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Analysis of Family Milieu of Asthmatic Children (Family explorations)

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Exploration within the families of 40 asthmatic children revealed that the child's disease has an important role in maintaining family homeostasis. Since recovery of the child would endanger the family's security, intrafamiliar forces are inhibiting his recovery and play a role in the precipitation of asthmatic attacks. The findings indicated that the characteristic attitudes termed in recent literature as maternal rejection, maternal overprotection and Chronos complex are motivated by a discrepancy of the mother's genuine ego and her ego-ideal.

In investigating asthmatic children, our starting point was the concept that, as with all psychosomatic diseases, the aetiology of asthma is multicausal. Instead of following the exaggerating attitude so common in the pertaining literature, which fails to take allergic and hereditary factors into consideration, the principle was accepted according to which it is rather doubtful whether any single factor in itself could be the underlying cause of a disease. It seems more realistic to talk of a certain constellation of factors prevailing in a certain disease, the single factors of which differ as to their importance. The fact has been generally accepted that there exist certain psychic phenomena inseparably accompanying somatic lesions and, also, that long-lasting functional disorders may cause grave organic changes. The individual's constitution, social position, experience in life, inherited and acquired immunity, physiological and psychological structure are all in a direct connection with causality. Man is the product of his environment and disease is the danger reaction of man as an entity.

Thus, the present investigations have been focussed upon one of the factors of asthma, the psyche, essentially upon the emotional factor. An attempt has been made to approach this factor by complex methods.

The main theories in the psychosomatic literature interpreting the emotional background of asthma deal with the personality signs of the patients and the characteristics of the mother–child relationship.

According to the concepts of maternal overprotection [12, 14, 16], maternal rejection [7], the emotional dominance called Chronos complex [1], the repression of aggression [2,

10] as well as that of the emotional instability in the whole family [9], mothers are overprotecting, emotionally dominating their child, who, due to this fact, is forced to repress his aggressions and, because of a far too tight emotional closeness, is afraid of losing his identity. Some authors are of the view that the background of the maternal attitude is an unconscious emotional rejection of the child and a consequential feeling of guilt. Overprotection and simultaneous rejection would result from this over-compensation. WEISS [18] already regarded dependence as the main characteristic of asthmatic patients. FRENCH and ALEXANDER [8] found that the patients are in a constant anxiety state throughout their life, being afraid of losing the love of their mother or that of the mother-substitute.

Few authors have dealt with the role of the father, and investigations into the effect of the entire family milieu in the field of psychosomatic diseases is still in a state of experimentation.

Our first studies have been directed onto the suffering child and the mother–child relationship. Later, we found that exploration of the milieu of the asthmatic child cannot be restricted to an analysis of the mother–child relationship; due to some chance results of family group sessions, our attention has been drawn to some essential connections which then have made us to perform regular family group explorations.

In modern psychopathology, family group explorations are performed since the fifties. In the course of these, investigations into common family interactions yielded some unexpected facts and helped us in understanding certain symptoms which can be recognized only by exploring the family patterns. It was found that pathological motivations occur not only in the patient, but subclinically in every member of the family. The decisive turning-point in psychiatric attitude has been brought about by the recognition that disease may play the same balancing role in the family, may serve the maintenance of the family homeostasis in the same manner, as intrapsychic forces do. It was found that intrapsychic fights within the family may transform into family transaction systems. For instance, healing of one of the members of the family may — in order to reestablish the balance of the system — necessitate the illness of another family member. Individual diagnostic aspects in psychiatry seem to give place gradually to a transactional diagnostic view.

The authors dealing with the investigation and psychotherapy of "pathogenic" families [3, 4, 5] have mainly explored families of schizophrenic patients and described the laws of transactions. Others [6] investigated the structures of neurotic families and described the characteristics of the family milieu of patients with ulcerative colitis [17], or carried out family group investigations and applied group psychotherapy in children with personality disorders [15].

Material and Method

Forty asthmatic children, 29 males and 11 females, from 8 to 14 years of age, and their family members were studied.

A detailed history was obtained separately from the mother and the father. Several individual explorations were carried out with the child and the parents separately, and Rorschach tests were performed with child and mother. Subsequently, with a therapeutic purpose, regular family group explorations were carried out. In order to standardize the investigations, the other family members were neglected.

Family explorations were performed for one and half hours once weekly on 10 to 15 occasions. The summarized result of the sessions was recorded. The therapist started the exploration by asking questions concerning the way of life of the family, then, if possible, displayed a passive attitude.

Results

In the course of the investigations, an unexpectedly uniform family structure was revealed. The distribution of roles in 31 families was as follows.

The directing role of the family was played by the mother;

mother and child formed a symbiotic association; the father played the role of an older step-child.

The dominating role of the mother was clearly recognized during the family sessions. At the first session, practically only the mother was talking; she started the talk, her husband and child were asking her for decisions or corroboration on every occasion.

It was striking to see that the questions addressed to the child are answered by the mother, who not only speaks instead of her child, but even thinks and feels for him. She claims to decide upon or to deny certain obvious ventures or experiences of the child. She tells the child whether he is breathing properly or suffocating, whether or not he feels well. She claims to be beyond any argument as to the child's demand for love which is entirely fulfilled by her maternal attitude and that he has no impulses directed against the mother, etc. disregarding whether or not her statements correspond to the subjective experiences of the child. The reaction of the child to the maternal attitude, called "mistification" [13] lacks in the majority of cases any revolt or demand for independency, even at prepubertal age. The child, by his few reactions, proves the maternal statements. Only in three cases did we meet with transitional resistance reactions. It seems that the mother transfers her unconscious demands onto the child in the form of super-ego demands, and the child by accepting it, satisfies his own dependency needs.

The counterbalance of the symbiotic mother—child relationship is the father, who being squeezed to the edge of the family, displays at the sessions a rather passive attitude. His manifestations are rarely verbal and his permanent emotional frustration appears in the form of an acting-out attitude (bouts of temper, alcoholism) or else in psychosomatic complaints (gastrointestinal symptoms, ulcer, etc.).

His excessive drinking expresses his great demand for dependency and emphasizes his reduced responsibility, forcing in this manner the mother to take upon her the bulk of responsibility and to exert maternal care. At his working place, on the other hand, the father who is obliged to keep a diet for gastrointestinal or ulcerous complaints, pretends to have great responsibilities, emphasizing his demand for love by being an overburdened and ill person.

Due to his alcoholism, disease and/or resistant-like attitude, the father easily becomes the scapegoat. He is the black sheep of the family, or the whining patient, giving always some extra work. The mother scolds, reproves him explicitly, but with her implicit attitude she cares for the father, — even if negatively, — only if he drinks or is ill, and so does not let him out of his role of a scapegoat.

Characteristic of the father—child relationship is a rivalizational aggression from the father's side, while the child displays a realistic fear of paternal aggression and a feeling of guilt for being a rival.

The boys, due to anxiety and the negative family role of the father, do not identify themselves with him. In some instances, the father succeeds in establishing a close relationship with his daughters, but even then the authority remains with the mother.

As a consequence of that, the mother seems to be the only mature, adult person in the family. On a closer investigation of the family interactions it becomes, however, evident that the adulthood of the mother is just an apparent one, a role played by her in the interest of achieving her ego-ideal. Her pretended adulthood can be maintained only by identifying herself with her mother-role, living in symbiosis with her child. Finally, after a number of observations, we understood that the discrepancy between the mother's infantilism and her ego-ideal must be the dynamic force standing behind the family interactions.

For a perfect recognition of the situation, HILL's [11] three-generation hypothesis has to be taken into consideration. Our individual and group explorations as well as the test material of the present investigations have provided sufficient data for this puspose, and the following hypothesis has been formed.

The parents of the mother, a strong-willed, dominating mother and an insignificant, weak father had formed the basis for their daughter's infantile need of dependency and at the same time also for the formation of her characteristic ego-ideal. At the side of the strong-willed, dominating mother, the ego-ideal of the dependent child had developed into an energetic mother, dominating and directing her family. At the same time, due to her infantilism, she is not suited either for a feminine role or for that of a mother. The basis of her emotional life becomes the solution of the discrepancy between her ego-ideal and her genuine ego. Since she had failed to become a mature woman, she has to chose an infantile husband,

and since she is not suited for a genuine mother role, she is obliged to create a situation giving the illusion of adequate motherhood.

The father as a child had in most cases been neglected and grown up in an atmosphere devoid of loving education, very often in a boarding school, or with step-parents. His mother always preferred her husband to him. The emotional hunger developed in this situation and his insufficient masculinity as the consequence of an unsuccessful rivalization with the father, have brought about his infantilism. His ego-ideal is therefore the privileged man, the victorious male. Owing to his unsatisfied mother-demand, he choses for a partner a woman of the mother type and expects to achieve the situation of the privileged husband which he had seen with his own father. Thus, the woman playing the role of the ego-ideal of the matriarchal mother seems to be a partner adequate for this demand. The mother, on the other hand, finds the insignificant, weak husband, to suit her ego-ideal.

Thus, of the two infantile individuals, the husband accepts openly his infantilism, requiring much care and maternal attitudes from his wife. The wife, hiding her infantilism, wants to have a weak husband whom it is easy to direct, responding thus to her ego-ideal. The husband, due to his inadequate masculinity, does not notice the fact that his wife is not suited for the role of a woman.

The mother, during her pregnancy, experiences maximum ambivalence. Because of her infantilism she is not suited for motherhood, while her ego-ideal obliges her to accept the role of the perfect mother. Her inability to fill a feminine role makes her to take the compensatory mother-role. Her motherhood becomes the proof of her being a woman of full value and permits her to switch over from the unsuccessful feminine attitude to that of a mother. Satisfaction of the infant's physical needs creates in her the illusion of adequate motherhood, and the ill child's demands of similar character are suitable for maintaining this illusion. Maintenance of the child's illness becomes therefore the basis of maternal security.

The father role of the father is also ambivalent. Instead of the position of the privileged husband, he has to put up now with the role of the neglected one. Emotional hunger and the situation of rivalization are repetitons of childhood traumas.

The position of the child is a consequence of the parental ones. As long as he is small and ill, he is protected against paternal rivalizational aggression and gets all the maternal love and care he needs. If he is cured or grows up and becomes independent, he is confronted by both. It is the child's illness role which makes it possible to maintain the family's homeostasis. This explains why the familial forces manifesting themselves in family interactions inhibit by all means the child's recovery.

The Figures display schematically the process taking place in the family at times of important events

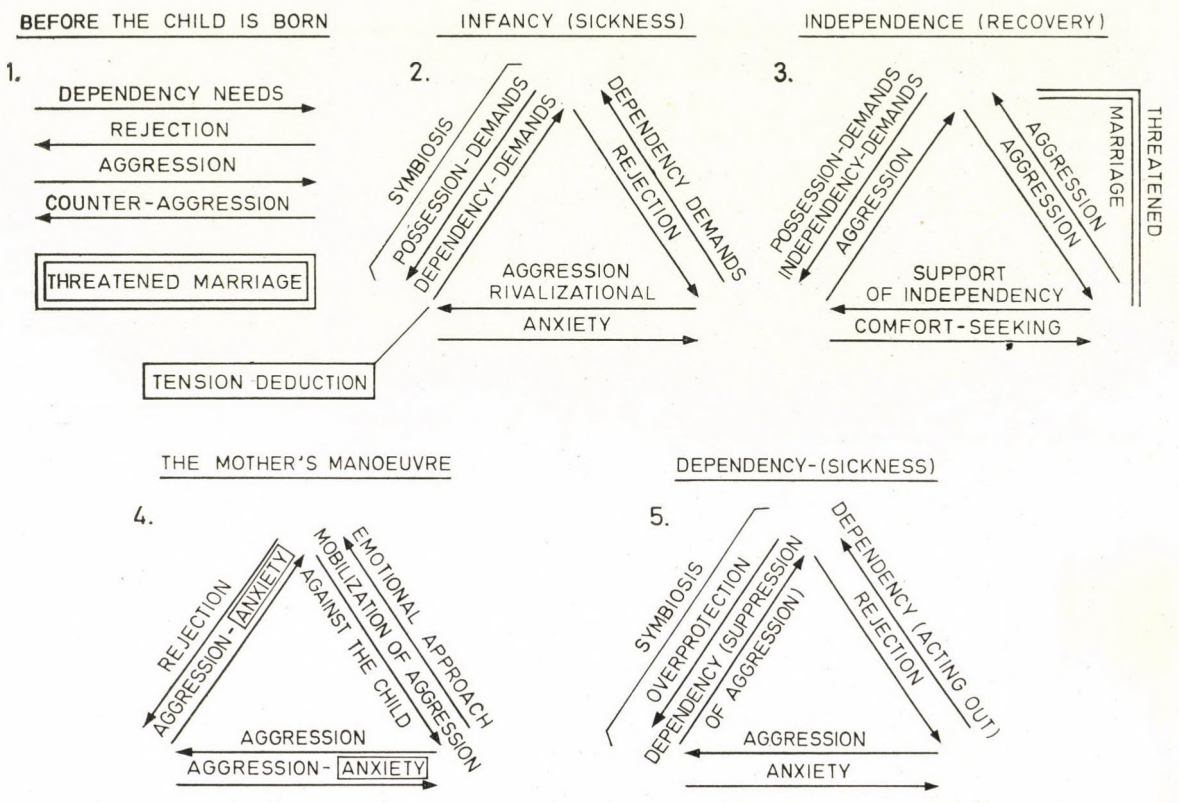

Fig. 1—5

and shows the role of the sick child maintaining family homeostasis.

Figure 1. This was the basic constellation of the marital partners before the child was born. The wife owing to her infantilism cannot satisfy the husband's dependency needs and her ego-ideal is also forcing her to play a different role. As a domineering woman, she rejects him. The emotional frustration is followed by aggression, and this results in counter-aggression. As a consequence, the marriage is threatened.

Figure 2. After the birth of the child, the mother achieves through motherhood and symbiosis with the child the adult-role she has longed for. As a consequence of the reciprocal satisfaction of possession demands and dependency needs between mother and child, an emotional balance develops. The father, though still rejected by his wife, now attributes this instead of his inadequacy, to the maternal care for the child. The husband's aggression turns against the child, finds an outlet, and does not any more endanger the marriage. The same happens if the child is ill.

Figure 3. The growth or recovery

of the child is a new threat. The mother's possession demands are faced by the independency demands of the child, which threaten the symbiosis and thus the role of the adequate mother. The father, being in a rivalry position, backs the child's demands for independence. The mother, fearing to lose the child, turns openly against her husband, who fights aggressively against the re-establishment of the symbiosis. The marital conflict flares up again.

Figure 4. In her emergency state the mother threatens the child with rejection (withdrawal of love) and seemingly nearing to her husband, forces him to support her intentions. The child cannot bear the double aggression, and capitulates. Afraid of losing his parent's love, the child is forced back into his helpless sickness situation. He suppresses his aggressions, endures the overprotection, domineering, engulfment and loses or is unable to form out his identity.

This was the process observed in most cases during psychotherapy.

The essential results of our investigation were as follows.

From among 40 cases in 23 the maternal grandmother had the role of a dominating support in the life of her daughter. Except in 4 instances, every woman had a dominating mother and the daughters stood entirely under her direction. Following their marriage, they still held onto their mother, or else sought security in an identification mother role.

Among the fathers, 16 had spent the main part of their childhood in a boarding school; 19 had step-parents; 27 are alcoholics, 20 have constant gastric troubles, and of these 11 have an ulcer.

Twenty-two of the mothers are, according to their own statement, frigid, and 31 are so according to the husband's statement. Only two couples had divorced. From among the 31 husbands stating that their wifes were frigid, two had divorced; six husbands had moved back to their own mother, and only 4 have tried a new sexual partner.

Of the children, 19 were born of unwanted pregnancies, 9 after spontaneous abortions and 6 following a long period of barrenness. During pregnancy, vomiting or other somatic complaints ocurred in 29 cases. The nursing period was usually normal but the number of poorly sucking, and later poorly eating infants was remarkably high. According to the mothers, 26 children are still poor eaters. Accepting the view that feeding problems basically point to an ambivalent mother–child relationship, as also that the breast-feeding capacity depends in a high degree on maternal emotions directed towards the child, the contradictory state between the mother ideal and the capacity for genuine motherhood may be assumed to have played an important role. The mother ideal necessitates breast-feeding of the baby, its emotional harmony is, however, disturbed by the ambivalence prevailing in the background.

The answers given by the children to the question what they do if they

are angry, were most characteristic for the suppression of their aggression (I sit down, I leave the place), 3 displayed an antisocial attitude (stealing), 3 maltreated or killed animals, 2 set the family members against each other. It seemed that for the majority of the children an asthmatic episode was the only means for working off their impulses.

In the Rorschach tests of the mothers, several signs referred to infantile and sexual anxiety. The prevalence of colour responses (CF) and the frequency of red shock referred to histeroid personalities. The high percentage of chiaroscuro (ChF) answers were indicative of a prevalence of emotional elements. The object of anxiety (the inability for the feminine and mother role) remains unconscious and is transferred to the illness, as established also from the high percentage of anatomy answers. Due to the mother—child symbiosis, the narcistic satisfaction in this case is not coming from her own illness, but from those of the child's. It serves as a defense against anxiety. Defense against self-knowledge, role playing were proved also by the conspicuously high number of derealization (inertia traits). On Table VII, not a single space response was given by the mothers and at the same time accumulation of shading responses was frequent, referring to a suppression of aggression. Table VII is usually considered to characterize the relation to womanhood and motherhood. If we accept this, a shading response accumulation expresses anxiety from motherhood and womanhood. A shading response accumulation was revealed also in Table VI, as the expression of sexual anxiety.

In the Rorschach tests of the children, infantile form-answers and plant-answers were registered in great number, referring to the increased dependency of the child. In Table VII, inhibition of aggression manifested itself with twice as many shading responses as space responses.

There were several similar essential traits in the registrations of mothers and children (social adjustement, control system, in the field related to aggression); they were interpreted by the intertwined, symbiotic relationship between mother and child.

Discussion

The mother—child relationship has been approached from different aspects in the literature. Certain laws have been recognized, but the studies have failed to give an adequate explanation for the development and formation of these characteristics.

The hypothesis discussed above seems to throw new light on the concept of maternal overprotection and emotional rejection, and also on the suppression of the child's aggression, all this on the basis of the discrepancy between the mother's genuin ego and her ego-ideal as the intrapsychic background.

Our experience gained in the course of family-group explorations points

unmistakably to the fact that the child's disease plays the main role in family homeostasis. Since recovery of the child endangers the family security, the intrafamilial forces by all means act against the success of complex therapy, inhibiting thus the child's recovery and even have a role in the precipitation of the asthmatic attacks. This means that psychotherapy of the asthmatic child cannot be successful, unless it is carried out in the form of a family-group therapy, by changing simultaneously the entire structure of the family.

The observed family structure, in spite of its apparent uniformity in the present study, cannot, of course, be considered asthma-specific. It is easily conceivable that similar results will be yielded by investigations of patients suffering from other psychosomatic diseases.

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