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The Dominant Matriarch Syndrome

By A. H. CLARKE

Introduction

This is a clearly recognizable complex of internal family relationships which lies behind, and is an integral part of, the illness presentation pattern of one or more of the individual family members. It may explain many of the emotional problems experienced by children which are noted by either the School Doctors or the Child Guidance Clinics. It is routine procedure in such cases to interview the mother of the affected child, but it is not the practice to see any older generation. Only the family doctor is in a position to see the three generation complex involved.

Description

This complex is made up of three female generations within one family—maternal grandmother, mother and girl-child. There are also two men involved, maternal grandfather and the grandmother's son-in-law.

The grandmother is the dominant figure throughout; she married a steady, quiet, reliable wage-earner, who soon discovered that any self-assertion on his part resulted in either fierce opposition or hysterical symptoms on the part of his spouse. He lost no time off work through illness in his youth, and spent all his spare time working at either "do-it-yourself" improvements to his house or making his garden (at his wife's request) tidier or neater than his neighbour's. The home is now, therefore, spotlessly clean and, usually, slightly "better class" than those which surround it.

Eventually grandmother decided to have a child. She "gave in" to her husband and produced a girl-child. Sex was distasteful to her and she continually reminds the family what a bad time she had during labour. She has often managed to persuade her former family doctor to agree that, "another baby would kill her", and by this means she completely extinguishes the weak sexual drive in her mate.

The daughter grows up markedly overprotected, often obsessionally clean and fastidious, and heavily mother-orientated. She suffers from repeated "dreadful colds", "victimization by teachers", is "discriminated against in examinations", has "frequent headaches" (or migraine), "constipation" and, inevitably, dysmenorrhoea.

In the typical case, she never gets pregnant before marriage and finally settles for a man who is quiet and unargumentative like her father. The prospective son-in-law has always been approved beforehand by grandmother.

The young wife and her husband live for some years with the grandmother and her husband. Whatever excellent (usually financial) justification is given for this arrangement, the real reasons are that the daughter needs her mother to help her dominate her new husband, and that grandmother and mother together form an invincible team which controls the two men absolutely.

After two or three years, the daughter gives birth to a granddaughter and the families continue to live together during the granddaughter's early life. This child suffers the same ailments as her mother, but often to an exaggerated degree. School problems and behaviour problems predominate. She is a regular patient, and is frequently accompanied to the surgery by both mother and grandmother. In any visit by the doctor to the child's home, grandmother does the talking, mother agrees, and the men (if not out at work) never say a word.

At some time before the granddaughter's puberty the young family leave home and move to their own house. It is significant, however, that they only move either round the corner or just across the road, and when either the mother

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or the girl-child becomes ill both these females move back to grandmother or she moves in with them.

Finally grandma begins to weaken physically —she is almost invariably hypertensive and often arteriosclerotic—and now her domination continues through her manipulation of her symptoms and her illness. She remains in charge until the moment of her death, after which the mother suffers a prolonged pathological depression, and the granddaughter again starts coming to see the family G.P.—only this time to say, "Something must be done about grandpa—can you get him into hospital?"

The men in the classical family may occasionally attend the doctor with various non-specific complaints, but usually never lose time off work, their womenfolk literally not allowing them to be ill. If in later life grandpa does become unarguably ill, his wife becomes more ill, and if in spite of her symptoms she survives him, she moves back to live with her daughter once more.

The classical pattern is not uncommon, but two main variations occur, and these are attributable to rebellion on the part of one individual member of the family unit. In such cases there is no insight as to the general situation to be found in the other members.

Classical—School phobia

Child just passed 11-plus examination. Afraid to go to new school—"Such a long, twisting journey on the bus, frightened I couldn't get home". Weeping +++ at school, insomnia, vomiting at the bus stop. Mother nervous and without insight. Both mother and child like new school and teachers. Family now lives across the road from grandma—only left her house three years ago. Both houses immaculate. Grandma obviously dominating until her husband's non-fatal coronary two years ago. Grandma now dominating through vertigo and dyspepsia. Grandfather (now retired), son-in-law and daughter constantly in attendance. Child reads to grandma and prays for her recovery each night (by request). Her presence is constantly demanded by the old lady to fetch and carry. Seven case-families show this pattern almost exactly.

Atypical—Premarital pregnancy—Granddaughter's rebellion

Child is quiet and moderate at school, few friends, heavily dominated by mother and grandma. Father insignificant and permanently depressed. Child becomes pregnant at eighteen years to a married casual acquaintance in time to prevent herself being sent away to college as her mother had planned. Father "collapses"—mother and grandma arrange for adoption and secrecy. Mother arranges for the girl to go to college next year—so this gesture fails. Three families show a similar pattern.

Atypical—Divorce—Father's rebellion

Father refuses to be dominated by his wife and mother-in-law (who lives two streets away), and resents having his daughter made frightened of him by constant discussion of his "horrible sexual habits" by the two women. His attempts to assert himself fail, and his wife and daughter go home to live with grandma. He takes to drink and takes another woman into his house. Grandma's darkest suspicions confirmed. Daughter seeks a divorce. Child brought to surgery because of insomnia and nightmares, temper tantrums, bed wetting and stammering. Three families exactly similar.

Discussion

In all the foregoing groups the constant reappearance of the child at the doctor's surgery with a steady progression of the symptoms listed is characteristic. In the later years, when grandma begins to fail physically, the younger women are always asking the doctor to visit her and wanting "something to be done". Again, although the middle generation woman will often accept that her own multitudinous symptoms are due to "nerves", she is invariably incapable of accepting this explanation as applying to either her mother or daughter.

The total of 13 case-families may seem a small proportion of an N.H.S. list of approximately 900 families, but the frequency of presentation of members of these families is from four to five times as high as that of normal families, thus the amount of time required for their care is disproportionately large. The social group repre-

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sented in this practice is almost entirely upper working class, and most of the people live in well-established 30 years old corporation housing estates. The normal family structure is clearly patriarchal in character, and there is relatively free movement by the second generation when they marry. This pattern is quite different from the strongly matriarchal family organization seen both in the Bethnal Green area of London (1) and in central Liverpool (2). It is this background which, by contrast, has mainly drawn attention to the matriarchal families discussed.

A knowledge of the facts concerning such a family group can only come into the possession of the G.P. as a result of his own direct observation. It is insufficient for a family history to be taken from one member because of the characteristic lack of insight exhibited in particular by the middle generation female—the mother of the most commonly presented member.

The management of this type of family presents a great challenge to the general practitioner and requires the exercise of all his psychological and "personnel-management" skills. He is either forced to enter into the homes and lives of these people and to attempt to use his unique position in order to control the situation by displacing the matriarch and substituting instead a father figure, or else he may accept the situation and treat each episode as it arises in each family member. The latter course is easier at the time, but simply perpetuates the unsatisfactory position.

For the above reasons it is unlikely that psychiatric referral will be of much help; too much of the cause is situational and yet unrecognized and therefore is not reported to the consultant by the patient or parent. It is suggested that a short telephone conversation (rather than a written letter) between consultant and G.P. might shed a great deal of light if such a family unit is suspected. It is further suggested that the relative commonness of this syndrome or its variants, even in a basically patriarchal community, makes a strong case for all referrals of disturbed children to go necessarily through the family doctor and not directly from the school clinics.

Summary

A three female generation complex dominated by grandmother is described in which psychosomatic and emotional illness in the younger members are prominent presenting features. The unique position of the family doctor is stated and the suggestion is made that his help is essential, no matter how cases arise.

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