpson²⁹² and Falloon and Pederson²⁹³ education about Schizophrenia is referred to but once again no details are supplied.

The UK study, described in TARRIER, Barrowclough, Vaughn, Bamrah, Porceddu, Watts and Freeman²⁹⁴, TARRIER, Barrowclough, Vaughn, Bamrah, Porceddu, Watts and Freeman²⁹⁵ and TARRIER, Lawson and

²⁹² Falloon, I R H, Boyd, J L, McGill, C W, Williamson, M, Razani, J, Moss, H B, Gilderman, A M and Simpson, G M. (1985) "Family management of a Two-Year Longitudinal Study." Archives of General Psychiatry. Vol. 42, pp 887-896.

²⁹³ Falloon, I R H and Pederson, J. (1985) "Family Management in the Prevention of Morbidity of Schizophrenia: The Adjustment of the Family Unit." British Journal of Psychiatry. Vol. 147, pp 156-163.

²⁹⁴ TARRIER, N, Barrowclough, C, Vaughn, C, Bamrah, J S, Porceddu, K, Watts, S and Freeman, H. (1988) "The Community Management of Schizophrenia. A Controlled Trial of a Behavioral Intervention with Families to Reduce Relapse." British Journal of Psychiatry. Vol. 153, pp 532-542.

²⁹⁵ TARRIER, N, Barrowclough, C, Vaughn, C, Bamrah, J S, Porceddu, K, Watts, S and Freeman, H. (1989) "Community Management of Schizophrenia. A Two-Year Follow-Up of a Behavioral Intervention with Families." British Journal of Psychiatry. Vol.

Barrowclough²⁹⁶, do not directly describe the educational content.

In the literature reviewed above, certain assumptions have been made which should not go unquestioned.

The first is the assumption of homogeneity of the education on offer in terms of describing the causes and treatment of Schizophrenia. Johnstone²⁹⁷, referred to above, assumes a certain commonality of approach. This may well be the case but would be somewhat surprising considering the lack of absolute consensus within professions let alone between professionals dealing with persons with Schizophrenia!

Indeed, another assumption, though one that has already been questioned by Hatfield²⁹⁸ above, is that EE in family members is a more significant problem than EE in professionals working with persons with Schizophrenia. The amount of work in this area is tiny compared with the volume of research on EE in families and the former is a badly neglected area of study. As anybody who has

154, pp 625-628.

²⁹⁶ Tarrier, N, Lawson, K and Barrowclough, C. (1991) "Some Aspects of family Intervention in Schizophrenia. II: Financial Considerations." British Journal of Psychiatry. Vol. 159, pp 481-484.

²⁹⁷ Johnstone, L. (1993) "Family management in "schizophrenia": its assumptions and contradictions." Journal of Mental Health. Vol. 2, pp 255-269.

²⁹⁸ Hatfield, A B (1987) "The Expressed Emotion Theory: Why Families Object" Hospital and Community Psychiatry. Vol. 38, No 4, p 341.

been part of a multi-disciplinary team knows, there is likely to be a wide range of views which will, in turn, lead to different attributions of the client/patient behaviour. At the very least, it would be intriguing to see if there was greater heterogeneity in views on the aetiology of Schizophrenia within psychiatric multi-disciplinary teams or within families of people with Schizophrenia.

Furthermore, there is the assumption, also questioned by Hatfield and Johnstone, that families accept the bland assurances of non-blame in the context of training that either implicitly or explicitly implicates them in the course of the illness. In addition, there is the assumption that non-blaming and the alleviation of self-blame is a simple matter which can be achieved in a short series of lectures. The literature on attribution discussed earlier casts doubt on this. One might speculate that, like the rape victims counselled to believe that this was an event beyond their control described by Janoff-Bulman²⁹⁹ above, the thought of the unjust world may drive members of families where there is Schizophrenia to prefer counterfactual thinking. If so, then this must be recognised within the psychoeducational programme and element of attribution change strategy incorporated as Barrowclough, Johnston, and

²⁹⁹ Janoff-Bulman, R. (1979) "Characterological Versus Behavioral Self-Blame: Inquiries into Depression and Rape." Journal of Personality and Social Psychology. Vol. 37, No. 10, pp 1798-1809.

Tarrier's³⁰⁰ work has already suggested. There is a limited amount of literature on how to change attribution in self blamers that is of relevance.

Sober-Ain and Kidd³⁰¹ looked at the feasibility of changing casual beliefs in people with self blaming tendencies. They replicated findings by Ickes and Layden (in Harvey, Ickes and Kidd eds.³⁰²) that self blaming tendencies tend to be remarkably resistant to change. The most effective method was "supportive suggestion" in which the therapist encouraged internal attribution for positive events and external attribution for negative events. The therapist tried to communicate understanding of subject's experiences and customary self blaming, supportively discounting the subject's self blaming, emphasising evidence for self enhancing ideas and emphasising self enhancing explanations for the subject's events. This "Supportive Suggestion package" appeared to be more effective than uniform instruction to take responsibility for positive but not negative events and "appreciative attention" in which subjects were asked to identify causes of positive and negative events in their lives. As in EBP professionals, the area of how attributions can be changed in the

³⁰⁰ Barrowclough, C, Johnston, M and Tarrier, N. (1994) "Attributions, Expressed Emotion and Patient Relapse: An Attributional Model of Relatives' Response to Schizophrenic Illness." Behaviour Therapy. Vol. 25, pp 67-88.

³⁰¹ Sober-Ain, L and Kidd, R F. (1984) "Fostering Changes in Self-Blamers' Beliefs About Causality." Cognitive Therapy and Research. Vol. 8, No. 2, pp 121-138.

³⁰² Harvey, J, Ickes W J and Kidd, R eds. 1978. "New Directions in Attributional Research (Volume 2)". Earlbaum,, Hillsdale, New Jersey.

context of families with a mentally ill member is under researched and is in need of further study.

Another assumption in the research is that although burden is acknowledged, the focus on the family is in terms of the impact on the member with Schizophrenia. The research on Expressed Emotion, understandably on one level, does not take cognizance of the other family members' reactions and feelings for their own sake. One wonders whether this causes resentment; whether the family members, not only in that type of study but in general contact with mental health care professionals, feel that they are in a patient centred system and *their* own cares and feelings are at best seen as being peripheral or at worst irrelevant? There may be an analogy with the growing discontent amongst crime victims that they are ignored in an offender centred process.

Finally, perhaps it is worth reminding ourselves of the literature mentioned in the Introduction to Part Two of this thesis on the needs expressed by the family members themselves contrasted with the professionals' assumptions about what the family wanted.

McElroy's³⁰³ study showed that families rated updates on research as a high priority along with information on medication. The major areas of concern, for the families, were suicidal,

³⁰³ McElroy, E M (1985) "A comparison of families' and nurses' perceptions of the educational needs of the families of the seriously mentally ill." Paper presented at the 6th Annual Psychiatric Nursing Professional Day, Brattleboro, Vermont.

aggressive and violent behaviour and information on how to cope with these situations would be welcome. Holden and Lewine³⁰⁴ showed that when family members did find contact with professionals useful the positives of the contact included increasing self confidence, understanding of Schizophrenia and learning coping strategies. Where family members were dissatisfied in information provided it was mostly because the information provided was insufficient, either too vague or not thorough enough. It was only a tiny minority who found the information too technical.

This raises an issue that neither this study or the previous research referred to can answer. When we design informational packages for parents and other family members, are we underestimating the capacity of the family to understand the real complexities of the issues? Do we fail to present the many unknowns that far outnumber the known facts about Schizophrenia, and present an inaccurate picture of the real state of knowledge? If we are doing so, do we do so more for our benefit than for theirs? Perhaps the family members' capacity for understanding the complexities of the clinical issues associated with Schizophrenia would be an interesting subject for future research, along with investigating whether there is a difference between what professionals believe about Schizophrenia and what they tell the families.

³⁰⁴ Holden, D F and Lewine, R J (1982) "How families evaluate mental health professionals, resources and effects of illness." Schizophrenia Bulletin. Vol. 8, no 4, pp 626-633.

SUMMARY AND CONCLUSION

In the first part of this thesis, the evidence for an organic model or models for Schizophrenia, or a number of separate disorders that we may think of collectively as the Schizophrenias, was reviewed. Then the history of psycho-social models of Schizophrenia was also reviewed and an explanation was provided of how these models held sway till comparatively recently despite the paucity of evidence to support them.

Explanations of why the psychosocial perspective did maintain its ascendancy included the influences of a view of mind originating in German Romanticism that dominated Nineteenth Century German psychiatry and passed virtually unchanged into Freud's theories. This was contrasted with the newer German experimental psychology owing its origins to the pioneering work of Wundt but having its most profound impact in the work of Kraepelin. For Kraepelin, dementia praecox, or Schizophrenia as we now call it, was a disease of the brain not the mind. In the terms used in Nineteenth Century German psychiatry, Freud represented the psychiatrist tradition while Kraepelin represented the somaticist position.

The author then had to explain the success, in the English speaking world, of Freud's theories. At the end of the Nineteenth Century, one of the dominant theories of madness was Morel's moral degeneration hypothesis, an essentially Lamarckian inheritance model which offered little but therapeutic pessimism.

Morel's model fuelled an already anxious debate about the rising numbers of the insane. Morel's followers included, amongst others, the influential English psychiatrist, Henry Maudsley. The ascendancy of neurology, particularly in the United States at the turn of the century, added greatly to knowledge but offered little in terms of treatment. To this, Freud brought a reversion back to mental diseases as diseases of mind with a therapeutic methodology.

There were several elements to Freud's theories which would always appeal to a wider audience including the titillation of the sexual elements and a theory that was couched in terms of and owed more to the arts than the sciences, thus making it more accessible to the lay reader. The First World War with its large number of the "shell shocked", for which conventional psychiatry seemed to have little to offer, was also an area in which psychoanalysis made claims for its efficacy. Psychodynamic psychology also promised, for the first time since the early days of moral therapy, a central role for lay therapists in the emerging professions of social work, psychology and counselling - challenging areas which had hitherto been the sole domain of the medically trained.

Bleuler³⁰⁵ was the pivotal figure in attempting to unite the two traditions embodied by Kraepelin and Freud into a unified model of Schizophrenia. In doing so, he sowed the seed, in the United

³⁰⁵ Bleuler, E. (1924) Textbook of Psychiatry. Translated A A Brill. Macmillan. New York.

States at least, of diagnostic criteria for Schizophrenia that were too wide and also established a basis for implicating parents, in some cases, in the cause of the illness. Despite the fact that Bleuler later felt that Schizophrenia was entirely biological in origin and probably inherited, the influence of his earlier thinking predominated in America until comparatively recently.

In 1948 Fromm-Reichmann published her paper on the "Schizophrenogenic Mother" describing a specific parent type likely to cause Schizophrenia in her child. Other pathogenic parenting theories followed, some in the psychoanalytical tradition, like Fromm-Reichmann, others in the newly emerging field of systems theory. Most of, though not all of, these theories emerged from the United States in the 1940s and 1950s. It may not be coincidental that these theories emerged in the aftermath of the Second World War and the "Cold War". At the end of the Second World War an army of demobbed men returned to the labour market to find jobs that, during the course of the war, had been held by women. Theories that stressed the importance of the mother's role and the consequences of bad mothering, including future mental illness, in the child would also discourage working mothers. Freud's own view of the role of women never progressed beyond his own childhood background of the middle European bourgeois household, the women's role in terms of "Kinder, Kuche und Kirche".

Support for Freudian and other psychodynamic models in the USA

in the late 1940s and 1950s may have also received support from the prevailing atmosphere during the "Cold War". The popularity of Romanticism in the late Eighteenth and early Nineteenth Century German states has been attributed, in part, to the repression of political debate at the time. Unable to discuss the significant events of the times, the French Revolution and its sequelae, the middle classes and the intelligencia turned inward instead. It could be argued that, a century and a half later, the same situation pertained in the United States with the impossibility of any dispassionate debate of the rise of communism and the relative merits of communism to capitalism. Once again, one can see the focus shifting from the outer to the inner world. Psychoanalysis, ostensibly a-political, was, in many ways, deeply conservative. It was the individual who had to change to fit his or her circumstances, the family and family relations were seen as being given and to be adapted to; there was no agenda for radically changing society; it fitted the mood of American society perfectly!

The contributions of the "anti-psychiatry" theorists in particular, focusing on the contribution of R D Laing has been reviewed. In a sense although Laing was not always the most coherent of theorists his attitude to the family and society was revolutionary. Of course he was most remembered for blaming the family for causing mental illness but not just individual families and family members but the institution of the family itself. Laing saw the mad as visionaries, heroic explorers of the transcendental and, an amateur artist himself, saw the importance of the

arts in exploring and explaining the experience of madness. As such, Laing was a direct heir to the German Romantic tradition.

Expressed Emotion (EE) theory, a theory that implicates the family in the course, rather than the cause, of Schizophrenia was developed in opposition to the position of Laing and other pathogenic parenting theorists. The stated position of many of the EE theorists is that the family is a valued resource in maintaining the patient in the community, and later variations of the theory view hostile or over protectiveness as at least understandable if undesirable effects of the family's predicament.

The claim of EE theorists to be non-blaming and to distance themselves from pathogenic parenting models was explored in more detail in the second part of the thesis. In Part Two the literature on the perspective of parents and other relatives of persons with Schizophrenia was reviewed. This literature, sometimes illustrated with telling first hand accounts, presented a picture of families sometimes under extreme stress, often neglected and sometimes mishandled by mental health care professionals. An apposite phrase was that the family members and professionals: "marched to the beat of a different drummer". Issues of guilt and being blamed or feeling blamed seemed to hint at a legacy of the pathogenic parenting models.

The empirical component of the thesis involved in depth inter-

views with parents of thirty patients with Schizophrenia, twenty-two from Rampton Hospital and eight from the catchment area of Bassetlaw District General Hospital. The interview consisted of a structured component and a tape recorded focused interview on the parents' experiences with their son or daughter's illness. The main areas explored in the structured component were the subjects' views on the aetiology of, and their sources of information on, Schizophrenia and issues of degree of burden and stress. The tape recorded interview was analyzed not only for these issues but also for quantity and quality of contact with mental health care professionals, their information giving and issues of blame and guilt.

The results showed high levels of stress in both groups. There was a paucity of information giving in the areas of diagnosis, nature of the disorder and treatment. Some of the examples of information being given were poor and misleading. A sense of guilt for causing the disorder was also a significant factor but this was in the absence of particularly high levels of being blamed by professionals and sometimes in the presence of being specifically counselled by professionals not to blame themselves.

The theoretical position that best made sense of these findings was Attribution Theory. The impact of this approach in the context of rape victims, families of homicide victims, patients with spinal injuries and mothers of children with disabilities were reviewed. All these studies refer to findings of self-blame but there is an interesting differentiation between characterol-

ogical self blame ("this thing happened to me because of the sort of person I am") and behavioural self blame ("if I hadn't have done X or Y this wouldn't have happened to me"). The first form of self blame is associated with poor post catastrophe adjustment whereas the second, even when the self-blame is counterfactual, is associated with better outcome. The implication for those counselling such persons is that to avoid discussion of causation or to couch causative explanations in terms of events beyond anybody's control may not be helpful. Behavioural self-blame may be positive if it gives the victim the sense that he or she might prevent a re-occurrence or gain control of the consequences by altering patterns of behaviour. Another important component is the sense of a "Just world", a belief that we get what we deserve and we deserve what we get. After a catastrophe, the victim may re-evaluate him or herself and be re-evaluated by others. This primitive causal model may be unjust and unfair but may present a better model for many people than the fact that on a personal level the world may be a frighteningly random place. If one sees the parents of people with Schizophrenia researched in this and other studies as the victims of, often, a devastating situation, and if one also takes into account the paucity of information that patients' parents seem to be given, Attribution Theory may well shed light on their experiences and make sense of the finding of guilt in the absence of blame.

The author returned to the subject of Expressed Emotion Theory. Best evidence (the Cochrane meta-analysis) showed that although family intervention did have an impact on relapse, the impact

rate was such as to raise cost benefit questions about the approach. In terms of the education content of the studies that were reviewed, it was difficult to identifying precisely what aetiological models were being presented to the family members and whether issues of attribution may be compromising the success of this approach. More serious were the accusations made by critics of Expressed Emotion who argued that Expressed Emotion theory was, notwithstanding the claims to the contrary by its supporters, a continuation of the pathogenic parenting position. Even if high EE in professionals may be an equal if not more important factor in relapse, this was under researched. One author alleged that professionals working in this field still had no real comprehension of the burden and difficulties of living with Schizophrenia. Another author saw Expressed Emotion Theory as an attempt by the medical profession to regain hegemony over the treatment of mental illness following the challenge of the anti-psychiatry movement.

The author also argued that if psychoeducation was to continue with parents and other family members, either for its own sake to relieve the distress of the family or for the sake of the family member with Schizophrenia to avoid relapse, two factors should be taken into consideration. The first is to consider seriously the implication of research into Attribution Theory in the context of catastrophe survivors and to see what lessons the limited literature on changing attribution might provide. The second is to look closely on the research that has already been done on what information the families say they need rather than

information needs that professionals attribute to families.

On a more general level, there are important lessons for all those working in the Mental Health professions.

It is vital to communicate more informatively and more frequently with the family and other significant persons in the patient's life. We must be aware that there is a great need for more information to be given to those caring for the mentally disordered. It is wrong to assume that carers are incapable of understanding information, even when it is of a technical nature. Such an approach by mental health care professionals may well invite requests for further information or disagreement; by sharing knowledge, the professional may be sharing some of his/her power, but it is in the nature of forming a partnership that power must be ceded and shared.

Professionals must become more aware of their profession's history. In doing so, they would become aware of how much their current thinking has been shaped by past ideas, and ideas that may have outlived their usefulness; they would also become aware of how ideas can be shaped as much by political and social forces as by dispassionate research. Perhaps the most important lesson to be learned is how ideas have been adopted, often with great passion, that are not only wrong or poorly supported by evidence but also damaging. In the context of this thesis, we see how damaging this may have been in the past to the parents of persons with Schizophrenia, and may still be today.

BIBLIOGRAPHY

Achte, R and Taylor, M A. (1976) "Catatonia: a prospective clinical study." Archives of General Psychiatry. Vol. 33, pp 579-581.

Affleck, G, McGrade, B J, Allen, D A and McQueeney, M. (1985) "Mothers' Beliefs About Behavioural Cause for Their Developmentally Disabled Infant's Condition: What Do They Signify?" Journal of Paediatric Psychology. Vol. 10, No 3, pp 293-303.

Alexander, F G and Selesnick, S T. (1967) The History of Psychiatry: An evaluation of psychiatric thought and practice from prehistoric times to the present. George Allen and Unwin. London.

American Psychiatric Association (1994) Diagnostic and Statistical manual of Mental Disorders, Fourth Edition. The American Psychiatric Association. Washington, DC.

Angermeyer, M C and Matschinger, H. (1994) "Lay beliefs about schizophrenic disorder: the results of a population survey in Germany" Acta Psychiatrica Scandinavica. Vol. 89 (supplement 382), pp 39-45.

Atkinson, J M. (1986) Schizophrenia at Home. A Guide to helping the Family. Croom Helm. Beckenham.

Axline, V (1964) Dibs, In Search of Self. Pelican. London.

Bagley, C. (1971) "The social aetiology of schizophrenia in immigrant groups." International Journal of Social Psychiatry. Vol. 17, pp 292-304.

Barr, C E, Mednick, S A and Munk-Jorgensen, P. (1990) "Exposure to Influenza Epidemics During Gestation and Adult Schizophrenia." Archives of General Psychiatry. Vol. 47, pp 869-874.

Barrowclough, C, Johnston, M and TARRIER, N. (1994) "Attributions, Expressed Emotion and Patient Relapse: An Attributional Model of Relatives' Response to Schizophrenic Illness." Behaviour Therapy. Vol. 25, pp 67-88.

Barrowclough, C, TARRIER, N, Watts, S, Vaughn, C, Bamrah, J S and Freeman, H. (1987) "Assessing the functional value of relatives' knowledge about schizophrenia: a preliminary report." British Journal of Psychiatry. Vol. 151, pp 1-8.

Bartlett, N (1989) "Agreeing to differ." Community Care. 20th of July, pp 17-19.

Bateson, G, Jackson, D, Haley, J and Weakland, J. (1956) "Towards a Theory of Schizophrenia." Behavioral Science. Vol. 1, p 251.

Bebbington, P and Kuipers, L (1994) "The predictive utility of expressed emotion in schizophrenia: and aggregate analysis." Psychological Medicine. Vol. 24, pp 707-718.

- Bentall, R. ed. (1990) Reconstructing Schizophrenia. Routledge. London.
- Berkowitz, R, Eberlein-Fries, R, Kuipers, L and Leff, J. (1984) "Educating relatives about schizophrenia." Schizophrenia Bulletin. Vol. 10, pp 418-429.
- Bernal, J D. (1965) Science in History. C A Watts. London.
- Berrios, G E and Hauser, R. (1988) "The early development of Kraepelin's ideas on classification: a conceptual history." Psychological Medicine. Vol. 18, pp 813-821.
- Bleuler, E. (1924) Textbook of Psychiatry. Translated A A Brill. Macmillan. New York.
- Bleuler, E. (1950) Dementia Praecox or the Group of Schizophrenias. Translated by J Zinkin. International University Press. New York.
- Brenner, M, Brown, J and Canter, D. (1985) The Research Interview: Uses and Approaches. Academic Press. London.
- Brown, G W, Birley, J L T and Wing, J K. (1972) "Influence of family life on the course of schizophrenic disorders: replication." British Journal of Psychiatry. Vol. 121, pp 241-258.

Brown, G W, Carstairs, G M and Topping, G. (1958) "Post-hospital adjustment of chronic mental patients." Lancet. Vol. II, pp 685-689.

Burke, A W. (1974) "First admission and planning in Jamaica." Social Psychiatry. Vol. 123, pp 109-111.

Burton, R. (1977, first published 1621) The Anatomy of Melancholy. J M Dent. London.

Butterworth, J S and Reppert, E H. (1960) "Auscultatory Acumen in the general Medical Population." Journal of the American Medical Association. Vol. 174, pp 32-34.

Bynum, W F. (1984) "Alcoholism and Degeneration in 19th Century European Medicine and Psychiatry." British Journal of Addiction. Vol. 79, pp 59-70.

Cape, G S, Antebi, D, Standen, P and Walden, C (1994) "Schizophrenia - The views of a sample of psychiatrists." Journal of Mental Health. Vol. 3, pp 105-113.

Castaneda, D and Sommer, R (1989) "Mental Health Professionals' Attitudes Toward the Family's Role in Care of the Mentally Ill." Hospital and Community Psychiatry. Vol. 40, no 11, pp 1195-1197.

Chadwick S (1992) "My patient wants to kill himself. Hospital, help!" The Independent. 7th of April, p 19.

The Child, the Family and the Young Offender. (1965) HMSO.
London.

The Children and Young Persons Act. (1963) HMSO. London.

Clare, A. (1980) Psychiatry in Dissent. Controversial Issues in Thought and Practice. Second Edition. Tavistock Publications.

Clardy, E R A. (1951) "A study of the development and course of schizophrenic children." Psychiatric Quarterly. Vol. 25, pp 81-90.

Clouston, T S. (1891) "Asylum Reports." Journal of Mental Science. Vol. 37, pp 598-599.

Cochrane, R. (1977) "Mental illness in immigrants to England and Wales." Social Psychiatry. Vol. 12, pp 25-35.

Cohen, I M ed. (1966) "Family structure dynamics and therapy." Psychiatric Research Reports of the American Psychiatric Association. No 20.

Cooper, J E (ed) (1994) The Pocket Guide to the ICD-10 Classification of Mental and Behavioural Disorders. Churchill Livingstone. Edinburgh.

Cooper, J E, Kendell, R E, Gurland, B J, Sharpe, I,
Copeland, J R M and Simon, R. (1972) Psychiatric Diagnosis in New
York and London. Oxford University Press. London.

Creer, C and Wing, J. (1975) "Living with a Schizophrenic
Patient". British Journal of Hospital Medicine. Vol. 14, p 73.

Crow, T J (1980) "Molecular pathology of schizophrenia: More than
one disease process?" British Medical Journal. Vol. 280, pp 66-
68.

Daley, L E, Bourke, G J and McGilvray (1995) Interpretation and
Uses of Medical Statistics. Blackwell Science. Oxford.

Dearth, N, Labenski, B J, Mott, M E and Pellegrini, L M (1986)
Families Helping Families: Living with Schizophrenia. W W Norton.
London.

Deasy, L C and Quinn, O W. (1955) "The Wife of the Mental Patient
and the Hospital Psychiatrist" Social Issues. Vol. 11, pp 49-60.

DePauw, K W and Szulecka, T K (1988) "Dangerous Delusions.
Violence and the Misidentification Syndromes." British Journal
of Psychiatry. Vol. 152, pp 91-96.

Der, G, Gupta, S and Murray, R M. (1990) "Is Schizophrenia
disappearing?" The Lancet. Vol. 335, pp 513-516.

Despert, L J. (1938) "Schizophrenia in Children." Psychiatric Quarterly. Vol. 12, pp 366-371.

Doerner, K. (1981) Madmen and the Bourgeoisie. A Social History of Insanity and Psychiatry. Basil Blackwell. Oxford.

Doll, W (1976) "Family coping with the mentally ill: an unanticipated problem of deinstitutionalization." Hospital and Community Psychiatry. Vol. 27, no 3, pp 183-185.

Earle, P. (1887) "The curability of insanity." American Journal of Insanity. Vol. 33, pp 483-533.

Falloon, I R H (1988) "Expressed emotion: current status." Psychological Medicine. Vol. 188, pp 269-274.

Falloon, I R H, Boyd, J L, McGill, C W, Williamson, M, Razani, J, Moss, H B, Gilderman, A M and Simpson, G M. (1985) "Family management of Schizophrenia, a Two-Year Longitudinal Study." Archives of General Psychiatry. Vol. 42, pp 887-896.

Falloon, I R H and Pederson, J. (1985) "Family Management in the Prevention of Morbidity of Schizophrenia: The Adjustment of the Family Unit." British Journal of Psychiatry. Vol. 147, pp 156-163.

Ferreira, A J and Winter, W D. (1965) "Family Interactions and Decision Making." Archives of General Psychiatry. Vol. 13, pp 214-223.

Ferreira, A J, Winter, W D and Poindexter, E. (1966) "Some interactional variables in normal and abnormal families." Family Process. Vol. 5, pp 60-75.

Fischer, M. (1973) "Genetics and Environmental Factors in Schizophrenia." Acta Psychiat Scand (Supplement). Vol. 238:1.

Foucault, M. (1971) Madness and Civilization: A History of Insanity in the Age of Reason. Tavistock. London.

Freeman, R V and Grayson, H M. (1955) "Maternal attitudes in schizophrenia." Journal of Abnormal and Social Psychology. Vol. 50, pp 45-52.

Freeman, T. (1977) "On Freud's theory of schizophrenia." International Journal of Psycho-Analysis. Vol. 58, pp 383-388

Freud, S. (1957) On the History of the Psycho-Analytic Movement. Hogarth Press. London.

Freud, S (1963) The Standard Edition of the Complete Psychological Works of Sigmund Freud. Strachey, J and Freud, A (eds). The Hogarth Press and the Institute of Psychoanalysis. London.

Friedan, B. (1963) The Feminine Mystique. Victor Gollanz. London.

Fromm-Reichmann, F. (1948) "Notes on the Development of Treatment of Schizophrenics by Psychoanalytical Psychotherapy." Psychiatry. Vol. 11, pp 263-273.

Gardner, G G. (1967) "The role of maternal psycho-pathology in male and female schizophrenics." Journal of Consulting Psychology. Vol. 31, pp 411-413.

Gerard, D L and Siegel, J. (1950) "The family background of schizophrenia." Psychiatric Quarterly. Vol. 24, pp 47-73.

Getzel, G S and Masters, M (1984) "Serving Families Who Survive Homicide Victims" Social Casework: The Journal of Contemporary Social Work. Vol. 65, Part 3, pp 138-144.

Gilbert, P, Pehl, J and Allen, S. (1994) "The phenomenology of shame and guilt: An empirical investigation." British Journal of Medical Psychology. Vol. 67, pp 23-36.

Gilling, I. (1715) The Life of the Rev. Geo. Trosse.
Late Minister of the Gospel in Exon. John Clarke. London.

Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Doubleday. New York.

- Goleman, D. (1990) "New Paths to Mental Health Put Strains on Some Healers." New York Times. 17th May.
- Grad, J and Sainsbury, P (1963) "Mental illness and the family." The Lancet. Vol. 1, pp 544-547.
- Green, Hannah (1964) I Never Promised You a Rose Garden. A Novel. Rinehart and Winston. New York.
- Grell, C E and Grusky, O (1989) "Families of the seriously mentally ill and their satisfaction with services." Hospital and Community Psychiatry. Vol. 40, no 8, pp 831-835.
- Griesinger (1965) Mental Pathology and Therapeutics. A Facsimile of the English Edition of 1867. Hafner. New York.
- Grimes, K and Walker, E F (1994) "Childhood Emotional Expressions, Educational Attainment, and Age at Onset of Illness in Schizophrenia." Journal of Abnormal Psychology. Vol. 103, No. 4, pp 784-790.
- Gulotta, G and de Cataldo Neuberger, L (1983) "A Systematic and Attributional Approach to Victimology." Victimology: An International Journal. Vol. 8, No. 1-2, pp 5-16.
- Hajdu-Gaines, L. (1940) "Contributions to the aetiology of schizophrenia." Psychoanalytical Review. Vol. 27, pp 421-438.

Haley, J. (1968) "Testing parental instructions to schizophrenic and a normal children: a pilot study." Journal of Abnormal Psychology. Vol. 73, pp 559-565.

Hamilton, M (ed). (1967) Abnormal Psychology. Penguin Modern Psychology.

Hare, E. (1983) "Was Insanity on the Increase?" British Journal of Psychiatry. Vol. 142, pp 439-455.

Hare, E. (1988) "Schizophrenia before 1800? The case of the Revd George Trosse." Psychological Medicine. Vol. 18, pp 279-285.

Harrison, G, Owens, D, Holton, A, Neilson, D and Boot, D. (1988) "A prospective study of severe mental disorder in Afro-Caribbean patients." Psychological Medicine. Vol. 18, pp 643-657.

Harvey, J, Ickes W J and Kidd, R (Eds) New Directions in Attributional Research (Volume 2). Earlbaum, Hillsdale, New Jersey

Hatfield, A B (1977) "Mental illness: Impact on the family." Paper presented at the 54th Annual Meeting of the American Orthopsychiatric Association, New York.

Hatfield. A B (1978) "Psychological costs of schizophrenia to the family." Social Work. September, pp 355-359.

Hatfield, A B (1987) "The Expressed Emotion Theory: Why Families Object" Hospital and Community Psychiatry. Vol. 38, No 4, p 341.

Hatfield A B and Lefley, H P ed. (1987) Families of the Mentally Ill: Coping and Adaption. Cassell. London.

Henry, J. (1973) Pathways to Madness. Vantage Books. London.

Hirsch, S R and Leff, J P. (1971) "Parental abnormalities of verbal communication in the transmission of schizophrenia." Psychological Medicine. Vol. 1, pp 118-127.

Hirsch, S R and Leff, J P. (1975) "Abnormalities in Parents of Schizophrenics." Institute of Psychiatry Maudsley Monograph. No 22.

Hirsch, S and Shepherd, M. (1957) Themes and Variations in European Psychiatry. John Wright. Bristol.

Hogarty, G E, Anderson, C M, Reiss, D J, Kornblith, S J, Greenwald, D P, Ulrich, R F and Carter, M. (1986) "Family Psychoeducation, Social Skills Training, and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia.

I. One-Year Effects of a Controlled Study on Relapse and Expressed Emotion." Archives of General Psychiatry. Vol. 43, pp 633-642.

Hogarty, G E, Anderson, C M, Reiss, D J, Kornblith, S J, Greenwald, D P, Ulrich, R F and Carter, M. (1991) "Family Psychoeducation, Social Skills Training, and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia.

II. Two-Year Effects of a Controlled Study on Relapse and Adjustment." Archives of General Psychiatry. Vol. 48, pp 340-347.

Holden, D F and Lewine, R J (1982) "How families evaluate mental health professionals, resources and effects of illness." Schizophrenia Bulletin. Vol. 8, no 4, pp 626-633.

Howe, D. (1987) An Introduction to Social Work Theory. Wildwood House. Aldershot.

Howe, D. (1989) The Consumers' View of Family Therapy. Gower. Aldershot.

Hunter, R. (1972) "Psychiatry and Neurology. Psychosyndrome or Brain disease." Proceedings of the Royal Society of Medicine. Vol. 66, pp 359-364.

Jackson, D D. (1957) "A Note on the Importance of Trauma in the Genesis of Schizophrenia." Psychiatry. Vol. 20, pp 181-184.

Janoff-Bulman, R. (1979) "Characterological Versus Behavioral Self-Blame: Inquiries into Depression and Rape." Journal of Personality and Social Psychology. Vol. 37, No. 10, pp 1798-1809.

Jarvis, E. (1852) "On the supposed increase in insanity."
American Journal of Insanity. Vol. 8, pp 333-364.

Jasper, K. (1963) General Psychopathology. trans. Hoeri, J. &
Hamilton, M W. Manchester University Press. Manchester.

Jeste, D V, del Carmen, R, Lohr, J B and Wyatt, R J. (1985)
"Did Schizophrenia Exist Before the Eighteenth Century?"
Comprehensive Psychiatry. Vol. 26, No. 6, pp 493-503.

Johnson, E. (1961) Acute hallucinosis, paranoid reactions and
schizophrenia as psychosis in alcoholic patients." Acta Societas
Medicorum Upsaliensis. Vol. 66, pp 105-128.

Johnstone, L. (1993) "Family management in "schizophrenia": its
assumptions and contradictions." Journal of Mental Health. Vol.
2, pp 255-269.

Johnstone, L. (1994) "Reply to Leff and Vaughn." Journal of
Mental Health. Vol. 3, pp 117-118.

Jones, E. (1953) The Life and Work of Sigmund Freud Vol. 1.
Basic Books. New York

Jones, K. (1955) Lunacy, Law and Conscience 1744-1845. Routledge
and Kegan Paul. London.

Jones, R. (1906) "The evolution of insanity." Journal of Mental Science. Vol. 52, pp 629-661.

Kallman, F J. (1938) The Genetics of Schizophrenia. J Augustin. New York.

Kaplan, H I and Sadock, B J. (1989) Comprehensive Textbook of Psychiatry Volume 1. Fifth Edition. Williams and Wilkins. Baltimore.

Kasanin, J, Knight, E and Sage, P. (1934) "The parent-child relationship in schizophrenia." Journal of Nervous and Mental Diseases. Vol. 79, pp 249-263.

Katschnig H and Konieczna, T. (1989) "What Works in Work with Relatives? - A Hypothesis". British Journal of Psychiatry. Vol. 155 (Supplement 5). pp 144-150.

Katz, M, Cole, J O and Lowry, H A. (1969) "Studies of the Diagnostic Process: the Influence of Symptom Perception, Past Experience and Ethnic Background on Diagnostic Decisions." American Journal of Psychiatry. Vol. 125, pp 937-947.

Kendell, R E, Pichot, P and Von Cranach, M. (1974) "Diagnostic Criteria of English, French and German Psychiatrists." Psychological Medicine. Vol. 4(2), pp 187-195.

Kennard, M A. (1936) "Age and other factors in motor recovery from precentral lesions in monkeys." American Journal of Physiology. Vol. 115, pp 138-146.

Kidder, L H, Judd, C M and Smith, E R. (1986) Research Methods in Social Relations. CBS Publishing Japan Ltd.

Kohn, M and Clausen, J A. (1956) "Parental authority behaviour and schizophrenia." American Journal of Orthopsychiatry. Vol. 26, pp 297-313.

Kornblum, H and Anderson, B. (1982) "'Acceptance" Reassessed - A Point of View" Child psychiatry and Human Development. Vol. 12, No 3, pp 171-178.

Kosky, R. (1986) "From Morality to Madness; Reappraisal of the Asylum Movement in Psychiatry 1800-1940." Australian and New Zealand Journal of Psychiatry. Vol. 20, pp 180-187.

Kreisman, D E and Joy, V D (1974) "Family response to mental illness of a relative: a review of the literature." Schizophrenia Bulletin. Issue 10, pp 34-57.

Kroll, J and Bachrach, B. (1984) "Sin and Mental Illness in the Middle Ages". Psychological Medicine. Vol. 14, pp 507-514.

Krupinski, J. (1967) "Sociological aspects of mental ill-health in migrants." Social Science and Medicine. Vol. 1, pp 267-281.

Laing, R D. (1960) The Divided Self: a Study of Sanity and Madness. Quadrangle. Chicago.

Laing, R D. (1967) The Politics of Experience and the Birds of Paradise. Penguin. London.

Laing, R D and Esterson, A. (1970) Sanity, Madness and the Family. Penguin. London.

Lane, R C and Singer, J L. (1957) "Familial attitudes in paranoid schizophrenics and normals from two socio-economic classes." Journal of Abnormal and Social Psychology. Vol. 59, pp 328-339.

Leff, J, Berkowitz, R, Shavitt, N, Strachan. A, Glass, I and Vaughn, C (1989) "A trial of family therapy v a relatives' group for schizophrenia." British Journal of Psychiatry. Vol. 154, pp 58-66.

Leff J, Kuipers, I, Berkowitz, R, Eberlein-Vries, R and Sturgeon, D. (1982) "A Controlled Trial of Social intervention in the Families of Schizophrenic Patients." British Journal of Psychiatry. Vol. 141, pp 121-134.

Leff J, Kuipers, I, Berkowitz, R and Sturgeon, D. (1985) "A Controlled Trial of Social intervention in the Families of Schizophrenic Patients: two Year Follow-up." British Journal of Psychiatry. Vol. 146, pp 594-600.

Leff, J and Vaughn, C. (1994) "Critics of family management in schizophrenia: their assumptions and contradictions."

Journal of Mental Health. Vol. 3, pp 115-116.

Levy, D M. (1931) "Maternal overprotection and rejection."

Archives of Neurological Psychiatry. Vol. 25, pp 886-889.

Lewis, S W. (1989) "Congenital risk factors for schizophrenia."

Psychological Medicine. Vol. 17, pp 5-13.

Lewis V S and Zeichner, A M (1960) "Impact of admission to a mental hospital on the patient's family." Mental Hygiene. Vol. 44, pp 503-509.

Lidz, T, Fleck, S and Cornelison, A R. (1964) Schizophrenia and the Family. International University Press. New York.

Lief, A ed. (1948) The Commonsense Psychiatry of Dr Alfred Meyer. McGraw-Hill. New York.

Littlewood, R and Lipsedge, M. (1981) "Some social and phenomenological characteristics of psychotic immigrants." Psychological Medicine. Vol. 11, pp 289-302.

The Local Authority Social Services Act. (1970) HMSO. London.

London, N J. (1973) "An essay on psychoanalytic theory: Two theories of schizophrenia. Part 1: A review and critical assessment of the development of the two theories." International Journal of Psycho-Analysis. Vol. 54, pp 169-178.

Lorr, M and Klett, C J. (1967) Inpatient Multidimensional Psychiatric Scale. Consulting Psychologists' Press. Palo Alto.

Lu, Y-C. (1964) "Mother-child role relations in schizophrenia." Psychiatry. Vol. 24, pp 133-142.

Mari, J J and Streiner, D (1996) "Family intervention for those with schizophrenia." The Cochrane Library (CD). Issue 3.

Mark, J C. (1953) "The attitudes of the mothers of male schizophrenics towards child behaviour." Journal of Abnormal and Social Psychology. Vol. 48, pp 185-189.

Masson, J M. (1985) The Assault on Truth. Penguin Books. London.

Maudsley, H. (1877) "The alleged increase of insanity." Journal of Mental Science. Vol. 23, pp 45-54.

McElroy, E M (1985) "A comparison of families' and nurses' perceptions of the educational needs of the families of the seriously mentally ill." Paper presented at the 6th Annual Psychiatric Nursing Professional Day, Brattleboro, Vermont.

McGhie, A A. (1961) "A comparative study of the mother-child relationship in schizophrenia." British Journal of Medical Psychology. Vol. 34, pp 195-208.

Meehl, P E. (1962) "Schizotaxia, schizotypy, schizophrenia." American Psychologist. Vol. 17, p 1.

McNeil, D E and Binder, R L (1994) "The relationship between acute psychiatric symptoms, diagnosis and short term risk of violence." Hospital and Community Psychiatry. Vol. 45:2, pp 133-137.

Menninger, K A. (1994, originally published 1925) "Influenza and Schizophrenia. An Analysis of Post-Influenzal 'Dementia Praecox', as of 1918, and Five Years Later. Further Studies of the Psychiatric Aspects of Schizophrenia." American Journal of Psychiatry. Vol. 151, Sesquicentennial Supplement.

Merquior, J G. (1991) Foucault. Fontana. London.

Minuchin, S (1983) Families and Family Therapy. Tavistock Publications. London.

Morrison, J R. (1974) "Changes in subtype diagnosis of schizophrenia 1920-1966." American Journal of Psychiatry. Vol. 131, pp 674-677.

Neill, J. (1990) "Whatever Became of the Schizophrenogenic Mother?" American Journal of Psychotherapy. Vol. 44, No. 4 pp 499-505.

O'Callaghan E, Larkin, C and Waddington, J L. (1990) "Obstetric complications in schizophrenia and the validity of maternal recall." Psychological Medicine. Vol. 20, pp 89-94.

Ødegaard, Ø. (1932) "Emigration and insanity. A study of mental disease among Norwegian population of Minnesota." Acta Psychiatrica et Neurologica. Supplement 4, pp 1-206.

Oelbaum, L R. (1972) "Clinical and moral views of madness: Laing and Goffman compared." Bulletin of the Menninger Clinic. Vol. 36, No 5, pp 487-504.

Office of Population Censuses and Surveys (1994) 1991 Census Economic Activity Great Britain. Volumes 1 and 2. HMSO. London.

Office of Population Census and Survey (1995) Social Trends, CD. HMSO, London

Olshansky, S. (1962) "Chronic Sorrow: A Response to Having a Mentally Defective Child" Social Casework. Vol. 43, pp 190-193.

O'Neal, P and Robins, L. (1958) "Childhood patterns predictive of adult schizophrenia: A 30-year follow-up study." American Journal of Psychiatry. Vol. 115, pp 385-391.

Orril, R and Boyers, R. (1972) Laing and Anti-Psychiatry. Penguin. Harmondsworth.

Otake, M and Schull, W J. (1984) "In utero exposure to A-bomb radiation and mental retardation: a reassessment." British Journal of Radiology. Vol. 57, pp 409-414.

Parker, G. (1982) "Re-Researching the Schizophrenogenic Mother." Journal of Nervous and Mental Diseases. Vol. 170, pp 452-462.

Pauley, P. (1983) "The political structure of the brain: cerebral localization in Bismarckian Germany." International Journal of Neuroscience. Vol. 21, pp 145-149.

Passamanick, B, Dinitz, S and Lefton, M. (1959) "Psychiatric Orientation and its Relation to Diagnosis and Treatment in a Mental Hospital." American Journal of Psychiatry. Vol. 116, pp 127-132.

Pearson, G, Treseder, J and Yelloly, M. (1988) Social Work and the Legacy of Freud. Psychoanalysis and its Uses. MacMillan Education. Basingstoke.

- Perfect, W. (1787) Select Cases in the Different Species of Insanity etc. Rochester. London.
- Peters, U H (1988) "Die Deutsche Scizophrenielehre und die psychiatrische Emigration." Fortschritte der Neurologie Psychiatrie. Vol. 56, no 11, pp 347-360. Translation C Bell.
- Peters, U H (1990) Studies in German Romantic Psychiatry: Justinus Kerner as a Psychiatric Practitioner and E T A Hoffman as a Psychiatric Theorist. Bithell Memorial Lectures. Institute for Germanic Studies. University of London.
- Ping-Nie Pao. (1973) "Notes on Freud's theory of schizophrenia." International Journal of Psycho-Analysis. Vol. 54, pp 469-476.
- Popper, K R. (1972) Conjectures and Refutations: the Growth of Scientific Knowledge. Fourth Edition. Routledge and Kegan Paul. London.
- Popper, K R (1977) The Open Society and its Enemies. Volume 2 Hegel and Marx. Routledge and Kegan Paul. London.
- Rado, S. (1956) Psychoanalysis of Behaviour. Grune and Stratton. New York.
- Rakic, P and Riley, K P. (1983) "Regulation of axon number in primate optic nerve by prenatal binocular competition." Nature. Vol. 305, pp 135-137.

Rapp, D. (1988) "The reception of Freud by the British press: general interest and literary magazines, 1920-1925." Journal of the History of the Behaviourial Sciences. Vol. 24, pp 191-201.

Ratcliffe, P. (1981) Racism and reaction: a profile of Handsworth. Routledge and Kegan Paul. London.

Reichard, S and Tillman, C. (1950) "Patterns of parent-child relationship in schizophrenia." Psychiatry. Vol. 13, pp 247-257.

Ringuette, E and Kennedy, T. (1966) "An Experimental Study of the Double Bind Hypothesis." Journal of Abnormal Psychology. Vol. 71, pp 136-144.

Robertson, C L. (1869) "The alleged increase in lunacy." Journal of Mental Science. Vol. 15, pp 1-23.

Rojek, C, Peacock, G and Collins, S. (1988) Social Work and Received Ideas. Routledge. London.

Rosen, G. (1968) Madness in Society. Chapters in the Historical Sociology of Mental Illness. Routledge and Kegan Paul. London.

Rosenthal, D, Sadler, A and Edwards, W. (1987) "Families and Post-Traumatic Stress Disorder." Family Therapy. Vol. 22, pp 81-95.

- Rosenhan, D L. (1973) "On being sane in insane places." Science. 19th January, pp 281-288.
- Royes, K. (1962) "The incidence and features of psychoses in a Caribbean community." Proceedings of the Third World Congress of Psychiatry 1961, Montreal. Vol. 2, pp 1121-1125.
- Rutter, M, Bolton, P, Harrington, R, Le Couteur, A, MacDonald, H and Simonoff, E. (1990) "Genetic Factors in Child Psychiatric Disorders - I. A Review of Research Strategies." Journal of Child Psychology and Psychiatry. Vol. 31, No 1, pp 3-37.
- Rutter, M, Izard, C E and Read, P B eds. (1986) Depression in Young People: Developmental and Clinical Perspectives. Guildford Press. New York.
- Rycroft, C. (1971) Reich. Fontana. London.
- Sacks, O W. (1976) Awakenings. Penguin Books. Harmondsworth.
- Salmon, T (1992) "It's our son who is ill. Why won't doctors consult us?" The Independent. 6th of October, p 15.
- Sand, R. (1988) "Early Nineteenth Century Anticipation of Freudian Theory" International Review of Psycho-Analysis. Vol. 15, pp 465-479.

Savino, M T and Mills, A B. (1967) "The Rise and Fall of Moral Treatment in California Psychiatry: 1852-1870." Journal of the History of Behavioral Sciences. Vol. 3, No. 4, pp 359-369.

Sayers, J. (1992) Mothering Psychoanalysis. Penguin Books. London.

Schaffer, L, Wynne, L C, Day, J, Rycoff, I M and Halperin, A (1962) "On the nature and sources of the psychiatrist's experience with the family of the schizophrenic." Psychiatry. Vol. 23, pp 32-45.

Scheff, T J. (1966) Being Mentally Ill. a Sociological Theory. Aldine. Chicago.

Scull, A. (1981) Madhouses, Mad-Doctors and Madmen. The Social History of Psychiatry in the Victorian Era. The Athlone Press. London.

Sederer, L. (1977) "Moral Therapy and the Problem of Morale." American Journal of Psychiatry. Vol. 134, No. 3, pp 267-272.

The Seebhom Report. (1968) HMSO. London.

Shannon, D A. (1967) The Socialist Party of America. Quadrangle Books. Chicago.

Shaver, K G and Drown, D (1986) "On Causality, Responsibility, and Self Blame: A Theoretical Note" Journal of Personality and Social Psychology. Vol. 50, No 4, pp 697-702.

Skultans, V. (1975) Madness and Morals. Ideas of Insanity in the Nineteenth Century. Routledge and Kegan Paul. London.

Sober-Ain, L and Kidd, R F. (1984) "Fostering Changes in Self-Blamers' Beliefs About Causality." Cognitive Therapy and Research. Vol. 8, No. 2, pp 121-138.

Sontag, S. (1979) Illness as Metaphor. Penguin Books. London.

Sorensen Snyder, K, Wallace, C J, Moe, K and Liberman, R P (1994) "Expressed Emotion by residential Care Operators and Residents Symptoms and Quality of Life." Hospital and Community Psychiatry. Vol. 45, No 11, pp 1141-1143.

Stierlin, H. (1967) "Bleuler's Concept of Schizophrenia: A Confusing Heritage." American Journal of Psychiatry. Vol. 123, pp 996-1001.

Szasz, T. (1962) The Myth of Mental Illness. Secker and Warburg. London.

Szasz, T S. (1962) "Bootlegging humanistic values through psychiatry." Antioch Review. Vol. 22, pp 341-349.

Talbott, J A (1978) The Death of the Asylum: A Critical Study of State Hospital Management, Services, and Care. Grune and Stratton. New York.

Tarrier, N, Barrowclough, C, Vaughn, C, Bamrah, J S, Porceddu, K, Watts, S and Freeman, H. (1988) "The Community Management of Schizophrenia. A Controlled Trial of a Behavioral Intervention with Families to Reduce Relapse." British Journal of Psychiatry. Vol. 153, pp 532-542.

Tarrier, N, Barrowclough, C, Vaughn, C, Bamrah, J S, Porceddu, K, Watts, S and Freeman, H. (1989) "Community Management of Schizophrenia. A Two-Year Follow-Up of a Behavioral Intervention with Families." British Journal of Psychiatry. Vol. 154, pp 625-628.

Tarrier, N, Lowson, K and Barrowclough, C. (1991) "Some Aspects of Family Intervention in Schizophrenia. II: Financial Considerations." British Journal of Psychiatry. Vol. 159, pp 481-484.

Templer, D I and Veleber, D M. (1982) "The Decline of Hebephrenic Schizophrenia." Journal of Orthomolecular Psychiatry. Vol. 11 No. 2, pp 100-102.

Tennen, H, Affleck, G and Gershman, K. (1986) "Self-Blame Among Parents of Infants With Perinatal Complications: the Role of Self-Protective Motives." Journal of Personality and Social Psychology. Vol. 50, No. 4, pp 690-696.

Terkelsen, K (1983) "Schizophrenia and the Family II: Adverse Effects of Family Therapy". Family Process. Vol. 22, pp 191-200.

Tessler, R C, Gammache, G M and Fischer, G A (1991) "Patterns of contact of patients' families with mental health professionals and attitudes toward professionals." Hospital and Community Psychiatry. Vol. 42, no 9, pp 929-935.

Thompson, E H and Doll, W (1982) "The burden of families coping with the mentally ill: An invisible crisis." Family Relations. Vol. 31, pp 379-388.

Tienari, P, Sorri, A, Lahti, I, Naarala, M, Wahlberg, K E, Pohjola, J and Moring J. (1985) "Interaction of Genetic Psychosocial Factors in Schizophrenia." Acta Psychiat Scand (Supplement). Vol. 71:19.

Tietze, T. (1949) "A study of mothers of schizophrenic patients." Psychiatry. Vol. 12, pp 55-65.

Turnbull, A P and Turnbull, H R (1978) Parents Speak Out. Merrill. Columbus, Ohio.

Vaughn, C E and Leff, J P. (1976) "The measurement of expressed emotion in the families of psychiatric patients." British Journal of Social and Clinical Psychology. Vol. 15, pp 157-165.

Wahl, C W. (1954) "Some antecedent factors in the family history of 392 schizophrenics." American Journal of Psychiatry. Vol. 110, pp 668-676.

Wahl, C W. (1956) "Some antecedent factors in the family history of 568 male schizophrenics of the U.S. Navy." American Journal of Psychiatry. Vol. 113, pp 201-210.

Ward, C H, Beck, A T, Mendelson, M, Mock, J E and Erburgh, J K. (1962) "The Psychiatric Nomenclature: Reasons for Diagnostic Disagreement." Archive of General Psychiatry. Vol. 7, pp 198-205.

Ward, E. (1984) Father, Daughter, Rape. Woman's Press. London.

Walsh, M (1985) Schizophrenia: Straight Talk for Families and Friends. William Morrow. New York.

Walvin, J. (1984) Passage to Britain. Harmondsworth. Middlesex.

Waring, M and Ricks, D. (1965) "Family patterns of children who become adult schizophrenics." Journal of Mental and Nervous Diseases. Vol. 140, pp 351-364.

Wender, P, Rosenthal, D, Zahn, T and Kety, S. (1971)
"The psychiatric adjustment of the adopting parents of schizophrenics." American Journal of Psychiatry. Vol. 127, pp 1013-1018.

Willis, M J (1982) "The Impact of Schizophrenia on Families: One Mother's Point of View." Schizophrenia Bulletin. Vol. 8, no 4, pp 617-619.

Wilson, M B and Meyer, E. (1962) "Diagnostic Consistency in a Psychiatric Liaison Service." American Journal of Psychiatry. Vol. 119, pp 207-209.

Wing, J K, Birley, J L T, Cooper, J C, Graham, R and Isaacs, A D. (1967) "Reliability of a Procedure for Measuring and Classifying 'Present Psychiatric State'". British Journal Of Psychiatry. Vol. 113, pp 499-515.

Wong, D F, Wagner, H N, Tune, L E Dannals, R F, Pearlson, G D, Links, J M, Tamminga, C A, Broussoule, E P, Ravert, H T, Wilson, A A, Toung, J K T, Malat, J, Williams, J A, O'Tauma, L A, Snyder, S H, Kuhar, M J and Gjedde, A. (1986) "Positron emission tomography reveals elevated D₂ dopamine receptors in drug-naïve schizophrenics." Science. Vol. 234, p 1558.

Woodall, R (1992) "Why my son went to live in a cave." The Independent. 7th of April, p 19.

World Health Organisation. (1979) The International Classification of Diseases. Ninth Edition. WHO. Geneva.

World Health Organisation. (1973) The International Pilot Study of Schizophrenia. WHO. Geneva.

Wynne, L C, Cromwell, R L and Matthysse, S ed. (1978). The Nature of Schizophrenia: New Approaches to Research and Treatment. Wiley. New York.

Wynne, L C, Ryckoff, I, Day, J and Hirsch, S. (1958)
"Pseudo-mutuality in the family relations of schizophrenics."
Psychiatry. Vol. 21, pp 205-220.

Xiong, W, Phillips, M R, Hu, X, Wang, R, Dai, Q, Kleinman, J and Kleinman, A. (1994) "Family-Based Intervention for Schizophrenic Patients in China. A Randomised Controlled Trial." British Journal of Psychiatry. Vol. 165, pp 238-247.

Yates, F A. (1979) The Occult Philosophy in the Elizabethan Age. Routledge and Kegan Paul. London.

Young, E (1989, first published 1742) The Complaint or Night Thoughts on Life, Death and Immortality. Cambridge University Press. Cambridge, UK.

Zhang, M, Wang, M, Li, J, Phillips, M R. (1994) "A Randomised-Control Trial of Family Intervention for 78 First-Episode Male Schizophrenic Patients. An 18-Month Study in Suzhou, Jiangsu." British Journal of Psychiatry. Vol. 165 (suppl. 24), pp 96-102.

Zuckerman, M, Oltean, M and Monashkin, I. (1958) "The parental attitudes of mothers of schizophrenics." Journal of Consulting Psychology. Vol. 22, pp 307-310.

APPENDICES

Appendix A - Letter and Checklist sent to the Patient's
Responsible Medical Officer

Department of Social Work

Tel.: Extension 516

Dear ,

I am currently engaged in a research project, which has recently been approved by this Hospital's Ethics Committee, on the subject of the experiences of parents of people with Schizophrenia.

I would be grateful for your help in part of the process of selecting subjects for this study (parents of people with Schizophrenia) by letting me know which of your patients are suffering from Schizophrenia. Within the Hospital it is difficult to obtain a definitive list of those patients who do suffer from Schizophrenia. What is easily available is a list of patients whose legal classification is Mental Illness, which should include all people with Schizophrenia (provided they are not also Psychopathically Disordered or Mentally Impaired) but will also include Mentally Ill patients who do not suffer from Schizophrenia.

Please find attached to this letter a form for each of your patients classified as suffering from a Mental Illness. Could you first of all let me know if, in your opinion, the patient suffers from Schizophrenia. If the answer is "no" do not proceed any further with that patient's form but go on to the next patient. The next question asks if Schizophrenia is the only significant psychiatric disorder the patient suffers from. If the answer is "no" do not proceed any further but, once again, go on to the next patient. For those patients who have Schizophrenia and for whom Schizophrenia is the only significant psychiatric problem the next questions asks what type of Schizophrenia the patient suffers from. If it is possible to classify the patient in terms of ICD9 please circle the appropriate reference number. If you feel that ICD9 is inappropriate in that patient's case or you have general reservations about the system please describe, in your own words, the patient's Schizophrenia in the space provided at the end of the form.

When you have provided me with this information on the patient I will then approach the Senior Social Worker on your clinical team for information on the availability and advisability of approaching the patient's parents to take part in the study.

I thank you in advance for your help and look forward to hearing from you soon. If you have any problems or wish to discuss the study further, please do not hesitate to contact me.

RMO:

Hospital Number:

Patient Name:

1. In your opinion does the above patient suffer from Schizophrenia? Please circle the appropriate answer.

YES

NO

If the answer to the above question is NO do not continue, if YES please answer the next question.

2. In your opinion is Schizophrenia the patient's only significant psychiatric problem? Please circle the appropriate answer.

YES

NO

If the answer to the above question is NO do not continue, if YES please answer the next question.

3. Can you classify this patient's Schizophrenia in terms of ICD9 classification system? If you can, please circle the appropriate reference number.

- 295.0 Simple type.
- 295.1 Hebephrenic type.
- 295.2 Catatonic type.
- 295.3 Paranoid type.
- 295.4 Acute schizophrenic episode.
- 295.5 Latent Schizophrenia.
- 295.6 Residual Schizophrenia.
- 295.7 Schizoaffective type.
- 295.8 Other (specify)
- 295.9 Unspecified.

If you do not think ICD9 classifications are appropriate please describe in your own words the patient's type of Schizophrenia.

.....

.....

Please return this form to Michael Ferriter, Department of Social Work.

Appendix B - Letter and Checklist sent to the Patient's
Social Worker

Department of Social Work
Tel.: Extension 516

Dear ,

I am currently engaged in a research project, which has recently been approved by this Hospital's Ethics Committee, on the subject of the experiences of parents of people with Schizophrenia.

I would be grateful for your help in the process of selecting subjects for this study, parents (blood only) of patients with Schizophrenia, by providing me with some information on the attached forms. There is a form for each of your patients diagnosed by the RMO as suffering from Schizophrenia.

Could you let me know if the patient's mother is alive. If she is alive could you tell me if, in your opinion, she would be capable of taking part in the research project. If you do not think she would be a suitable subject it would be helpful if you could briefly state the reason why e.g. physical or mental infirmity. If the patient's mother is alive and would be a potential subject could you let me know if she is aware of the diagnosis of Schizophrenia and give me her address and, most important, her telephone number. Alternatively, you may prefer to contact the patient's mother yourself to inform her that she may be invited to take part and to gain her views before proceeding any further.

Could you then repeat the process for the patient's father. If the address and telephone number is the same as for the mother just write "as above" or "ditto" etc.

I thank you in advance for your help and look forward to hearing from you soon. If you have any problems or wish to discuss the study further, please do not hesitate to contact me.

Yours Sincerely,

Michael Ferriter

Social Worker:
Patient Name:

Hospital Number:

1. Is the patient's mother still alive? Please circle the appropriate answer.

YES NO DONT KNOW

2. If the answer to the above question is "YES" would she be capable of taking part in the research project?

YES NO DONT KNOW

If "NO" why not?

3. If she is alive and would be capable of taking part is she aware of the patient's diagnosis of Schizophrenia?

YES NO DONT KNOW

4. If she is alive and would be capable of taking part please supply her full address and telephone number.

Number and street:
District:
Town:
County:
Code: Tel.:

5. Is the patient's father still alive? Please circle the appropriate answer.

YES NO DONT KNOW

6. If the answer to the above question is "YES" would he be capable of taking part in the research project?

YES NO DONT KNOW

If "NO" why not?

7. If he is alive and would be capable of taking part is he aware of the patient's diagnosis of Schizophrenia?

YES NO DONT KNOW

8. If he is alive and would be capable of taking part please supply his full address and telephone number.

Number and street:
District:
Town:
County:
Code: Tel.:

Appendix C - Consent to Tape Recording Form

RESEARCH PROJECT ON THE EXPERIENCES OF PARENTS OF People with
Schizophrenia

CONSENT TO TAPE RECORDING

Subject No.: _ _

I,

give my consent to the following interview being tape recorded
and give my consent to having the tape recording transcribed and
used for research purposes.

I do so on the following understanding:-

1. That all tape recordings, when not being transcribed or used for research purposes, will be stored in a locked cabinet in a secure building as will all transcripts of such recordings.
2. That all data extracted from the interview stored on a computer will be subject to the strictures of confidentiality and security required by the Data Protection Act, 1984.
3. That interview subjects will be referenced by number in the transcript and computer file to guarantee anonymity.
4. That if any part of the interview is used in a subsequent document or publication (e.g. thesis or journal article) all identifying references to the interview subject(s) or their schizophrenic son or daughter will be removed to guarantee complete anonymity.
5. That when the research work is complete and written up in its final form the transcripts will be shredded, computer files deleted and tape-recordings erased.

Signed:

Date: _ _ / _ _ / _ _

Appendix D - Protocol for Subjects and Questionnaires (Rampton Group)

INTRODUCTION

First of all, may I thank you for agreeing to take part in this research project and for allowing me the time to see you in your home.

Can I start by saying what the research project is about and what it does and doesn't cover.

The aim of the research project is to find out more about the experiences of parents of people with Schizophrenia and in particular what have been *your* experiences of dealing with professionals in the mental health field such as psychiatrists, psychiatric nurses and social workers.

I am interested in both good and helpful experiences as well as the bad and unhelpful.

This information will have no impact on your son/daughter's progress, talking to me will neither help or hinder his/her discharge but the information I get from you and other parents may help us to avoid certain mistakes that may have been made when mental health care professionals deal with patient's parents and also, perhaps, to develop our services in a way that may be closer to your needs.

The period I am interested in is from the time that you first noticed there was something wrong with your son/daughter up to his/her admission to Rampton. I will not be asking you for your experiences of staff in Rampton because this may put you in a difficult position. I can assure you that any information you give me will be treated in confidence, and I will be talking a little bit more about confidentiality in a minute, but there may still be a nagging doubt in the back of your mind that if you do criticise Rampton staff it may have an impact on your son/daughter's progress. If we confine ourselves to the period before Rampton Hospital it should be easier for you to be frank in your criticism as well as your praise.

It will be necessary for me to tape-record our interview. You may have a lot of useful information to give me and taking notes as you talk may not be reliable. I need your formal consent, for you to sign this form, before I can commence recording.

Any information you give me, including the tape recordings and any transcripts of the tapes will be kept in the strictest confidence. The tapes and transcripts will be kept in a locked cupboard when not being used and will be destroyed when the research project is over. You will be identified only by a number and it will not be possible to link you and what you say to your son/daughter. The summaries of the interview will be stored on a computer for analysis but once again, when the research is

over, the computer files will be wiped out. In the research thesis and other reports it may be useful to quote from some interviews but care will be taken to eliminate any names of persons, institutions or any other factors that could in any way lead to the identification of the person quoted.

I would like to start by asking a few basic questions about you and then I will be asking you some questions on your views about what causes Schizophrenia, about who has seemed helpful to you with your son/daughter's illness and the problems the illness has caused. Then we will go into the main part of the interview which is when you tell me, in your own words and in your own time, what your experiences have been.

1. Subject Number: . . .
2. Subject Sex:
3. Subject Ethnic group:
4. Could you tell me how old you are?: . .
5. What is/was your occupation?:
.....
6. Occupation Classification: . . .
7. What was your highest level of education?:
.....
8. Area of residence town/county:
9. What is your religion?:
.....
10. How religious would you say you were?
 1. Not very religious.
 2. Moderately religious.
 3. Very religious.
 4. Don't know?
11. How old was your son/daughter when you first noticed something was wrong?: . .

12. How old was he/she when he/she received first
treatment/hospitalisation for Schizophrenia?: . .

13. Have you known anybody else who suffers from Schizophrenia?

If "yes" who?

14. What in your view is the cause, or are the causes, of
Schizophrenia?

15. I am now going to show you some cards which describe, briefly, theories that have been developed over the years to explain the cause of Schizophrenia. I will first tell you the name of the theory then ask you if you have ever heard of it. I will then give you the card to read and ask you, having read the description, if you now remember having heard of the theory. Then, finally, for each theory I would like you to rate how important you think the theory is in explaining the cause of Schizophrenia, either of no importance or some importance or moderate importance or very important or of prime importance or don't know. Some of the theories can be combined together so it is possible to rate several as being of very or of prime importance.

Importance

	1	2	3	4	5	6	Model known?		
	None	Some	Mod'ly	Very	Prime	DK	B	A	
Genetic									
Brain P.									
NTD									
Virus									
Double bind									
SP mother									
Frag. FC									
Scapegoat									
S and S									
Life events									
Other									
Specify									

16. Have you read any books, seen any TV programmes, heard any radio programmes or received any other information on Schizophrenia? If "yes" could you please specify?

17. In general, to what degree have you found the following sorts of people helpful to you concerning your son/daughter's illness? Please rate as either helpful, partly helpful, not helpful or don't know.

	1 Helpful	2 Partly	3 Not	4 DK
Psychiatrist				
GP				
Social Worker				
Psychologist				
Nurse				
Clergy				
Police				
Neighbours				
Family				
Friends				
Self Help (specify)				
Other (specify)				

18. Has your son/daughter ever displayed any of the following problem behaviours?

Violence YES/NO/DON'T KNOW

Verbal aggression YES/NO/DON'T KNOW

Self injurious behaviour YES/NO/DON'T KNOW

Suicidal behaviour YES/NO/DON'T KNOW

Destructiveness YES/NO/DON'T KNOW

Sexually inappropriate behaviour YES/NO/DON'T KNOW

Phobias YES/NO/DON'T KNOW

Undue suspiciousness YES/NO/DON'T KNOW

Withdrawal YES/NO/DON'T KNOW

Poor self care YES/NO/DON'T KNOW

Rapid mood change YES/NO/DON'T KNOW

Obsessions YES/NO/DON'T KNOW

Has he ever caused problems for you with the neighbours?

YES/NO/DON'T KNOW

Do you find it difficult to know how to respond appropriately towards him/her?

YES/NO/DON'T KNOW

Does he/she upset every day routines?

YES/NO/DON'T KNOW

Does he/she need a lot of supervision?

YES/NO/DON'T KNOW

Does his/her behaviour ever embarrass you?

YES/NO/DON'T KNOW

Does his/her behaviour seem, at any time, more than you can cope with?

YES/NO/DON'T KNOW

Do you ever feel trapped by the way things are?

YES/NO/DON'T KNOW

Do you ever feel resentful because of your situation with him/her?

YES/NO/DON'T KNOW

Do you ever feel that your problems with him/her has shut you off from normal life?

YES/NO/DON'T KNOW

Now we come to the main part of the interview.

As I explained at the beginning, I would like you to tell me what were your experiences in general, but in particular in dealing with mental health care professionals, from the time you first felt that something was wrong with your son/daughter to admission to Rampton.

I have a checklist of topics that I feel are important and from time to time you may see me making a note on this sheet of paper. This is to provide a record that you have just mentioned one of the topics on the checklist. If at the end some areas have not been covered I will ask you directly. Apart from this, and when I would like a few more details, I will leave you to tell your own story in your own time.

However, as a tip I would suggest that most people find it easier to tell their story in chronological order.

CHECKLIST

	WHO	WHERE	WHEN
GUILT		BLAME	SHOCK
FEAR		CONFUSION	STRESS
NEGLECT (by MHP)		GRIEF	INFORMATION
SELF ESTEEM		RELIABILITY (of MHP)	
BEHAVIOUR PROBLEMS		FINANCIAL BURDEN	EMOTIONAL BURDEN
PSYCHIATRIST		SOCIAL WORKER	PSYCHOLOGIST
NURSE		VOLUNTARY GROUP	POLICE
NEIGHBOURS		SIBLINGS	FAMILY
GP		CHURCH	MEDICATION
HOSPITAL		CLINIC	PRISON
COURT		LOSS (might have been)	
DIAGNOSIS		ANGER (against MHP)	

Appendix E - Aetiological Model Descriptions

Viral Theory

In this theory, Schizophrenia is seen to be the result of damage caused by a virus infection. The infection may have occurred before birth. Alternatively, it may have been that the infection occurred in later life. An important type of virus are the so called 'retro-viruses', which are caught like any other virus but then become incorporated in the gene and can be passed on to future generations. One variation of the viral theory is that Schizophrenia might be the result of a 'retro-virus'.

Structural Brain Pathology Theory

In this theory, Schizophrenia is seen to be the result of physical damage to the brain structure. This damage might always have been present but only become obvious in later life or could have occurred at any point during the sufferer's life. An example of a structural brain pathology theory is the obstetric complication theory which says that complication before or during the birth led to damage, perhaps through oxygen starvation, to the baby's brain, the consequences of which only became obvious in later life.

Neurotransmitter Disorder Theory

Messages are passed from one brain cell to another by a complicated process involving chemical messengers known as neurotransmitters. In this theory, it is suggested that Schizophrenia is the result of problems of transmission of messages between brain cells. Dopamine is an important neurotransmitter chemical and one theory states that the brains of people with

Schizophrenia are malfunctioning and are over-producing dopamine. Another variation is that the areas of the brain cell that receive the dopamine message are defective or have been burnt out, perhaps by too much dopamine.

Genetic Theory

In this theory, Schizophrenia is seen as being in part or whole an inherited disease; it runs in families. In its simplest form the disease itself is seen to be inherited but other variations of this theory say that it is vulnerability to the disease that is inherited but that something else in the person's environment must act as a trigger. This trigger factor may be biological such as an infection or it can be psychological such as a stressful life.

The Double-bind Theory

The double-bind theory states that the cause of Schizophrenia is in the parents' relationship with the child. The child is subjected to contradictory messages from the parent, for example the parent may avoid physical contact but ask the child why it doesn't show more affection. In this situation the child cannot win and it feels emotionally paralysed. If this continues, it either causes Schizophrenia directly or makes the Schizophrenia worse.

Family Imbalance Theory

This theory looks at the relationship between father, mother and the future schizophrenic child and explains Schizophrenia, in

some cases, as a result of problems of imbalance in the parents' marriage. Examples of such problems are 'marital schism' where the parents are cold, hostile or destructive to each other leaving the child with divided loyalties and 'marital skew' where one parent is dominant and the other parent is weak or inadequate. Another form of imbalance is where the parent treats the child as an adult and expects the child to behave as an adult or even a parent to them.

Fragmented Family Communication Theory

In this theory, patterns of disordered communication between parents and child are thought to be linked to the severity and type of Schizophrenia. In conversation between the parents and the child there is frequent use of odd language and odd ideas. Two examples of such styles of communication are an 'amorphous style' in which communications are vague and a 'fragmented style' in which communications are easily interrupted, poorly put together and unfinished.

Scapegoating Theory

In this theory, the person with Schizophrenia is seen to be the scapegoat for the problems of others. In the family, his or her behaviour may be the excuse other family members need to avoid looking at their own problems, and in some cases the schizophrenic member of the family deliberately acts the role of the "sick" family member. Outside of the family, society may identify certain of its members as schizophrenic and "sick" as a way of avoiding examining the problems in society itself.

The Schizophrenogenic Mother Theory

In this theory, Schizophrenia is said to be the result of early childhood experiences of being both over protected and rejected by the mother. Repeated experiences of this kind lead to a state of great sensitivity to rejection which, in turn, leads the individual to think that he or she is being rejected. Eventually, in a state of distrust and hostility, the person with Schizophrenia retreats into a world of his or her own.

Life Event Theory

In this theory, stressful events are seen to be either the cause or the trigger factor in Schizophrenia. As well as stressful events that are personal to the individual, certain types of problems in life have been said to increase the risk of developing Schizophrenia. These include being an immigrant (and perhaps being the victim of racism), the stress of poverty or unemployment and the stress of the change from being an adolescent to being an adult.

Interview Number: _ _ Date: _ _ / _ _ / _ _ Number: _ _ _ _

Response	Ψi	GP	SW	Ψo	Nurse	SHG
Blame						
No Blame						
Neglect						
No Neglect						
Anger To						
No Anger						
Unreliable						
Reliable						
Helpful						
Not helpful						
Contact						
No Contact						

Response	Cle	Pol	Nei	Fam	Frie	Sibs
Blame						
No Blame						
Neglect						
No Neglect						
Anger To						
No Anger						
Unreliable						
Reliable						
Helpful						
Not helpful						
Contact						
No Contact						

Interview Number: _ _ Date: _ _ / _ _ / _ _ Number: _ _ _ _

How old when

First noticed something wrong: _____

First Clinic/MHCP: _____

Hospital: _____

Court: _____

Prison: _____

Informed diagnosis by	Ψi	GP	SW	Ψo	Nurse	SHG
Yes						
No						

Informed med/treatment	Ψi	GP	SW	Ψo	Nurse	SHG
Yes						
No						

Informed about disorder	Ψi	GP	SW	Ψo	Nurse	SHG
Yes						
No						

Emotional Burden: Yes/No

Financial Burden: Yes/No

Guilt: Yes/No Shock: Yes/No Fear: Yes/No Confusion: Yes/No
Stress: Yes/No Grief: Yes/No -SE: Yes/No Sense Loss: Yes/No

Other (list): _____

Behavioural Problems (List)

Section 1 Interview Duration: _ _ : _ _

Interview Number: _ _ Date: _ _ / _ _ / _ _ Number: _ _ _ _

Response	Ψi	GP	SW	Ψo	Nurse	SHG
Blame						
No Blame						
Neglect						
No Neglect						
Anger To						
No Anger						
Unreliable						
Reliable						
Helpful						
Not helpful						
Contact						
No Contact						

Response	Cle	Pol	Nei	Fam	Frie	Sibs
Blame						
No Blame						
Neglect						
No Neglect						
Anger To						
No Anger						
Unreliable						
Reliable						
Helpful						
Not helpful						
Contact						
No Contact						

Interview Number: __ Date: __ / __ / __ Number: __ - - -

How old when

First noticed something wrong: _____

First Clinic/MHCP: _____

Hospital: _____

Court: _____

Prison: _____

Informed diagnosis by	Ψi	GP	SW	Ψo	Nurse	SHG
Yes						
No						

Informed med/treatment	Ψi	GP	SW	Ψo	Nurse	SHG
Yes						
No						

Informed about disorder	Ψi	GP	SW	Ψo	Nurse	SHG
Yes						
No						

Emotional Burden: Yes/No

Financial Burden: Yes/No

Guilt: Yes/No Shock: Yes/No Fear: Yes/No Confusion: Yes/No

Stress: Yes/No Grief: Yes/No -SE: Yes/No Sense Loss: Yes/No

Other (list): _____

Behavioural Problems (List)

Section 2 Interview Duration: __ : __

Total Interview Duration: __ : __

Appendix G - Protocol for Subjects and Questionnaires (Bassetlaw Group)

INTRODUCTION

First of all may I thank you for agreeing to take part in this research project and for allowing me the time to see you in your home.

Can I start by saying what the research project is about and what it does and doesn't cover.

The aim of the research project is to find out more about the experiences of parents of people who have Schizophrenia and in particular what have been your experiences of dealing with professionals in the mental health field such as psychiatrists, psychiatric nurses and social workers.

I am interested in both good and helpful experiences as well as the bad and unhelpful.

This information will have no impact on your son/daughter's progress but the information I get from you and other parents may help us to avoid certain mistakes that may have been made when mental health care professionals deal with patient's parents and also, perhaps, to develop our services in a way that may be closer to your needs.

The period I am interested in is from the time that you first noticed there was something different about your son/daughter to date.

It will be necessary for me to tape-record our interview. You may have a lot of useful information to give me and taking notes as you talk may not be reliable. I will need your formal consent, for you to sign this form, before I can commence recording.

Any information you give me, including the tape recordings and any transcripts of the tapes will be kept in the strictest confidence. The tapes and transcripts will be kept in a locked cupboard when not being used and will be destroyed when the research project is over. You will be identified only by a number and it will not be possible to link you and what you say to your son/daughter. The summaries of the interview will be stored on a computer for analysis but once again, when the research is over, the computer files will be wiped out. In the research thesis and other reports it may be useful to quote from some interviews but care will be taken to eliminate any names of persons, institutions or any other factors that could in any way lead to the identification of the person quoted. If, at any point, you do not wish to continue then please say so and I will terminate the interview. You also have the right to ask for any part or whole of the interview to be erased.

I would like to start by asking a few basic questions about you and then I will be asking you some questions on your views about what causes Schizophrenia, about who has seemed helpful to you with your son/daughter's illness and the problems the illness has caused. Then we will go into the main part of the interview which is when you tell me, in your own words and in your own time, what your experiences have been.

1. Subject Number: . . .
2. Subject Sex:
3. Subject Ethnic group:
4. Could you tell me how old you are?: . .
5. What is/was your occupation?:
.....
6. Occupation Classification: . . .
7. What was your highest level of education?:
.....
8. Area of residence town/county:
9. What is your religion?:
.....
10. How religious would you say you were?
 1. Not very religious.
 2. Moderately religious.
 3. Very religious.
 4. Don't know?
11. How old was your son/daughter when you first noticed something was wrong?: . .

12. How old was he/she when he/she received first
treatment/hospitalisation for Schizophrenia?: . .

13. Have you known anybody else who experiences Schizophrenia?

If "yes" who?

14. What in your view is the cause, or are the causes, of
Schizophrenia?

15. I am now going to show you some cards which describe, briefly, theories that have been developed over the years to explain the cause of Schizophrenia. I will first tell you the name of the theory, then ask you if you have ever heard of it. I will then give you the card to read and ask you, having read the description, if you now remember having heard of the theory. Then, finally, for each theory I would like you to rate how important you think the theory is in explaining the cause of Schizophrenia, either of no importance, or of some importance, or of moderate importance, or very important or of prime importance or don't know. Some of the theories can be combined together so it is possible to rate several as being of very or prime importance.

Importance

	1	2	3	4	5	6	Model known?	
	None	Some	Mod'ly	Very	Prime	DK	B	A
Genetic								
Brain P.								
NTD								
Virus								
Double bind								
SP mother								
Frag. FC								
Scapegoat								
S and S								
Life events								
Other								
Specify								

16. Have you read any books, seen any TV programmes, heard any radio programmes or received any other information on Schizophrenia? If "yes" could you please specify?

17. In general, to what degree have you found the following sorts of people helpful to you concerning your son/daughter's illness? Please rate as either helpful, partly helpful, not helpful or don't know.

	1 Helpful	2 Partly	3 Not	4 DK
Psychiatrist				
GP				
Social Worker				
Psychologist				
Nurse				
Clergy				
Police				
Neighbours				
Family				
Friends				
Self Help (specify)				
Other (specify)				

18. Has your son/daughter ever displayed any of the following problem behaviours?

Violence YES/NO/DON'T KNOW

Verbal aggression YES/NO/DON'T KNOW

Self injurious behaviour YES/NO/DON'T KNOW

Suicidal behaviour YES/NO/DON'T KNOW

Destructiveness YES/NO/DON'T KNOW

Sexually inappropriate behaviour YES/NO/DON'T KNOW

Phobias YES/NO/DON'T KNOW

Undue suspiciousness YES/NO/DON'T KNOW

Withdrawal YES/NO/DON'T KNOW

Poor self care YES/NO/DON'T KNOW

Rapid mood change YES/NO/DON'T KNOW

Obsessions YES/NO/DON'T KNOW

Has he ever caused problems for you with the neighbours?

YES/NO/DON'T KNOW

Do you find it difficult to know how to respond appropriately towards him/her?

YES/NO/DON'T KNOW

Does he/she upset every day routines?

YES/NO/DON'T KNOW

Does he/she need a lot of supervision?

YES/NO/DON'T KNOW

Does his/her behaviour ever embarrass you?

YES/NO/DON'T KNOW

Does his/her behaviour seem, at any time, more that you can cope with?

YES/NO/DON'T KNOW

Do you ever feel trapped by the way things are?

YES/NO/DON'T KNOW

Do you ever feel resentful because of your situation with him/her?

YES/NO/DON'T KNOW

Do you ever feel that your problems with him/her has shut you off from normal life?

YES/NO/DON'T KNOW

Now we come to the main part of the interview.

As I explained at the beginning I would like you to tell me what were your experiences in general, but in particular in dealing with mental health care professionals, from the time you first felt that something was different about your son/daughter to date.

I have a checklist of topics that I feel are important and from time to time you may see me making a note on this sheet of paper. This is to provide a record that you have just mentioned one of the topics on the checklist. If at the end some areas have not been covered I will ask you directly. Apart from this, and when I would like a few more details, I will leave you to tell your own story in your own time.

However, as a tip I would suggest that most people find it easier to tell their story in chronological order.

CHECKLIST

	WHO	WHERE	WHEN
GUILT	BLAME		SHOCK
FEAR	CONFUSION		STRESS
NEGLECT (by MHP)	GRIEF		INFORMATION
SELF ESTEEM	RELIABILITY (of MHP)		
BEHAVIOUR PROBLEMS	FINANCIAL BURDEN		EMOTIONAL BURDEN
PSYCHIATRIST	SOCIAL WORKER		PSYCHOLOGIST
NURSE	VOLUNTARY GROUP		POLICE
NEIGHBOURS	SIBLINGS		FAMILY
GP	CHURCH		MEDICATION
HOSPITAL	CLINIC		PRISON
COURT	LOSS (might have been)		
DIAGNOSIS	ANGER (against MHP)		

Appendix H - Blamed/not being blamed for the son or daughter's mental illness. Who blamed or did not blame?

Table 42 Blamed

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	1	1	1	0	3
GP	0	1	0	0	1
Social Worker	1	0	0	0	1
Psychologist	1	0	0	0	1
Nurse	1	1	0	0	2
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	1	0	0	1
Friends	0	0	0	0	0
Patient's Sibling	1	0	0	0	1
Total	5	4	1	0	10

Table 43 Not Blamed

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	2	1	1	2	6
GP	0	0	0	0	0
Social Worker	0	0	0	0	0
Psychologist	0	0	0	0	0
Nurse	0	0	1	1	2
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	2	1	2	3	8

Appendix I - Subjects' feelings of being neglected/not being neglected by mental health care professionals

Neglected

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	4	2	3	1	10
GP	3	1	0	0	4
Social Worker	1	0	1	0	2
Psychologist	0	0	0	0	0
Nurse	1	2	2	0	5
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	9	5	6	1	21

Not Neglected

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	1	0	0	0	1
GP	0	0	0	0	0
Social Worker	0	0	0	0	0
Psychologist	0	0	0	0	0
Nurse	0	0	1	0	1
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	1	0	1	0	2

Appendix J - Expressions of anger towards/no anger towards

Anger to

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	2	3	2	0	7
GP	1	2	0	0	3
Social Worker	0	0	0	0	0
Psychologist	0	0	0	0	0
Nurse	1	2	1	0	4
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	4	7	3	0	14

No Anger to

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	1	0	0	0	1
GP	0	0	1	0	1
Social Worker	0	0	0	0	0
Psychologist	0	0	0	0	0
Nurse	1	0	0	0	1
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	2	0	1	0	3

Appendix K - Feelings that professionals were reliable/unreliable

Reliable

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	0	0	1	0	1
GP	0	0	0	0	0
Social Worker	0	0	0	1	1
Psychologist	0	0	0	0	0
Nurse	0	0	1	0	1
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	0	0	2	1	3

Unreliable

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	3	0	2	0	5
GP	2	1	2	0	5
Social Worker	0	0	0	0	0
Psychologist	0	0	0	0	0
Nurse	0	0	3	0	3
Self Help Group	0	0	0	0	0
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	0	0	0	0	0
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	5	1	7	0	13

Appendix L - Feelings that professionals were helpful/unhelpful

Helpful

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	1	0	2	0	3
GP	1	0	0	0	1
Social Worker	3	1	0	1	5
Psychologist	0	0	0	0	0
Nurse	2	2	2	0	6
Self Help Group	0	2	0	2	4
Clergy/Church	1	2	1	0	4
Police	4	2	1	1	8
Neighbours	1	2	0	1	4
Family	2	2	0	0	4
Friends	2	0	2	0	4
Patient's Sibling	2	4	0	1	7
Total	19	17	8	6	50

Not helpful

	Rampton		Bassetlaw		Total
	Unprompt	Prompted	Unprompt	Prompted	
Psychiatrist	13	0	2	0	15
GP	8	0	0	0	8
Social Worker	3	2	0	0	5
Psychologist	1	0	1	0	2
Nurse	5	1	5	0	11
Self Help Group	2	0	2	1	5
Clergy/Church	0	0	0	0	0
Police	0	0	0	0	0
Neighbours	0	0	0	0	0
Family	1	0	1	0	2
Friends	0	0	0	0	0
Patient's Sibling	0	0	0	0	0
Total	33	3	11	1	48