Family Tension and Psychophysiological Illness

MILTON ROSENBAUM

Department of Psychiatry, Albert Einstein College of Medicine of Yeshiva University, Bronx, New York 10461

As a result of spending a sabbatical year visiting psychiatric centers throughout the world, in addition to trying to figure out what is going on in my own department in this time of turmoil, uncertainty and rapid diffusion of professional roles, I have arrived at a philosophical formulation of what a modern psychiatrist needs to maintain his identity, his integrity and, perhaps, even his sanity. First, he needs a sense of humor; second, he needs a deep sense of humility; and third, he must commit himself to do the best he possibly can for his patients without believing that what he does *is* the best. But perhaps the most helpful advice I can offer colleagues and students as to how to proceed in these perplexed times is that given me some years ago by a Bronx citizen of whom I asked directions to the Yankee Stadium. I stopped my car and asked the citizen what I would now consider a rather silly question, namely, "Pardon me, Sir, could you tell me how far it is to the Yankee Stadium?" The citizen replied, "So you have to know how far it is? What difference is it to you how far it is? Just keep on going and don't worry about how far it is."

The title of this talk, "Family Tension and Psychophysiological Illness," in itself implies that physiological changes may result from psychological forces connected with interpersonal as well as intrapersonal factors. This I firmly believe. For the most part, people do not become ill solely as the result of physiological changes. Illness usually occurs within the context of difficulties in interpersonal relations which, in the majority of instances, means the family. This does not mean that, once the patient becomes ill, he cannot be treated individually, or that, once the illness starts, the intrapsychic conflicts unleashed by it will not run their course despite favorable changes in the family situation which precipitated the illness. Actually the real test of the clinician is in coming to a decision as to where he should focus his therapeutic interventions when dealing with a patient in whom family tension is clearly playing an important role.

Not long ago I asked myself a simple but basic question, namely, "Would I handle certain cases of a psychosomatic nature today in the same manner that I did 15, 20 or 25 years ago?" After I posed this question, I looked over some old papers and, in order to honor the chairman of our host department, selected two cases from a paper "The Treatment of Psychosomatic Disorders by the General Physician," written with him and Robert Crede (1950).

The first case was as follows:

D.Z., a 23 year old white housewife, entered the hospital with severe headaches (typical of migraine) and attacks of pain in the right lower quadrant of three years' duration. Physical examination revealed persistent hypertension (blood pressure 170 systolic and 130 diastolic) and spasm of retinal arterioles, with scattered tiny scars throughout both retinas. The heart size was at the upper limits of normal, and studies of renal function revealed moderate impairment. Her personality structure was that of an immature, hysterical person with severe frustrated dependent longings.

There was intense sibling rivalry and definite underlying hostility to a rejecting mother. Problems related to sexuality and pregnancy were colored with intense unresolved hostility and guilt, which she had had as a child toward her pregnant mother and younger siblings. In adult life she was unable to adjust to the role of housewife or mother. She lived with her parents, and her own babies were cared for by her mother.

The current illness had started when her younger brother returned from the army and she had been forced to move into her own apartment to make room for him at her parents' home. From this situation, which was a repetition of the original traumatic experience, she developed intense underlying feelings of hostility toward her mother and her siblings who were still living at home. These unexpressed feelings appeared to be associated with the severe attacks of headache and abdominal pain for which she was hospitalized.

After formulation of the psychodynamics in the psychosomatic conference, a therapeutic plan was proposed which was directed at meeting her frustrated dependent needs. This included occasional contacts with the psychiatric consultant, offers of material giving when indicated and continued contacts with the medical resident. However, her presenting symptoms in combination with hypertension and severe spasm of the retinal arterioles aroused considerable anxiety in the medical resident who was following the case. The physician's anxiety was manifested by repetitive physical and laboratory examination,

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with frequent consultations. This affected the patient in two ways: first, it gave the symptoms attention-getting value, and, second, it augmented the patient's anxiety, with a resulting increase of symptoms.

The psychiatric consultant continually reassured the medical resident that the patient was being handled properly, and, after a few months, the resident became more secure in dealing with her, because he recognized that the symptoms were not evidence of malignant hypertension but that they recurred in direct relation to emotional and environmental problems. As a result of this knowledge, each time the patient suffered an exacerbation of symptoms the physician immediately inquired into her current life situation, with special emphasis on immediate difficulties with her husband, children, siblings or mother which created frustration of her dependent needs with resulting hostility. The patient was allowed to talk freely about such problems, and temporal relationships to the development of symptoms were discussed. This discussion, plus a rapid physical check-up, served to relieve both the patient's and the physician's anxiety. With such therapy there was a remarkable diminution in both the frequency and severity of the "attacks." At the time of writing, although the blood pressure was unchanged, the patient was not only symptom-free but had matured considerably and was functioning adequately as a mother and wife. When there is trouble she and her doctor have little difficulty in quickly discovering the precipitating factors.

We did help the patient considerably, but I find myself wondering whether I would take the same approach today in handling her situation. The key figure in the family constellation was the patient's mother, yet none of us ever saw her. Certainly the husband must have been playing a role in her illness, too, but he was never seen or interviewed. What would I do if faced with a similar situation today? To be as honest as I can, I must confess that, if I had seen her as a *private* patient in 1950, I would probably have done then what I would do today, namely, I would have seen her husband and, perhaps, her mother, too. But, remember, in 1950 D.Z. was not a private patient but a clinic patient —what at that time we used to call a "charity case"—and it was not the custom then for house officers in a teaching general hospital to see members of the family, especially of patients on the medical wards or in the medical clinics. Certainly it was unheard of for the teaching members of the faculty to spend their time so wastefully. I will discuss this particular matter in more detail later.

Now let us review another case from the same paper.

L.M., a 37 year old married white man, seen in the Psychosomatic Clinic because of a chronic recurrent duodenal ulcer of many years' duration. In the past, numerous exacerbations of the ulcer symptoms had responded temporarily to medical treatment. When he was first seen in the Clinic, the current exacerbation of symptoms was of several months' duration.

The patient was seen for one hour each week for six weeks. During this period he was given the usual medical treatment, antacid agents, antispasmodic drugs and a special diet. The interviews were taken up with a discussion of the patient's difficulties on his job, problems with his wife and financial worry. The therapist attempted to give the patient a good deal of emotional support and would offer suggestions which were designed to relieve some of the tension connected with the patient's employment and marital difficulties. The patient developed a slight degree of insight into the fact that certain tensions associated with his job and marriage seemed to cause exacerbations of his symptoms. Symptomatic improvement was noted within three weeks, and at the end of a six week period the patient was asymptomatic. Gastrointestinal roentgenograms revealed that the ulcer had healed. As the patient became aware of the tension surrounding his job, he made the decision to quit and obtain other employment. This was done, and the patient stopped coming to the clinic because he was unable to get time off while working at his new job.

The patient was not seen again until he appeared in the emergency ward with a perforation of the duodenal ulcer. An interval history revealed that the day before the perforation he had been discharged from his job as a truck driver after a slight accident which he felt was not his fault. The next day his wife had left him after an argument, and a few hours later while on his way with a friend to a house of prostitution, he was suddenly seized with the severe pain of the perforation.

Obviously in this case the key family member was the wife, yet she was never seen, let alone brought into the therapeutic program. At the time the case was summarized as follows: "It is our feeling that had this man been able to continue his relationship with his physician, he might have been given enough support and gratification of his dependent needs during the period of acute emotional distress related to his wife's leaving that the perforation might not have taken place." Perhaps this was true, but if I were to handle this patient today, before making the above statement I would certainly see the wife to determine whether anything might be worked out to help her. Instead of just using the physician to meet the patient's dependent needs, I might be able to use a genuine rather than an ersatz source of support.

In addition to the fact that it was not particularly fashionable to use the family approach when dealing with charity cases, such as the two just described, there was another factor that limited us. At the time we were very much influenced by Franz Alexander's concepts in psychosomatic medicine (1950). He stressed the connection between repressed instinctual impulses —especially pregenital ones—and the development of pathophysiological states as well as emphasizing the manipulation of the transference to elicit repressed impulses, especially in the aggressive/dependent areas. This discussion is

not intended as a criticism of Alexander's formulations but is meant rather to point out that we were so fascinated and curious about them that we felt compelled to clarify his formulations as well as meet certain of the patient's needs by acting completely on our own. This is just another example of the frequency with which the narcissistic needs of the doctor take precedence over the needs of his patient.

Let me jump from the past to the present with this case vignette. The patient was an extremely narcissistic and successful businessman in his late 50's who consulted me because he felt depressed. Initially, I thought his depression was related to narcissistic blows resulting from the threat of business failure. But after a few interviews, I realized that this giant of the business and social world became depressed when his covered-up dependency needs were frustrated by his wife, for example, when she paid more attention to her grandchildren than to him. On realizing this, I contacted his wife, explained the situation to her and brought her into the "therapeutic alliance." His improvement was immediate and remarkable. Some six months later he called me—again depressed. As usual, he emphasized the threat of business failure, but, when I focused the interview on the relationship with his wife, the following amazing story emerged.

On Monday his wife had come down with an upper respiratory infection and suggested that he sleep in another room to avoid catching her cold. On Wednesday she was up and around but remained home. On Thursday she resumed her usual routine of charity work for a variety of social agencies. But Thursday night she did not ask him to return to her bed. (Incidentally, their sexual life was practically nil.) On Friday he came to see me and was quite depressed. I immediately called his wife and explained the situation to her. She invited him back to her bed, and he was fine for another long stretch of time.*

Now let us return to a point I brought up earlier regarding the almost universal resistance of house officers to seeing family members, let alone involving them in diagnostic and therapeutic programs. Whenever an inpatient is presented to me by a medical student, an intern, or a resident, I always ask whether they have seen the patient's family. The non-psychiatric house officer responds to the question with either surprise or disdain, as if to say, "Man, what's bugging you? Don't you realize I'm so busy I hardly have time to see my patients?" If, by chance, the family is seen, it is usually for a courtesy call during visiting hours or for permission to carry out special procedures, etc.

The psychiatric trainee on an inpatient service, whether a medical student or resident, usually but not regularly sees a member of the patient's family for the purpose of obtaining information, since he quickly learns that, without such outside information, it is difficult to make a diagnosis. Thus, unfortunately, the family member is placed in the role of an informant rather than drawn into the clinical situation in a meaningful way. But what is far more serious and pernicious, in my opinion, is the good old-fashioned custom in psychiatry of using the social worker to get the so-called family and social history so that, in the classical case conference, the doctor presents the patient's story and the social worker the family's. Now let me make it clear that I am not against the role of the psychiatric social worker in clinical psychiatry, but rather I am against using her to relieve the doctor of his responsibility. I insist that the doctor, at least in the diagnostic work-up, see the family as well as the patient, since to me it is essential to the work-up. Once the doctor assesses the situation, then, of course, he is in a position to call on the social worker for those tasks for which she is equipped, ranging from home visits to a variety of therapeutic interventions with family members and/or the patient directly.

It is always amazing to me how marked the contrast is between the style in which excellent psychiatric teachers function as practicing psychiatrists and the style in which their trainees function in certain areas of clinical work. Actually because of this kind of discrepancy, we at Einstein started our "Walk-In Clinic" when we first opened our clinical facilities. Contrary to what some think, the Walk-In Clinic (Coleman and Rosenbaum, 1963) was started not to do away with the waiting list, so characteristic of psychiatric outpatient departments, or to better meet community needs by offering crisis intervention, even though it did both. Rather, it was established to provide teaching and training experience for second- and third-year residents assigned to the Outpatient Clinic by giving them an opportunity under close supervision to function in their outpatient assignments as they will have to function later when practicing psychiatrists. In other words, we made the training program in the Outpatient Clinic assignment more reality oriented. We simply had them do what most of us do in the real world of psychiatric practice.

When I am asked to see a patient for consultation or evaluation, I usually ask the individual to bring the key family member with him (spouse, parent, etc.) to the consultation. Unlike the practice of

* It may be important to emphasize that I focused on the patient and not his wife. I did not put the wife into the position of a patient by suggesting that she should enter therapy to gain insight or understanding into her obvious hostility towards her husband. The latter course might have been recommended by a family therapist and, thus, have switched the focus from the patient to the seemingly well, but actually sick wife.

some of our university teaching clinics, my practice is not to tell the patient to first see a social worker or a psychologist. Once I see the patient alone and the key family member alone and then both together, I can come to a decision as to how to handle the situation. In some instances I might say, "Let me see you again in a week"; in others I might make a referral to a psychotherapist, a psychoanalyst, a psychiatric hospital, or a social worker. The main point is that the initial responsibility is mine. It is up to me to gather the necessary data from the patient and family or other possible sources. Yet, in many a training program, the resident—usually in his second or third year in his Outpatient Clinic assignment—has his psychotherapy patients referred to him as if he were already a practicing psychoanalyst or psychotherapist.

By now, hopefully, some of you may be saying to yourselves, "What we have heard so far is interesting, but what does it have to do with the topic "Family Tension and Psychophysiological Illness?" Perhaps very little or perhaps a good deal. I could have cited a variety of studies showing that there is a relevant relationship between family tension and psychophysiological illness, but I assume we all know this. What is more important, at least from the point of view of a psychiatric educator, is to develop a method by which the physician and the clinician—the student and the trainee—can be taught to gather information in a systematic way, so that he can formulate family psychopathology and its effect on his patient.

As I have indicated already, I believe data gathered in a family interview is essential in a diagnostic work-up, especially in psychiatry. The challenge for us is to develop a structured outline for gathering the pertinent information from questions and observations which would be similar to the classical mental status examination guide.† But such a guide to the family interview must be tailored to the needs of the average psychiatric clinician rather than to the specialist in family psychiatry. Actually, I have presented this challenge to those members of my department specializing in teaching and training in family diagnosis and treatment. When they come up with a useable and useful form, I will be happy to share it with you.

References

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† Before such a form can be useable or useful, the administrator (trainee, clinician, student, etc.) must have had meaningful exposure to family interviews conducted by experts and some actual experience in conducting such interviews on his own under proper supervision.