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THE ROLE OF THE FATHER WITH CHRONIC SCHIZOPHRENIC PATIENTS*

A Study in Group Therapy

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Boston State Hospital has a relatively long tradition of interest in the group psychotherapy of psychoses. Observations have been reported by Semrad, (18) Mann, (15) Arsenian, (1) Blau, (3) and others of various aspects of the group treatment of psychotics, while Limentani (12) has discussed the symbiotic identification between the schizophrenic patients and their mothers.

This paper is in the same tradition of interest but focuses the attention on the role of the father. It will be the question of the role of the father mostly as it was possible to perceive it through the eyes of the patients and the patients' mothers.

In fact most of the fathers themselves were inaccessible for direct observation by the therapist and the importance of their "role" appeared at times to be in almost direct relation with its non-existence.

In spite of the apparent contradiction it appeared to us that the role of the fathers in the maintenance of the illness of male chronic schizophrenics was essentially the fact that they had no role; that they were either physically or emotionally absent as fathers and that if present they were expected by both patients and patients' mothers to play a substitute mother role.

Glassman, Lipton and Dunstan, (8) describing "group psychotherapy with a hospitalized schizophrenic and his family" wrote: "The primary conflict area in this family . . . focused on the father's passivity. It was the topic most often alluded to . . . and it was the topic which evoked the most intense emotions." Their observation reveals that the "group session highlights the acute feelings of aloneness and lack of support that the father's inadequacy elicits in the male patient during the pubertal and adolescent years. . . . The clash (between parents) as seen by mother had been a continuous effort to regain what she felt was lacking by constant recriminations, criticisms, and nagging in a furious attempt to activate the father". Ruth and Theodore Lidz, (11) were of the opinion that "had there been a stable father . . . the patient would not have been so seriously affected by the mother's difficulties". To which we would like to add: indeed the mother's difficulties in separating herself from her child would not have been so great.

We believe further that the term "schizophrenogenic" mother is a poor one as it tends to over-emphasize the role of the mother alone in producing a schizophrenic process in her child and tends to underestimate other factors which may also come into play before schizophrenia appears and maintains itself.

Eisenberg, (6) remarks that "the psychiatric literature is rife with studies of childhood disabilities in which detailed attention is given to personality traits in the mother presumed relevant to the disorder in the child . . . (while) the father is the forgotten man." He feels that writers in psychiatry have pursued with great verve the theme that if something goes wrong in this world: "*cherchez la femme!* . . ." Morris Parloff, (17) comments on the same subject: "The patient's mother appeared (in the psychiatric literature) to have the remarkable knack of being able to produce, singlehandedly, neuroses, psychosomatic syndromes, psychoses or even juvenile delinquency with equal facility and from either side of her ambivalence." Leo Bartemeier, (2) remarks that "while it

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is true that a woman's attitude toward pregnancy, childbirth and motherhood has been definitely moulded and determined by her relationships with her own parents and siblings, it is equally true that . . . how adequately or inadequately her husband's relationship with her satisfies her own needs, determines how well or how poorly she functions as a mother to their children."

Method

This paper is essentially a product of the present writer's frustration when he was given the responsibilities as ward physician for a population of 250 extremely regressed male schizophrenics on the chronic service of Boston State Hospital.

Working with these chronic patients, one begins rapidly to feel that one is living in a museum of psychopathology and that, in order to shake the dust off some of the specimens of the collection amassed over the years, one had better concentrate one's energies on a few of them.

In an attempt to find out what made these patients "wish" to stay in the hospital I began to comb my population of patients in search of suitable patients for a small ward of only 23 beds, staffed with one registered nurse, one male and one female attendant during the day shift. In order to be a candidate for transfer to this ward, a patient had: 1) to be fairly young, 2) without brain damage, 3) to be a chronic schizophrenic with whom previous attempts at therapy had failed. In fact, most had had group therapy or individual therapy, EST, insulin therapy at some time or other in their hospital careers. All had multiple types of drugs; 4) there was another important prerequisite: all patients were chosen by the writer on the occasion of trips through the chronic wards but at least one member of the staff had to have some liking and interest in the patient: if there was any difficulty on the ward, that particular person would be responsible for handling the patient. These were the only criteria established and except for what has already been mentioned no attention was given to any particular personality characteristics or historical data in the patients' background. Indeed these were largely unknown at the beginning of the project. It is only as our study progressed that some common denominators began to emerge.

After our group of 23 patients were assembled on the ward, it became obvious that they were extremely ill: only one patient was capable of working in the hospital industry, nine were mute, four were incontinent of urine and another incontinent of urine and feces. They were all chronic schizophrenics and the breakdown by diagnosis gave: nine catatonics, ten undifferentiated schizophrenics with hebephrenic or paranoid features, and four paranoid schizophrenics. Their age range was from 18 to 48 years while the average age was 30. The average duration of hospitalization was six years eight months, with a range from one to seventeen years. We realized also that we were in the presence of a particular group of patients who had "come to the hospital to stay": 19 out of 23 patients had never been released and were still hospitalized under their original admission. Our group of patients was also remarkable for the high incidence of paternal deprivation: eleven fathers were dead, three were divorced, three had been chronic alcoholics for years, one was blind and a chronic invalid.

Most of the patients chosen were extremely regressed. For example, M.J.N. was a 31 year old catatonic schizophrenic who had been hospitalized continuously at B.S.H. for the previous 14 years. In the course of his hospitalization he had remained unchanged, in spite of all types of treatment, becoming on occasion assaultive or a feeding problem. Most of his days were spent lying on the floor, incontinent and mute. A second patient

M. Ed. McD. was transferred to B.S.H. at age 19 from another hospital where he had been for five years. He had remained at B.S.H. continuously from age 19 until 29 at which time he was started on our project. He was transferred to our ward from the cottage where he was living on the hospital grounds with other chronic patients, after I had surprised his mother in the cottage basement during visiting hours, alone with her son whom she had undressed and was giving him a bath as one does to an infant. The patient was lying nude on a table while mother was using oil and baby powder, vigorously cleaning his penis!

The group therapy sessions with the patients consisted of a weekly ward meeting of one hour during the morning, attended by all 23 patients plus the day shift personnel and the student nurses rotating in groups of four every four months. Minutes of the meetings were taken by one student nurse. The meetings were held in a relatively small room so that it was possible to watch the interaction in spite of the large number of people attending. Following the meetings, the personnel met together for a one hour discussion of what went on and for reading the minutes.

Besides these weekly morning meetings, another group therapy session was held during the evening, every other week, also for a period of one hour and with the patient and evening shift personnel attending. A discussion period of one half hour with the personnel followed each evening session.

A total of 94 group meetings were held from March 1958 until July 1959.

A daily report of the patients' behavior was also kept on a 24 hour basis so that correlations could be made between the behavioural communications of the patients during the week and their verbal or non-verbal communications during the group meetings.

The group therapist was also the ward physician and spent two to three hours per week seeing patients individually for medical problems and crises on the ward.

The first five months of meeting with the patients was a period of complete despair and frustration for the therapist. Through this period patients remained withdrawn, isolated, sleepy, mute and generally disinterested in the psychoanalytically inspired interpretations of the therapist! The monotony of the meetings was only occasionally broken by anxious laughter of a student nurse, a patient "bumming" a cigarette from the therapist instead of insight, or a sudden outburst of "barking", assaultiveness or incontinence.

Parents Participation

The patients' mothers appeared omnipresent and disruptive, demanding immediate medical attention for a callus developing on their sons' toes, carrying bundles of food so that their sons could "survive" from one visit to the next or, in the case of one mother, establishing quarters in the male patients bathroom every visiting day to take her own bath with state soap and water!!

After five months of trying, almost consciously, to avoid the parents it became increasingly clear that they needed to be seen if one was to understand something of the psychopathology of their sons. Observation had also been made that when the mothers were given plenty of time to listen to their complaints regarding the alleged mismanagement of their sons they would very quickly stop being so troublesome and disruptive. It had become equally apparent that they were competing for the attention given to their sons and that an interview granted to discuss the patients would often end up in discussion of the mothers' own problems.

An invitation was therefore sent to all parents to meet with the patients' therapist, and the ward nurse acting as an observer, in group sessions of parents only. Meetings were held for one hour every week on visiting day. The reason given

to the parents for the meeting was the therapist's feeling that having a son in a mental institution must bring questions and problems for the parents and the therapist's willingness to discuss these problems and to try to be of help if he could.

Out of a possible total number of 31 parents: eight (seven mothers and one father) were faithful members and almost never missed a meeting; seven other parents (six mothers and one father) came intermittently to the group; another nine parents (seven mothers and two fathers) could not come to the meetings because of their work but were seen regularly and individually twice a month while another father maintained sporadic individual contact. The other six parents were either never or only rarely seen.

There was a total of 42 group therapy sessions held with the parents in the course of one year from August 1958 until July 1959.

Summary of the meetings with both groups

The patients' reaction to the announcement that their therapist would also begin meeting with their parents was a violent one. One patient, H. R., whose childhood had been marked by several surgical interventions and whose mother was working as an aide in an operating room while father was a diamond cutter, announced that he had a knife to keep the women away and cut someone's head off. He suggested that all patients "burn some rotten eggs to smoke them all out of here." Following this statement all patients grouped together and remained silent for the 35 minutes that was left of the meeting in spite of my attempts to get them to verbalize their feelings. Even the therapist's cigarettes could not bring a word from them as no one wanted to be a scab and break the strike. But they did not only go on a silence strike, they also went on a hunger strike. Nine of them refused their meals that day while one patient refused to eat for three days. I was extremely worried and was almost ready to give up my plan to meet with the parents. An interview was scheduled with every one of them individually and recommendation was made to students and personnel to spend a great deal of time with them. The strike ended promptly and at the next meeting they began to talk, mostly asking for some reassurance on my part that "*their needs would come first.*" Concerns were expressed about confidentiality, and fear of being "double crossed". They talked about surgery, having stomachs being taken out and legs cut off. One patient said: "you were a good father to us but we don't understand you any more."

In spite of patients' verbal opposition to their therapist meeting with their parents there was one encouraging fact; while during the previous five months there had been only isolation and regression and withdrawal during the group sessions, for the first time the patients were able to react as a group in their opposition to the therapist. The silence strike was actually the first time that members got together.

Fourteen people attended the first parents meeting: 13 mothers and one father, M. D. who also was accompanied by his wife. Confusion characterized this first meeting. M. and Mrs. D. launched an attack against drug experimentation. Mrs. M., the intellectual of the group, delivered a speech whose title could have been: "Parents are to blame for whatever happens to their children" while the whole group listened, terrified. The focus however was on Mrs. C. who was completely deaf but insisted on knowing what was happening. Mrs. F. wanting to be helpful (!) suggested that, maybe, I could, in the course of the meeting, write to Mrs. C. things I wanted to say. She did not think it would be disruptive to the meeting as I could limit myself to writing only the *important* things! . . .

At the next meeting they talked about *someone influential* referring to the nursing supervisor who was, just as they, concerned about new rules regarding shaving. Their sons were too regressed to shave themselves and might kill themselves with the razors: if they did, the therapist would be held responsible. In fact, both patients and parents tried frequently to get the therapist to fight with the nursing supervisor and to test which one was really the supreme power and had the greater authority. They talked about doctors who have nervous breakdowns and doctors telling them that their sons hated them. Mrs. F. said: "How could they hate us? Mothers are all good, mother means only goodness." After a bitter argument with Mrs. M. who repeated her speech blaming mothers for all the ills of their sons, Mrs. F. corrected her previous statement and declared that: "at least, all the mothers who are here today are good." The blame switched to the Hospital and the doctors who were killing their sons by making them work in the hospital industry. They also wondered about what their sons were saying during the ward meetings.

One month later, Mrs. F. predicted the therapist's failure with her son and Mrs. B. made a slip saying that her son refused to go back "home" after a week-end visit. Home being actually the Hospital. When the slip was pointed out, they agreed that the Hospital was their sons' home. In fact, this slip was made repeatedly not only by the parents but also by the personnel. Mrs. B. cried and complained how different her situation was from that of her son who was cared for while she had to go out and make a living for herself. Repeatedly, they complained that life had been unfair to them: why did they have to work while their sons were taken care of. Mrs. M. said they felt like coming and forgetting about their responsibilities. Actually, nine mothers had been working for years, either because their husbands were dead and they had no support, or because husbands had abandoned them or were chronic alcoholics. The therapist's attitude was to repeat that he was not here to blame but to help, since it must be very difficult for a mother to have a son in a mental hospital and be also working to provide for herself and receive no support from parents or husband.

They developed a pattern: instead of facing a group issue, they would displace it to their sons and reproach them for doing what they were doing themselves. Frequently they used their sons in order to express their own feelings towards the therapist or towards each other. For instance, after Mrs. W. had complimented Mrs. D. on a new hat, Mrs. D. answered her: "My son seems to like your son". In another instance, Mrs. M. and Mrs. McD. had a violent argument in a meeting. During the following week, Mrs. M's. son assaulted Mrs. McD's. son. At the following meeting, Mrs. M. apologized to Mrs. McD.: "I am so sorry my son punched your son on the nose last week". To which Mrs. McD. replied that "it had not really hurt"!

In a recent book edited by Don Jackson, "*The Etiology of Schizophrenia*", Murray Bowen (4) reports the same kind of mechanisms occuring frequently in the 14 families of schizophrenics he studied. The mother would deny a feeling or sensation in herself, for instance a sensation of hunger and then would go and feed her psychotic child. So that "a situation that begins with a feeling in the mother becomes a reality in the child".

In our own two groups, we were further impressed how frequently the same topics were brought up with the patients and with the parents, even though both groups had had no contact.

In the same time that they would talk about themselves through their sons, they would also, as if to counteract this fusion of identity, place some distance between themselves and their sons. Mrs. McD. for instance never said "my son Edward" but would say: "my patient Edward". Mrs. M. once said that sometimes she

wonders if she was really her son's mother because "he really looks like the people on my husband's side of the family".

Thanksgiving was the occasion for much talk about their incapacity to rejoice on holidays. For years they had been coming to visit their sons, never missing a visiting day. How could they take a vacation and celebrate during holidays; when there is a corpse in the house, it's time for mourning not for celebrating. And there was a corpse in their house. Mental illness is worse than death; when one dies, grief passes after a short while but mental patients keep dying without really passing away. There was a consensus of agreement when Mrs. D. said that their sons would be better off dead. And Mrs. McD. added: "At least, when they are in the cemetery, you know exactly what they do and where they are, you can visit the grave and bring flowers; but when they are mentally ill you always wonder how they are and if they get hurt". Their sons were poisoning their lives.

Christmas time reminded the mothers that they had failed in their progeniture. Jesus was born to be a great man but their sons reminded them of their worthlessness as mothers.

Three fathers attended the group meetings, two of them intermittently. One of the two was a chronic alcoholic who was blasted for his "vice" each time he appeared. The other was suffering from stomach ulcers and would talk only to express his somatic complaints; he was listened to sympathetically and treated like a baby. The only father who came regularly was M. D. Each time he would try to say something, he would promptly be shut up, often by his wife. When it was learned he had a car he became the chauffeur for two other ladies of the group. In the group, he was largely ignored and the therapist's attempts at supporting him were met with fierce hostility. One day, he was absent and when the therapist remarked about it, his comments were at first ignored. Finally the mothers asked: What good are men for any way?

They said that men were useless in the house and did not even know how to take care of babies. Men were good for nothing. The therapist had better not continue on this subject because they would "pin him down". In subsequent meetings, more of the same feelings were expressed and always with the most intense emotions: men were just like kids, always in need of praise and support. If they had had a girl instead of a boy, things would have been different. Some said that they had given to their sons the name of their husband and that was why they became sick. They had been deceived by men and were bitterly disappointed in their marriage. Many had lost their husbands through death soon after their marriage and had been obliged to carry the burden of raising a family alone. It was unfair to women to get impregnated and then get stuck with kids. Others were abandoned through divorce or separation. Still others who were living with their husbands complained that they were receiving no support or encouragement from them. It was not the mother's fault if she had to wear the pants in the house; they were forced to do it because their husbands were not capable of taking their responsibilities. Men were animals and their sons were really like animals: regressed, voracious and incontinent. They had tried at first to change their husbands but had given up because "how do you change a man"?

They felt guilty at the same time for having lost their husbands. Mrs. M. said her son accused her of having killed his father, and Mrs. McD. had not told her son that his father had died "because he would have killed me". His father had died two years before but the therapist was the first person to announce it to him. At the same time they would accuse their sons of being responsible for the

death or divorce of their husbands or for their general indifference towards them.

On the ward with the patients there were frequently the wishes expressed by the patients that "men outnumber women". They demanded of the therapist that he bring more male personnel on the ward. Referring to female personnel and student nurses, they complained that women were just capable of caring for babies, and they were tired of having to ask permission of women all the time. There were too many of them in the hospital already. Women did not wear "make up" on their face but "war paint". If they were to learn to work outside the hospital they needed men to teach them. They were extremely depressed when a male attendant left and they accused the nurse in charge of being responsible for driving him away. The nurse and women in general were like monkeys. The men came from the women and came also from monkeys. Both women and monkeys ate "bananas". The therapist should provide them with more "bananas" and with more male attendants.

As was mentioned earlier, the therapist's attitude with the patient at the beginning was very non-committal, interpretative, and with no results. Probably as a consequence of the work with the parents, who alternately infantilised their children or expected unrealistic achievements from them, the therapist became more aware of his own unrealistic expectations of the patients and began to focus more on little reality problems in their everyday life and less with their unconscious. In response the patients began to improve. The unhealthy aspect of their personality was constantly in front of them. They did not need to be reminded of it. More benefit was obtained when more focus was given to the little areas of the personality which had been left intact in spite of the chronic psychosis and deterioration.

The patients reacted as if dealing with women and dealing with their unconscious, provoked too much rage at unsatisfied dependent wishes and this rage was so overwhelming it could not be handled. They claimed that they wanted to deal with men but it seemed that their desire to deal with men was only a denial of their very intense oral wishes which could be expressed more safely with men, as if dealing with men was delaying the regressive trends to be like babies. They demanded of these men however that they take care of them, protect them and "mother" them better than they felt their own mothers had done.

They were able to talk about how much they missed their fathers and those who had lost their fathers were hoping to be reunited with them. They never said that they missed their mothers since they were fused with them. Both patients and mothers complained about the absent fathers. It was he or whoever he represented that they said they wanted.

The patients' feelings of despair when discussing having been abandoned by their fathers were extremely poignant. The world looked cold and empty without a father. Historically in several cases, the appearance of acute psychiatric symptoms had followed a desperate attempt at trying to identify with father in a manly endeavour, usually the beginning of work. Patient H. B., 27 years old exemplifies this dramatically: his father, a chronic alcoholic, had constantly ridiculed him because "he was not a man". He would expect him to perform unrealistic tasks and then tease him in front of his friends and frequently beat him physically when he failed. The patient's acute symptoms appeared on his 21st birthday when father forced him to come to work with him. He has been hospitalized (six years) ever since. A similar case is patient O. McA. who proceeded to expose himself to little girls in a park after father had made arrangements so that he could begin to work with him. He has been hospitalized for ten years.

It might be that these desperate attempts at trying to identify with father

were really desperate attempts at cutting themselves off from mother.

Some of the greatest benefits in treatment arose when the patients' and the parents' attempts at manipulation and at stirring confusion and conflicts between the different members of the personnel, failed. Repeated attempts were made in both groups at blurring the lines of authority. At one point, the therapist had to take a strong stand regarding the patients' care and make a decision to oppose some decisions taken by the female supervisor of the building after she had been pressured by some mothers of the group. We believe it is important to note here that these decisions involved the patients' care in specific ways: in these instances where conflicts occurred, the therapist was in the position of giving or wanting to give more food or privileges, while the supervisor and the mothers of the group were in the position of refusing to give. These incidents actually took place after we had challenged the parents' opinion that their sons were hopeless.

On the ward the patients saw the therapist's attitude as evidence that he was determined to protect them. They talked about the "man being the boss", and began to show considerable improvement: assaultiveness disappeared completely, ward meetings were friendlier, some began to work and we saw the formation of friendships. Prior to this, every patient had been very isolated and there were few exchanges between them. Now all of them, except one patient, began to pair off. At first, there was some rigidity and exclusiveness in the pairs of "friends", each pair defending its unity against outsiders. Many were seen holding hands and walking together for a long period. Later, however, they stopped holding hands and pairs began to join so that small groups of four or five patients could often be seen together. Still later, these groups began to mix.

In the group of parents, they discussed the therapist's attitude as "a revolutionary change". One day, they all lined up along the wall facing him instead of sitting in a circle as usual. Mrs. M. wanted to organize a fund-raising drive, to get care for their sons in a private hospital so that they could get better treatment. Mrs. B., who was a nurse and considered herself best qualified, discussed plans to open a house for the care of the mentally ill. Mrs. M., who had been previously obsessed with the fear that her son might hurt himself with a knife during meals, brought him a cake and a knife. Mrs. F. brought in a newspaper article saying that schizophrenic patients who commit suicide are not responsible themselves, since they are simply executing the hidden wish of a relative who then becomes guilty of psychic murder. She wanted me to state if I agreed with this article. Mrs. D., who had been absent for months, stormed in, delivered a speech in Russian and Yiddish in a prophetic tone and when asked to translate it, said it meant that she had had a heart attack recently and if her son came home, she would have another one and die. She then quickly rushed out of the meeting.

The mothers felt they had been cheated; the therapist was guilty of treason and they wanted him to state if he was for them or for their sons. They had great difficulty accepting that he was "for" both.

When termination was announced, the mothers talked about being forced to take responsibilities all the time because nobody else did. Their husbands abandoned to them the whole burden of decision and the care of the children. Similarly, if the therapist was taking his responsibilities seriously, he would not abandon them and leave to work elsewhere. At the last meeting, they came in with bags of food, saying that their sons or the therapist could eat and have a party but there was no party for them as long as their sons were sick. As the therapist focussed on the meaning of the food instead of eating it, Mrs. M. said he meant to tell them that they too had the right to enjoy parties and have things for

themselves so that they will be better able to give if they could learn to receive. M. D., the father who attended regularly, offered the therapist a gift, a pen, which he had bought after collecting money from the members.

On the ward, the last meeting with the patients was a very sad one. A group of patients on the ward started a song about a father who had died and about his son who was terribly lonely. To console him, father appeared to him and promised him that one day they would again meet and never separate. M. M. asked repeatedly when he could join his father who was now dead and in Heaven. He felt restless waiting for his father as he had a terrible longing for him.

In January 1962, two and a half years after termination of the group another meeting was held with 15 patients attending. A meeting was also held with the parents, ten of whom attended. A few patients and a few parents could not be reached. The first question was the same in both groups: they wanted to know if the therapist was going to resume work with them.

Some patients showed the therapist blisters and scars they had since "we had last met"; another patient left, slamming the doors, (he came back later). The other patients thought that he was angry because the therapist had walked out on them more than two years before. One patient said he wanted the therapist's identity, his life, his glasses. He wanted to be in the therapist's shoes because "I feel I am in you, Doctor". Another patient kept rocking himself and, looking at the therapist, was yelling: "Eat, drink, eat, drink!" Several talked about homosexual maniacs who sucked men and several complained with anguish of stomach aches and ulcers.

In spite of the separation of two and a half years or maybe because of it, they immediately and directly verbalized their unsatisfied hunger. At the end of the meeting, one patient, who suffers from a conversion reaction affecting his legs, had to be carried out.

Ten parents (eight mothers and two fathers) were present in this "follow up" group meeting. They all appeared glad to meet again with the therapist, shook hands with him and commented that he looked fatter and that it was becoming to him. They were very interested in what the therapist had done during his absence and what his plans were for the future. They teased him, saying that he had invited them to find out if they were still holding on or if they had broken down after the termination of the group. They said they were holding on but Mrs. F., the mother of the patient who could not walk, told of her own inability to walk for a while after she had been in a car accident. But she thought her son's inability to walk was "all in his mind". Another mother, Mrs. D., showed a pair of crutches: she had broken her hip in a fall one and a half years ago and now she could not stand on her feet but had to lean upon her crutches and her husband. Mrs. M. said that her husband had changed to the point where he even spends money on her now.

They wanted the therapist's address in Montreal when he leaves Boston. Mrs. S. D., who, three years earlier, had said in a prophetic voice that she would die if her son left the hospital, now said that she had wanted to see the therapist once more before dying. Now that her wish had been fulfilled she could die peacefully. As she talked, the other members listened approvingly. The whole group appeared agreeably surprised and very much pleased when the therapist reminded them of the pen they had given him and showed them how beautifully it still worked. Mrs. R., a former regular member who could not come that day, called and wanted the therapist to know she had changed her job. In the past she had been an aide in an operating room which used to scare her son who had multiple surgical interventions during his childhood years, but soon after termination of the

group she had started working for the Family Service Association. Her job, she said, consisted of talking with people who felt lonely and needed encouragement and companionship.

Discussion

I—To the question raised earlier in this paper: "What keeps these patients in the hospital?" I would like to propose a tentative answer: It is my feeling that the *absence* of the father was an important contribution to the maintenance of the illness of our male chronic schizophrenics. The word *absence* here is understood as meaning not only the physical distance such as death, divorce, separation or long travels but also as an emotional distance characterized by a lack of involvement as leader of the family unit. Our patients acted as if they did not want to go back to the outside world where there was no father, and chronic hospitalization was felt as the only way of escaping the absolute and overwhelming control of the mother with whom they had symbiotic ties. The relationship between the parents was characterized by active attempts on the part of the mother to eliminate father, out of mother's anger at his lack of support for her, and by inability on the father's part to resist successfully this process of elimination. The women in the group saw their husbands, their therapist and men in general as maternal figures, mother substitutes who, like their own mothers, had not done enough for them, were depriving and ungiving and therefore useless. In the same way that they felt abandoned by their own mothers and later again had been abandoned by these useless men, their husbands, they were now being abandoned by their therapist at the group termination.

The past history of the mothers in our group revealed that they have had to endure great emotional deprivations and isolation, both as children themselves and later as wives. Several had lost their parents early in childhood and later in life had lost their husbands soon after their marriage and had been forced to work in order to support their children. Nine mothers were still working when the group started even though most were in their fifties or sixties. The more one listened to the mothers, the more one became impressed by their achievements in the face of great difficulties, deprivations and almost total lack of encouragement and support from the fathers.

In our sample of 23 chronic schizophrenics, there were 14 fathers who were completely absent (11 dead and three divorced), another three fathers who were chronic alcoholics and another one who was blind and a chronic invalid.

The percentage of paternal mortality in our sample of patients is about double the one found in the average population: 47% among our patients vs. 25% in the general population.* (By comparison among 69 medical students, only 17% had no father, according to Lidz, (11), and among 22 residents in psychiatry of the Boston State Hospital with an average age of 31 only five or, 22%, had no father.)

The percentage of parental divorce and separation is also more than double than is found in the general population of parents of the same age: 13% vs. 5%.*

We took a random sample of another 23 patients in the same male chronic service with a similar average age of 31 years and hospital stay of six years and eight months and found again a high incidence of "absent" fathers: 15 out of the house (13, or 56%, were dead and two divorced).

In our own 23 patients we see some correlations between the total physical paternal *absence* (father dead or divorced) and an incomplete paternal absence, (what we called earlier emotional distance, meaning father is at home but he is drunk, invalid, passive or indifferent), and the length of hospitalization. We find

*Henry S. Shyock, Jr., acting chief, Population Division, Bureau of the Census: in a personally written communication. Jan. 30, 1962.

that the length of hospitalization climbs from the average 6.6 years to 8.2 years when there was a physical *total* absence, but goes down to 3.7 years when there was an emotional or "incomplete" absence. When calculated, this finding is statistically significant at the 0.01 level of confidence.

What is even more impressive is the fact that the paternal deprivation in our 23 patients was early; before they reached 15 years of age, seven had lost their fathers through death, another two because father had deserted the family, three had already a chronic alcoholic father and one a blind and invalid father. If we take into account only the nine fathers who were completely out of the house before the patient became 15 years of age, we obtain a figure of 39% of total paternal absence. The comparable figures for normals by other investigators were below 15%. Others give similar figures to the ones we found: Wahl, (19) studying several antecedent factors in the family histories of 392 schizophrenics reports 43% of them had lost one parent before age 15. Lidz, (11) in his study of 50 schizophrenics found that 40% lost at least one parent before age 19.

According to Fisher, (7) (as quoted by Wahl, (19)) the incidence of orphans (who had lost one or two parents before 18 years of age) in the general population is 6.3%. In our sample of patients it was 30.4%.

Some workers have also reported a high incidence of parental loss among disturbed populations: Lindeman, (13) among psychosomatically ill and Glueck, (9) among delinquents, (as quoted by Wahl). What we think is striking in our patients is that the parental loss was a paternal one. This paternal loss occurred early and it appeared that there had been no substitute paternal figure to support both the patient and his mother.

II – For the purpose of our study we chose as a criterion of maturation, the patient's ability to start working and maintain work because of the identification to the working father and because we felt it indicated a beginning of renunciation of the pleasure principle or as Joost Merloo, (16) puts it, a beginning of renunciation of the *realm of the mother* and a willingness to accept demands of the reality. In the course of the life of the group seven patients out of 23 started to work, either in the hospital industry (four patients) or outside the hospital (three patients) even though they never were particularly pressed to work. *Every one of those seven patients had a relative who had regular contact with the therapist*, five of them whose mothers were coming regularly to the parents' group.

We feel that if the chronic schizophrenic is to improve and start working after months and years of inactivity and complete regression, it is necessary for someone, a father substitute, to fulfil some of the mother's need for support, encouragement and help in decision-making about the child. This someone should be willing and available to "step into the mutual relationship between mother and child and cut the symbiotic umbilical cord which retained the child to the world of the unconscious represented by the mother, and prevented him from moving into the world of the conscious represented by father" (16).

If the father is not there to do this specific job of stepping between mother and child and *cutting the cord* or "if the father is too weak or too busy to do the job, if he is either physically or emotionally distant, then the dependency upon the mother remains relatively too strong or too lasting", (16). Neither child nor mother can alone free themselves completely of the ties that join them.

III – We have noted earlier that the greatest benefits in the patients were derived after the therapist was forced to clarify, without doubt, the lines of authority and dispel the confusion of roles

among the different people in charge of caring for the patients. One person has to be clearly in charge of the others. Many workers have described the pathological system of interaction going on within the families of schizophrenic patients.

According to Haley (10) "each member of the family, mother, father and schizophrenic child, is unable to acknowledge responsibility for his actions and each will disqualify the attempts of any other to announce a decision".

Murray Bowen, (5) gives an excellent example of dramatic disappearance of psychotic symptoms in a schizophrenic boy after father, in spite of his fear of his son, took a strong stand and asserted himself as the head of the family. The son reacted by assaulting father, but father was able to control him physically, after which the psychosis subsided and remained quiet as long as father continued to police the house. His relationship to the son had changed, but because the father's relationship to his wife had not changed, father could not maintain his strong stand more than one month. After a month, he gave up his leadership, the mother resumed her picking on the patient and the patient resumed his psychotic behaviour and his crazy demands on the mother.

The more we listened to the mothers, the more sympathetic we became to them until it was impossible to feel at all critical of them for the illness of their children.

Marguerit Mahler, (14) in her work with schizophrenics and autistic children, observes that "there are infants with an inherent ego deficiency" (who do not appear to perceive the ministration of care by their mothers). Similarly there are also adult chronic psychotics who do not appear to perceive the ministration of care by both their parents and hospital personnel.

It might be that the mothers in our study were forced in a symbiotic fusion with their sons because of the schizophrenic process in them and that they could not resist involving themselves in this mutual parasitosis because there was no father to cut the cord and protect them.

It might be that the only way one can protect oneself from the fantastic withdrawal and enormous demands of chronic schizophrenics and still live with them over a long period is to withdraw also and stop making demands on them for improvement. It is hoped that studies involving long treatment relationship over periods of several years between chronic schizophrenic patients and experienced therapists could be set up so that more could be learned about ways to maintain demands on patients for improvement and resist the immense frustration generated by their enduring chronicity.

Summary

The author accepts the concept of symbiotic identification between the chronic schizophrenics and their mothers. However he feels that the term *schizophrenogenic* mother is a poor one as it tends to overemphasize the role of the mother alone in producing schizophrenia in her child. He makes the point that the role of the father has been too neglected in the psychiatric literature and agrees with Marie Bonaparte's* comments that "psychiatrists have killed the father in the psychiatric literature." The role of the father as contributing to the maintenance of the illness of male chronic schizophrenics is studied through a clinical experience in which group psychotherapy is conducted with a group of 23 male chronic schizophrenics and another group with their fathers and mothers. This clinical experience is reported extensively. In the discussion part of this paper, several points are made, with statistical data and review of the literature to support them: a) the *absence* of the father, whether it is a physical absence (death, divorce, long separation) or an emotional absence (lack of involvement as leader of the family

*as reported in a personal communication by Dr. J. B. Boulanger.

unit) appears to contribute significantly to the illness of the son; b) if the child is to grow up independently, it is necessary that someone, a father substitute, do the specific job of stepping between mother and child to cut the symbiotic umbilical cord uniting them. Neither child nor mother can alone free themselves completely from the ties that join them; c) the point is made also of the necessity, in order to make therapeutic gains, to clarify without doubt the lines of authority among the people caring for the patient so that the confusion of roles could be dispelled and so that the pathological system of interaction going on in the families of schizophrenic patients could not be repeated among the personnel involved in caring for these patients. d) A last point is made concerning the fierce competition between mothers and schizophrenic children. The fathers and the therapist are seen by the schizophrenic children and their mothers as maternal figures, depriving as their own respective mothers were, and a fierce struggle goes on to obtain from these men as much as they can. This competitive struggle is intensified by the feeling that "there will not be enough for everybody around".

It is postulated that if there had been a more *present* father, such a father could have prevented the mother from becoming so involved in a symbiotic fusion with her schizophrenic child. It is observed that when coping over a long period of time with the fantastic withdrawal and enormous demands of chronic schizophrenics, it is almost impossible to resist the temptation to stop making demands on them for improvement and to capitulate to the illness. Experienced therapists must find new ways to resist this temptation.

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Résumé

L'auteur accepte le concept d'identification symbiotique entre le schizophrène chronique et sa mère. Il croit cependant que le terme de "mère schizophrénogénique" est un terme maladroit parce qu'il peut laisser supposer le rôle unique de la mère dans l'apparition d'une schizophrénie chez son enfant. L'auteur souligne que le rôle du père a été négligé dans la littérature psychiatrique et se trouve bien d'accord avec l'observation de Marie Bonaparte (telle que rapportée dans une communication personnelle par le Dr. J. B. Boulanger) que "les psychiatres ont tué le père deux fois, d'abord dans leurs fantaisies oedipiennes, ensuite dans la littérature psychiatrique". Le rôle du père en tant que facteur contribuant à la persistence de la maladie chez des schizophrènes chroniques males, est étudié à partir d'une expérience clinique de psychothérapie de groupe avec 23 schizophrènes et leurs parents. Cette expérience clinique est rapportée de façon extensive. Ensuite une discussion des principales observations et conclusions est présentée, de même que des données statistiques et une revue de la littérature pour supporter ces conclusions: a) "l'absence" du père, que ce soit une absence dite physique (mort, divorce, longue séparation) ou une absence dite émotive, (absence de participation en tant que leader de l'unité familiale) semble contribuer de façon importante à la maladie de leur fils; b) afin que le fils puisse grandir de façon indépendante, il doit de toute nécessité avoir quelqu'un, un substitut paternel, dans son entourage, qui puisse accomplir la tâche spécifique de s'introduire entre la mère et le fils afin de couper le "cordon ombilical symbiotique émotionnel" qui les unit. Ni la mère ni son enfant ne peuvent seuls se libérer des attaches qui les joignent; c) afin d'accomplir des gains thérapeutiques, il est indispensable de clarifier la hiérarchie d'autorité parmi les personnes qui s'occupent du soin de ces malades de sorte que la confusion des rôles puisse être dissipée et que le système d'interaction pathologique qui prévaut dans les familles de schizophrénes puisse être contrecarré parmi le personnel; d) enfin il est observé que la compétition entre la mère et son enfant schizophrène chronique est farouche: le père et le thérapeute sont perçus à la fois par le schizophrène chronique et par sa mère comme des "figures maternelles", tout aussi frustrantes que leur mère respective; et une bataille acharnée se livre entre le patient et sa mère pour obtenir du père et du thérapeute le plus possible. Cet acharnement dans la compétition est exacerbé par le sentiment que la "nourriture" de ces "figures maternelles" est limitée et qu' "il n'y en aura pas suffisamment pour tout le monde."

C'est la conviction de l'auteur que si un père "présent" avait existé, un tel père aurait pu empêcher la mère de se fusionner dans une relation symbiotique avec son enfant. Lorsqu'un thérapeute travaille au cours d'une longue période avec des schizophrènes chroniques, la tentation devient presqu'insurmontable de cesser d'exiger du malade qu'il s'améliore. Cette tentation du thérapeute est le principal obstacle au traitement du schizophrène chronique.

Dr Elvin Semrad.

Certainly, Dr da Silva's paper presents us with an abondance of observation and data. Too much for one paper and too much for one brief discussion.

Since I wish to pick and choose that which interest me most and nobody told me I cant do this, so I will take the prerogative that Dr da Silva did in setting up the project that he sought to such successful conclusion. Most impressive is the overall teneur of the report. It's a report of a growth experience that takes up its clues from the clinical situation, from clinical data, it is sort of born out of clinical necessity. It is born out of dissatisfaction; dissatisfaction with things as they are. It leads to a clinical hypothesis, a clinical idea and finally through all the hard work that went into testing it.

I am also impressed that it is a very cathex project. Dr da Silva cared, the patients mattered, the parents mattered and the communication of this experience matters. He is not, he was not, satisfied to study only the fatherb' reputation. He says:"it will be a question of the role of the father mostly as it was possible to perceive it through the eyes of the patients and the patients' mothers".

This could have been a very serious mistake that he went further to set up a situation namely a living experience with these people, both the patients, the parents and the personnel, with himself in the father' role: a resource, a scape goat, a rock of Gibraltar around which the turbulence in this sea of mothers, fathers, sons swirled with pain and anguish and despair.

Dr da Silva made his first observation of the interaction in his carefully set up clinical laboratory. It deserves and merits high scientific respectability; that is, he observes, he collects data and then he looks at the data, he stares at it until it says something to him that is significant.

Certainly, observations of both these groups as they went through the process, very much follows the pattern that the pressure torch actions, according to Dr da Silva's standards of expression of at least one situation namely, he was very careful to care and to pick patients that at least one personnel had attachement to. "At least one person of the staff personnel", he says, "had to have some liking and interest in the patient." I might say that he also stacked the cards in his favor because if your are able as a person to have at least one person to have an interest in you, then, you are already well on the road to potential incorporation of other people into your sphere. So, it was not only the choice but the determination which at first run counter to the patients and the parents deepest and most consistent need to satisfy self consoling purposes that the success

of patients and parents demonstrate their surviving willingness to give up one of the wishes for the good of the group, to give up their personnal wishes for the group is also evident in this material.

They struggle and not without a very competitive struggle; that the competitive struggle ran its course from active and passive aggressivity, apparent interest in driving each other away, a depressive hostility in the service to avoid closeness and what's more important "hurt", is well documented here.

Their fantasies of the leader, the fantasies of his strenght allow them agressive identification at first, relatively non creative, unproductive, scapegoating and even sabotaging. Gradually, this was sacrified and came perhaps to a head, if I understood his material, at the point of his announced termination. When this became an issue, useful identification because of hidden love coming to the foreground for the leader, came into some evidence.

Perhaps people who have lost, who are not experienced in having people come and go in their lives may profit by some structured experiments whereby experience like this can be worked through; they can be aided and abetted in surmounting this trauma and perhaps here is a clue, again a clinical clue to some such experiment in the future.

That the experiment was too short was regretful and I would ask Dr da Silva if the shortness of the contact had something to do with the fact that some chronicity persisted.

My clinical observation of the father role specifically in chronic schizophrenic patients does not essentially disagree with Dr da Silva's formulation. However, perhaps I would say it differently, perhaps even emphasize different parts of the data that he brought to us, and perhaps this difference, if there is any, would come in that I had the opportunity to study them through a microscopic tool namely free associations. And usually in these people at different level of personnality, maturity, four themes appear:

1- there is the theme of maternal seduction, that is when the father is absent, all the affection, all the struggles go in the direction of the child and Freud noted this in 1910 and emphasized it in 1915.

2- then, there is the theme of rejection. There is residual bitterness in disordered behavior and the theme essentially of revenge to pay back the agressor held responsible if he is not in fact, in fantasy, by the one deprived;

3- then, there is the perennial simple theme of loss, the finality question that Dr da Silva brings to our attention. And this has been brought forth by Ferenczi, Aichorn, Klein, Fenichel and Anna Freud, when due to the absence, and here Dr da Silva makes a point, that in the natural course of events in

the competitive struggle, the oedipal struggle, that the child does not have full benefit of this struggle to add to his maturation.

Now all the same themes appear in people who have very little relevance to this clinical paper with only one addition in schizophrenic patients and that is:

4- the theme of the cold war: the infantile parents operate on the basis of images, what they want the other one to be. And they dont give up the struggle very easily to change them or try to change them into being what they want them to be. And their acceptance of the reality of living with them as independant units such as they are is ever at a point of struggle and it is in this milieu that the situation comes into focus and makes it so difficult for, let's say, the son, to take a stand, because he has to take sides; if he takes side with the mother, then forever he has the emotional problem of anxiety that has a very close relationship to the incest quality; if he takes side with father, then he has the anxiety that has the flavor of closeness to males, homosexuality, and he is caught , and the only thing left is to withdraw from the fray (especially when one parent or the other disappear from the scene), and do nothing but console himself until somebody comes along with whom he can start work again to continue what had not been finished in the first place.

I dont like in this paper the tendancy to depreciate the maternal deprivation because I think that if more data were available and if the patients were studied more closely, that we would very clearly see that maternal deprivation lays the soil, if you wish, already put the cross on the back of the developing youngster as he enters into his oedipal period of development, and burdened already, not supported sufficiently, caught in a battle of the sexes, if you wish, where destruction is an ever present part of the air, if you wish, the oedipal development is very much distressed, disturbed, disfigured and perhaps this is what Dr da Silva tells us and calls to our attention but I would put it rather as a consequence of a disturbed relationship much earlier, than as an entity in itself.

As in this cold war situation, the phases of development are interfered, the ego is continually in a state of being overwhelmed and its defensive operations are in the service of taking it out and away from the pain quite contrary to the normal development or neurotic development where the ego is always in some state of mastery so that it can postpone the conflict for a later date; depression develops well and flight is at a minimum. In these patients they developed capacity do deny rather than to repress. They develop habits of ego restriction rather than capacity to inhibit and suppress excitations.

To their agressive identification, they lose out on ego ideal identification. In other words, they accumulate burdens rather than incorporate, assimilate, accumulate in their system, strenght of ego ideal identification of variety.

They became addicted to fantasy at the expense of reaction formation and last but not least, habits of projections at the expense of capacity for varying affects, bearing anxiety, bearing depression and bearing dread not by successful postponements but by technics of flight that always have the theme of denial, projection or distortion.

They need a father protector, that is true; that these fathers have probably flunked out in some measure because they are asked to do more than is their share and although I may sound like speaking in self defense, the burden if you wish, may be too much and when we see them, they act as "flunked out", they dont fit the bill and this is something that perhaps can be studied more in the future. As a matter of fact, one is often surprised in the history of these patients who have developped such capacity of flight at the price of inability to postpone and repress because their histories usually, their ordinary anamnesis says everything is fine until they run out of people, until they run out of a protector: at that time, that which had been hidden, comes to light.

That Dr da Silva became a protective figure, firm, fair and understanding is clear to me in these data; that he achieved more in fact is reflected very much in the work index that he chose. This is an index that we have not used and I think it is a very excellent one to develop. Through his fairness, firmess and determination, he really offered the patients collectively a corrective ego experience, up to a point. He consolidated his gains by his termination and I take it, partial working through of the termination period.

His wish to situate his paper in the tradition of the Boston State Hospital Staff and alumni is certainly respectively received. I personally would look forward to future papers published probably in the Canadian periodicals that will bloom in face of the potential that is demonstrated in this paper. Thank you.

Discussion of a paper presented at the meeting of the Northeastern Group Psycho Therapy Association, Boston, February 1962 and published in the " Canadian Psychiatric Association Journal " Vol. 8, No. 3, June 1963 under the title: " The Role of the Father with Chronic schizophrenic patients."