Why Some Patients Prefer to Become Manic-Depressive Rather than Schizophrenic

HELM STIERLIN, M.D., Ph.D., GUNTHARD WEBER, M.D., GUNTER SCHMIDT, M.D., AND FRITZ SIMON, M.D.

Heidelberg, West Germany

Received November 19, 1984

This paper reports the authors' observations on fifteen families in which a young adult member had been diagnosed as manic-depressive. All families were seen in systemic family therapy, with intervals of four to six weeks between sessions. The circular questioning method developed by Selvini-Palazzoli [1] and her team was widely employed. All families could be described as extremely rigid and bound-up systems characterized by a "restrictive parental complementarity," typical dynamics of reciprocal delegation, and certain cognitive features and shared assumptions. These "manic-depressive" families show similarities as well as differences when compared with families with schizophrenic members (i.e., "schizo-present" families). Finally, some therapeutic implications of this view and approach are developed.

So far, family approaches to the treatment of manic-depressive (or bipolar) psychoses have not shown much promise. Apparently, they made little sense in the light of the many studies which stressed genetic and neurophysiological factors. Relevant works in family therapy remained understandably sparse. Therefore, we had to ask ourselves whether the title of this paper should not instead read: "Why some therapists prefer to treat families with manic-depressive rather than with schizophrenic members."

Be that as it may, in the past couple of years we have preferred to treat "manic-depressive" families rather than others mainly for two reasons: first, we wanted to break new ground, and, second, we felt that to work with such families would give us important information about the families of schizophrenics (i.e., schizo-present families).

These two motivating factors—to break new therapeutic ground and indirectly to learn more about schizophrenia—also underlie another research project with manic-depressive psychotics. We have in mind the classic study by M. Cohen, G. Baker, R. Cohen, F. Fromm-Reichmann, and E. Weigert [2], published almost 40 years ago, in which these psychotherapists report on their experience with manic-depressive patients.

Their findings are based on 12 cases which they treated intensively at Chestnut Lodge over an extended period with psychoanalytically oriented psychotherapy. Interestingly, the authors did not focus on their patients alone but also paid much attention to their family backgrounds.

As regards the prospects of psychotherapy for manic-depressive patients, however, their study did not sound very encouraging: it made the study appear as if work with manic-depressives was rewarding for neither the patients nor their therapists. These
therapists, so the Chestnut Lodge authors concluded, tend to become stalemated with patients, who always seem to want more and different things than they, the therapists, can give them. Consequently, these authors drew a rather gloomy picture of their manic-depressive patients. They perceived the patients as showing infantile dependency, as tending to exploit others, as being overly moralistic and conventional, and as viewing others only as either good or bad. In this work as therapists, they found themselves feeling drained and frustrated. Apparently, their patients were not in the least interested in what the therapists had to offer them as psychoanalytically trained experts. Most aggravating of all, these authors missed in their manic-depressive patients that interpersonal sensitivity which they were accustomed to finding in their schizophrenic patients, even though these latter seemed in many respects more seriously disturbed than the former.

In Heidelberg, we started off from a different vantage point. Even though we had similar intentions regarding therapy and research, we pursued them within a different observational and therapeutic setting. Also, we adopted other theoretical models. The following findings and conclusions, however, should be considered preliminary at best.

Within the past five years we have seen a total of 15 families in which at least one young adult member had been diagnosed as manic-depressive. The interviews usually lasted 2 to 2 1/2 hours. In the case of several younger patients, we had some doubt as to whether a manic-depressive or a schizo-affective psychosis should be diagnosed. Usually, no more than ten interviews were conducted, the intervals between these lasting from four to five weeks (and sometimes even longer). Consequently, in some cases the therapy went on for years. Ordinarily, the interviews took place when the patient was not hospitalized or could take a leave of absence from his hospital. In the interviews, we were mainly applying the circular questioning method as described by the Milan team of Mara Selvini-Palazzoli [1]: we asked one member at a time about how he or she viewed other members in their relations with each other. Our questions sprang from hypotheses which we formed from the answers, information, and metaphors with which the family had supplied us. With more answers coming in, we developed ever-new hypotheses which we, in turn, sought to verify or disprove by asking further questions, and so it proceeded. Wherever possible, we gave the answers a positive connotation, and we displayed neutrality; at the same time, we tried, again and again, to introduce new information and experiences either by supplying new points of view or by asking the members to perform explicit tasks. Our hypotheses were built on concepts which try to grasp the vicissitudes of family-wide co-individuation and co-evolution as well as the prevailing dynamics of binding, expulsion, and reciprocal delegation. These concepts constitute major elements of our team's theoretical orientation. The following pattern seemed typical:

There are two parents who do not seem to match but simply cannot do without each other. They appear chained to each other by social pressures (for example, the fear of social decline, the fear of being unable to survive), as well as by pressures arising from within the family, such as the injunction against any form of separation. They finally settle in a mutually restrictive complementarity, leaving no room for their needs and abilities to develop. Accordingly, each is controlled and delimited by the other; each is lacking inner controls and is unable to develop them. The more they need each other in this way, the more
they become each other’s burden and jailer. It is only natural that they will increasingly frustrate each other, that sexual activities between them will cease, that a (symmetrical) power struggle will threaten their complementarity, that a “malign clinch” will develop. Under these circumstances, the relational system becomes rigid: the partners are no longer capable of responding to the demands of the individual and family life cycle and other stresses, are no longer capable of working out a viable balance of closeness and distance, allotting tasks, and negotiating new rights, duties, and expectations. Accordingly, we find here a disturbance of related individuation or a blocking of overdue family-wide co-individuation and co-evolution. Within the restrictive complementarity described, both partners now occupy extreme positions. Typically, one parent appears generous, emotional, adventurous, irresponsible, and disorderly; the other, in contrast, seems strict, rational, conscientious, hyper-responsible, and orderly. (In order to simplify, we will henceforth speak of the “orderly” versus the “disorderly” parent.)

One may say that the “disorderly” parent tends toward the manic, the “orderly” toward the depressive position (or pole). These positions may be permanently held by one parent, or may, in rare cases, be occupied alternatively by both partners. We would like to propose the following thesis: in families with manic-depressive members, the children are typically needed and used to support the previously described restrictive parental complementarity. At the same time, the parents are needed and used by the children: all members become vital elements in a characteristic family system. This is, as stated in the letter of one manic-depressive patient, “a system in which, due to certain constellations and role distributions, certain characteristics of the members come to life whereas others remain suppressed.” One could characterize this system as massively bound up or enmeshed, as extremely rigid and opposed to necessary developmental changes.

This picture accords with some of the observations and conclusions offered by the Chestnut Lodge authors mentioned earlier. They noticed, for example, that their manic-depressive patients considered their families of origin to be “different,” i.e., defective and more in danger of social decline than other families in their environments. Consequently, social prestige and conventionally valued successes become unduly important for these families. These authors also noted a rigid splitting of parental roles, as we did. Usually, the mother was seen as the decisive, orderly and prestigious parent, the father in contrast as a weak outsider and as (overtly or covertly) despised by the mother.

A COMPARISON BETWEEN “MANIC-DEPRESSIVE” AND “SCHIZO-PRESENT” FAMILIES

Nevertheless, there exist many other rigid family systems whose development, i.e., whose co-individuation and co-evolution, appears blocked. These include, as one example, many families with a schizophrenic member (so-called “schizo-present” families). Hence the question: how do manic-depressive families compare with schizo-present families?

Certainly, there exist many transitions and intermediate forms between these family systems. We can therefore only give a rough outline that stresses ideal types. Nonetheless, we would like to proffer the following thesis: schizo-present as well as
manic-depressive families fail to co-individuate and co-evolve because of certain characteristics of their prevailing relational reality. This reality is made up of the members’ shared basic assumptions, expectations, and rules, which govern their respective behaviors. Only where such relational reality manifests a certain solidity and inner cohesion and where it is consensually validated through ongoing transactions can functioning roles, hierarchical structures, and clear definitions of relationship evolve. We think that schizo-present families fail in their co-individuation and co-evolution because their relational reality is too “soft.” The only valid rule here is the meta-rule, postulating that no rule is valid. If one member tries to assert his point of view or tries to leave the family field (that is, tries to individuate and become more autonomous), he will immediately be made the target of disqualifying remarks and thereby risk losing his certainty of purpose; thus, he will, to use Murray Bowen’s [3] term, be pulled back at once into the soft, binding, and undifferentiated family ego mass. This holds true for parents as well as children, i.e., everybody will fail in an active self-demarcation against others, which these others may experience as a rejection or devaluation. In sum, these families lack sufficiently hard structures or counterpositions, as well as reliably negotiated and shared definitions of relationship; in short, they lack those elements which could serve as supports to any necessary “individuation against,” as described by H. Stierlin [4].

If, in the light of these observations, we compare the families of manic-depressive with schizo-present families, we find in the former a hard, super-hard, relational reality; we find the force of reciprocal delegations, expectations, and rules internalized unquestioningly, as well as the espousal of family unity and harmony. Their creed is: we can only survive if we stick together, come what may. The members of our manic-depressive families were able to define their relationships more or less easily and clearly. This ability was atypical of schizo-present families. In the circularly conducted interview, we could soon determine who in the family was closer to whom and vice versa, and which rules, values, and expectations and which roles and delegations prevailed. The interviewer found himself, so to speak, on solid relational ground. Nevertheless, under certain circumstances, particularly when the momentum of one member’s manic episode was building up, this ground could give way, could rapidly “soften.” When this happened, a family-wide psychotic loosening-up of reality—be it of a more manic, or of a more depressive coloring—could be observed. At that point our manic-depressive families began to resemble more closely our schizo-present ones. For example, there appeared at this time to be more “double-talk,” more disqualification of messages, more avoidance of a definition of relationships—up to the point when the family once again found its bearings and again hardened its relational reality, so to speak.

Such periodic loosening-up of reality seemed to fulfill a safety-valve function: suppressed “counter-values” and needs could come to the fore, tensions could be reduced, and conditions within the rigid family system could be re-arranged. To make this possible, one member’s manic-depressive behavior proved to be of central importance: this member took now charge, as it were, of the periodic equilibration of a system which, because of its peculiar features, could not have been equilibrated otherwise.

Elsewhere Stierlin [4] and Wirsching and Stierlin [5] have compared “schizo-present” families with the families of members suffering from serious psychosomatic disorders. In general, these latter families could be characterized as resembling our
typical "manic-depressive" families in that they, too, accepted or constructed a hard, if not super-hard, relational reality. Most of the "psychosomatic" families, however, were found to lack a similar safety-valve function that could periodically "soften" their hard reality and re-equilibrate the family system. It appears that more "normal," i.e., less bound-up, families can avail themselves of re-equilibrating mechanisms that will also facilitate an ongoing co-individuation and co-evolution of individuals and family alike. Further comparative studies will be needed, however, to provide satisfactory answers here.

THE MANIC-DEPRESSIVE MEMBER AS A BOUND-UP DELEGATE

The central function of the manic-depressive member will become more understandable if we view him as a massively bound-up delegate in Stierlin's [6,7] sense of the term. This member is torn between two parents who can neither live together nor do without each other—unless he, the manic-depressive offspring, attunes himself in a sensitive and loyal manner to their contradictory needs and delegations, tries to satisfy and integrate these as much as possible, and, at the same time, manages periodically to loosen up the rigid family system. Again and again we were impressed by the selfless and devoted way in which such bound-up delegates took on this difficult task. At the same time, we observed how this delegate profited by being so indispensable: it gave him or her an enormous sense of importance.

Applying a systems perspective, we can now offer the following theses regarding the manic-depressive events: first of all, we recognize one family member's manic behavior as an attempt to help the family to escape from a hard and rigid relational reality, as an attempt at emancipation, and as an attempt to trigger overdue, family-wide co-individuation and co-evolution. At the same time, such behavior amounts to a species of revolutionary upheaval. By throwing restraints to the winds, the index patient discards the family's as well as the surrounding bourgeois world's restrictive values. As is the case in the initial phase of a political revolution, he is carried away by feelings of omnipotence, grandiosity, and invulnerability. Such sense of omnipotence corresponds to this patient's role and function within the family and the importance derived therefrom. Such striving for freedom and omnipotence will, however, soon meet its limits: limits either imposed by the environment, which will declare the manic person incompetent, will punish and/or hospitalize him, or limits imposed from within the person; for example, in the form of re-emerging inner censors who condemn and curtail his excesses. Once this happens, the euphoria will usually give way to depression.

However, that which at first sight appears as an attempt at liberation, on closer inspection will also turn out to be an act of submission; that is, it will appear as a faithfully carried-out delegation. Typically, the delegating parent is the disorderly partner, whose manic inclinations have been tamed by the orderly partner. Now the disorderly partner can recruit the manic offspring to live vicariously his own rebellious, "flipped out," i.e., disorderly, needs and tendencies.

The manic member, however, functions not only as the disorderly parent's delegate. Through his excesses he also ensures that the disorderly parent will remain "tamed": by getting into a manic state he also supplies a dire warning as to what could happen "if one lets go of oneself"; thus he challenges the disorderly and potentially manic parent to "behave," i.e., to become more organized, responsible, and self-controlled. At the same time, the responsible, orderly parent is being vindicated and confirmed in his taming function. Being thus confirmed, his intrafamilial power and prestige will
increase. As this change happens, the manic offspring will again tend toward identifying more with that parent who, as we saw, tends to be the more important and consistently internalized parent after all. With that transition, the bound-up delegate will be increasingly steered away from the manic and into a depressive condition.

There is, finally, one further way in which the manic member safeguards the equilibration of the parents' relationship: by supplying worries and troubles, he forces them to get together, to close ranks. Thus, their previously described overt as well as covert antagonism and frustrations will recede into the background. Their solidarity is required; separation is more than ever out of the question.

SOME CHARACTERISTICS OF MANIC-DEPRESSIVE FAMILIES

The equilibration of such a system under the signs of either mania or depression may become even more understandable if we take into account some further characteristics of the typical "manic-depressive" family.

For one thing, we notice a tendency to evaluate one's own as well as the other's experiences by strict adherence to certain mutually exclusive categories: a person is either good or bad, honest or dishonest, controlled or uncontrolled, responsible or irresponsible, and so on. There is no in-between. This accords with the so-called digital code as used in computer science; it accords, furthermore, with certain notions that are sanctioned by religion and cultural traditions; and it accords, finally, with linguistic and grammatical constraints which enforce an either/or dichotomy.

Another important feature of these families, closely related to their use of a "digital code," is the notion shared by all members that one can and must "will" certain emotions. Again, there is a strict distinction between desirable loving and detestable bad/hating emotions. Both notions—that one must use a digital code and that one can achieve emotions through an effort of will—seem appropriate in many domains outside the family. For example, the law presupposes that one can and must distinguish between good and bad and hence between punishable and non-punishable acts. Furthermore, it assumes that the individual can decide in favor of or against certain actions. If such notions are rigidly and unreflectedly applied to behaviors and experiences within the family, however, unresolvable dilemmas must result. If one proceeds from the assumption that human beings are either good or bad, honest or dishonest, that they belong totally or not at all together, it is only logical that one has to negate or distort important aspects of one's relational reality. Similarly, if one assumes that one can and should love one's partner unconditionally without restriction, then one must either suppress many spontaneous "unbecoming" emotions or must all too often consider oneself a weak, bad, and contemptible human being.

Manic-depressive families are, it seems, in the grip of such dilemmas. They live in a world of mutually exclusive yet constantly re-constructed extremes—extremes in attitudes, roles, behaviors, and values. In this world it is hard for a member to own up to a sense of ambivalence and uncertainty and to find the "golden" mean, in Aristotle's sense of the term. This condition then, one might state in brief, is the result of an inappropriate application of the digital code to the intrafamilial domain. For members of schizo-present families, especially the openly schizophrenic ones, the opposite holds true: they prefer to apply an analogue code, which, as P. Watzlawick, J. Beavin, and P. Jackson [8] have described, employs more non-verbal cues such as facial expressions, gestures, tone and rhythm of voice, and so on, and which, in general, tends to circumvent or disqualify any rigid either-or dichotomies. Such an analogue code
seems, by and large, “functional” when used within the family, but it will become dysfunctional when applied uncritically in their social environment. Such application will then get the members into conflict with the environment’s norms and expectations.

The previously mentioned Chestnut Lodge authors also recognized certain dilemmas rooted in their patients’ families as being central to their manic-depressive symptomatology. According to those authors, the later manic-depressive offspring loved the weak, disorderly, and (in the mother’s view) unsuccessful father more than that child loved the mother. Frequently, he tried to defend the father against the latter, yet at the same time could not free himself of the mother’s standards. Furthermore he perceived the more beloved father as unreliable, the unloved mother as reliable. In order not to be torn apart by painful ambivalence, the child had to dissociate his incompatible attitudes vis-à-vis the parents. Also, he remained stuck in a rigid either/or (and especially good/bad) mode of thinking while all the while he tried to be accepted and loved at all costs. Thus, pathways were formed early in life to view and show himself as either totally bad, culpable, and restricted, i.e., as depressed, or as totally good, guiltless, and unrestricted, i.e., as manic.

THE SIBLINGS OF THE MANIC-DEPRESSIVE OFFSPRING

How do the siblings of the manic-depressive member fit into such a system? We observed that they, too, tend to assume missions and roles that safeguard their parents’ restrictive complementarity and help themselves and the system to survive. Typically, they function as delegates of either the orderly (and potentially depressive) or disorderly (and potentially manic) parent. In general, these siblings seem less driven to excesses and seem inwardly less conflicted and vacillating but, often, also seem more constricted than the manic-depressive sibling. A sibling can, we found, vicariously live out parental wishes for emancipation and yet not become manic. For example, in two families we observed sisters who acted as the “feminists” in the family. They were involved in feminist causes and protests but would do this with both parents’ covert approval and would not challenge central family values and structures. A few siblings showed sociopathic and/or schizoid tendencies. In these instances, the parents seemed fixated on, and greatly invested in, their other, more important children, viewing the children in question as an expendable surplus. These children lived in the shadows of their more bound-up and more needed siblings, as it were. It might have been thought they had a better chance than their “more important” siblings to leave the family field. However, if they did have this chance, they hardly used it to their advantage. They either seemed to live as schizoid outsiders peripheral to the family’s concerns or got themselves temporarily into center stage by showing alarming behaviors. (For example, one brother who lived a very solitary life, kept a loaded rifle hidden in his study. He insinuated that he might shoot a professor, who, he felt, was set against him. Later he was arrested for fraud. His character pathology made us think of various young men who had been in the headlines because of their attempts, successful or unsuccessful, to assassinate U.S. presidents.)

Finally, we need to mention that some members of our manic-depressive families showed either schizophrenic or psychosomatic symptoms. Thus, there exist links and transitions with regard to schizo-present as well as psychosomatic families. In some cases members suffered from serious and chronic psychosomatic diseases; in at least two families we observed that one member showed a lasting schizophrenic thought
disorder. These cases pose questions which we plan to pursue in our future work. They also remind us that human relational reality is always much more complex than our concepts suggest.

**THERAPEUTIC IMPLICATIONS**

The family therapy of manic-depressive psychoses leads us into as yet uncharted territory. In this presentation we can merely offer some basic guidelines along with our first experiences. One way of changing the family’s interactional patterns would be to foster the patient’s attempts to individuate himself within the family. Especially at the beginning of a manic phase, such attempts could mean that he tries to keep his thoughts to himself, that he does not want to share anything or everything with his parents, that he insists on his own point of view and his own rights.

In order to promote such co-individuation and co-evolution we must, we believe, simultaneously exert therapeutic leverage at different points in the system; on one side, we need to foster all members’ motivation and capability for individuation. On the other, we need to question those basic assumptions and values which prohibit such individuation, and we must, at the same time, introduce alternative assumptions and values. This is usually best done through questions, preferably posed to one member but intended for another, which open up new perspectives without directly challenging the old values. Finally, we need to intervene—if need be forcefully—in those transactional feedback loops which normally keep these systems (in the words of Ashby[9]) “too richly cross-joined” and hence unchangeable.

The circular questioning method, when flexibly handled, can help a great deal to realize these different aims. It can, first, quickly generate vital information necessary for any intervention in changing the family’s structures; second, it provides us with ample opportunities for “softening up” these families’ excessively hardened relational reality while bypassing their resistance. Finally, it can highlight an individual’s options (or decisions) for different actions that will have different future consequences.

To repeat, we are reporting on our first therapeutic ventures with these families. Even now, however, we feel encouraged by what could be achieved. As an example, we would like to quote from the letter of a patient, then 34 years old, who had been diagnosed as manic-depressive when she was 14. For two decades the autumn had always been the season when manic episodes had loomed. Last fall she wrote us: “I could have easily slipped into another manic phase. However, I decided that this time I would not slip.” And she did not slip, neither last fall nor this. Perhaps that is no answer to the question as to why some patients prefer to become manic-depressive rather than schizophrenic; yet it suggests that some patients, with a little help from us, may prefer to become neither one nor the other.

**REFERENCES**

1. Selvini-Palazzoli M, Boscolo L, Cecchin G, Prata G: Hypothesizing—Circularity—Neutrality: Three Guidelines for the Conductor of the Session. Fam Proc 19:3–12, 1980
2. Cohen MB, Baker G, Cohen RA, Fromm-Reichmann F, Weigert E: An Intensive Study of Twelve Cases of Manic-Depressive Psychoses. Psychiatry 17:103–137, 1954
3. Bowen M: A family concept of schizophrenia. In The Etiology of Schizophrenia. Edited by DD Jackson. New York, Basic Books, 1960, pp 346–372
4. Stierlin H: Family Dynamics in Psychotic and Severe Psychosomatic Disorders: A Comparison. Family Systems Medicine 1:41–50, 1984
WHY SOME THERAPISTS PREFER TO TREAT “MANIC-DEPRESSIVE” FAMILIES

5. Wirsching M, Stierlin H: Krankheit und Familie. Konzepte, Forschungsergebnisse, Behandlungsmöglichkeiten. Stuttgart, Klett-Cotta-Verlag, 1982
6. Stierlin H: Separating Parents and Adolescents. A Perspective on Running Away, Schizophrenia, and Waywardness. Enlarged new edition. New York, J Aronson, 1981
7. Stierlin H: Delegation und Familie. Second edition. Frankfurt, Suhrkamp-Verlag, 1982
8. Watzlawick P, Beavin JH, Jackson PD: Pragmatics of Human Communication. New York, Norton, 1967
9. Ashby WR: Design for a Brain. London, Chapman & Hall, 1952