

# Family Talk

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In my family of origin, talk was buried under layers of fear and silence. It wasn't until I was 49 and diagnosed as having posttraumatic stress disorder and dissociative identity disorder that I broke through the wall of speechlessness.

In the intervening years, mental illness had ripped me from my four young children. My fragmentation, although unconscious, could not bear the weight of child rearing. My mind was lost in visions of a special spiritual mission in the world. Although my children and I managed to maintain our disrupted relationships, I had no words to explain why I left them in our home with their father. Even in the therapy room, speech was beyond my reach. When I once broached the subject of changing the world, my therapist looked at me and said, somewhat sarcastically, "What could you do?" Neither he nor I were able to explore the troubled world that lay within me.

After a decade of community organizing, I returned to school for the study of social work. I learned about family dynamics and unresolved intergenerational pain. With a new therapist, words began to rise slowly in my mouth, words like abuse and violence. I was beginning to make sense of my history and recognized how critical it was to end silence in my family.

As I worked in therapy over a ten-year period, words became bridges that linked my history with the lives of my children. The first disclosures were in 1989. I needed them to

know that I had been sexually abused by my father, that what happened to me impacted my mothering of them. I wanted them to know that I left them because my anger and anxiety frightened me. At an unconscious level, I left out of fear that I would hurt them.

We sat around the old family table. Their father was now dead, and I could be in the house with ease. I spoke slowly, crafting words strong enough to stand on. My daughters, now 16 and 18, reached out for my hands, expressing sadness that such things had happened to me. My older son, age 24, looked quizzical and wondered what it had to do with him. I said that family secrets divide us, that if we can heal the wounds of one generation, they will not burden the next. My younger son, who was 22, rose from the table and hugged me. "My friends tell me that I'm a good hugger; I learned it from you," he said, offering me comfort.

That moment in our lives was deeply painful. I knew that I was telling them that the grandfather they had never known had assaulted me, that his hands reached beyond me to shape their lives. I was also telling them something important about myself, something that they perhaps would have chosen not to know. Despite this pain, I felt convinced that these words needed to be said.

Three years later, my younger son shared with me some poems about his childhood. He wrote about his alcoholic father, the physical abuse he inflicted, and his own rage. I pictured the little boy hiding in the woods to avoid his father—with no one to protect or nurture him. I also remembered how in adolescence he closed himself in his room, unwilling to talk to me. His honest poems gave me the courage to tell more of my

story. I disclosed the dissociation and told him about the multiple parts of myself. I wanted him to understand that it was not for a lack of love that I left him, but terrible inner confusions that overwhelmed me. "The family should know about this," he said.

It was difficult to talk about my fragmentation and about the fact that disconnected parts of me were involved in their young lives. I felt ashamed. I had come to understand that inconsistencies in my behavior, confusions in memory, and emotional instability were linked to dissociated alters. I wanted them to know these things. I hoped it would help them come to a deeper knowledge of themselves and an acceptance of me.

My older son was disbelieving, stating that memories could not be forgotten, then remembered. Multiple personality disorder was in the news, along with reports about false memories. The pain of his childhood made it impossible for him to hear my story.

By the time I spoke with my older daughter, she had already distanced herself from me in protest against the harm I had done to her. Like her brother, she believed I was making up reasons to excuse the bad choices I had made in my life. Her understandable anger remains difficult to bear, but I have hope that we will someday talk with each other.

My younger daughter asked serious questions. She wondered about a link between her depression and my mental illness. I let her know that her depression had a genetic component and that it wasn't her fault.

As the years went on, my multiplicity was never mentioned. At times my behavior was erratic, but nothing was said. I came to sense that, for them, turning a light on the past was much too difficult to be en-

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dured. To speak directly of their mother's mental illness was too frightening.

In my profession as a clinical social worker, I listened to clients talk about a parent's mental illness and their fear that they might be "crazy" too. I thought of my children and wondered if they had the same fear. We have never talked about this matter.

I apologized to my children repeatedly, seeking forgiveness for the hurt I had caused. My entreaties embarrassed them, I think. After a while I concluded that I had to forgive myself, a seemingly impossible task. How could I reconcile with the young mother who left her four small children in the care of a father who had a serious drinking problem? I prayed, exposed the problem to the light of therapy, and tried to mother well in the present.

Last year, after a lengthy therapeutic process, I accepted the additional diagnosis of a thought disorder underlying the dissociation. I reached a new level of clarity about myself and my history and saw the limitations that shaped earlier life decisions. I began to hold my parents in a different light, believing that they likely suffered from untreated mental illness. Forgiveness toward myself, them, and others spread in me like a wild vine.

I gradually accepted my own genetic vulnerability to mental illness and the possibility that this predisposition could emerge in family members. More than ever, I felt it was important to talk to my children.

If it was difficult to reveal abuse and dissociation, it was even harder to disclose psychosis. The need to tell was heightened by my younger daughter, who showed symptoms similar to my own. I carefully planned the conversation. I talked to her about mixed-up thoughts about myself, others, and the world, as well as intense physiological experiences. I was also able to tell her about the kind psychiatrist who had treated me and prescribed medication to stop my bizarre thinking. I wanted her to know that medication might hold out the possibility of a clear mind for her as well.

My disclosures exhausted and distressed me. I left her apartment abruptly and refused to respond to her phone call. Revealing the secret had been a positive step, but one that I hadn't been ready to make. I fell into bed, shaken by what I had done. The next day my daughter and I talked about what had happened. She heard me with compassion.

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## ECONOMIC GRAND ROUNDS

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care is available. Offering programs such as intensive outpatient treatment, community outreach, and home visits can help encourage compliance among chronic mentally ill patients. When these programs don't work, outpatient commitment laws should be considered.

The state of Kentucky does not currently allow for outpatient commitment except when patients sign an agreement during their inpatient commitment. This procedure allows patients to be discharged to the community with specific guidelines. Failure to adhere to these guidelines, such as keeping all scheduled appointments and maintaining therapeutic blood levels of medications, can result in readmission to the hospital. Unfortunately, patients such as the four described here, who do not believe they have mental illnesses or need psychiatric treatment, will not sign these agreements.

## Conclusions

Over the six years examined, caring for the four patients in this study consumed a surprisingly large number of dollars due to hospitalization alone. With Kentucky Medicaid now converting to a capitation system, the resources consumed by these patients must be taken into consideration when estimating a budget. Ideally, a change in the commitment laws in Kentucky to include outpatient commitment with forced treatment and allow for compliance monitoring by periodic measurement of blood levels of mood stabilizers would improve the situation for these patients.

As yet I have not told my three other children about my thought disorder. I am waiting for the convergence of clarity, opportunity, and personal strength. I'm confident that the moment will come, that I will find the necessary words to expose the reality of serious mental illness in myself and in our family. Silence is no longer an option. ♦

The study was limited by the small sample size and the lack of availability of data on the number of patients with bipolar disorder in the catchment area and on the costs of outpatient treatment for the four patients. To examine the exact economic impact of noncompliance among patients with bipolar disorder, prospective studies are needed. ♦

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