6th Int. Congr. of Psychotherapy, London 1964; Selected Lectures, pp. 8–13
(S. Karger, Basel/New York 1965)

Joint Treatment of Schizophrenic Children and their Mothers in a Group

J. Campos Avillar

The group which I am going to report about has been functioning for a period of over one year, on the basis of one hour per week. The room where we meet is a consultation room of a general children's hospital. The room is 4 m by 4 m and furnished with a desk, two arm chairs, four other iron chairs, an examination couch, a negatoscope, a hand basin and a tall and narrow metal cabinet.

The members of the group are:

1. Charles, aged four, a beautiful, well developed young boy. At the beginning of treatment he shows well coordinated motor functions, his facial expression is bright and pleasant, he continuously smiles but he appears completely unrelated to people around him. He looks through you rather than at you. He uses no verbal communication to express his needs or wants; instead he uses his mother's hand as an extension of his own when he lacks the strength or skill to do something himself, but he does so without even looking at his mother. He shows no pain if he harms himself, he never cries, he has not reached toilet training and his mother still has him in diapers. He has been very healthy, not having even had any of the usual childhood diseases. He took the breast after birth but following a mastitis of the mother, which interrupted breast feeding for a week when he was eight days old, he refused to take to the breast again. He never plays with toys, the mother, or other children, with the exception of twirling some objects or letting the water run for hours at a time; he engages himself in some autistic activities such as rocking of the head at bed time or occasionally playing with his genitals.

2. Charles' mother, a 28 year old woman, overweight and depressed looking. Charles is the only child of the marriage; they waited six years to have Charles because of economical reasons. She feels guilty about everything and especially her son's illness. She feels anxious about the child, always running after him hoping the child one day will respond to her and feeling rejected by his behavior. In her relation with me she presents herself as a helpless, small child who wants me to take care of her and protect her. Her relation with her husband is said to be satisfactory. The husband is not so over-concerned about the child as she is, although they have not tried to have another child for fear of having their bad luck repeated. There are no antecedents of mental illness in the family.

3. Mike, aged six, a rather thin, but well developed child. He clings to his mother but shies away from others. He does not use conventional language. He seems to understand some of his mother's orders, but responds rather negativistically to her. He displays motor hyperactivity, shows curiosity towards objects but his activities tend to be stereotyped. He is toilet trained. His sleep has been poor from birth; he refused breast feeding. He never played. He is fond of physical contact, but since this has sexual connotations it threatens his mother and relatives.

4. Mike's mother, a 36 year old woman, who has a gloom all about her. Her father died two years ago and she is still mourning him. She cries easily when talking about her son, she feels ashamed of his condition and resents it. She is full of anger which she can hardly keep under control. She feels challenged by her son's negativistic behavior and at times feels angered to the point of wishing him dead. In handling the child she shows rejection of which she rarely is aware. Mike is also the only child. They do not want any more children because Mike is going to require from them all the money and efforts they can afford to give.

Progress of the Group

This group at its conception had as a main goal the study of the kind of relationship established between a schizophrenic child and his mother, and as a secondary goal the use of the understanding of this relationship to achieve operative changes in the relationship.

The children were given plastic bricks and building blocks and balls, but they paid no attention to them. Instead Mike concentrated his attention on the closet that is in one corner of the room, getting in and out of it, and Charles would mainly play with the water of the basin. The mothers were given instructions to do as they feel and to try to put into words whatever they thought or felt.

At the beginning I adopted the passive role of an observer. I was mostly impressed by the degree of unrelatedness that was present in this group. The mothers would stand up, withdrawing into gloomy thoughts, watching their children but not seeing them. There was shame, self-pity or guilt in their expressions, but I could not help them to bring their thoughts out. Meanwhile, the children engaged in their autistic activities, putting themselves into situations of real danger, as for instance knocking their heads on the corner of a cabinet, without the mother showing any sign of anxiety nor the child showing pain or looking for the mother after having hurt himself. For the children the mothers were just partial objects, a hand to do something which they could not do themselves, or a neck to hold onto in order to reach an object.

My attempts to interpret the behavior were fruitless. The mothers, the only ones in the group with whom I could enter into verbal contact, would take my interpretations as accusations which were increasing their guilt and provoking withdrawal.

I was aware that the mothers and the children had serious difficulty in handling their dependency needs, which were denied, projected on to others and frustrated by them. I decided to change my line of approach and letting myself be guided by my contratransferential feelings I adopted a kind of mirror technique which consisted in counteridentifying myself with the members and responding to them as I would have liked myself to respond if I was in their situation.

The first one to show some response to my new approach was Charles. He was attracted by my habit of smoking. When I lit a cigarette he would come to me and repeat with his lips the movements I was making with mine when I was expelling the smoke. Then he would take my hand and put the cigarette on my lips, again and again. At the beginning this was some sort of imitation but soon it became a deep identification, practically a fusion with me, where my activities were giving him pleasure. This manoeuver served to establish a bridge between Charles and my smoking. However, he also had physical contact with me. To his expressions of pleasure I cued to him and we were engaged in a pleasurable relationship, an experience his mother never had before.

Mike started to use also me as an extension of his hand. I had observed that when he did this kind of manoeuver with his mother she would respond to it passively as if she was not a different object to him. At the beginning I would follow him, but soon I started to show some resistance which frustrated Mike very much, but instead of giving up he would try to engage the rest of my person in order to get me to do what he wanted.

The two children were jealous of my attention, rarely showing it openly but most commonly retiring into their autistic activities. Soon however the mothers joined the interaction and when I was busy with one child, his mother was able to interact with the other. It was very interesting to see how these mothers soon started to imitate me, and the funny thing was that they were more able to establish contact with the child of the other mother than with their own.

These mothers who had not been able to laugh for years were now during the therapeutic hours enjoying themselves and their children. Soon they started to report about progress the children

were making at home and at the same time were able to express all the frustration, shame, guilt and anger they had been experiencing through the years.

Both, children and mothers, had shown progress during this year of therapy. Charles' mother is less depressed and withdrawn than she used to be. She accepts the child at his own level of emotional development. She has gained self-esteem and is not so overprotective as she used to be. Charles is playing with other children. He makes contact with people more easily. He has obtained bladder control during this time, is starting to respond to his mothers commands and encouragements, he has started to utter his first words "papa" and "mama" and uses them to attract their attention or to ask for something. He uses his smile to charm people and is more lovable than he was. He does not run away from his mother or ignore her as he used to do.

Mike, has had a harder time during this year of therapy. He is less affectionate than he used to be, but he clearly differentiates between friends and strangers. He now is frequently depressed, cries if he is punished, but in general his quality of contact has improved. There was one time when the child seemed to be hallucinating, just before he started to have his spells of depression. For a while he suffered from insomnia but that cleared up once he was given his own room and taken away from the parents bedroom. Mike's mother is more rigid than Charles'. She is however less depressed than she used to be, she faces now the illness of her son more realistically. She has been able to find some outlets for her frustrations instead of masochistically taking her problems. She has gone back to work full time which gives her some break from her obsessional preoccupation with her child, some gratifications and allows her to use more constructively the fewer hours she spends with her child.

What stands behind the progress reported? I have to confess that I do not know for sure, but I personally believe that it is mainly due to the changes that have taken place in the child—mother relationship. No stress has been put upon uncovering unconscious material in this group, and what is more, I do not think that this setting would be appropriate for any such work.

The big question, whether childhood psychosis is mainly a congenital disease or an environmental one, is still unanswered and it will be for many years to come. My views in this respect, based on the material brought up by these mothers and other mothers of schizo-

phrenic children I have treated, are that there is no specific personality of schizophrenogenic mothers. I have seen rejecting ones, overprotecting ones, ranging from the diagnostic point of view from mild character disorders to open psychosis. But who would escape a psychiatric diagnosis if one was to come into contact with a psychiatrist?

But there are consistent features arising from the nature of the child-mother relationship. Nobody can be a mother by herself. A mother needs a child to be mother to, and a child needs a mother to be mothered by. When the mother or the child, for whatever the reason may be, is not up to her or his role, the child-mother relationship is altered and instead of becoming a mutually rewarding experience which fosters growth and maturity in both participating members, a vicious circle is started where the child is fixated at primitive levels of functioning and the mother regresses to inadequate levels of relationship at least as far as the child is concerned.

What holds true for the child-mother relationship in the case of psychotic children, I think can be extended also to the cases of many other atypical children. The relationship is not only pathologic but becomes pathogenic. Any help which can be brought upon this transactional pathogenetic relationship that helps to break the vicious circle and allows for more healthy and mature processes to take over, will facilitate the growth and mental health of any of the individuals involved.

The technique of treating together schizophrenic children and their mothers is not new. It is just an expression of the ever growing interest in the dynamics of the family unit. What I think is original in my experience, is putting more than one of these units into a group setting. The group approach I think facilitates the establishment of strong identifications with the therapist, gives them the opportunity of having a mothering and a mothered experience with others than his or her own. The relationship free from blood ties is also to a certain point free from many personal anxieties, and finally I think the group is a mutually supporting experience that helps them to try new approaches and attitudes, with their own mother or child, first within the frame of the group and later on back in their own home.

I do not think that this kind of approach serves for attempting to cure schizophrenic children, a more intensive individual therapy is necessary for that, but what I am quite sure about is that it can be a help in selecting the patients which can benefit from more intensive methods of treatment and/or for supporting their relationship while

they are having other kinds of therapy which are mostly aimed at achieving intrapsychic changes.

I also think that this method can be applied to other kinds of physical or mental conditions—such as mentally defective children or cerebral palsy—where a special kind of mothering experience is required.

It is possible also, that this method could be applied as a preventive measure, when serious disturbances in the child-mother relationship are detected in earlier stages of development.

I would specially recommend this approach for the anxious time that follows in child guidance clinics, when after having reached a diagnosis we are forced to put the case on the waiting list until the time when we are to start treatment.

Summary

This paper describes the treatment of two non-verbal schizophrenic children, 4 and 6 years of age, and their mothers, in one year of group analysis.

The theoretical basis of the treatment in brief is: modifying the child-mother relationship through the analysis of the interactional and interpsychic processes in the group and making possible the achievement of a "corrective" mothering experience during the days and hours in between therapeutic sessions.

Technically the group is a mixture of the techniques used in family therapy and the one used in group analysis of neurotically interacting couples.

The results achieved so far are encouraging. The mothers have gained some insight into their feelings about their children and themselves. They are now able to partially accept the children and to a point even enjoy them. The children are less hyperactive, less withdrawn and are starting to see their mothers and myself as external objects and not as projected parts of themselves. Also, they are now using the smile, signs and some words indicating that they are in closer contact with the environment, and at times understand and make themselves understood.

The aim is to make this approach a useful tool in dealing with such a hard and economically difficult problem as is childhood schizophrenia in child guidance clinics with overcrowded waiting lists and shortage of therapists.

Author's address: JUAN CAMPOS AVILLAR, M.D., Paseo de San Gervasio 30, Atico, *Barcelona, 6* (Spain)