Madness and the Family:
Exploring the Links between Family Dynamics and Psychosis

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There are very few things considered more taboo in the world of mental health than the suggestion that problematic family dynamics can lead to a child developing a psychotic disorder. And yet, when we look honestly at the history and research of psychosis and the broader concept of "mental illness," it becomes apparent that there are few subjects in the mental health field that are more important. I'd like to invite you, then, to join me on a journey into this taboo territory, first going back in time to explore how such a crucial topic has become so vilified, then embarking upon a flight for an aerial view of some of the most essential findings of the last 60 plus years of research that look at the links between problematic family dynamics and psychosis, and finally reaping the fruits of this journey and contemplating how what we have learned may guide us as parents, as family members, and as society as a whole in offering genuine support to those who continue to grapple with these extreme states of mind.

A brief history of a serious taboo

Between the late 1940s and the 1980s, there was a steady flow of exploration and research on the links between certain kinds of parent/child dynamics (and general family systems dynamics) and the subsequent development of psychosis within the child. Among those leading the charge on this research were pioneering psychologists and family systems theorists such as Freida Fromm-Reichmann, Gregory Bateson, R.D. Laing, Murray Bowen and Carl Whitaker. Based upon the fruits of this exploration, there was a period of time in which tremendous hope existed that certain kinds of family therapies and parent education could lead to a significant reduction in the amount of adolescents and young adults who went on to experience psychosis and other distressing states of mind, or that such interventions could at least foster recovery for those who had already gone down this path. One book from that era that I find particularly illuminating and accessible to the layperson, highlighting the hopeful family-oriented movement of this time, is *The Family Crucible,* which documents a successful family therapy process that leads to the reversal of an adolescent girl going down the path of a schizophrenia diagnosis (Napier & Whitaker, 1978).

Fast forward to today, however, and we find that any quick surf across the internet will pull up a plethora of mainstream mental health organizations that are very quick to denounce the possibility that problematic family dynamics has anything at all to do with a young person developing a psychotic condition. So what happened? It appears that the general assumption within mainstream society today is that somehow the entire 60+ years of research finding links between problematic family dynamics and psychosis must have been thoroughly debunked; and in fact you will find explicit statements to this effect throughout the mainstream mental health field today. And yet, after years of poring over the literature

on the etiology and recovery of psychosis, I have yet to find any substantial research that directly contradicts the essential premise that problematic family dynamics can lead to extreme psychological breakdown. So again, what happened?

Let's rewind to the early 1950s, when the development of the first psychiatric drug, the "antipsychotic" drug Chlorpromazine, led to one of the most powerful industries the world has ever known—that formed by a coalition between the pharmaceutical and the psychiatric industries (which I'll just refer to as the *psychopharm industry* for short). This industry was founded on a single ideology—the "mental illness" theory, or "medical model" (which I'll refer to simply as the *medical model*)—an ideology that gave this industry tremendous power and influence. The medical model essentially states that distressing states of mind can, for the most part, be categorized into discrete "mental illnesses," and that although these mental illnesses continue to the present day to be rampant and even growing within our society, we must rest assured that the great medical advances of this industry have already developed powerful drugs that can generally contain them, and that it is just a matter of time before our medical technology will eliminate these illnesses altogether (see my book, Rethinking Madness, or my article here for a more thorough critique of the medical model).

The medical model had already been in existence with varying degrees of power for many decades prior to the development of psychiatric drugs, having been particularly fostered within the field of psychiatry. However, up until this point, the medical model had not been able to fully overcome the popularity of the more psychosocially oriented models and methods when it came to making sense of and dealing with human distress, and this presented a particularly challenging dilemma for the psychopharm industry. How could this industry convince the public that much of human distress could be conceived of as discrete "mental illnesses" arising from diseases of the brain and requiring "medical treatment" with psychiatric drugs at a time when psychosocial interventions were showing so much promise? In the 1970s, the answer to this dilemma came in a somewhat surprising form—the parents of those diagnosed with schizophrenia.

As mentioned earlier, beginning in the late 1940s, we find this very dynamic period of time in the field of psychosis theory and treatment/recovery models in the West, in which a series of studies and projects emerged that offered considerable hope for the prospect that for many young people who were experiencing psychosis, their recovery could be greatly facilitated by addressing the problematic relationships within their life. These included various family and social systems models that supported the entire family or social system, seeing the "identified patient" as essentially a canary in a troubled coal mine; residential facilities such as Soteria, Diabasis and I-Ward, which fostered the development of healthy relationships in away-from-family environments; and transpersonal approaches that viewed such crises from within a spiritual context (i.e., as "spiritual emergencies"), and supported the development of healthy relationship between the "self" and the entire web of interdependence that extends beyond simply one's immediate social network.

But as this psychosocial movement entered the 1970s, just as it was reaching a point of truly game-changing momentum, a tremendous backlash occurred. Many parents,

understandably not feeling comfortable with so many fingers being pointed at them, resisted the idea that they played any role in their children's development of psychotic conditions, and they began to push back, hard. And it just so happened that the psychopharm industry was more than happy to take full advantage of the situation, providing these parents with the perfect remedy to their dilemma—the medical model. For these parents, this model offered them an alternative narrative that relieved them of any burden of responsibility—their children simply have brain diseases, which is terribly tragic but has nothing to do with family and social dynamics; and for the psychopharm industry, these parents provided the ideal platform with which to spread this model so crucial to increasing their power and their profit margin—what could possibly be a more persuasive "grass roots movement" than an army of concerned parents willing to offer their complete devotion?

The power of this coalition between defensive parents and the psychopharm industry rapidly escalated, leading to a kind of perfect storm that essentially obliterated the movement towards family therapy and general relationship support as a means to addressing psychosis and other extreme states. The flagship organization of this coalition, which still maintains extraordinary power and influence within the mental health field today, is the National Alliance for the Mentally Ill (NAMI). As an indication of just how successful this coalition has been, in spite of over 60 years of very robust research showing strong correlations between problematic family dynamics and psychosis, and in spite of robust research showing the great benefits of fostering healthy interpersonal relationships as a means to support recovery from psychotic conditions (discussed in more detail below), it has become one of the most serious of taboos within the mental health field to suggest that problematic family dynamics can precipitate psychosis and other extreme states of distress.

In short, then, we find ourselves living in a society in which disability due to psychological breakdown has been continuing to grow at nearly exponential rates in spite of (or perhaps partially *because* of, as documented so well in Robert Whitaker's *Anatomy of an Epidemic*; 2010) a psychopharm industry whose scope and power has likewise grown at a nearly exponential rate. And all the while, we find that the very hopeful and well established premise that so much of this psychological breakdown is rooted in problematic family dynamics has been discarded like so much outdated and worthless trash.

I and others have come to believe, however, that this has been a colossal mistake—that if we take the time to pick up this "trash" and carefully reconsider it, we will find that we have thrown away some truly valuable gems, gems that have the potential to offer real peace of mind to so many troubled individuals and families within our troubled society. So let's take the time now to look more closely at some of the key findings of the links between family/relational dynamics and psychosis, and explore some of the implications of these with regard to avoiding the onset of psychosis in youth, and in supporting the recovery of those who have already experienced such a breakdown. But before we do, let's first take a closer look at what we mean by the term "psychosis."

What Exactly Is Psychosis?

We typically throw the word "psychosis" around freely as if we're pointing to a condition or illness that is well established, but I've come to feel that the term "psychosis" is far overused and abused in our society. Essentially, whenever someone has beliefs, perceptions or behaviors that don't line up with the generally accepted norms of one's society (i.e., consensus reality), they're at risk of being diagnosed with a "psychotic disorder," typically "schizophrenia," "schizoaffective disorder" or "bipolar disorder." However, just because certain beliefs, perceptions or behaviors are considered "abnormal" does not automatically imply that they are "unhealthy," and vice versa. To the contrary, contemporary society as a whole is extremely violent and destructive—indeed, multiple indicators suggest that we as a species will be quite fortunate if we survive the 21st century; so we need to rein in any tendency we may have to automatically assume that "abnormal" beliefs, perceptions and behaviors are problematic or represent "mental illness," and that "normal" beliefs, perceptions and behaviors are necessarily "healthy."

As I've discussed extensively elsewhere (and as summarized in my article here), I think it's helpful to first make the distinction between those anomalous experiences (shorthand for "nonconsensus beliefs, perceptions and behaviors") that are harmful/distressing and those that are not. If they're not harming anyone or distressing the individual, then what's the problem? Why give them any kind of label at all? And in those cases where they *are* harmful or distressing, this still does not necessarily mean that they are qualitatively any different than other harmful or distressing beliefs and behaviors that are considered more "normal," such as burning fossil fuels, eating meat, getting drunk or believing in the special entitlement of one's nation, race or religious group.

There clearly are, however, certain states of mind that are more than simply the existence of certain anomalous beliefs, perceptions and behaviors, or experiencing particularly intense states of emotions. Many people clearly do develop a condition in which these kinds of extreme experiences become significantly unstable and overwhelming, and it is this condition to which I think it can be helpful to refer to as "psychosis." I have come to see this condition as generally representing an unconscious attempt of a desperate psyche to radically transform one's deepest experience and understanding of the self and the world—a condition that occurs when one's current experience and understanding of the self and the world has reached a point where it is simply no longer tolerable, for whatever reason. And considering that our capacity to relate to ourselves and others is so profoundly shaped by our relationships with our parents and other close family members, it stands to reason (and to the research, as discussed below) that these most primary of our relationships can profoundly affect our vulnerability or resilience to such psychological breakdown.

An Overview of the Research on Family Dynamics and Psychosis

Regardless of the particular theoretical model used—whether seeing the etiology of psychosis as being predominantly due to "nature" (i.e., biological/genetic) or "nurture" (i.e.,

one's environment), or some combination thereof—what remains undisputed is that the development of psychotic conditions tends to run in families. In spite of the fact that the prevailing mainstream belief is that psychotic disorders are caused by yet to be established genetically inherited brain diseases, the research supporting this is actually very weak (discussed more thoroughly in *Rethinking Madness;* 2012). On the contrary, when looking at the research linking psychosis to environmental conditions, and especially interpersonal conditions, we find quite a rich and compelling history of research that strongly supports this link. Let's take a moment now to go over some of the most significant of these:

Between the late 1920s and the late 1950s, psychotherapist Frieda Fromm-Reichman devoted much of her time to trying to understand the nature of psychosis, and to working therapeutically one-on-one with people struggling with such conditions. Building her own theories from a predominantly psychoanalytic relational orientation, she essentially came to the conclusion that psychosis typically occurs when a person becomes overwhelmed by a dilemma in which they both intensely long for and intensely fear the symbiotic merger with another. She believed that such a predicament most commonly emerged as the result of early childhood relational confusion and injury associated with the child's primary caretaker, which is most often the mother (and hence her coining the controversial term, "schizophrenogenic mother.") In 1964, Joanne Greenberg, a patient of Fromm-Reichman who experienced full recovery from a debilitating psychotic condition, published the bestselling book, *I Never Promised You a Rose Garden,* which offers a compelling autobiographical account of the potential for full recovery from long-term psychosis when such individuals are supported in repairing early childhood relational injuries.

In the 1950s, Gregory Bateson and his colleagues followed a line of reasoning similar in some ways to that of Fromm-Reichman, and after extensive research, proposed the "double-bind hypothesis" (Bateson et al., 1956). This hypothesis suggests that if the authority figures within a family (typically the parents) place the child in a double-bind by setting up conflicting injunctions so that it is impossible for the child to satisfy one without violating another, then a situation can result in which the child experiences such overwhelming distress that they are forced into a kind of psychotic reaction as a kind of extreme strategy to tolerate this otherwise intolerable situation.

Piggybacking off of the work of Bateson and his team's double-bind hypothesis, R.D. Laing suggested that these kinds of interpersonal and intrapersonal binds that develop within dysfunctional family systems go on to create an *incompatible knot,* or untenable dilemma within the child that forces her to essentially "go mad," which he saw as a profound transformation of the self resulting from a desperate attempt to resolve this otherwise irresolvable dilemma. After closely studying the family and social systems surrounding over 100 cases of individuals diagnosed with schizophrenia, he concluded that, "*without exception* the experience and behavior that gets labeled schizophrenic is *a special strategy that a person invents in order to live in an unlivable situation* [author's emphases]" (1967, pp. 114-15). So Laing was one of the first in the West to emphasize the deeper wisdom and potential for positive transformation and renewal within the process of psychosis. Laing went on to write extensively on these topics, with *The Divided Self* (1961), *Sanity, Madness*

and the Family (1964) and *The Politics of Experience* (1967) being among the most essential of these.

In the late 1940s and 1950s, Murray Bowen, a founding pioneer of family systems theory and therapy, came onto the scene as a leader in researching links between certain kinds of family dynamics and the development of "schizophrenia." Among his most well-known family systems concepts is *Differentiation of Self*, which essentially refers to the capacity to experience a self as distinct from others, and particularly from one's primary caretakers. He derived this concept during his years of working with those diagnosed with schizophrenia, when noticing that those so diagnosed typically developed an unusually poor Differentiation of Self.

Bowen also came to notice a significant pattern in which patients diagnosed with schizophrenia often improved when being separated from their families (typically when being placed in the hospital), but then deteriorated upon returning to their families. Subsequently, he became inspired to head an inpatient hospitalization project for the National Institute of Mental Health, in which he compared family members deemed "schizophrenic" with those considered "normal," and concluded that:

> . . . family members were involved in the [psychotic] process with the patient more deeply than had been hypothesized. Fathers were admitted to the family groups, and the hypothesis was extended to think of schizophrenia as a symptom manifestation of an active dynamic process that involved the entire family, and a plan was devised to treat the family as a single unit rather than individuals within a unit. (Bowen et al., 1960)

In this and his other work, then, Bowen contributed significantly to the idea that what is called "schizophrenia" is more appropriately seen as a problem existing broadly within the entire family system rather than simply existing solely within the "identified patient."

In 1966, George Brown and his colleagues effectively demonstrated that "schizophrenia" patients discharged from the hospital and returned to family environments that have particularly high degrees of criticism, hostility and emotional dependency, are much more likely to return to the hospital. He coined the term "expressed emotion" or "EE" to describe this particular family dynamic, and found that patients from high-EE homes were about 6 times more likely to be rehospitalized than those from low-EE homes (Brown et al., 1966), a finding that has since been replicated numerous times. A later closely related study followed adolescents for 15 years and found that of those whose parents both scored highly on EE measures, 36% of them went on to become diagnosed with schizophrenia, whereas not a single youth became so diagnosed if one or both parents scored low on EE measures (Goldstein, 1987).

In the 70s, stemming directly from this earlier research and Laing's Kingsley Hall experiment, we witnessed a movement towards the development of residential facilities whose aim was to provide the opportunity for young people grappling with psychosis to extract themselves from problematic family systems and live within social environments

designed to maximize healthy relationships with others while offering support in resolving their psychotic crises and moving towards independence. The most well known of these is Loren Mosher's *Soteria* home, which was originally established as a National Institute of Mental Health funded research project, comparing the recovery outcomes of such a home with those of mainstream "treatment as usual" (which primarily consisted of hospitalization and psychiatric drugging). This study demonstrated that the Soteria project was equal or superior to the standard treatment on every outcome measure studied, with a significantly higher percentage of Soteria residents going on to live independently with less psychiatric drug use and fewer rehospitalizations (Bola & Mosher, 2003).

Two other similar but lesser known "madness sanctuaries" developed in the 70s were *Diabasis*, designed and directed by John Weir Perry, and *I-Ward*, a project initiated by the Contra Costa County Hospital. Though less well researched than Soteria, the evidence suggests that these other homes were able to demonstrate very hopeful outcomes similar to those of Soteria. After reviewing the collective research on the outcomes of such homes, Mosher concluded that "85% to 90% of acute and long-term clients deemed in need of acute hospitalization can be returned to the community without use of conventional hospital treatment" (1999, p. 142).

Unfortunately, in spite of their success, all of these homes were closed due to a lack of funding, which Mosher and others have ascribed to an underhanded political assault by the psychopharm industry, as the existence of such homes clearly represented a potent existential threat to the psychopharm industry. Since that time, several other Soteria and Soteria-based homes have been established within the U.S. and Europe, but these have generally demonstrated less successful outcomes, due most likely to the fact that these more recent homes have been crippled by a mental health system that has become increasingly entrenched within the medical model paradigm. In particular, these more recent homes have generally not been trusted to receive people experiencing first-episode psychosis, they have often been forced to alter their approach in certain ways to conform more with the medical model, and they have often found themselves excessively burdened by being required to support individuals who have already received significant psychosocial injury from years of previous drug treatment and institutionalization (see this article by Dan Mackler for a more thorough analysis of these issues).

Beginning in the late 70s and through the early 90s, several other models that drew from a family systems perspective came onto the scene. In contrast to the Soteria-type homes, these programs consisted of trained facilitators who worked directly with the families (and extended social systems to various degrees) within the family's natural environment. One such approach is Windhorse Community Services, which draws its guiding principles from the Tibetan Buddhist tradition, and attempts to foster the "basic sanity" and wisdom that underlie the chaotic system that has emerged within the mind of the individual and the broader family system. Windhorse continues to provide services in several regions of the United States, though remains generally marginalized by the mainstream system and forced to conform to some extent with the medical model philosophy and treatment approach.

In the late 70s, a team of Italian psychologists developed the Milan family systems approach to working with those diagnosed with schizophrenia, drawing particularly from Bateson's work on the double bind theory, and developing what they called the "counterparadox" technique, which consisted of various ways to directly counter the entrenched double binds, or "paradoxical communication," that had formed within such families (Selvini-Palazzoli et al., 1978). Drawing directly off of the work of both Bateson and the Milan team (as well as Russian philosopher Mikhail Bakhtin's *Dialogism*; 1984), a group of mental health professionals in Western Lapland, Finland, developed the *Open Dialogue* approach, which involves a team of facilitators who work with the family in their own natural environment, and who create a space in which the principles of "tolerance of uncertainty," "dialogism," and "polyphony" are emphasized (Seikkula & Olson, 2003). In essence, this approach attempts to create a space in which all voices are heard, and any existing rigid right/wrong or true/false frameworks held within the family system are exchanged for one that is more open to multiple perspectives, with the idea being that such a space provides the fertile ground for genuine resolution and a more sustainable order of harmony to emerge. After documenting the outcomes of this approach for over 25 years, the Open Dialogue approach has demonstrated the best evidence-based recovery outcomes in the entire Western world, with over 80% of individuals experiencing a psychotic breakdown going on to experience full medication-free recovery. The Open Dialogue approach has recently begun to spread to other parts of the world, continuing to offer significant hope for individuals and families so afflicted.

Presumably due to the increasing dominance of the medical model paradigm in the later decades of the 20th century and up to the present day, research into problematic family dynamics and psychosis has become increasingly sparse. However, over the past 20 years or so, a closely related line of research has come into sharper focus—research into correlations between childhood trauma and the subsequent development of psychosis. In particular, a number of *adverse childhood experiences* have been shown to be highly correlated with the development of a psychotic disorder, particularly those listed in *Table 1*.

The findings of several such trauma-based studies have been particularly striking, essentially shattering any doubts people may still have about environmental and relational factors playing a major role in precipitating a psychotic condition in a young person. For example, a 2004 Netherlands study followed 4,045 participants who were initially free from psychotic symptoms for 3 years. They found that victims of child abuse were 9 times more likely to go on to develop psychosis, and that the victims of the most severe child abuse were *48 times* more likely to develop psychosis (Janssen et al., 2004). And in 2007, a UK study went over the records of 8,580 participants to identify the correlations between a broader array of childhood trauma and psychosis. They found that individuals with 3 types of trauma were 18 times more likely to have subsequently developed a psychotic condition, and that those with 5 or more types of trauma were *198 times(!)* more likely to have subsequently developed psychosis (Shevlin et al, 2007). In contrast, research into biological or genetic correlates for psychosis has not been able to establish degrees of correlation anywhere close to these (for a particularly comprehensive review of the literature on childhood trauma and psychosis, see Read et al., 2008).

Factors typically *internal* to the family system	**Typically *external* factors likely to impact the family system**
Prenatal stress and poor health	Poverty
Early parent attachment issues	Urban living
Childhood physical abuse	The target of racism
Childhood sexual abuse	Sexual assault
Childhood physical neglect	Physical assault
Childhood emotional neglect	Exposure to combat
Parental loss	Peer bullying
Sibling bullying	

Table 1. Adverse Childhood Experiences (ACEs) established to correlate with the risk of developing a psychotic disorder.

Note that one factor not listed in Table 1 in spite of significant correlations with the onset of psychosis and other extreme states is the use of psychoactive drugs, including both recreational drugs (such as cannabis and methamphetamines) and most major classes of psychiatric drugs. I didn't include this factor in the table, however, since drug use doesn't typically represent an adverse childhood experience in itself, but rather is generally best seen as a common response *to* the distress caused by such experiences, as psychoactive drugs can often provide temporary relief from such distress. There is a painful irony in using such drugs to ameliorate distress, however—although they may provide significant relief in the short term, they actually increase the likelihood that the person will go on to develop psychosis and other distressing states of mind further down the road (see Whitaker's *Anatomy of an Epidemic* or my own *Rethinking Madness* for more about this).

When looking at the list above of childhood traumas, it's easy to see that all of them are either directly related to serious problems within the family system, or at least directly impact upon them. So looking more closely at this list, and at the types of problematic family dynamics that have been implicated within the research mentioned above, a very important question emerges: What do all of these have in common? In other words, is there some common denominator that all of these types of trauma and patterns of problematic family dynamics share, a single underlying factor that makes someone particularly vulnerable to experiencing a psychotic breakdown? Indeed, I believe that there is.

Seeing Psychosis as a Crisis of Individuation

In essence, I believe that in order to maintain wellbeing, we must ensure that certain core needs remain "well enough" met; and when this doesn't happen, psychosis is likely to ensue. Furthermore, given the importance of our development throughout our earliest

years in determining how well we do with regard to meeting these basic needs, and the importance of our family system in shaping our early development, we can connect the dots and say that problematic family dynamics can set the stage for our inability to adequately meet these basic needs, which in turn can lead to the vulnerability to experience a profound psychological crisis (i.e., psychosis). To better understand this, let's start from the beginning.

As I've discussed at length in *Rethinking Madness* and elsewhere, we can see the very elaborate experience and understanding of our self and the world (our "personal paradigm") as being akin to a tall skyscraper, with the very ground floor consisting of our most fundamental existential dilemma—the need to experience our "self" as a relatively secure and stable "being" living in a relatively secure and stable world, when the actual nature of the world and of our existence within it is not particularly stable and secure at all. Converging from numerous perspectives—spiritual, psychological, physical—is the recognition that the raw fabric of our world and of our experience is profoundly impermanent, interconnected and therefore fundamentally unitive—in other words, ultimately not consisting of discrete and permanent entities or selves. This is the basic fabric of existence to which many religions, spiritual traditions and even the current frontiers of Western science point to; and it is also these deepest waters of existence in which those who enter a psychotic process often find themselves desperately struggling not to drown.

Considering this "ground floor" existential dilemma from the perspective of a human being in the very early stages of development, we can say that as an infant emerges from the intra-uterine experience of relatively undifferentiated unity with the mother to the experience of a differentiated sense of self, he experiences an increasingly reified experience of both "self" and "other." This experience in turn leads to the increasing importance of learning how to develop a relatively secure and enjoyable relationship between "self" and "other." We can say that it is at this stage when the young person is developing the second floor of what will ultimately be the tall and elaborate skyscraper of his personal construct system of self and the world. I have referred to this second tier elsewhere as the "self/other dialectic," or more appropriate to the context here, as the "autonomy /connection dialectic."

To summarize these two most foundational tiers of our development, then, we can say that as newborns emerging from the womb and into the world, we must first experience a "good enough" sense of safety, stability and a nurturing welcome (first tier needs) before having the capacity to properly venture into the risky business of differentiating into a unique "self" that is able to relate effectively with "others" (second tier needs). So generally speaking, safety ("It's safe enough") and belonging ("I belong here"; "My existence is welcomed") can be seen as our most essential core needs, which are followed closely by our rapidly increasing needs for both autonomy and secure connection with others as our self/other differentiation develops (see *Figure 1*).

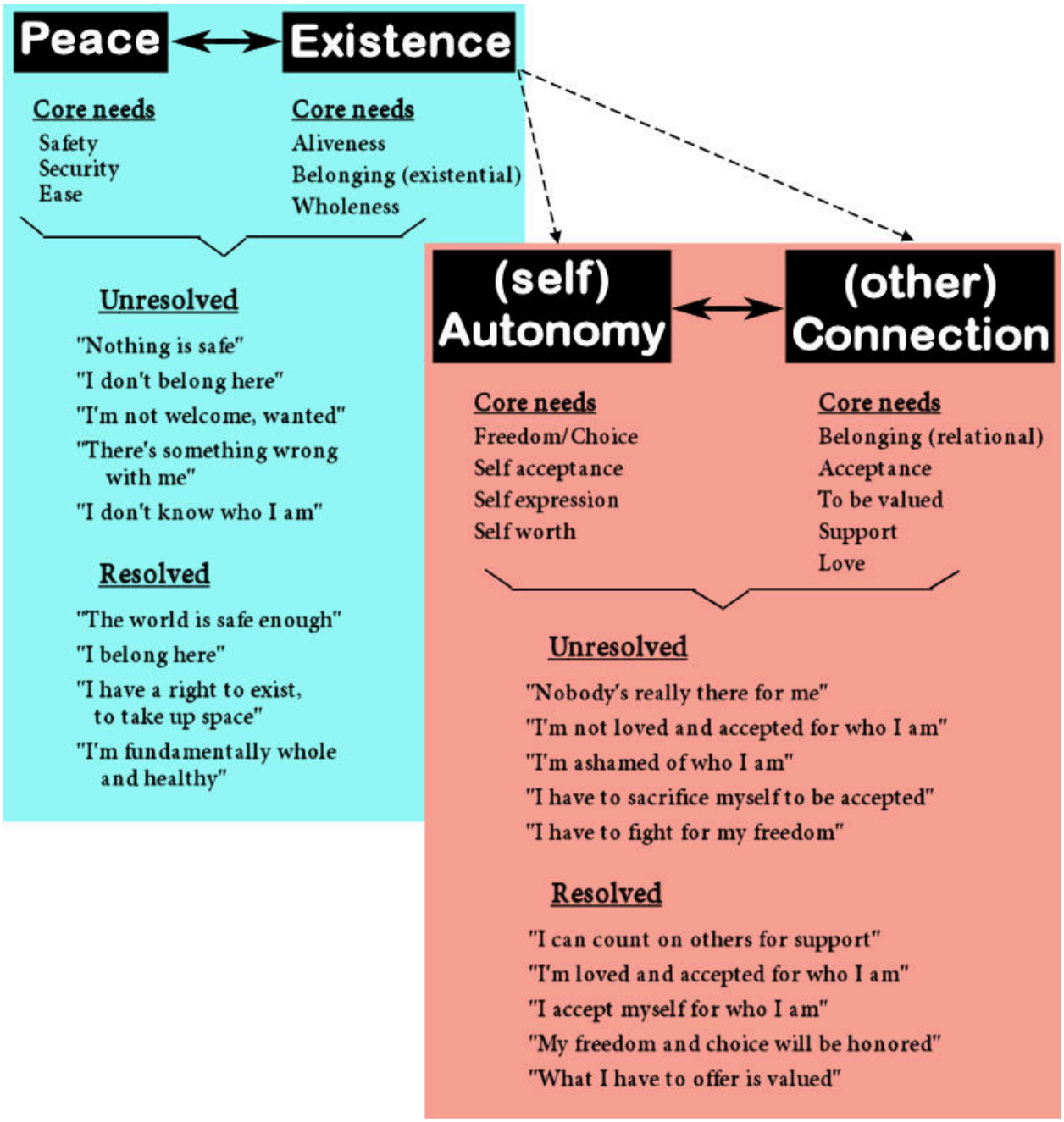

Figure 1. The first two tiers of the development of our personal construct system, with the most primary of these consisting of the peace/existence dialectic, and the second tier, the autonomy/connection dialectic, being constructed directly off of this. Each dialectic is comprised of two core needs or drives that are set in diametrical opposition to each other, and yet it's possible to arrive at a successful "resolution" with regard to each dialectic, in which both sets of needs are adequately met and even mutually reinforcing.

Focusing on this second tier, then, we can say that the autonomy/connection dialectic results from the universal human dilemma that, like it or not, we are profoundly relational beings. The nature and quality of our social relationships play a huge role in our wellbeing, and developing healthy, satisfying relations is generally very challenging for any of us, due in large part to this dilemma that we all share—one hand, we require a certain amount of healthy connection with others in order to survive and to ultimately thrive; and on the other hand, we also require a certain degree of autonomy (e.g., freedom, choice, personal power, self agency and a general sense of self worth). So the dilemma lies in the inherent difficulty of trying to develop healthy relationships with others in which we experience *both* secure enough nourishing connection and intimacy *and also* enough freedom and autonomy so that we can tolerate (and hopefully enjoy!) our existence; hence the term "autonomy/connection dialectic."

The other key component of this term is "dialectic," which is derived from the Hegelian notion of two apparently contradictory elements (the "thesis" and the "antithesis") coming together to form a unified whole (the "synthesis"). So the autonomy/connection dialectic refers to the fact that on one hand, it can be challenging to find a balance between two seemingly contradictory needs, or drives—autonomy and connection—but on the other hand, we find that it's possible to develop in such a way that these actually become mutually reinforcing—the more we develop a sense of genuine comfort and security with our autonomy and self worth, the more likely it is that we will feel at ease while connecting with others, and vice versa. So we find that it is possible to arrive at a state of "synthesis" or "resolution" in which we experience wholesome and nourishing relationships in which both autonomy and connection are satisfyingly met (see *Figure 1*).

While this dilemma of the autonomy/connection dialectic shows up within all of our social relationships—be they with siblings, friends, romantic partners, colleagues or other peers—it first shows up in our relationship with our parents (or other primary caretakers, which I'll collectively refer to as simply "parents"). And not only does it merely show up in our relationship with our parents, but the degree of success we experience with regard to resolving this dilemma within these primary relationships powerfully influences how successful we are in developing into a mature, relatively happy human being. These first relationships form the foundations for the way that we feel and behave in all subsequent relationships with others, and also how we relate with ourselves.

This process of developing a healthy, wholesome relationship with ourselves, and the capacity to experience such relationships with others, is sometimes referred to as "individuation," a term popularized by transpersonal psychologist Carl Jung, and a concept that has been further explored and expanded upon within *Attachment Theory,* as first developed by John Bowlby in the late 50s and 60s (Bowlby, 1969). To put this term into the context I'm presenting here, we can say that "individuation" essentially refers to our developing in such a way that we experience a "good enough" resolution of the autonomy/connection dialectic (which is in turn dependent upon our resolution of the more primal peace/existence dialectic), which then gives us the capacity to experience healthy, nourishing relationships with ourselves and others.

As we develop as children, while of course our entire childhood influences our process of individuation, it does appear that there are two particularly critical periods in this regard. The first period is more or less our first 2-3 years of life, in which we first develop *attachment styles* that are likely to remain relatively robust throughout our lives. These refer to habitual patterns of relating to others, and can be seen as corresponding directly to the autonomy/connection dialectic. During these very early years of our life, the way that our parents behave and relate to us profoundly shapes the personal lens through which we make sense of ourselves and others. If we experience an adequate degree of both secure connection and autonomy/validation, then the message that becomes imprinted deeply within our being is, "I'm welcome here, I can count on being supported, and I am loved and valued for who I am." This experience of the world as generally nourishing and supportive is associated with the development of what is referred to within attachment theory as a *secure attachment style*, and can essentially be seen as indicating that the child has so far been successful in achieving a relatively sustainable and healthy resolution to the autonomy/connection dialectic, at least at this early stage of development.

If our connection and/or autonomy needs are not adequately met during these early years, then according to attachment theory, we are likely to develop an *insecure attachment style*, a problematic relational style that is generally recognized as veering into one of three extreme relational directions. On one extreme, we become excessively fearful and avoidant of intimate contact, so experience an excessive fear of connection (what I like to refer to as *engulfment anxiety*, as in a fear of being "engulfed" or overwhelmed by the other), and this is typically referred to as an *avoidant* insecure attachment style. On the other extreme, we become excessively clingy, so experience an excessive fear of autonomy (what I like to refer to as *isolation anxiety* or *abandonment anxiety*), and this is typically referred to as an *ambivalent* insecure attachment style. Finally, in the most extreme cases, we find that a person can swing radically from one of these extremes to the other, or even experience them both simultaneously (an excessive fear of *both* autonomy *and* connection), what is often referred to as a *disorganized* insecure attachment style.

When a person develops an insecure attachment style during this early stage of development, certain limiting core beliefs become imprinted deeply within one's being, such as: "I'm not welcome here," "Nobody cares about me," or "I'll be cared for, but only if I give up my freedom or suppress my authentic self." And when reflecting upon the autonomy/connection dialectic, it's easy to see how such beliefs, which initially emerged out of a failure to experience successful resolution with regard to this dialectic at this early stage, are then likely to interfere with the individual's ability to achieve successful resolution of this dialectic during the second critical stage of this process occurring much later, in late adolescence (discussed below).

Research into links between attachment styles and psychosis has only recently begun to be carried out; however, we are already finding strong correlations between early insecure attachment styles and the later development of psychosis (Berry, Barrowclough & Wearden, 2007; Read & Gumley, 2008; Williams, 2011). I think to fully grasp the significance of this link it will help to bridge my own exploration of the fundamental

existential and relational dialectics (the peace/existence and autonomy/connection dialectics, respectively) with Gregory Bateson's work on the links between double binds and psychosis. Recall that Bateson describes a double bind essentially as that which occurs when we find ourselves torn between two injunctions that are placed in mutual opposition, so that following one injunction is likely to lead to punishment associated with betraying the other; and yet there is the possibility of finding a resolution to this dilemma, by either finding a way to shift from the impossible "either/or" dichotomy to a "both/and" solution and/or by transcending the system altogether. Closely related to this, I see the peace/existence and autonomy/connection dialectics as essentially representing such double binds that have been imposed upon us by our very existence, with our healthy development requiring that we find a way to transcend the possibility of becoming caught indefinitely in an impossible "either/or" dichotomy with regard to these, and to instead arrive at a workable "both/and" solution (i.e., developing a belief system and life strategy that allows us to have *both* enough peace *and also* enough meaningful/sustainable existence, and *both* enough autonomy *and also* enough nourishing connection with others). *Figure 1* shows some common core beliefs likely to be associated with these dialectics being unresolved vs. resolved.

So using this framework, we can say that the degree of relational security we have achieved as indicated by our particular attachment style essentially represents the degree to which we have experienced resolution of these two core double binds that are inherent within our very existence. Bridging the works of Bateson, attachment theory, and my own explorations, then, we can say that while we all share these core existential dialectics/double binds, the family and social dynamics within which we are raised profoundly affects our ability to achieve a "good enough" resolution to these so that we may live enjoyable lives.

The second particularly critical period with regard to healthy individuation occurs in late adolescence and early adulthood. It is at this stage that healthy development requires that we undergo a transition in our primary attachment figures, from our parent(s), who have likely been our primary attachment figures up until this point, to a romantic partner, with a relatively secure and longstanding romantic relationship generally considered the most natural and optimal developmental aim in this regard. This transition is difficult for most children and parents to various degrees, but for some children and parents, the difficulty of this stage of individuation can be completely overwhelming, and therefore pave the way to the development of psychosis. I believe that this is why the large majority of people who experience psychosis first do so during this particular developmental stage—between mid/late adolescence and early adulthood. Some people do experience their first onset of psychosis much later in life, but from what I've seen in the literature and in my own clinical experience, I would say that the majority of these cases are still closely related to a problematic relationship with a primary attachment figure, but that the primary attachment figure is often a romantic partner rather than a parent. Furthermore, I suspect that in the majority of even these cases, the person likely had some pre-existing vulnerability as a result of earlier attachment issues stemming from childhood.

So why is this particular stage of individuation—that of young adulthood—so difficult for some people, children and parents alike, and why can it be so difficult as to sometimes lead to psychosis? In order to answer these questions, it will help to contemplate this stage of individuation as directly experienced by both the child and the parent:

The child's perspective. For those of us who have already passed into adulthood, it will help to take a moment to reflect upon our own transition from childhood into adulthood. Most of us will be able to recall several very powerful drives that greatly influenced our behavior during this time. There is usually the drive to distance ourselves from our parents, and to spend an increasing amount of time with peers, including both friends and romantic partners. There is also the drive to come out from under the authority of our parents and to experience as much freedom and autonomy as possible. So in general we can see these as healthy drives pushing/pulling us towards mature adulthood, in which we make the transition to more equal footing in our relationship with our parents—ideally coming to see them more as supportive close friends than as authority figures—and from having our parents as our primary attachment figures to having a romantic partner take on that role.

But along with this pull we feel towards increasing autonomy, most of us also experience some fear associated with this. Will I be able to make it out there in the world without the support of my parents? Can I actually handle the self-responsibility that goes along with being an autonomous adult, taking full responsibility for all of my own actions? Will I be able to develop enough nourishment and satisfaction within my relationships with friends and romantic partners?

With some honest reflection, I think that all of us who have gone through this transition into adulthood should be able to recognize this dilemma—the ambivalence of wanting more freedom and autonomy on one hand, and on the other hand, feeling some degree of insecurity with regard to our ability to really handle these. And closely related to this is usually the concern associated with our ability to continue adequately meeting our connection and belonging needs as we transition away from the direct care of our parents and more fully into the fold of peers and lovers. Some of us struggle with this dilemma much more than others, and the reasons for this can be numerous, but it is clear that the nature of our relationship with our parents, both prior to and during this transition, plays a major role in how difficult this transition will be for us.

When this transition fails, the person essentially fails to achieve healthy individuation (i.e., to successfully resolve the autonomy/connection dialectic), and certain harmful core beliefs associated with this develop or are reinforced, such as: "There's something wrong with me," "I won't be able to find someone who will love me for who I am," "I have to choose between being authentic and being loved," and "I can't handle it out there." The person then feels trapped in a very painful dilemma: on one hand, the experience of overwhelming engulfment by the parent(s) to whom they continue to feel so dependent upon, which is often associated with powerful feelings of anger and resentment towards them as a result of this; and on the other hand, the overwhelming fear of isolation and loneliness should they fail to develop secure and nourishing relations with others upon

leaving home. And further stacked upon these feelings is often deep shame and even self loathing as a result of finding oneself so stuck within such a predicament.

This predicament, with so many painful feelings that go right to the core, has the potential to be powerful enough to push anyone over the edge, though we may each differ in just how much we can tolerate before this tipping point is reached. And unfortunately, many parents, wittingly or unwittingly, often directly exacerbate this predicament and increase the likelihood of the ultimate failure of their child's individuation, due to their own ambivalent feelings.

The parent's perspective. As any parent knows, raising a child requires an enormous whole-being commitment typically lasting at least two decades, often entailing the sacrifice of deep personal ambitions in the process. This great sacrifice combined with the very natural tendency to become deeply attached to one's children can make it very difficult to let them go when they come of age. To devote so many years and resources towards the life of this being, and then to simply let them go free into an unpredictable and frankly dangerous world . . . this is no easy task for any loving parent, and yet if we want our children to experience the fullness of mature adulthood, this is exactly what is called for. It's no wonder that many parents really struggle with this, and in spite of what may be the best of intentions, may directly undermine their child's individuation process.

Just as in the case of the child, the parent may find that she is harboring or reinforcing certain personal core beliefs that ultimately cause more harm than benefit to their child's individuation process, such as: "There's something wrong with my child," "He's not ready to handle the world," "I have to protect her from the world," "I have to protect him from himself." And just as in the case of the child, the parent may struggle with very powerful and ambivalent feelings associated with this dilemma. On one hand, the parent probably really does want to see their child transition to an independent and enjoyable life, and may even genuinely desire a bit more personal space and freedom for themselves; and on the other hand, they may also fear for their child's safety and/or fear becoming overwhelmed by their own feelings of loneliness and meaninglessness once the child leaves (the so called empty nest syndrome). While it's natural for most parents to struggle with such mixed feelings, if these feelings are powerful enough and not adequately checked by the parent, they are likely to only reinforce their child's own ambivalence about individuation and increase the likelihood of failure.

Implications for Supporting Recovery

When we consider that psychosis often results from the failure to experience healthy individuation, we can see that a kind of intrapsychic split has developed, where a person feels terribly torn between a longing for freedom and autonomy on one side, and a longing for love, belonging and nourishing connection on the other side. Or to consider this same dilemma from the perspective of fear rather than longing, we can say that a person feels terribly torn between a fear of loneliness and isolation on one side, and a fear of being

oppressed or "losing oneself" within relationship on the other side. When we recognize this tension lying at the root of a person's psychotic process, we find that it offers us some very useful guidance in supporting a person working with experiences that may otherwise seem so chaotic and unpredictable. In particular, what we find is being called for is supporting this person in experiencing both healthy autonomy and personal empowerment, and also healthy connection with others. To begin laying down an effective framework for how we may best be able to do this, let's first briefly touch into the concept of *parenting styles*.

Towards an effective parenting style. There has been a lot of theory and research on different parenting styles over the years, with some styles being seen as more problematic than others. One relatively simple framework that a lot of people resonate with makes a distinction between *authoritarian, neglecting, permissive* and *authoritative* parenting styles, and I think it's helpful to consider these different styles from within the context of healthy autonomy and connection as presented within this article series (see *Figure 2*).

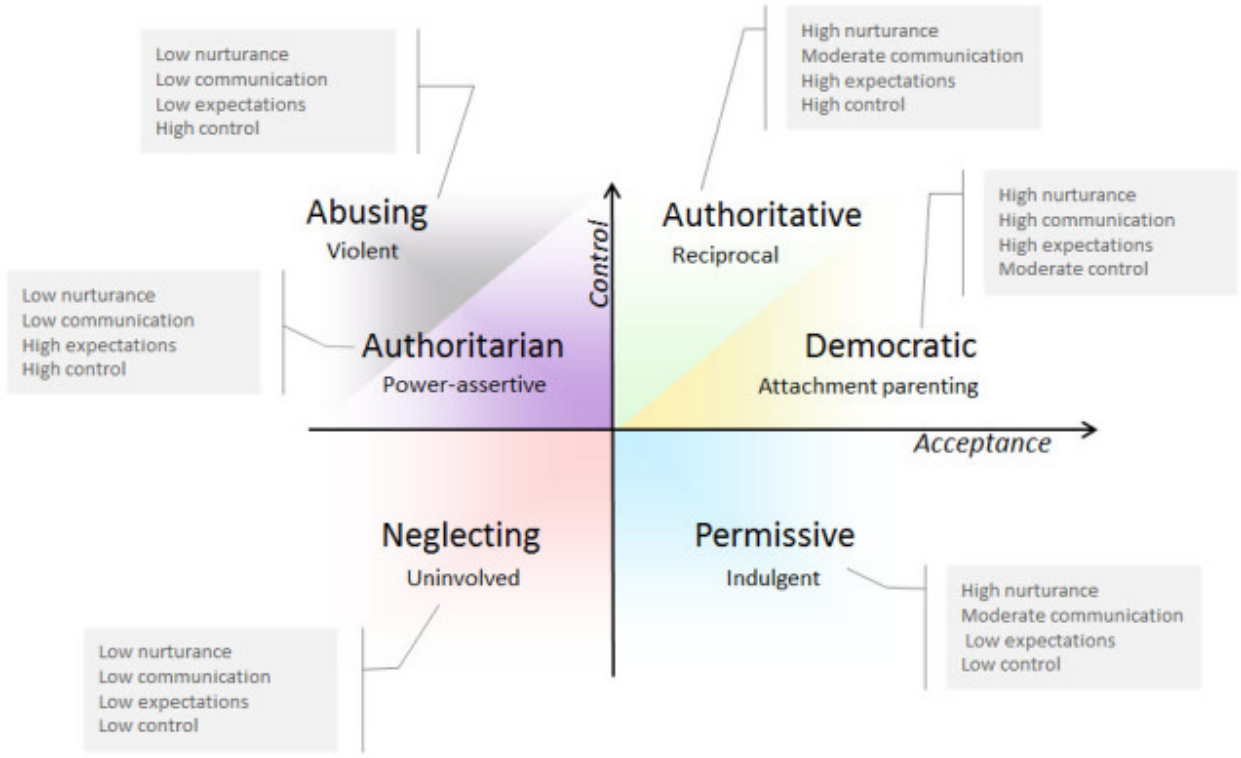

Figure 2. Different parenting styles as mapped along the dimensions of Control *and* Acceptance*, which closely correspond to my use of the terms "autonomy" and "connection." An increase in control corresponds with a decrease in the child's autonomy, and the degree of acceptance corresponds directly with the degree of healthy connection experienced by the child. (Source: Parentastic.org).*

With authoritarian parenting, there is little collaboration or discussion with the child regarding the setting of limits, and these limits are strictly enforced typically with

punishment. The child's autonomy needs are generally oppressed, and while there may be genuine love and affection from the parent, communication is generally poor, leading to the child's connection needs also generally not being adequately met.

With permissive and neglecting parenting styles, limits are generally not discussed or even set, let alone enforced. While it could be argued that their autonomy needs are being met, in actuality, because developing children need guidance in understanding their limits and developing self responsibility for the consequences of their actions, the kind of autonomy developed with these styles often consist of poor impulse control and poor self responsibility, which in turn limits the ability to develop healthy relationships with both self and others. Regarding healthy connection needs, a significant difference between neglecting and permissive parenting styles is that the permissive style generally includes more healthy connection—the child is treated like a "loved friend"—whereas there is very little nourishing connection with a neglecting parenting style, the child being treated essentially as a nuisance to be tolerated with minimal effort on the part of the parent(s).

With the authoritative (*not* authoritarian) parenting style, the emphasis is placed on setting clear reasonable limits, using as much warmth, collaboration and communication with the child as possible while setting and enforcing these limits. The child is then allowed essentially as much freedom and autonomy as possible within these limits. Considering this style from within the framework presented here, it's easy to see that this particular style is likely to be the most effective style in supporting the child in resolving the autonomy/connection dialectic and ultimately achieving mature individuation. And indeed, extensive research has demonstrated that children raised with this particular style are most likely to develop satisfying and nourishing relationships with self and others (Baumrind, 1989; Furnham & Cheng, 2000; Galambos, 1992).

Two sub-categories of the authoritative parenting style that are helpful to consider are *attachment parenting* and *democratic parenting.* These can essentially be seen as simply a sequence of two stages following the same pattern of maximal warmth, communication and freedom held within clear and reasonable limits, with "attachment parenting" typically referring to practicing this within the communication constraints of infants and toddlers, and "democratic parenting" referring to the practice of increasing communication and collaboration with the child as she matures and develops increasing life experience and critical thinking skills. The nice thing about this approach is that not only does it maximally support the child in meeting her autonomy and connection needs, but it naturally follows the child's developmental process culminating in healthy adult individuation. [A couple of useful books that offer guidance to parents in developing these types of parenting styles are *No-Drama Discipline*, by Dan Siegel and Tina Bryson (2015), and *Hold On To Your Kids,* by Gordon Neufeld and Gabor Mate (2014).

While the concept of implementing such a reasonable parenting style as a means to support a child in developing secure attachment styles and ultimately adult individuation may seem simple enough, many parents will recognize that the reality is often far more challenging. When raising a child, we find that we typically encounter the unresolved developmental wounds of our own past, which can then result in powerful emotions that "hijack" us and

compel us to behave in ways towards our children that we may later regret. One way to think of this is that when raising children, our own insecure/unresolved attachment issues show up and are easily transmitted to our children. The research suggests that insecure attachment styles are very often transmitted this way from one generation to the next, in spite of what may be the parents' best intentions (Karen, 1994; Siegel & Hartzell, 2003).

Fortunately, the research also suggests that it's never too late for any of us to work on increasing the security of our own attachment styles both in relationship to our self and with others, especially by utilizing the practices of mindfulness, creating a coherent narrative of our own lives, and seeking skilled relationship support (Siegel & Hartzell, 2003). And the research also suggests that parents who have been able to do this personal relational repair work, regardless of how troubled their own childhood may have been, are far more likely to raise children with secure attachment styles and the many benefits of this, as we've been discussing (Karen, 1994; Siegel & Hartzell, 2003).

So it's all well and good to learn about effective parenting styles, and to try one's best to implement them from the very beginning, but what do we do once we find ourselves in the midst of a crisis with a child/adolescent/young adult exhibiting psychotic or other extreme behaviors, and/or a family system that has already become destructive and out of control? The following are some of the most common problematic dynamics the recovery research suggests are found within such family systems, along with some suggestions for transforming these patterns from problematic to beneficial, or in other words, from vicious cycles into victorious cycles.

From "power over" to "power with." As implied in the above discussion on effective parenting styles, it appears that developing a "power with" relationship with one's child, rather than a "power over" relationship, is key. So often in family systems in which a child becomes diagnosed with a psychotic disorder, a strong "power over" dynamic has developed, typically between one or more parents and the child, though we can also find this particular dynamic within other aspects of the family system, such as between siblings.

Even if this particular dynamic was not prevalent initially, once the child is deemed "mentally ill," the individuation fears as discussed above can become exacerbated, leading to increasing tension within the autonomy/connection dialectic for the child and hindering even further her movement towards individuation. In this case, out of natural concern, the parent may well become increasingly critical, demanding, overprotective, etc., further undermining the child's autonomy/connection needs; and the child is likely to experience increasing self doubt, self fear, etc., increasing her ambivalence of moving towards healthy individuation. This situation is likely to further increase the "power over" dynamic at play, even further interfering with the child's individuation process, and we find that a kind of positive (self reinforcing) feedback loop (i.e., "vicious circle") develops, in which the system can become very entrenched within this particular dynamic, with the child unable to go any further towards individuation and remaining hyper-dependent upon the parents indefinitely.

Unfortunately, the mainstream mental health care system often further exacerbates the situation, by adding its own "power over" structure to the already existing "power over" dynamic occurring within the family. It does this by generally insisting that the youth "accepts" that they have a brain disease, insisting that they remain "compliant" with psychiatric drugging, and generally behaving in a way that is likely to exacerbate whatever trauma the youth has already experienced and even further encouraging the "power over" dynamics within the family (see my article here for more about these and similar problems within the mainstream mental health care system).

Breaking this vicious cycle requires first a willingness by all parties to recognize that this is occurring, followed by a concerted effort to gently make the transition from "power over" to "power with." This includes the need for all family members to resist any tendencies to make demands of each other, and to instead make clear, doable requests, with a willingness to hear "no." It also includes the need for each person to set personal limits and boundaries as would be done within any other healthy relationships, and to do their best to honor those set by others. In other words, if a person is behaving in a way that is directly harmful to us or our loved ones, we do need to set some personal limits and do our best to minimize that harm, which may entail attempting further communication with the person, or if this fails, then seeking external support or even limiting contact with the person, if necessary.

From mystification to transparency. The recovery research also suggests that transparency within our communication and our general self expression is also very important. Without doubt, one of the main factors that has made the Open Dialogue approach and other similar family systems approaches so effective is that they facilitate transparency, which we can define as first developing self connection (connecting with one's own feelings and needs associated with a particular situation), and then expressing this to the relevant other openly and honestly. As discussed earlier, Bateson's and Laing's work in this area, with their concepts of "double binds" and "mystification," offer compelling theories as to how the lack of transparency, especially between the parents and the child, can result in the child experiencing overwhelming confusion and distress, even to the point of ultimately developing a psychotic condition.

To be more specific, being transparent essentially means finding the courage to express our concerns, frustrations, fears, etc. directly to the relevant person—to clearly state what it is about the others' behavior that is so distressing to us, and then depending upon what feels most appropriate, to either do some personal work on developing more tolerance for that behavior, or to open up dialogue with this person about what changes could be made to make the situation more workable for all involved. The other important piece to this is resisting the temptation to complain to a third party about a person's behavior, and to instead find the courage to discuss the problem directly with that person. Murray Bowen refers to this—the tendency to form an alliance with one person against another—as *triangulation*, and his research has demonstrated it to be a particularly destructive relational pattern within families and other social systems (Bowen, 1993).

From scapegoat to canary. A common pattern we find within many social systems when they're not functioning well is scapegoating, the tendency of the majority of members to

attribute the brunt of the responsibility for the dysfunction within the system to a particular minority. We see this within the broader social systems in which minority members are scapegoated, in smaller social systems such as schools in which children who are perceived as "weak," "nerdy," or otherwise "weird" are bullied, and within family systems in which one member is perceived to be the "problem child," or what family systems therapists often refer to as the "identified patient."

It's important to recognize, however, that this tendency is usually misguided and often very destructive, not only to the one who is scapegoated, but to the overall health of the family system, in that scapegoating may buy some security in the short term, but leaves the family system vulnerable to collapse in the likely event that the strategy eventually fails. It is for this reason that scapegoating can become so entrenched within a dysfunctional family system, with all members, *including* the one scapegoated, often striving to maintain this status quo in order to maintain the survival of the family system (although the family members are often not consciously aware that they are doing so). Unfortunately, this problem can become even further exacerbated by a mainstream mental health care system that feeds this dynamic by generally being more than happy to diagnose and "treat" the identified patient, with many professionals sincerely believing that they have the expertise to declare that there is indeed something broken or diseased about the brains of such individuals, in spite of extensive evidence to the contrary (see this article or Rethinking Madness for more a more thorough discussion about this).

In order to pull ourselves out of such a problematic family dynamic, it helps to recognize that the "identified patient" is often merely particularly sensitive to the dysfunction within the family system, and therefore is vulnerable to acting as a kind of channel for this dysfunction, personally acting it out in a way that is likely to land her with the diagnosis of a "mental illness." Therefore, it's often much more helpful and accurate to see the "identified patient" as a "canary in the coal mine" rather than "mentally ill," in that she is simply the first to perceive and openly demonstrate the toxicity within her environment.

From multiple monologues to authentic dialogue. When we shift our perspective to see "psychosis" occurring within an individual as actually most likely being indicative of a problem occurring within the larger family and social system, then we recognize that it is only by honoring everyone's unique perspective that we are able to acquire a view broad enough to lead to the resolution of whatever is occurring within that system. In order to do this, we find that we must face a somewhat daunting but not impossible task: To practice open and authentic dialogue with the others in the system, which requires a willingness to alternate between (a) honest self connection and authentic self expression, and (b) temporarily setting aside our own assumptions, beliefs, feelings, etc., so that we can listen to the others in a receptive and empathetic way.

When we are distressed, it is a natural tendency to become so inflexible in our own perspective and/or so absorbed in our desire to express this to the other, that we then are simply unavailable to genuinely listen to and digest the perspective of the other. This results in communication consisting of multiple monologues (i.e., multiple individuals essentially expressing themselves to "brick walls") rather than an authentic dialogue. Yet,

in order for the broken system to change in any fundamental way, the different members of that system must each be able to bring their voices to the table and be genuinely heard by the others so that a new and hopefully more harmonious and sustainable relational dynamic may unfold. I have found that a particularly simple and effective approach to such communication is *Nonviolent Communication [NVC]*, developed by Marshall Rosenberg, student of the pioneering humanistic psychologist, Carl Rogers.

Secure attachment as a buffer against bullying and other adverse childhood experiences. As discussed earlier, we are all "hardwired" to strive to develop secure attachments with one or more primary caretakers from birth, and recall that such a secure attachment involves the experiential knowledge that we are deeply loved for who we are—that both our primary connection needs and our primary autonomy needs are securely held and supported. And when children and adolescents are unable to develop these with their parents, they naturally direct these attachment-forming instincts toward their peers. But since other children and adolescents are generally not able to take on the role of caring, mature caretakers for each other, what typically results is a situation in which the "blind are leading the blind," or worse yet, the immature are leading the immature; and this in turn can set the stage for an absolutely devastating blow to occur at a very deep level when the youth is exposed to the experience of being harshly rejected by those with whom she or he is so desperately trying to attach. [See *Hold on to Your Kids* by Neufeld & Mate (2014) for a much more thorough discussion about these issues.]

Considering the situation from this perspective, it actually makes a lot of sense that bullying and peer rejection have been so well established to be a significant risk factor for youth developing psychotic disorders. It's easy to see that when youth try to get their primary attachment needs met from other immature youth, this sets the stage for a catastrophic blow to one's ability to sustain a tolerable experience with regard to the autonomy/connection dialectic. But fortunately, it has also been well established that a secure attachment with an adult acts as a powerful buffer against the harm caused by such peer bullying and rejection.

One particularly striking study involved 90,000 adolescents from 80 different communities throughout the United States, and found that those who were securely attached to at least one parent were much less likely to exhibit the behaviors typically associated with problematic peer attachment issues—drug and alcohol dependency, attempted suicide, engaging in violent behavior, and risky sexual activity (Resnick et al., 1997). This study didn't include psychosis as an outcome variable; however, given the established correlations demonstrated between poor attachment with parents, bullying and psychosis, I think it's safe to connect these dots and recognize that secure attachment with a parent almost certainly acts as a direct buffer against the possibility of bullying and peer rejection precipitating psychosis. Furthermore, following a similar line of reasoning, I think we can safely say that secure attachment with a parent is likely to act as a buffer against most of the other psychosis risk factors mentioned in *Table 1* above.

From blame to shared responsibility. As discussed earlier, it's a very delicate matter to suggest that, in many cases, the parents of a youth who develops a psychotic disorder may

have played some role in that occurring. This suggestion has resulted in a polarization within the field in which on one extreme we find an inappropriate degree of blame being placed onto the parents, especially the mothers, of all youth who develop a psychotic condition; and on the other extreme, those who suggest that family dynamics often *do* contribute to the development of psychotic conditions are themselves vilified.

To give one example of the first extreme, a term often used throughout the last decades of the 20th century is "schizophrenogenic mother," a term coined by psychiatrist Frieda Fromm-Reichmann in 1948 to highlight her belief that certain mothering/parenting styles are causally linked to the development of "schizophrenia." Regardless of the intention of Fromm-Reichman and others who have found utility in this term, it can easily be interpreted as implying a kind of black-and-white blaming and shaming of parents whose children develop a psychotic condition, which I feel is likely to only reinforce the problem. The risk in the use of this kind of language is that it can understandably lead to many parents becoming defensive, which may then result in even further disconnection and disharmony within what is likely already quite a troubled family system.

On the other extreme, those who suggest that there may be something about family dynamics that can contribute to a child's psychosis are sometimes referred to derogatorily as "mother blamers," a term I feel is equally problematic, in that this term typically represents a complete deflection of any parental responsibility in cases where some responsibility by the parent(s) may indeed be warranted—if not direct responsibility for the onset of the child's psychotic condition, then at least a certain degree of responsibility with regard to supporting their child through the recovery process.

Between the extremes of blaming and shaming parents on the one hand, and denying any responsibility whatsoever of the parent/child relationship on the other hand, I believe there is a middle path that we can follow that will allow us to have a fruitful exploration of this issue while not losing sight of the humanity of all involved. Very often, parents do love their children very much, and do strive to do the best that they can as parents, and yet their behavior and parenting style still unwittingly contribute to their child developing such a distressing condition. In many such cases, the parents were themselves raised as children in a similarly problematic environment, and are merely passing along what they have learned. Such problematic dynamics can become profoundly entrenched within a family system, often lasting for many generations and making it very difficult for the parents of any one generation to fully extract themselves from them. Furthermore, it must be acknowledged that many parents in the world today are forced to try to survive in the life-crushing conditions of poverty, isolation and/or political oppression, which in turn simply leaves parents with few remaining resources with which to nourish their children. Indeed, the literature is robust with evidence that poverty, discrimination and other forms of political oppression are highly correlated with the development of psychosis (Read, 2004).

So I think that rather than resorting to "parent blaming" and suggesting that parents in these cases must have malevolent intentions, it's important to recognize that in probably the majority of these cases, the parents are simply ignorant of the serious harm that their behavior is causing, and/or they are merely passing down inter-generational trauma or

relational dynamics that they themselves have inherited from their own parents and/or a dysfunctional society. Rather, what is likely to be more helpful than blame is to invite an attitude of open curiosity about what problematic family dynamics may be involved in the distress, and to encourage an attitude of shared responsibility among the members of the family and the broader social system with regard to repairing any harm done and transitioning to a more harmonious system.

Another point that needs to be stated here is that, as discussed above, the research is quite clear that many different factors may contribute to a person developing psychosis. Yes, relational factors, and especially childhood relational factors, do seem to be at play in probably the majority of cases of psychosis, at least those that have been thoroughly explored; but we are complex organisms, whose wellbeing is based on a multiplicity of factors occurring within multiple domains—physiological, psychological, social, environmental, spiritual, existential, etc.—and if we consider that psychosis is often a desperate strategy to cope with otherwise overwhelming experience, it becomes clear that multiple factors and experiential domains often converge to create such overwhelming conditions. So, in many cases, pointing towards any one single factor as *the* cause of a person's psychosis is far too simplistic.

What this understanding implies, then, is that if we want to offer genuine support to people struggling with overwhelming distress, then all members of a particular family system and even the broader social systems need to acknowledge some degree of shared responsibility and to act from that place. However, along with this recognition needs to come the recognition that different members within these social systems do hold different degrees of power, and greater power naturally entails greater responsibility. Since it is the parents who typically hold the most power within the family system, it's important that they acknowledge the greater responsibility that goes along with this. The same applies to the broader social systems within which we live, in that certain members hold greater power and influence—especially those who are white, male, relatively wealthy, and those who hold certain professional roles, with health professionals having a particularly high degree of power within the context discussed here. Along with this greater power comes the potential to cause relatively greater harm or benefit, a fact that can be particularly destructive if not consciously acknowledged and carefully held by these more privileged members.

Distancing when unable to repair. Soteria-style homes, The Family Care Foundation, peer respites, and other similar methods have demonstrated that when repair of a particular family system is not working for whatever reason, moving into a healthier environment can be very beneficial for a person's recovery. Bowen's research (1960) has demonstrated that even moving into an environment that is not so healthy (such as an inpatient ward of a hospital) can have limited benefits, depending of course on just how harmful the individual's family system has been. Of course, most hospital environments, and unfortunately most mainstream residential homes, are themselves antithetical to a person's recovery process when considered from the perspective presented here, in that they are typically highly oppressive and don't particularly convey the message that "you are loved, accepted and valued for who you are."

It's unfortunate that in spite of the very hopeful outcomes demonstrated by the Soteria-style homes that were developed in the 70's, they remain extremely rare and therefore inaccessible for most people. However, there are signs that the tide is turning, as new Soteria-style homes and other similar kinds of residences are being established, and the peer and peer respite movement is gaining steam. With increasing awareness of the tremendous benefits of such residences for individuals, families and communities, hopefully there will come a time when every community will have a "madness sanctuary" to offer much needed compassionate respite to those in crisis. [See my resource list here for some of the organizations and services that are available.]

Conclusions

As we draw near to the end of this journey through the research on the links between family dynamics, human development and psychosis, we can reflect on what we have learned and wrap up a few conclusions to take away with us:

1) Certain traumatic incidents, particularly many of those listed in *Table 1*, can directly or indirectly lead to a psychotic crisis.

2) We all share certain core needs and existential and relational dilemmas (see *Figure 1*), and when these are chronically unmet and/or unresolved, as can result from the traumatic incidents listed in *Table 1*, we may experience enough overwhelm that our organism initiates a psychotic response as a desperate strategy to tolerate what would otherwise be intolerable.

2) It's likely that we all have a tipping point, a point at which we become overwhelmed to the point of initiating a psychotic response, although personal vulnerability to this may differ substantially from one individual to another.

3) Fortunately, there are a number of strategies we can implement to reduce the likelihood of ourselves or a loved one going down the path of psychosis, or to support recovery once someone has already gone down this path. What is likely to be of particular benefit is transforming problematic family and relational dynamics into more harmonious ones, including especially:

- Striving to develop parenting styles with high degrees of collaboration, communication and nourishing connection.

- As parents, developing and maintaining secure attachment with our children through adolescence, and then supporting them in transitioning towards increasing autonomy as developmentally appropriate.

- Developing "power with" rather than "power over" relationships.

- Working towards maximal transparency (rather than mystification or triangulation) and authentic dialogue (rather than multiple monologues) within our communication.

- Letting go of blame and scapegoating, and working towards personal accountability and shared responsibility.

- Recognizing the benefit of distancing from unhealthy family relationships and pursuing alternative nourishing relationships when we are unable to repair the family relationships.

4) Finally, it's important to recognize that we are profoundly social beings living not as isolated individuals but as integral members of interdependent social systems—our nuclear family system, and the broader social systems of extended family, peers, our community and the broader society. Therefore, psychosis and other forms of human distress often deemed "mental illness" are best seen not so much as something intrinsically "wrong" or "diseased" within the particular individual who is most exhibiting that distress, but rather as systemic problems that are merely being channeled through this individual. Furthermore, certain members of these social systems clearly hold more power than others; and those who hold the greatest power, such as parents and health professionals, also hold the greatest potential to produce both harm and benefit, therefore making it essential that the greater burden of responsibility that goes along with this greater power is acknowledged and carefully held. In spite of these power differentials, however, we must not forget that all members of a particular social system hold some degree of power—with every action we take, every word we utter, every vote we make, and every dollar we spend, each and every one of us plays a role in perpetually co-creating the social systems in which we live. So it's up to each of us to ask ourselves what kind of world we want to aspire towards—a world filled with fragmentation, blame and disconnection, or a world of open dialogue, shared responsibility and nourishing support and connection.

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