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THE FATHERS OF AUTISTIC CHILDREN*

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THE syndrome of early infantile autism, first described by Kanner in 1943 (1), occupies a position of considerable interest for clinical investigation. Predominant opinion would appear to hold that autism is to be properly classified among the group of childhood schizophrenias (2), although dissenting viewpoints should be noted (3, 4). If this nosologic allocation be granted, then early infantile autism is the earliest of the schizophrenic reactions known to occur in man, being evident usually within the first and certainly by the second year of life. As such, it offers the implied promise that analysis of its etiology may cast additional light upon the general problem of the schizophrenias.

The psychiatric literature is rife with studies of childhood disabilities in which detailed and particular attention is given to personality traits in the mother presumed relevant to the disorder in her child. This theme has been pursued with a verve greater even than that epitomized by the "*cherchez la femme*" of the fictional writer. Father has been the forgotten man. With little in the way of conclusive data to support the concept, the term "schizophrenogenic mother" has become almost a cliché of clinic usage, often perhaps not intended "too" seriously, yet nevertheless employed so freely as to indicate covert acceptance of the notion. This rigid insistence on the pathogenicity of the mother is a cultural phenomenon of contemporary psychiatry and social work itself worthy of study, but beyond the scope of the present paper.

This study of the fathers of autistic children was undertaken in an effort to contribute to a broader view of the family dynamics related to the personality development of the child. Special emphasis has been placed on those personality characteristics which involve the ability to form meaningful relationships with other people and which influence marital and parent-child configurations. Underlying this approach has been the premise that the father is no less important a member of the family unit than his wife, both in terms of his direct influence upon the child and of the fact that any inadequacy in the execution of his role is likely to affect the adequacy of the mother's performance.

Before proceeding to a consideration of the data obtained in this study, it is necessary to pause briefly to recall the diagnostic criteria which characterize the cases in this group. The term, early infantile autism, has been employed with increasing frequency in the literature, often in a rather imprecise fashion. This can result only in blurring the distinctive features which

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serve to set this syndrome apart and in obscuring investigations into the etiology of autism by including heterogeneous disorders. Extensive clinical experience with early infantile autism at this clinic and the opportunity for long-term follow-up of a considerable number of cases (5) has served to verify the perspicacity of the original observation (1) which suggested that early infantile autism constitutes a specific clinical picture.

The pathognomonic features of autism are extreme self-isolation and an obsessive insistence on the preservation of sameness (2). Isolation as a descriptive term, rather than withdrawal, appears warranted in view of the frequent observation that the infant was notably *alone* from the first months of life; that is, he failed to exhibit the responsiveness and the anticipatory reactions to cuddling so readily elicited in the normal infant. The relationship of the autistic child to the world about him is extremely tenuous; any change in its configuration, fraught with anxiety, is resisted strenuously. Left to his own devices, the autistic child engages in rhythmic repetitive patterns of motor behavior and adheres to rigorously routinized daily schedules. As a consequence of these primary symptoms, to employ the term in Bleuler's sense (6), secondary phenomena appear. The profound detachment from interpersonal contact results in language disturbances, ranging from total failure to develop speech, through echolalia, to highly idiosyncratic use of language. Many of these children acquire remarkable verbal facility, indicative of superior intellectual abilities, but without concomitant concern for the communication of content. They exhibit an almost uncanny preoccupation with things to the exclusion of people, often treating parts of people as objects (7). Peculiarities of thought are notable; similarity is confused with identity (8), wholes with parts (9). Difficulties with feeding, refusals to chew, problems with toilet training and other secondary symptoms are frequent. Autistic phenomena may be observed, as has been recently pointed out (10, 11), in retarded and brain-damaged children. But only the highly selective findings, self-isolation and obsessiveness, permit the establishment of the diagnosis of early infantile autism.

So much, then, for a definition of the criteria by which the diagnosis was established in the 100 cases which comprise this study. The results to be reported are based on a careful review of the material recorded in the case histories about family structure. Since, from the first, certain unusual aspects of the family unit had been noted (1), specific attention was devoted to elucidating what were suspected to be salient personality features in the parents in all subsequent cases seen. Hence, the case records are fairly complete in this regard and suitable for retrospective evaluation. Inevitably, recorded histories lack the immediacy and vividness of the impressions to be drawn from interviews personally conducted as part of a planned investigation. In this connection, attention should be called to the detailed and

thorough preliminary report on the fathers of 16 schizophrenic patients by Lidz, Parker and Cornelison (12), which gave impetus to the present endeavor.

A study of personality characteristics is peculiarly resistant to statistical quantification, at least in the present state of psychiatric methodology. To report findings in terms of percentages can be misleading, as it might suggest more precision than we have any wish to claim. What does emerge from the case material is a pattern of behavior among the fathers of autistic children that is to be found with remarkable frequency. This may be most graphically conveyed by citing three brief case studies, chosen because they exemplify, in a heightened and dramatic but nonetheless typical fashion, the features evident in 85 of the 100 fathers in this series.

Case 1. Dr. R was a caricature of the conventional psychiatric stereotype of a surgeon. He boasted that he never "wasted time" talking to his patients or their families. When feasible, his first transaction with the patient took place with a draped and disinfected torso prepared for the surgical incision. He conscientiously supervised details of postoperative care but through his assistants. He dealt with infected gall bladders, diseased bowels, or tumors, with little or no curiosity about the person in whom these anatomical problems were housed. His day was thoroughly organized from the first surgical scrub to the last journal he might glance through while preparing for bed. The work he accomplished was prodigious and had earned him a position of considerable solidity in the professional community. Family life was the one item for which his schedule had no provision, not because of an inability to fit it in, but rather because of no perceived need for it. There were, of course, contacts with wife and children but these were kept to the unavoidable minimum inescapable at meals and bedtime. It was not that he could not see the need for relaxation; on the contrary, within each week's schedule was a half day for fishing or hunting—alone; each quarter there was a long vacation trip—alone.

His wife was well provided for. She could spend what she chose. A mink coat was far more easily obtained than a discussion. If she were to bring up details of family living when they were together, she would draw a reproving look, a contemptuous dismissal of the problem as too petty to trouble him, and cold silence as he returned to his scheduled activity. Insecure, frightened by his cold and unaffectionate manner, and unable to express her overwhelming resentment, she grew less and less able to bring any matters to his attention. Intelligent and attractive when they married, she became progressively more of a slavey to the household and presented an incongruous appearance for the wife of a leading professional man.

Distressed by her son's problems—the third of her children to show emo-

tional difficulties—she at length had the temerity to suggest that a psychiatric consultation was indicated. Her husband's reply was a gruff statement that the boy would "outgrow this nonsense," but he was quite willing to displace the responsibility on to another and agreed to allow her to make the appointment. Mrs. R's account of her marital situation was indeed pathetic. Her husband had no apparent need for social life himself. As for her friends, "he doesn't care for them. He says they talk too much." He displayed affection neither toward her nor the children and had succeeded in isolating her from any possible satisfactions outside of her immediate family. He was himself the youngest of 11 siblings and by far the most successful in terms of money and prestige. He boasted—with justification—that he had achieved what he had on his own and with no dependence on others. All the less could he comprehend her feelings of inadequacy and self-pity.

He agreed to come in to review the situation with the psychiatrist. He arrived on the scheduled moment prepared to deal with the problem in a forthright and businesslike manner. He discussed the child's symptoms in an "objective" and detached fashion. Once he had assured himself, through discreet inquiry, of the psychiatrist's competence, he was willing to accept the diagnosis and its full implications. He felt that the child had had "something basically wrong with him from the beginning." That there might be any possible connection between the child's difficulties and his (the father's) role in the family was a completely foreign notion, intellectually and emotionally alien to him. When, in an effort to provoke some feeling on his part, the question was posed as to whether he would recognize the child if he met him on the street, he gave the matter a moment of deliberation, answered "objectively" that he was not entirely sure that he would, and gave no evidence of resentment of its obvious implications. Once the diagnosis had been decided, the issue was to determine with dispatch what course of action should be followed. The possibility of placement with affectionate and relaxed foster parents was mentioned. Almost at once he proposed two families in his own kinship and was prepared to terminate the interview, the problem in his view having been resolved. The possibility that either or both might find it impossible or undesirable to go along with the plan was simply beyond his comprehension.

This rather grim account had a happier issue than its own logic suggests, for the mother was helped to rouse herself from her torpor and to take the child on as her own responsibility, with a remarkable flowering on his part. The accomplishment was one of main force, stemming from untapped resources within the mother, with the father, all along and to the present, remaining as a barrier to be overcome.

Case 2. Mr. S's role in the family was rather neatly epitomized in his wife's account of his attitude toward the suggested psychiatric consultation for

their son. Larry for some months had been a source of concern to his mother because of his social isolation and his odd and unusual use of language. So deviant were his behavior and appearance that not only did her family advise her of the need for professional guidance but even the neighbors felt constrained to say something. Mr. S himself had never given any indication that he was aware a problem existed. Characteristically, when his wife brought the question up for discussion, he professed mild surprise to learn that she thought anything was wrong, made a feeble effort to reassure her, and then retreated behind his newspaper, abdicating this decision, as he did all others, to her jurisdiction. He came dutifully along to the clinic when she had made the appointment and sat by preoccupied while she did the talking. He answered when questioned but in a singularly unperceptive manner, and volunteered only the bland comment that he was certain there had been much ado about nothing. At the end of the consultation, the parents were told that Larry was autistic and the meaning of the diagnosis was spelled out for them. While the mother reacted with increasing agitation and finally tears of dismay, the father sat by blankly with an uncomprehending look. He became alarmed only when his wife appeared upset and then reacted ineffectually with embarrassment and futile efforts to comfort her.

His own childhood had been an unhappy one. As an only child, he had been under the thumb of a neurotic, domineering mother. So pallid was his image of his own father that we were unable to get any clear picture of what he had been like, except to surmise that the two men had been much the same. He grew up with few male friends and an almost total inability to get along with women. He completed his studies as an accountant with excellent grades but refused to venture on his own, as many of his classmates did. He sought out and soon became comfortable in a job working for a large firm, completing his work satisfactorily and returning home to spend his evenings reading avidly in his mother's house. It was at this juncture that he met his future wife. She, just over a frustrating affair, felt, in her words, that "he needed me." After courtship of several years, the marriage took place, largely at her initiative.

Her husband, according to her description, rarely showed any affection or even awareness of her presence, except in bed, when he would on occasion rouse from his lethargy, make love in an inept fashion, and roll over to sleep, leaving her unfulfilled and resentful. She became increasingly dissatisfied with her marriage, which compared unfavorably with her sister's. Her husband refused to stir from his sinecure despite her insistent urging. He spent his evenings reading indiscriminately: newspapers, mathematical treatises, and trash. Her attempt to create a social life resulted only in annoyance on his part and frustration for the invited guests, who rarely returned.

The children were largely her idea. He appeared pleased that the first child

was a girl, though he spent little time with her till she grew old enough to be taught algebra. He was disappointed that the second child, the patient, was a boy, and almost totally ignored him. At no time was he cruel or abusive to the child, though at times he might shout if his privacy was invaded, but neither would he play with him nor become concerned with his needs. There were no family arguments, perhaps largely because there were no discussions. Family problems were the wife's to dispose of, except insofar as they interfered with his incessant reading. His lack of awareness of Larry's problems reflected his lack of awareness of Larry.

During clinic visits, he was pleasant, obviously gifted intellectually, and willing to discuss what he regarded as objective facts, but singularly obtuse when feelings were sought after. Whereas his wife resisted accepting the diagnosis, he was much more readily persuaded of its accuracy. This he could look at "objectively" without displaying the distress one would expect of a parent confronted with so serious a problem.

His wife was herself a very troubled woman. It is perhaps true, as well, that only such a person as she would have considered marrying Mr. S. But such considerations should not be allowed to obscure the destructive effect on the family of his ineffectualness as father and husband.

Case 3. Mr. T, at the initial interview, introduced himself as "Doctor." Then, with an embarrassed laugh, he explained that he didn't quite have his Ph.D. as he still lacked course credits which he some day hoped to complete. He was a shy and uncomfortable person who said of himself: "I'm interested in my work to the point of detachment from other things." He was the sixth of seven siblings and had always been jealous of his next oldest brother, an aggressive and demanding person who insisted that Mr. T would never amount to anything and still regarded him as a failure. His father had been a religious zealot who was constantly at odds with him during his adolescence because he alone in the family did not share his father's fundamentalist views. His sole recourse during this period was an avid interest in reading which kept him locked in his room, isolated from family and peers. He met his future wife at college while he was an undergraduate and she a graduate student. They were able to marry on the basis of a small income she had from the investment of a dowry given by her father "to make her more attractive to men." The fact that the major part of their support stemmed from his wife was to prove quite threatening to Mr. T, who had an urgent need to assume a fully masculine stance.

The neglect of his studies occasioned by the courtship resulted in his failing his major. He was severely shaken by this event, which appeared to be a fulfillment of his brother's prophecy. He devoted himself to his work with a vengeance over the next few years. Neither parent wanted a child but they became careless about prophylaxis, with twins as the issue 13 months after

marriage. Children, he felt, were a wife's responsibility and he shared no part in their care. The sudden death of one twin, ascribed by their physician to a "thymic crisis," occurred after an evening during which the infant had been crying continuously but had not been visited. This, both had decided, would "spoil" children and was studiously to be avoided. Mr. T, nevertheless, felt the death was his wife's fault. He responded by drinking heavily and spending even less time at home, during a period in which his wife was desperately in need of support.

He was now majoring in bacteriology and his one concern for the surviving twin was to prevent infection. He and his wife kept Billy almost completely isolated from human contact, which was viewed solely as a source of bacteriological contamination. They were at first pleased by Billy's quiet acceptance of this sterile world, only to become concerned when he continued to give no evidence of recognition of their presence, failed to speak, and actively resisted any intrusion upon his self-imposed repetitive activities. They started on a round of medical consultations, searching for a physician who would ascribe Billy's psychotic state to avitaminosis or an endocrine abnormality. The wife subsequently became pregnant two more times. After the second, which she succeeded in having aborted, Mr. T had himself sterilized to obviate future pregnancies.

At no time during the year of Billy's hospitalization was it possible to convey to his father the notion that there might be a relationship between the child's condition and the severe isolation he had experienced. Mr. T's questions about the hospital course were almost always in terms of the adequacy of Billy's nutrition, his toilet training and his vocabulary. During visits, he was stiff and distant toward his son. He stayed the prescribed length of time and separated with no evidence of concern. He seemed as indifferent to Billy as a person as Billy was to him.

The characteristics exemplified in these illustrative vignettes recur with monotonous regularity in 85 of the fathers in this series of 100. They tend to be obsessive, detached and humorless individuals. An unusually large number have college degrees, as do their wives. Though intellectually facile, they are not original thinkers. Perfectionistic to an extreme, they are preoccupied with detailed minutiae to the exclusion of concern for over-all meanings. Thus, though a number are scientists, none is a major contributor to his field. They have a capacity for concentration on their own pursuits amidst veritable chaos about them. One father, in describing this feature in himself, cited as an example the prototypical behavior of his own father who, in the midst of a train wreck, was discovered by a rescue squad working away at a manuscript while seated in a railroad car tilted 20 degrees from the vertical!

It would seem that they have children, not because they want them, but

because children are part of the formal pattern of marriage, an obligation to be assumed. They rear them, if according to any plan, by a caricature of Watsonian behaviorism, a doctrine they find congenial. Such interest as they have in the children is in their capacity as performing automata. Hence, the frequent occurrence among autistic children of prodigious feats of recitation by rote memory. Conformity is demanded; what is sought is the "perfect" child—i.e., one who obeys, who performs, and who makes no demands. The very detachment of the autistic child, so distressing to other observers, has almost always been viewed by the father initially as an asset.

They are no less inadequate as husbands than they are as fathers. Work takes precedence over family life. Marriage seems mostly a convenient arrangement for meals and laundry. Efforts to make day-to-day family decisions a matter for joint concern are resented as unwarranted intrusions upon an evening's reading. At home as well as elsewhere they exhibit a remarkable lack of empathy for and sensitivity to the feelings of others.

For purposes of comparison, a brief survey was made of the fathers of a control group of 50 private patients. These men had achieved levels of educational and professional attainment that were measurably lower. Far more striking, however, was the absence of the coldly mechanical attitude toward child rearing and the formalistic approach to marriage so widespread in the autistic group. This is to be contrasted with the total absence of overt psychosis among fathers of autistic children; indeed, only one was alcoholic and one other had exhibited an acute anxiety neurosis (13). This differs sharply from the experience of Bender with the fathers of schizophrenic children (14).

At the same time, it should be noted that in 15 of the 100 fathers in this series, the usual pattern was not at all in evidence. They were described as warm, giving and devoted. While it is true that in 11 of these instances there was obvious maternal psychopathology, there remain 4 families in which neither parent exhibited such qualities. Equally disturbing for any theory of a simple one-to-one correlation between parental attitudes and children's behavior is the observation that of 131 known siblings of our 100 children only 8 gave evidence of an emotional disorder, 3 of whom were autistic. That is to say, the fathers of autistic progeny were capable of rearing an equal number of normal offspring. Caution is indicated before implicating the characteristics of these parents too exclusively in the genesis of the disorder in their children, although it is difficult to believe that such gross distortions in paternal behavior were without effect on the development of these children.

There are relatively few studies in the literature on the family of the schizophrenic patient that consider the paternal role and only one that focuses specifically on it. Where the problem has been examined, there is

agreement that pathology exists but disparity in the type described. Lidz and Lidz (15) state succinctly that "paternal influences are noxious as frequently as are the maternal." Gerard and Siegel (16) report the "typical" father of a male schizophrenic as weak, immature, passive and retiring. Reichard and Tillman (17) define as "schizophrenogenic" a domineering, sadistic and overtly rejecting father. Ellison and Hamilton (18), who studied 100 male schizophrenics, described 80 of the fathers as poor models, either because they were domineering and sadistic or indifferent and passive.

The excellent study by Lidz, Parker and Cornelison (12) on the fathers of 16 middle-class schizophrenic patients, based on extensive interviews supplemented by psychological tests, concludes that these fathers "exerted seriously pathogenic influences upon the family structure and upon the rearing of the children." In their experience there was no single pattern of behavior common to all. Our own observations underscore the insightful comment by the Yale group that the personality difficulties of the fathers of schizophrenic patients "contribute greatly to the disharmonies and eccentricities of the families in which the patients grow up. Some would have made it difficult for any mother to fill her role adequately. The material also emphasizes the need to recognize that the mother can be seriously influenced in her mothering by her spouse" (12).

SUMMARY

An analysis of the behavior of the fathers of autistic children reveals the evidence of serious personality difficulties that markedly impair the fulfillment of a normal paternal role and that seriously influence the pattern of family living in a detrimental way. It suggests a need to reconsider the pat formulation that ascribes to maternal inadequacies alone the psychopathology in the schizophrenic child. The observation that the same parents who give rise to autistic progeny rear normal offspring implies the existence of other factors, residing perhaps in the child, that are necessary before psychosis appears.

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