

Virtual Mentor

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OP-ED

The Ghost of the Schizophrenogenic Mother

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A few years back, my colleague Erik Parens and I ran a project whose basic aim was to understand the debate over using psychotropic medications to treat children with emotional and behavioral problems [1]. Of course this debate is really a number of debates nested together. Some say that diagnostic thresholds in psychiatry are too low, causing too many children to be diagnosed, while others counter that mental disorders are underrecognized in children. Some argue that troubled children need behavioral treatments not drugs, while others point out that many medications show impressive efficacy in clinical trials. Some say that problematic moods and behaviors are caused by brain malfunctions that are no more prevalent today than they were 30 or 50 years ago, while others argue that we have the etiological picture all wrong: it's our society that is troubled, not our kids [1, 2]. We found important insights on all sides of these debates—and, in fact, if you scratch the surface you find significant agreement where you initially saw polarization (overdiagnosis and underdiagnosis can coexist, for instance [3]) [1].

We also observed that some issues are particularly difficult to discuss. The role of parents in this whole debate is one such question. On the one hand, we all know that parents can have a significant impact on the mental health of their children, not just because they may pass on a genetic risk but because they control and constitute a significant part of their child's environment. On the other, while we might gripe to each other (or online) about unskilled, lazy parents using medications as a quick fix, or overly ambitious parents using medications to give their children an advantage, there is a deep reluctance, even among clinicians, to interfere with how people raise their kids.

There are a number of possible reasons for this reluctance, including an appropriate concern about respecting the privacy of families. Developmental psychologist Jerome Kagan points to “[t]he American ethic of egalitarianism, which obligates each individual to award dignity and respect to all citizens independent of their values or practices” [4]. While there is much positive to be said about this moral imperative, Kagan argues that it can create problems for child psychiatry because “it makes it more difficult to blame parental neglect or ineffective socialization practices as contributors to aggressive behavior or poor academic performance and easy to award power to genes for which no one is responsible” [4]. Anyone who criticizes the way parents raise their children, including by suggesting they do it differently, risks disrespecting individual choice and equality, and possibly alienating parents, a

necessary ally for pediatricians and child psychiatrists and psychologists, in the process.

Still other factors are likely to reinforce this reluctance—clinicians’ (reasonable) desire to attend to the issues on which they have received training, which may not include family dynamics or parenting strategies [5, 6]. Clinicians may also know that parents can struggle to find the time to participate in parent training or other psychosocial interventions [7]. And perhaps most importantly, the constraints of the U.S. payment system can make it difficult for clinicians to find the time to delve deeply into the child’s home environment [8].

I suspect there are still other factors at work that end up inhibiting a frank and open discussion about how we can get at the role of the child’s environment in creating and ameliorating problematic emotions and behaviors, including the role of parenting practices and expectations. Psychiatry has made some mistakes investigating the environmental—and particularly the parental—causes of dysfunction, and this difficult past haunts the field today. I am referring not only to Freudian theory and analysis, which stressed the importance of childhood events and experience to understanding adult mental health and which now enjoys a mixed reception, but also to the extension of these ideas beyond neuroses to psychosis, specifically to schizophrenia.

Beginning in the mid-1930s, clinicians looked to the families of schizophrenic patients to better understand what might be causing their dysfunction. One study published in 1934 reported maternal rejection in two patients and maternal overprotection in 33 out of 45 schizophrenic patients in the study [9]. The idea that a mixture of maternal overprotection and maternal rejection could cause schizophrenia gained steam, and in 1948 psychiatrist Frieda Fromm-Reichmann named these rejecting and overprotective mothers “schizophrenogenic,” writing that “[t]he 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” [10]. Mothers with their own psychological problems, it was thought, “gave birth to healthy children and then literally drove them mad” [11]. In these homes, according to the theory, the mother and her delusional ideas dominated, making her unaware of the needs of other family members. Schizophrenic behaviors were a way for the child to make sense of this toxic home environment.

Studies published in the 1950s and 1960s seemed to confirm the schizophrenogenic mother—and later schizophrenogenic families—theory. It was not until the mid-1970s that the concept lost favor [11]. In 1982, Australian psychiatrist Gordon Parker published a review of schizophrenogenic mother research, concluding that, while the distant and controlling mothers probably exist, there was no evidence that they were more likely than anyone else to have schizophrenic children.

The most plausible explanation is that there is no *sui generis* schizophrenogenic mother; instead, there is a parental type distinguished by a hostile, critical, and intrusive style, and it is not particularly over-represented in parents of schizophrenics. This explanation would account both for the description and delineation of a schizophrenogenic maternal style in uncontrolled studies of schizophrenics and for the failure to find clear and replicable differences in case-control studies [12].

Today, in light of what we now understand about schizophrenia, the theory of the schizophrenogenic mother seems hopelessly mistaken, and more than a little embarrassing. But (of course) its wrongness doesn't mean that parenting and the family environment play no role in children's mental health or that addressing these aspects is the same as blaming mothers—or parents. We know, for instance, that a parent's mental health status can have a negative impact on a child's well-being. Psychiatric epidemiologist Myrna Weissman at Columbia University has led a number of studies showing that children of depressed mothers have higher rates of psychopathology than those of nondepressed mothers *and* that a powerful way to help these children is to treat their mothers' depression [13, 14]. We also know that altering parenting practices can improve the mental health of some children. Clinical psychologists like William Pelham have shown that parent training—teaching parents basic strategies for effective parenting—is an important component of an effective treatment plan for children diagnosed with ADHD (indeed, Pelham argues it is the most effective component) [15].

Yet we also know that many children in the U.S. do not receive the kind of integrated mental health care that they need. While some of the public debate about pediatric psychiatry pits drug treatments against psychosocial interventions, treatment guidelines for many disorders favor combining drug and psychosocial treatments because medications can quickly reduce the severity of children's symptoms so that they and their parents can begin to engage with psychosocial interventions [16].

Despite these recommendations, many children treated for mental disorders only take medications. Epidemiologists Mark Olfson and Steven Marcus have documented this trend in the general population, reporting that between 1998 and 2007 the percentage of people in outpatient mental health care who received psychotherapy declined significantly and the percentage who received only drugs increased 13 percent [17]. In children, Olfson and colleagues found that amongst privately insured children aged 2 through 5 years who were taking antipsychotic medications, fewer than half received a psychotherapy visit during a year of medication use [18].

I am not attributing these problems solely to the ghost of the schizogenophrenic mother. Indeed, I have no doubt that the other factors I described above, including importantly the constraints of managed care, are more directly responsible for our failure to attend to the whole child. But I suspect that the desire to stand apart from

the psychiatrists of the mid-twentieth century and their mother-blaming beliefs is also part of the story.

Mother blaming helps no one, that much should be clear. But when we ignore the child's context—particularly the practices of those adults who most affect the child's life—we risk locating the child's problems solely in the child and suggesting that the child is the only one who needs to change. That, too, can be a mistake. I know psychiatrists who firmly advocate the use of behavioral treatments, which very often attend not just to the child but also to the child's context, frequently requiring changes in how parents parent and how teachers teach—and some of these physicians are able to raise behavioral treatment options with parents and suggest that parents go to family therapy and parent training classes. It isn't always easy to do this. Venturing into the home environment, and parenting practices in particular, is delicate territory for physicians. But it is territory worth exploring. Many children can be helped by an enlarged clinical focus that seeks to make changes in the child's environment, including at the level of the family. Don't be spooked.

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